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Establishing a pediatric prenatal visit at The Health Center (THC) in Plainfield, VT

Katie Price
Dr. Houser
September 2018
Description of Need

- The AAP has long recommended a prenatal visit as part of the continuum of well-child care. However, this visit is underutilized by new families:
  - “Although survey results show 78% of pediatricians offer a prenatal visit, only 5-39% of first-time parents actually attend a visit.” (11)
- AAP Bright Future’s guidelines updated in July 2018 include the following visit objectives (11):
  1. Establishing a relationship with family
  2. Assessing obstetric, prenatal, and family history
  3. Providing infant care guidance
  4. Evaluating psychosocial factors affecting family function
  5. Sharing medical home routines for visits and procedures after delivery
- THC does not currently have an established pediatric prenatal visit for expecting parents.
  (THC does not provide prenatal care for pregnant mothers and not all mothers are THC patients; therefore, first contact with a new family is often at the hospital just after delivery.)
- Prenatal education
  - 51% of VT mothers took a childbirth education class (2)
  - Most prenatal education focuses on labor and childbirth with little to no information about parenting and the postpartum period. (5)
  - The PRAMS VT Survey 2012-2014 identified “a class for new parents (parenting, not childbirth)” as a requested resource by respondents. (3)
  - The pediatric prenatal visit provides infant care guidance and can connect families with community organizations that provide postpartum education. (11)
Influence on public health

- The pediatric prenatal visit influences multiple public health measures in both child and maternal health.
  - One RCT with urban low-income families showed a prenatal visit had positive effects on breastfeeding initiation, emergency services usage, and the relationship with the provider. (10)

- Important public health measures include:
  - Breastfeeding duration
  - Postpartum mental health education, screening, and management
  - Substance use during and after pregnancy
Common barriers cited by women who have stopped breastfeeding before 6 months include: trouble suckling or latching, inadequate supply, trouble starting milk flow, insufficient weight gain, sore or crackle nipples, pain. 

Prenatal education can set expectations before birth and may help alleviate some of these challenges.

In US, 51.8% mothers breastfeed at 6 months (6)

91% mothers started breastfeeding
83% mothers breastfed at 4wks
77% mothers breastfed at 8wks

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83% mothers breastfed at 4wks
77% mothers breastfed at 8wks

If 90% of families follow guidelines to breastfeed exclusively for 6mo, US save $13B annually from direct medical and indirect costs (8)

Estimated $1200-$1500 savings for families in first year (8)
Public Health Costs: Postpartum Mental Health

VT PRAMS 2015: postpartum depression (5)

- Prenatal: 83% discussed what to do if experienced depression during or after pregnancy
- Postpartum: 91% talked with a provider about postpartum depression in postpartum period
- Affordable mental health identified as resource need (3)

- Primary care and especially pediatric primary care is an opportune environment to monitor and manage postpartum depression due to increased frequency of contact with new parents. (9)
- Established treatment protocols are essential: “Large-scale screening efforts that are not connected to follow-up do not influence treatment access or maternal outcomes” (9)

Annual cost of not treating a mother with depression is $7200 (4)

Estimated $5.7B annual US cost (4).

Combined cost of not treating mother AND child is $22,647 annually. (4)
“Smoking during pregnancy is estimated to account for 20% to 30% of low-birthweight babies, up to 14% of preterm deliveries, and about 10% of all infant deaths.” (1)

- Costs associated with caring for low-birthweight babies with smoking mothers are estimated to be $20,732 in the first year of life (1)

- Evaluating environmental exposures is part of the prenatal pediatric visit. Screening for substance use and providing counseling can reinforce efforts by OB providers to engage pregnant mothers in cessation.
Community Perspective

1 patient and 2 community providers were interviewed to help generate important topics to discuss during the visit

Ana Capone - Good Beginnings of Central Vermont
• “Establishing social support early is essential for the transition home.”
• Better communication through providers about available community resources for parent education is needed.
• We are doing a better job of screening for postpartum mood disorders, but getting families into treatment quickly is important. Optimizing referral processes and increasing awareness of local providers should be a focus.

THC Patient, primiparous 26 weeks gestation:
• Unsure what will be most challenging postpartum. Most information comes from family, friends, or individual research.
• Meeting the provider before birth would be helpful to learn about breastfeeding and connecting with community education resources.

Katy Leffel BSN, RN, CLC - Maternal-Child Health at Central Vermont Home Health Hospice
“Many parents don’t know what they don’t know.”
• Parents receiving postpartum home visits often have questions with a focus on ‘What is normal?’
• Our culture does not have a formal process of teaching essentials to parents, so a lot of basic newborn knowledge comes from practice.
• “Many parents think having home help is for families in crisis. Normalizing in-home help will benefit all families.”
Intervention and methodology

- Created provider in-office checklist for prenatal visit discussions
  - Reviewed AAP updated 2018 clinical report for goals of visit
  - Used reputable resources combined with topics gathered from community interviews to generate the visit form with questions for providers to use.
  - Created a background handout for providers detailing overarching goals of the visit and anticipated benefits for patients

- Patient Education Materials
  - Used interview material to create multiple patient education documents
    - What to expect at the Hospital’
    - Newborn and maternal care in the first few weeks at home
    - Building your circle: community classes and other resources
Results/Response Data

- Due to time constraints and patient availability, we were unable to implement this material in a visit with a family.
- Provider background handout and in-office checklist was presented at weekly medical meeting
  - Positive feedback regarding visit objectives and patient materials
  - Discussed importance of keeping patient education topics succinct during the visit
- Patient education materials shared with community providers for feedback
Evaluation of effectiveness & limitations

- **Proposed evaluations**
  - Patient survey at 1 month well-child check
    - This would provide an opportunity to gather more topics families feel are lacking
  - Similar projects focusing on prenatal patient education have had “quiz” material and graded parents’ performance.

- **Limitations**
  - THC has variable populations of newborns entering the office. It may take an extended period of time to gather enough feedback on the visit
  - The prenatal visit is time-limited, and given the volume of important information, it will be important to narrow down visit essentials.
Future projects

- Outreach with community prenatal educators and OB offices to let patients know THC offers this visit
- Create smart text or form within EMR for visit type
- Host prenatal postpartum courses in coordination with community organizations at THC
- Develop patient resources to be distributed electronically
References


Consent

Thank you for agreeing to be interviewed. This project is a requirement for the Family Medicine clerkship. It will be stored on the Dana Library ScholarWorks website. Your name will be attached to your interview and you may be cited directly or indirectly in subsequent unpublished or published work. The interviewer affirms that he/she has explained the nature and purpose of this project. The interviewee affirms that he/she has consented to this interview. Yes _____/ No _____. If not consenting as above: please add the interviewee names here for the department of Family Medicine information only. Name: ______ Katy Leffel & Ana Capone________________________________________