Benefits, Barriers, and Challenges: Caring for Women in a Community Clinic Setting

The Women's Health Center Evaluation Project White Paper

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Study Sponsor

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EXECUTIVE SUMMARY

One need look no further than the local paper to read about the healthcare crisis in America: Soaring costs, decrements in quality, fewer employers offering insurance benefits, fewer insurers offering affordable coverage -- issues affecting all of us but ones that place particular burdens on our already-vulnerable neighbors. Neighbors who are poor, uneducated, minorities . . . and female. Recent studies paint a disturbing picture of barriers to access, gender- and ethnicity-specific disparities in quality, and financial disadvantages that threaten the physical and emotional well-being of women of all ages.

Women-Focused Care: The Same But Different

Women are not simply variations on men. Both groups need, and have the right to, targeted approaches and choices that enable them to realize and maintain the highest possible levels of health and well-being. While anatomical, biological, and physiological differences between men and women are the most obvious indicators that healthcare policy and practice need to be responsively differentiated, contributory factors such as economic status, availability of social supports, and cultural expectations and norms have tremendous influence on the quality and accessibility of healthcare resources for women.

- Poverty, in particular, is associated with women's decreased use of health services and poor outcomes. Low-income women tend to delay seeking care and go without drugs or other therapies because of concerns about costs (Salganicoff et al., 2005).
- Social disadvantages, cultural values, discrimination, lack of culturally appropriate services, and inadequate childcare and transportation are just a few of the indirect barriers women must overcome to access medical care (Brittle & Bird, 2007).

Why Does Women-Focused Care Matter?

A recent review by the Office on Women's Health (Brittle & Bird, 2007) revealed that women who attend women-specific clinics not only experience a higher quality of care but greater satisfaction with that care.

- Compared with their peers who obtain care from other practitioners, these women consistently receive all six standard screening tests (e.g. PAP tests and clinical breast exams), and are more likely to report having received counseling for smoking cessation, exercise, alcohol or drug use, domestic violence, and STIs (Brittle & Bird).

As California's economy continues to deteriorate, it is likely there will be further compromises in availability and access to care for underserved women. Our expectation is that, as in the past, women will be most adversely affected by the deepening crisis: While conscientious about obtaining care for their families, many women fail to seek the attention and treatment needed to achieve and maintain their own health.

The Women's Health Center: A Case Study in Making a Difference

In 2004, California Hospital Medical Center (CHMC) embarked on a multi-year plan to divest its portfolio of community clinics -- including the Keith P. Russell Women's Health Clinic, started over 20 years previously as an outpatient department. Eisner Pediatric & Family Medical Center's (EPFMC) proposal to acquire the Clinic was accepted and by 2007, the renamed Women's Health Center (WHC) was "in residence" at EPFMC's Olive Street campus.

Choosing Care: WHC Services

In 2009/10, the WHC provided 21,326 clinical, educational, and ancillary visits. Approximately 30 percent of appointments are made for gynecological exams and well-woman care, and 70 percent for pre-conception, pregnancy, and hospital-based labor and delivery services.

Seeking Care: WHC Patients

EPFMC's highly urbanized service area encompasses several communities in downtown and South Los Angeles, with most WHC patients coming from Los Angeles County Department of Public Health Service Planning Areas 4 (SPA 4, 32 percent) and 6 (SPA 6, 68 percent). Demographically, WHC patients reflect the target population for the entire agency: Low- and very low-income (98 percent live at or below 1.5 FPL), cultural and ethnic minorities (Latino, 86.3 percent; African American, 11.6 percent), uninsured (44 percent), and young (42 percent are less than 24 years old).

Giving Care: WHC Providers

In 2009/10, the WHC roster included 15 CNMs (full- and part-time and contracted), 10 board certified OB/GYNs (full- and part-time and contracted), and 17 enabling professionals (MAs, RNs, educators, and counselors).

The WHC Evaluation Project

Purposes and Objectives

As part of a larger capital grant made in 2008, The California Endowment provided support for a large-scale assessment and outcomes evaluation of the WHC. Conceived and designed as a mixed-methods assessment of dimensions of clinical and operational quality, the project was guided by three improvement-driven purposes:

1. Formative: To identify strengths and weaknesses; to support quality improvement plans and accountability systems; to identify current and emerging opportunities
2. Summative: To document achievements and challenges relative to baseline data; to demonstrate value relative to local, state, and national standards
3. Knowledge Generation: To identify promising practices; to describe model(s) of quality care and delivery systems; to contribute to policymaking and reform

What the Evidence Shows

Quality in any large-scale endeavor is related to a significant number of inputs: People, settings, equipment, training, feedback mechanisms, pay scales, motivation, and rates of compliance, to name just a few. A review of the literature uncovered four broad dimensions of effectiveness relevant to the WHC's institutional and strategic goals: Processes of care, health outcomes, patient satisfaction, and provider satisfaction.

Processes of Care

- ✓ Annual/biannual PAP tests: The WHC performed better than its peers at both the state and national levels at providing recommended gynecological exams.
- ✓ Initiation of prenatal care: 87 percent of WHC perinatal patients started care in their first trimester – compared with 77 percent statewide and 68 percent nationally.
- ✓ APNCU Index: Rates of Adequate/Adequate Plus prenatal care (Kotelchuck, 1994): The WHC met the rate reported for Los Angeles County while bettering that for Los Angeles city and the state as a whole.

Health Outcomes

- ✓ Preterm Delivery: In 2010, less than 7.1 percent of WHC patients delivered prematurely, in comparison to 10.9 percent statewide, 11.9 and 11.7 in the city and county of Los Angeles respectively, and 12.7 nationally.
- ✓ Low Birthweight Births: The WHC's LBW rate of 5.4 percent compares favorably to that achieved by three key comparison groups: EPFMC Service Area (7.8 percent), 118 California FQHCs (5.6 percent), and 1131 U.S. FQHCs (7.2 percent).
- ✓ NICU Admissions: The WHC NICU admissions rate of 4.9 percent (women initiating care at the WHC, including multiple births) bests the 6.1 percent reported by the 19 states that reported in 2006 using the new birth certificate.

Patient Satisfaction

- ✓ With Prenatal/Childbirth Education Classes: Average patient score for items coded "General Satisfaction": 1.96 on a scale with a theoretical mean of 1.
- ✓ With Prenatal Care Experience: Average patient score for items coded "General Satisfaction": 2.42 on a scale with a theoretical mean of 1.5.
- ✓ With Hospital Experience: Average patient score for items coded "General Satisfaction": 2.32 on a scale with a theoretical mean of 1.5.

Provider Satisfaction

- ✓ Overall, satisfaction among providers of perinatal care through and at the WHC outweighed dissatisfaction in 72 percent of items on a questionnaire developed for the study. Explanatory factors include a **positive workplace culture** that encourages **collaboration** between providers, staff, and patients, and fosters a strong sense of **personal pride** and **shared commitment**.

Implications: Practice and Policy

Promising Practices

What practices were brought to light by the WHC evaluation project that might be feasible strategies for policymaking and program building in similar environments?

- ✓ The WHC is committed to **culturally responsive care and relationships**, including having **linguistically competent** support staff and medical assistants available.
- ✓ The WHC's marketing and patient recruitment efforts draw on **community knowledge and community-based outreach**.
- ✓ The WHC is **proactive and persistent about patient follow-ups** to ensure they keep appointments, understand treatments, and stay connected.
- ✓ The WHC emphasizes both **"high touch" relationships** between patients and providers and **visible and congenial collaborations** between clinicians and staff.

Recommendations

By employing a **data-driven systems model** as an evaluative lens, providers and clinical practices will be able to better identify and understand effectiveness. Building knowledge of what works, why, and how to improve operations at every level requires:

- ✓ Fostering organizational "cultures of evidence"
- ✓ Implementing single- or multi-agency (colocated) programs of practitioner research
- ✓ Designing, integrating, and using high quality data management systems
- ✓ Committing to systematic QI strategies that include benchmarking and goal setting

"With the Least Harm"

Despite the heightened risks and barriers faced by most of its patients -- among them social and educational disadvantages, poverty, discrimination, and inadequate childcare and transportation -- the evidence presented here shows the WHC performing very well on multiple indicators of clinical and operational quality.

A rational model of medical care should be evidence based and constructed on the principle of "effective care with the least harm" (Sakala, 2008, p. 68). The logic of evidence-based care offers the most feasible and affordable alternative to the expensive, confusing maze that too many patients confront when attempting to access healthcare in America. If the goals of administrators, providers, and policymakers are to maximize the good and minimize the bad, models such as the Women's Health Center suggest ways to optimize the allocation of scarce public and private resources to benefit even the most vulnerable populations.

Historically, medical research has failed to adequately assess important differences between men and women, or at times to even distinguish between men and women.

Brittle & Bird, 2007, p. 12

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In thinking about gender-based medical care, one issue that immediately arises is the problem of how to define and measure quality care for men and women. If men and women have different health concerns and needs, then what constitutes quality care for women and men likely differs in important ways. Thus, it becomes a challenge to determine when quality objectives have been achieved, because equivalent care may not be sufficient to meet quality objectives.

Brittle & Bird, 2007, p. 20

WOMEN-FOCUSED CARE: THE SAME BUT DIFFERENT

> Males and females have different patterns of illness and different life spans . . . Dissimilar exposures, susceptibilities, and responses . . . result in variable responses to pharmacologic agents and the initiation and manifestation of diseases . . . Understanding the bases of these sex-based differences are important to developing new approaches to prevention, diagnosis, and treatment. (Institute of Medicine, 2001, p. 4)

Women are not simply variations on men. Both groups need, and have the right to, targeted approaches and choices that enable them to realize and maintain the highest possible levels of health and well-being. For example, both men and women develop heart disease, but *experience* different symptoms, *respond* differently to treatments, and *achieve* different levels and qualities of outcomes. The task of designing women-focused medical options that address gender-specific characteristics and social dimensions of both men's and women's lives has, in the last 30 years, gone from being considered a specialty to being recognized as a professional field.

While anatomical, biological, and physiological differences between men and women are the most obvious indicators that healthcare policy and practice need to be responsively differentiated, contributory factors such as economic status, availability of social supports, and cultural expectations and norms have tremendous influence on the quality and accessibility of healthcare resources for women.

Why Does Women-Focused Care Matter?

> The United States provides the world's most expensive maternity care but has worse pregnancy outcomes than almost every other industrialized country. (Rooks, 1997, p. 385)

Placing a well-defined focus on women's health concerns and issues improves outcomes for both the women and those they care for: Women make the vast majority of medical choices not only for themselves but also for their families. Furthermore, research indicates substantial benefits accrue from primary and specialty care provided by integrated medical homes, especially those such as EPFMC that are located in neighborhood settings. Cultural and linguistic competency, consistency and accessibility, a focus on prevention and self-care management -- all promote effective communication and lead to better outcomes, quality of life measures, and health status levels than those achieved by irregular episodic or emergency care.

Barriers to Care: Women Fall Further, Faster

American women -- most particularly poor, minority women -- seeking medical services appear to be at greater risk of receiving inadequate care than are American men due to lasting effects of a variety of sex-based factors that correlate with inferior outcomes. Recent studies (see, for example, Brittle & Bird, 2007 and Los Angeles County Office of Women's Health, 2007) paint a disturbing picture of discrimination, gender- and ethnicity-specific disparities in quality, and financial disadvantages that threaten the well-being of women.

> *A sizable minority of women face considerable challenges in accessing even basic health care services. Latinas, in particular, consistently are more likely to report that they encounter numerous barriers, such as limited access to child care and transportation services, poorer continuity of care, and inability to receive specialty care.*
> (Wyn et al., 2004, p. 6)

- Women's **incomes** are often lower than men's are, yet their out-of-pocket and overall medical costs are comparatively higher. Women require more care: They visit the doctor more (Bertakis et al., 2000), and take more medications (Correa-de-Araujo, 2005). "Women [are more] sensitive to differences in co-pay amounts, thus contributing to poorer quality of care and reduced outcomes" (Brittle & Bird, 2007, p. 77).
- The **quality of care** women receive is typically worse than men receive, especially for acute conditions. Although somewhat mitigated by women's more frequent use of preventive care, "the fact that women's higher rates of healthcare utilization do not carry over into better treatment in general is particularly striking" (Brittle & Bird, 2007, p. 45).

> *Health care costs are increasingly acting as a barrier to health care for many women. One-quarter of women delay or don't get needed medical care because they cannot afford it . . . Many women also cannot afford prescription drugs. They do not fill prescriptions or resort to skipping doses and splitting medicines. These problems do not just affect uninsured women.*
> (Salganicoff et al., 2005, p. v)

- "**Ethnic minorities** tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled" (Smedley, Stith, & Nelson, 2003, p. 1).

As the economy continues to deteriorate, there will be further compromises in availability and access to medical care for underserved children, youth, and families. Our expectation is that, as in the past, women will be most adversely affected by the deepening crisis: While conscientious about obtaining care for their families, many women fail to seek the attention and treatment needed to achieve and maintain their own health.

THE WOMEN'S HEALTH CENTER: A CASE STUDY IN MAKING A DIFFERENCE

In 2004, California Hospital Medical Center (CHMC) embarked on a multi-year plan to divest the organization of its portfolio of community clinics -- including the Keith P. Russell Women's Health Clinic, started over twenty years previously as an outpatient department of the hospital. By 2006, the newly named Women's Health Center (WHC) became the last entity to be released through a competitive RFP process, with Eisner Pediatric & Family Medical Center's (EPFMC) proposal accepted as the winning bid.

Although EPFMC has provided quality women-focused healthcare since its founding in 1920, the acquisition and development of the WHC was seen as representing a forward-looking opportunity not only to maintain valuable and much-needed medical services within the communities the agency serves, but also to consolidate and develop already-existing perinatal and well-woman programs.

Choosing Care: WHC Services

Approximately 30 percent of WHC appointments are made for gynecological exams and well-woman care, and 70 percent for pre-conception, pregnancy, and labor and delivery services. In 2009/10, the WHC provided 21,326 clinical, educational, and ancillary visits.

- Provider visits (65.5 percent of the total) include appointments for obstetrics and gynecological exams, initial checkups, pregnancy tests, and family planning visits.
- Ancillary services (17.8 percent of the total) include childbirth and prenatal classes, dental exams for prenatal clients, reassessment visits, nutritional consults, new patient intake and registration appointments, and mental health counseling.

- Hospital visits (16.7 percent of the total) include gynecological procedures, labor and delivery care, triage for acute and episodic conditions, and fetal non-stress tests.

Many women in their reproductive years flow from one group to another, starting as primary care patients in adolescence, returning later as soon-to-be mothers, and then continuing to access well-woman services after they have stopped having children.

Gynecology and Well-Woman Care

Most of the medical care a woman will receive during her lifetime is designed to help her maintain day-to-day health and well-being. Along with basic gynecological services -- PAP tests, pelvic and breast exams, reproductive counseling, and peri- and postmenopausal care -- annual well-woman exams may include tests for STIs, flu shots or other immunizations, screenings for heart disease, diabetes, high blood pressure, high cholesterol, and thyroid disease, and help with weight control and diet.

Lower rates of prematurity and low birthweight babies are seen when well-woman and prenatal services are made available to expectant mothers -- while the provision of family planning and reproductive health services delivers improved outcomes by reducing the numbers of teen pregnancies and STDs in sexually active adults of all ages.

Pregnancy Care

From pre-conception counseling to postpartum support, the WHC's foremost priority is caring for mothers-to-be throughout their pregnancies.

- Preconception Exams
- Clinical Care and Prenatal Education: Certified Nurse-Midwifery Program; High-Risk Special Care Clinic; Medi-Cal Comprehensive Perinatal Services Program; March of Dimes Comenzando Bien; and CenteringPregnancy®.
- Labor and Delivery: EPFMC OB Panel at California Hospital Medical Center
- Postpartum Care

Seeking Care: WHC Patient Community

EPFMC's highly urbanized service area encompasses several neighborhoods in downtown and South Los Angeles, with most patients coming from Los Angeles County Department of Public Health Service Planning Areas 4 (SPA 4, 32 percent) and 6 (SPA 6, 68 percent).

Located in both State Assembly and Senate districts identified as having the highest levels of non-elderly uninsured (Assembly 46th – 34% uninsured; Senate 22nd – 33% uninsured [UCLA Center for Health Policy Research, 2009]), nearly 60 percent of the neighborhoods EPFMC serves have been designated as Medically Underserved Areas (MUA), with many closest to its Olive Street facility 100 percent MUA-designated; a significant number are also Health Professional Shortage Areas (HPSA).

Demographically, the women coming to the WHC for their primary and pregnancy care reflect the target population for the entire agency: Low- and very low-income, cultural and racial/ethnic minorities, un- and under-insured, and young. However, EPFMC's patients are significantly poorer than those visiting FQHCs at both the state and national level.

Over 750,000 people reside in the 13 zip codes called "home" by two-thirds of the Center's client community, areas distinguished by high population density, overcrowded schools, high rates of crime and gang-related disturbances, high concentrations of un- and underemployment, and low levels of literacy and formal schooling.

- Ninety-eight percent of EPFMC's patients live at or below 150 percent of the FPL, compared with other FQHCs in California at 91 percent and nationally at 86 percent.

Race has also been identified as a risk factor for poor health outcomes, with preterm and low birthweights (LBW) persistently high for Hispanic/Latino and African American women.

- These two groups comprise 98 percent of the WHC's perinatal patients -- compared with 93 percent of those in the Center's service area, 58 percent in California, 71 percent in Los Angeles County, and 39 percent in the U.S.

Giving Care: WHC Staff and Providers

In 2009/10, the WHC roster included 15 Certified Nurse-Midwives (CNMs, full- and part-time and contracted), 10 board certified Obstetrician-Gynecologists (OB/GYNs, full- and part-time and contracted), and 17 enabling professionals (MAs, RNs, educators, and counselors). The WHC's "philosophy of care" organized around three principles.

1. Women have a right to be heard regarding their healthcare needs.
2. Having a baby is a natural, healthy event.
3. Women desire to give birth in a caring environment.

- ✓ *CNMs are advanced practice nurses trained and licensed to provide a range of primary care services for women of all ages, focusing particularly on pregnancy, childbirth, the intrapartum and postpartum periods, infant care, and family planning and reproductive health. Under the supervision of and in consultation OB/GYNs, CNMs manage low-to-moderate risk clients and attend cases of normal childbirth.*
- ✓ *Of the 63.29 FTE Certified Nurse-Midwives working in California's 118 Federally Qualified Health Centers in 2009, almost 17 percent were on staff at the WHC.*

THE WHC EVALUATION PROJECT: WHAT THE EVIDENCE SHOWS

Quality in any large-scale endeavor is related to a significant number of inputs: People, settings, equipment, training, feedback mechanisms, pay scales, motivation, and rates of compliance, to name just a few. A review of the literature uncovered four broad dimensions of effectiveness relevant to the WHC's institutional and strategic goals:

1. Processes of care
2. Health outcomes
3. Patient satisfaction
4. Provider satisfaction

Why Not Simply Measure Outcomes?

Problems arise when health outcomes are used as a proxy for effectiveness due to the unpredictable influence of intervening and/or interfering patient characteristics Behaviors, lifestyles, home and work environments, education and income -- measurable or not, all will be factors in whether a program, treatment, or care plan leads to improved health outcomes.

(Murata, McGlynn, Siu, & Brook, 1992)

The Processes of Care Dimension

Focusing on processes of care as a cornerstone dimension of quality is necessary considering that "adverse outcomes in pregnancy are relatively rare events, [making] the ability to detect clinically meaningful differences" (Murata et al., 1994, p. 41) in and between groups very difficult. Additionally, health status and treatment outcomes always "result from a complex interaction of medical care and genetic, environmental, and behavioral factors" (p. 42). Because such factors can be only imperfectly controlled, the

most useful approach -- especially to practitioners -- is to measure the **qualities of quality**: Aspects of the timing, appropriateness, and adequacy of received services.

Receiving Timely and Appropriate Care

Key Question 1: Did female patients at EPFMC and WHC receive timely and appropriate care as recommended by professional standards and guidelines?

- Two fundamental indicators of timely and appropriate provision of medical services for women are frequency of PAP tests and trimester of entry into prenatal care.
    - PAP tests: Out of 70 random chart pulls, 47 women aged 24-64 "had at least one PAP test performed during the measurement year or during one of the two previous years" (2009 UDS Report, Table 6B.D). The Center performed better than its peers at both the state and national levels (Figure 1).

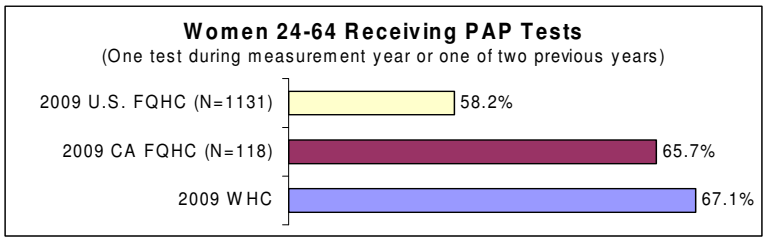


Figure 1. Percentage of Women 24-64 Receiving PAP Tests

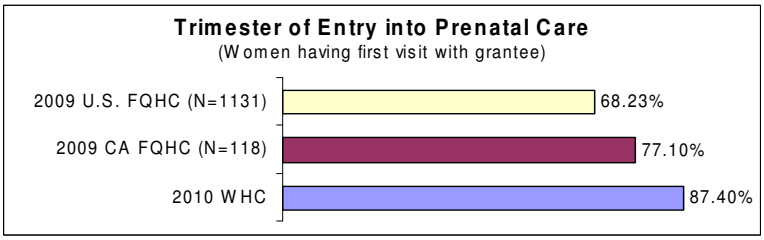


Figure 2. Prenatal Care Initiation for Women Having First Visit at the WHC

- First trimester initiation of PNC: Analysis of WHC data from the first six months of 2010 shows over 87 percent of patients starting care in the first trimester -- compared with 77 percent statewide and 68 percent nationally (Figure 2).

Receiving Adequate Care

Key Question 2: Was the care provided adequate -- based again on professional standards and guidelines -- to support quality health outcomes?

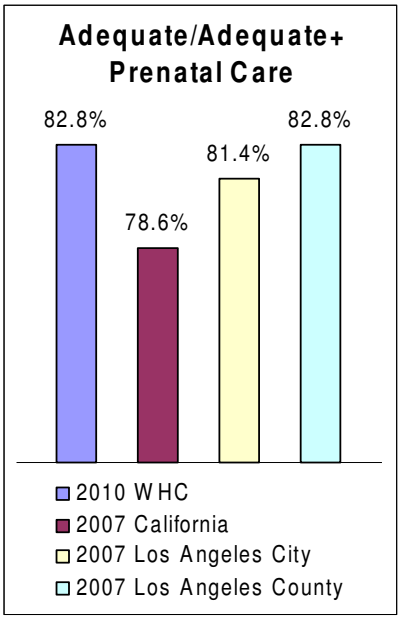


Figure 3. Comparison of APNCU: Rates of Adequate & Adequate+

The APNCU (Kotelchuck, 1994) combines month of initiation of care with number of prenatal visits in a matrix that readily reveals the proportion of patients receiving adequate (or better) amounts of prenatal care as defined by ACOG.

- Figure 3 compares the APNCU Adequate/Adequate Plus rates generated from 2010 WHC data with the rates reported for California and the city and county of Los Angeles (Source: March of Dimes Peristats, http://www.marchofdimes.com/PeriStats).
  - Adequate/Adequate Plus: Using unweighted data, the WHC meets the rate reported for Los Angeles county while bettering that for Los Angeles city and the state as a whole. Considering that the three comparison groups include all live births regardless of SES, minority status, or other recognized risk factors, it appears that the WHC was successful both in providing adequate levels of care and motivating patients to comply with visit recommendations and adhere to care regimens.

The Health Outcomes Dimension

While the WHC does provide comprehensive well-woman services (preventive and episodic care, chronic disease management, family planning, and health education), a longitudinal assessment of the outcomes of primary care was beyond the scope of the evaluation study. More suitable -- and more fitting to a focus on usability and feasibility -- was a closer investigation of a practice specialty within the field of women's health: Pregnancy care and education. "An important indicator of the health of a population is its infant morbidity and mortality rates" (Murata, McGlynn, Siu, & Brook, 1992, p. 1).

"Variations in the outcomes of pregnancy provide the most compelling evidence of differences in the quality of prenatal care" (p. v). Of the handful of key outcomes known to be affected by timely and appropriate pregnancy care and education (perinatal mortality, low birthweight, preterm delivery, admission to the neonatal intensive care unit, neonatal complications, and maternal complications), sufficient data were available on WHC patients to compare:

- ✓ Rates of preterm delivery (gestational age less than 37 weeks)
- ✓ Rates of low birthweight births (less than 2500 grams)
- ✓ Rates of admission to a neonatal intensive care unit (NICU)

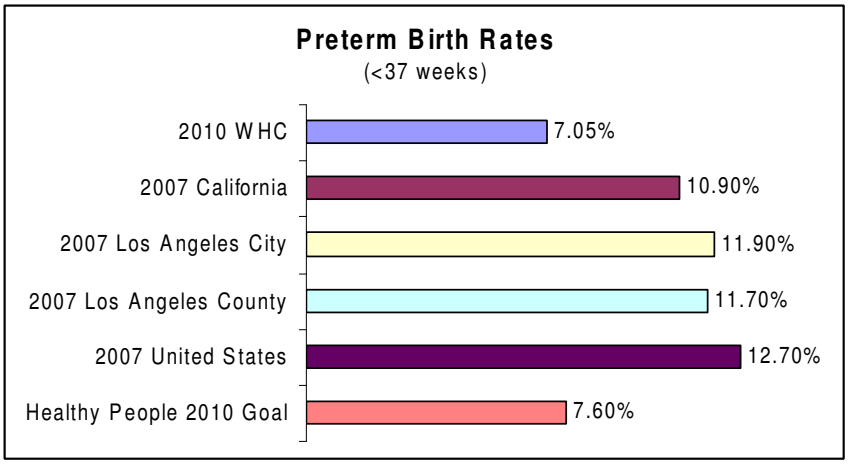


Figure 4. Preterm Birth Rates Compared

Preterm Delivery:

Although we would expect the inclusion of higher risk pregnancies in the WHC's patient population to result in higher rates of preterm births than those seen in comparison groups, this (Figure 4) was not the case in our sample (N=241). As shown, the WHC also exceeded the Healthy People 2010 goal of 7.60%.

Low Birthweight Births:

Furthermore, despite the increased risk of poor outcomes due to poverty and minority status, LBW rates for patients who initiated their prenatal care at the WHC (N=241; Figure 5) also compare very favorably to those achieved by three key comparison groups: "EPFMC Service Area" (zip codes where at least 66 percent of the agency's patients live) and 118 California and 1131 national FQHCs reporting in 2009.

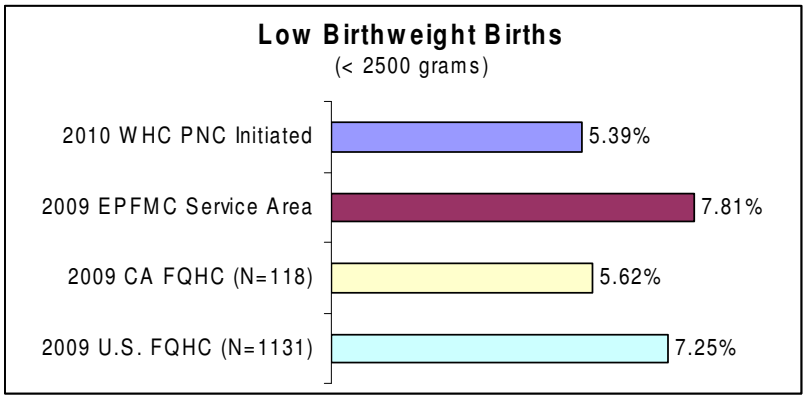
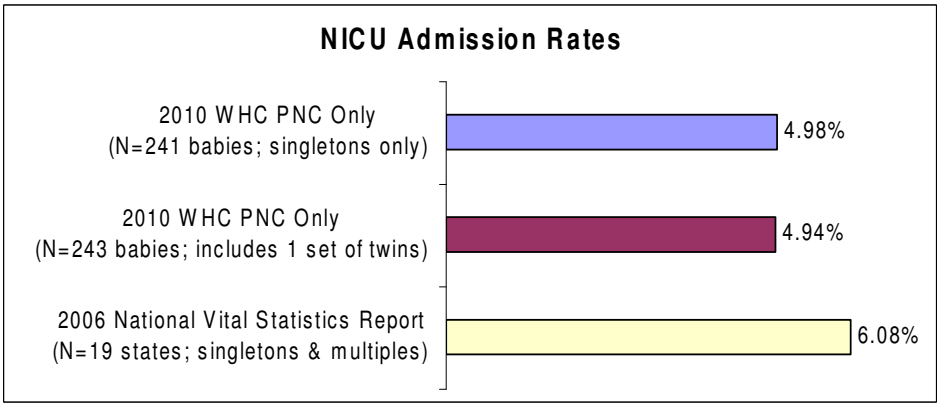


Figure 5. LBW Rates Compared

NICU Admissions: In 2003, new checkbox items were added to the U.S. Standard Certificate of Live Birth – by 2006, 19 states had implemented the new certificate. One new category is "Abnormal Conditions of the Newborn," and includes a checkbox for "NICU Admission" (see Osterman, Martin, & Menacker, 2009, for a full discussion).



Looking at data on women who received all their prenatal and maternity care from the WHC, whether for singleton or multiple births (considered a risk factor for LBW and prematurity), the Center is shown as bettering the performance of states that reported using

the new birth certificate (Figure 6).

Figure 6. NICU Admission Rates Compared

The Patient Satisfaction Dimension

What does it mean when patients are satisfied with their providers and the care they receive? Positive experiences with providers, settings, and support staff has been shown to correlate strongly with behaviors that support clinical effectiveness and improved outcomes: Compliance with self-care regimens (Hudak & Wright, 2000), keeping appointments and managing medications (Carr-Hill, 1992), referring friends and family (Ware & Hayes, 1988), and consistent use of medical services and health information (Ferris, 1992). Simply put, "satisfied and dissatisfied patients behave differently" (p. 1728).

Three features of patient satisfaction with the WHC were measured using a 39-item phone survey: Prenatal/Childbirth Education Classes, Prenatal Care Experience, and Hospital Experience. Each subsection included one or more "General Satisfaction" items -- reported here (Figure 7) with range, scale midpoint, and item mean for each feature.

	Range	Scale Midpoint	GS Item Mean
PC General Satisfaction Items	0-2	1	**1.96**
PCE General Satisfaction Items	0-3	1.5	**2.42**
HE General Satisfaction Items	0-3	1.5	**2.32**

Figure 7. Patient Satisfaction Survey Composite Results

In each of the three subsections, WHC patients indicated high levels of satisfaction with their physicians and midwives, the Center staff, the clinical environment, and the hospital. Internally (additional data and analysis available in the full report), the marks for interpersonal aspects, perception of provider skills and knowledge, and communications point toward the WHC's core strengths: **Skilled care provided in a respectful, attentive, and community-oriented setting.**

The Provider Satisfaction Dimension

Empowering workplace environments and motivating relationships have been linked to several high-value management goals, including improved performance and outcomes, higher rates of retention, reduced turnover, and decreased institutional risk (Collins, 1990; Conway, 2007; Konrad, et al., 1999; Laschinger & Finegan, 2005; Lichtenstein, 1984; Loke, 2001). Although typically well paid and respected, providers must contend with a unique variety of stressors and claims on their time that may be perceived as unfair and unsupportable in both managed care systems and clinic-based employment situations (Linzer, et al., 2000).

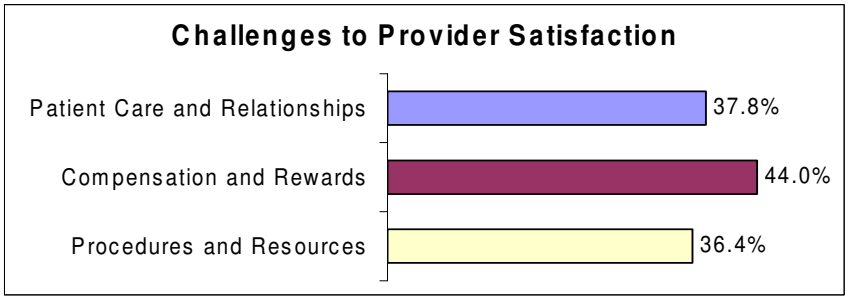
Twenty-nine OB/GYNs, CNMs, and enabling professionals completed an on-line scaled questionnaire developed for the study. Responding to 39 items grouped into nine Core Themes, WHC providers reported substantial levels of satisfaction in areas critical to ensuring and supporting quality care, employee retention, and motivation.

- They are strongly **committed** to their patients, with deep **connections** to their practice areas and their EPFMC peers and colleagues.
- They appreciate the generally **good communications** and **sense of autonomy**, of "having say" over their patients' care plans and day-to-day workflow.
- They expressed **confidence in the organization** and the supervisorial structure in ways that appear to be stimulating and rewarding both personally and professionally.

Challenges appeared in three Core Themes. Figure 8 illustrates the areas where the proportion of providers indicating "more dissatisfaction" exceeded 30 percent.

- Patient Care and Relationships: Over half reported feeling overwhelmed by the needs of their patients –- although perceived lack of time with patients produced the most serious dissatisfaction, with "more time" equated with higher quality of care.
- Compensation and Rewards: Half of the respondents felt there was a discrepancy between their job performance and their salary level(s); 40 percent would like more recognition for quality work; and a significant number noted a lack of sufficient appreciation for the work of nurses and midwives.
- Procedures and Resources: Fifty percent of respondents thought the WHC needs more support staff; while 71 percent said they "do a better job if I didn't have so much to do all the time."

Figure 8. Challenges to Provider Satisfaction: Thematic Analysis



Overall, satisfaction among providers of perinatal care through and at the WHC outweighed dissatisfaction in 72 percent of items on the PSQ (two-thirds or more of respondents indicated "more satisfied than dissatisfied" on 28 out of 39 items). Explanatory factors include a **positive workplace culture** –- collegial relationships, modest stress, and rewarding responsibilities –- that encourages **collaboration** between providers, staff and patients, and fosters a strong sense of **personal pride**.

IMPLICATIONS: PRACTICE AND POLICY

Despite the heightened risks and barriers faced by most of its patients among them social and educational disadvantages, poverty, discrimination, and inadequate childcare and transportation -- evidence presented here shows the WHC performing very well on multiple indicators clinical and operational quality. Through measurably consistent provision of high-value, high impact care, the Center is not meeting rigorous performance goals but exceeding those achieved by its peers serving less at-risk communities. However, WHC is -- and is integrated into -- a unique practice setting, designed to serve a specific population within a distinct social and cultural context.

> *After a decade of erosion in employer-sponsored coverage, rapidly rising health care costs, and persistent growth in the number of the uninsured, health reform has reemerged as a national policy issue. Women have much at stake in this national debate in their roles as health care consumers, mothers, caregivers, and as an integral part of the health care workforce.*
> (Salganicoff, 2007, p. 275)

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Promising Practices

Given that it is not possible for every FQHC to acquire an already-functioning women-focused clinic, or for all existing women's centers to merge with full-service community agencies, what promising practices brought to light by the WHC case study might be feasible strategies for policymaking and program building in similar environments?

- The WHC is committed to **culturally responsive care and relationships**, including having **linguistically competent** support staff and medical assistants available at all times. "In the highly technologically complex world of health care delivery, cultural considerations in the provision of care often are overlooked. But the achievement of the measurable as well as what is termed 'soft' outcomes can make a critical difference in promoting the health and well-being of women and newborns" (Callister, 2001, p. 213).
- The WHC's marketing and patient recruitment efforts -- a challenge within medically underserved populations -- draw on **community knowledge and community-based outreach**, "reaching people where they are" (Brittle & Bird, 2007, p. 48).
- The WHC is **proactive and persistent about patient follow-ups** to ensure they keep appointments, understand diagnoses and treatments, and stay connected with the healthcare system. "It is critical that healthcare facilities establish ongoing monitoring procedures to assess the timely occurrence of follow-up, particularly for those women with a medical condition that requires a distant follow-up procedure, and implement tracking systems to identify women who have not returned" (Kaplan et al., 2004).
- The WHC emphasizes **"high touch" relationships** between patients and providers that build trust and confidence, while **visible and congenial collaboration** between physicians, CNMs, and non-provider professionals increase satisfaction and the benefits that come from it. "Patient satisfaction results when individuals feel that providers care about them, are nonjudgmental in their approach, encourage the patient's participation in health care decisions, and demonstrate concern for the quality of daily living of the patient and family" (Hankins, 1996, p. 1014).

Recommendations

Patients and providers work together to ensure processes of care lead to healthy outcomes. Each case is different, true, but well-being is a result of innumerable choices, events, circumstances, and relationships. By employing a **data-driven systems model** as an evaluative lens, we believe other providers and clinical practices can better identify and

understand effectiveness (did the treatment work?), causes and processes (why did it work?), and promising practices and policies (can it work in other settings?).

1. All organizations would benefit through the fostering of "cultures of evidence" that serve to identify and remove barriers to access and mitigate risk factors by prioritizing data-driven planning and decision-making.
2. Single-agency or multi-agency colocated programs of ongoing research and evaluation would generate important data and analyses for funders, policymakers, and advocates; for program and institutional quality improvement/assurance efforts; and for ongoing advancement of the field of gender-specific medicine.
3. Better data management systems, especially those that integrate health information technology, would support the development of knowledge critical to ensuring differences in and between groups are real and significant. Credible data is the keystone of not only improvement, but also of visibility and advocacy: Without it, failure will be rewarded as often as success and achievements will not be replicated.
4. "Fit for the purpose and right the first time": Systematic quality improvement (QI) strategies that include benchmarking and goal setting would maximize outcomes while reducing waste, achieving efficiency savings, and improving productivity.
    - "Quality improvement . . . emphasizes system and processes indicators, rather than individuals, and examines objective data to improve these processes, even when high standards of performance appear to have been met. Benchmarking is a part of the quality improvement process" (emphasis added, Collins-Fulea, Mohr, & Tillett, 2005, p. 462).

"With the Least Harm"

A rational model of medical care should be evidence based and constructed on the principle of "effective care with the least harm" (Sakala, 2008, p. 68). Effective care that is provided by well-trained and compassionate clinicians and other professionals; that takes into account patients' cultural and family contexts, education, personal values, and economic resources; and that is available at times and accessible in places suited to the characteristics of the community being served.

This is not to say that such approaches and perspectives can eradicate all risks, motivate all providers, retain all patients, or avoid all bad outcomes. However, it is the "least harm" logic of evidence-based care -- in both practice and policy -- that offers the most feasible and affordable alternative to the expensive, confusing maze that too many patients confront when attempting to access the healthcare system in America. If the goals of administrators, providers, and policymakers are to maximize the good and minimize the bad, models such as the Women's Health Center suggest ways to optimize the allocation of scarce public and private resources to benefit even the most vulnerable populations.

> *Neither men nor women are receiving optimal care from the U.S. healthcare system, with both genders experiencing significant and well-documented disadvantages in healthcare. Both men and women would benefit from a move toward a gender-based system of care in the United States.*
>
> (Brittle & Bird, 2007, p. 6)

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DATA SOURCES

- EPFMC year-over-year records [Source: 2009 Uniform Data System Report (UDS)]
- EPFMC patient records and databases (Sources: HealthPort Practice Management System, perinatal screens; hard copy files and charts)
- All 2009 California FQHCs (Source: http://www.hrsa.gov/data-statistics/health-center-data/StateData/2009/2009CATOTsumdata.html; N=118)
- All U.S. FQHCs (Source: http://www.hrsa.gov/data-statistics/health-center-data/NationalData/2009/2009nattotsumdata.html; N=1131)
- National FQHC benchmark goals (Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, http://www.hrsa.gov/about/budget/ index.html)
- Birth statistics for EPFMC's service area (Source: California Department of Public Health, Birth Profiles by Zip Code, http://www.cdph.ca.gov/data/statistics/Pages /BirthProfilesbyZIPCode.aspx; zip code matching for top 66 percent of EPFMC patients)
- Local and regional health data (Sources: County of Los Angeles Public Health Department Maternal, Child & Adolescent Health Programs)
- City-, county-, state-, and -level perinatal statistics (Sources: March of Dimes PeriStats, http://www.marchofdimes.com/PeriStats; National Vital Statistics System, http://www.cdc.gov/nchs/nvss.htm; National Center for Health Statistics, http://www.cdc.gov/nchs/)

ACRONYMS

ACOG: American Congress of Obstetricians and Gynecologists
APNCU: Adequacy of Prenatal Care Utilization
CNM: Certified Nurse-Midwife
FPL: Federal Poverty Level
FQHC: Federally Qualified Health Center
HIPAA: Health Insurance Portability And Accountability Act
HPSA: Health Professional Shortage Area
HRSA: Health Resources and Services Administration (U.S. DHHS)
IOM: Institute of Medicine
MOD: March of Dimes
MOU: Memorandum of Understanding
MUA: Medically Underserved Area
NVSR: National Vital Statistics Report
NVSS: National Vital Statistics System
OB/GYN: Obstetrician-Gynecologist
PSS: Patient Satisfaction Survey
PSQ: Provider Satisfaction Questionnaire
SPA: Los Angeles County Department of Public Health Service Planning Areas
STI: Sexually Transmitted Infection
UDS: Uniform Data System

Kamella Tate Associates, LLC This white paper and accompanying final project report was prepared by KTA/LLC, Kamella Tate, Principal Investigator. KTA/LLC is a woman-owned small business that provides research, program design, advancement, and evaluation services to community-based organizations working in the arts, education, and healthcare.

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