Update on Early Prenatal Care

New Jersey's Prenatal Care Access Grantees

NJ DEPT OF HEALTH

March 2013
Maternal and Child Health Epidemiology
And Reproductive and Perinatal Health Services

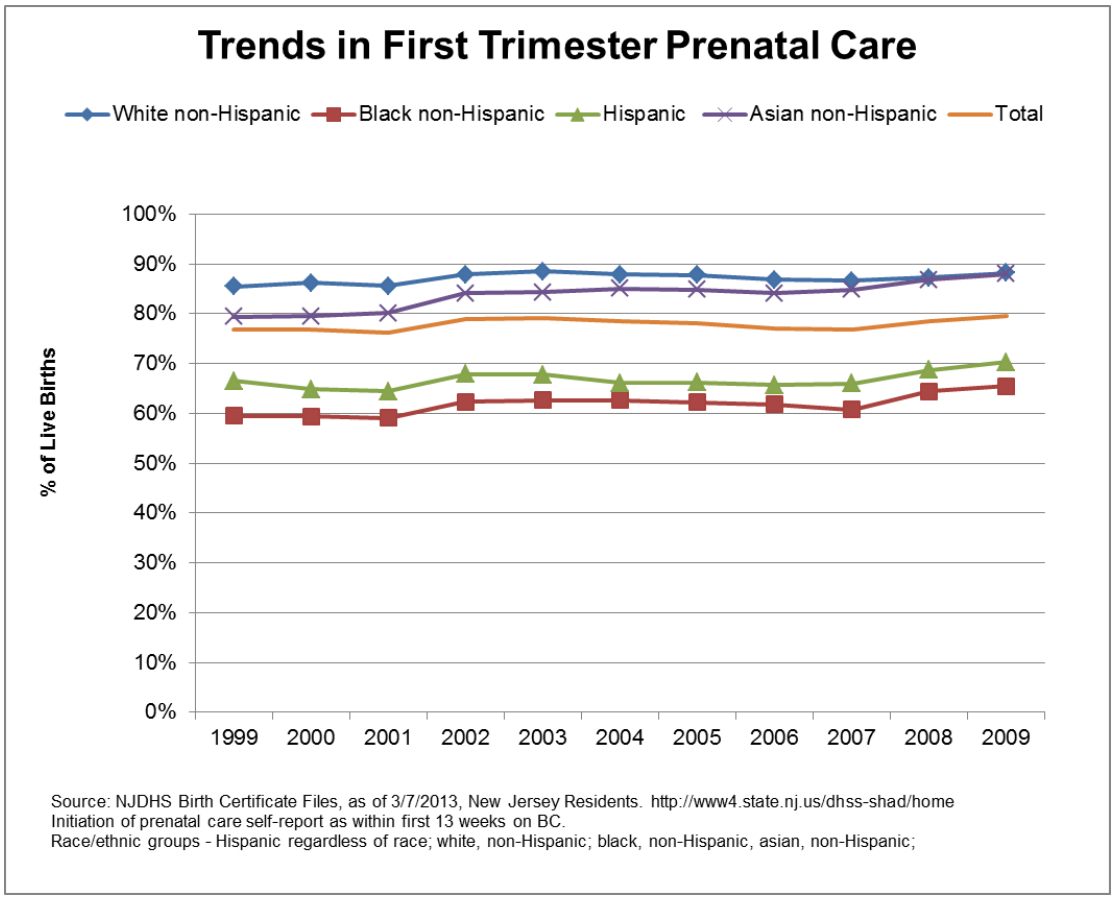
Overview

Improving access to early prenatal care is essential to promoting the health of New Jersey mothers, infants, and families. Early prenatal care is an important component for a healthy pregnancy because it offers the best opportunity for risk assessment, health education, and the management of pregnancy-related complications and conditions.

Efforts to improve access to early prenatal care must take a multi-pronged approach in order to reduce barriers. Despite major expansions of health care access, many women giving birth in New Jersey still failed to receive first trimester prenatal care. Mothers most likely to benefit from early prenatal care because of their higher risk of poor birth outcomes remain even less likely to receive it.

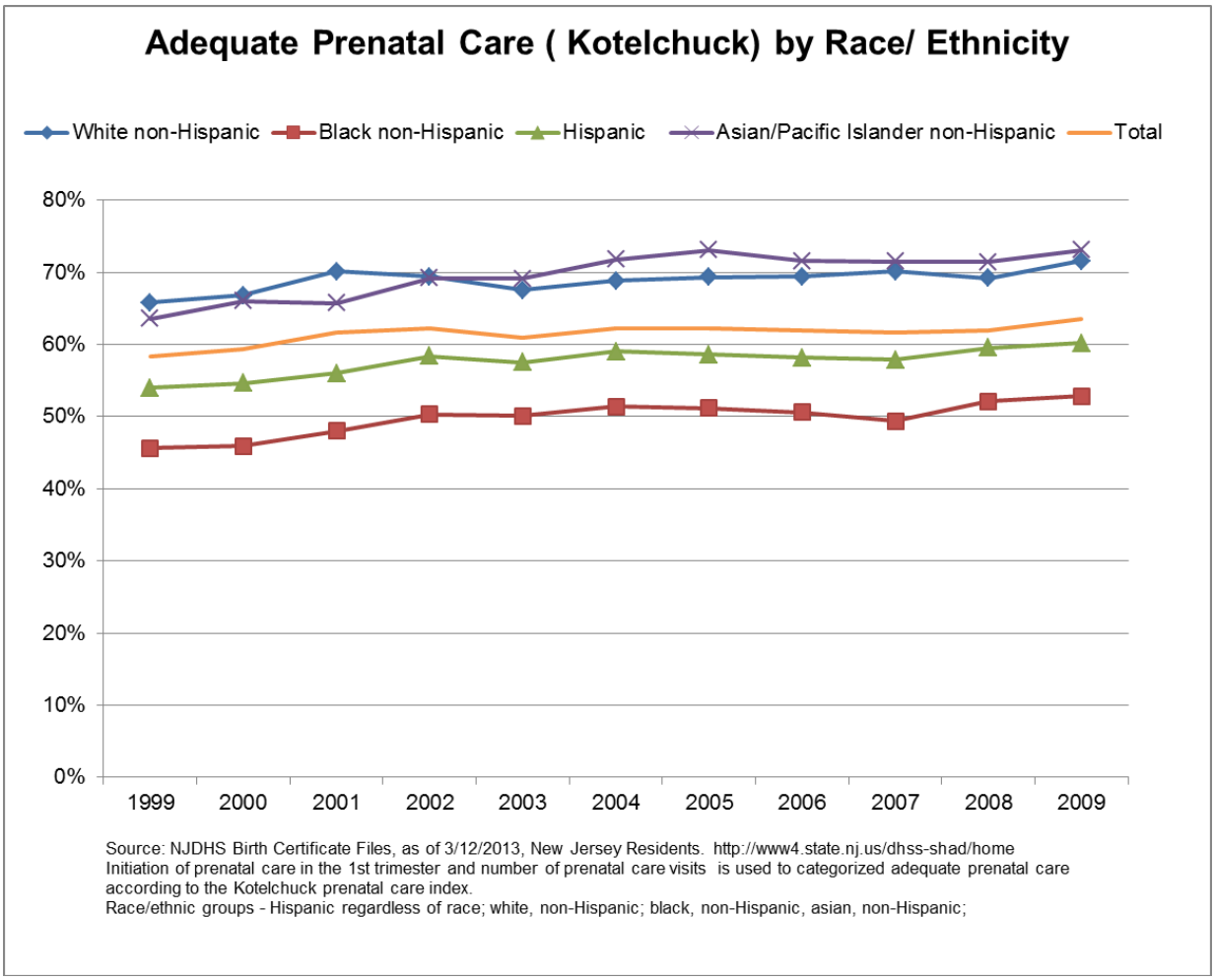
Overall Trends in First Trimester Prenatal Care

The overall trend in first trimester prenatal care for New Jersey mothers has continued on its upward trend since the release of the Prenatal Care Task Force Report in 2008. While improvements in rates of first trimester prenatal care continue across all groups, significant racial/ethnic disparities exist.



Source: NJDHS Birth Certificate Files, as of 3/7/2013, New Jersey Residents. http://www4.state.nj.us/dhss-shad/home
Initiation of prenatal care self-report as within first 13 weeks on BC.
Race/ethnic groups - Hispanic regardless of race; white, non-Hispanic; black, non-Hispanic, asian, non-Hispanic;

Similar increases occurred across racial and ethnic categories in adequacy of prenatal care based on the Kotelchuck Index. As can be seen in the chart below, the overall rate of adequate care is improving.



In 2008, a Task Force of stakeholders was convened to identify an approach for improving New Jersey's rate of first trimester prenatal care. The Task Force produced a report highlighting goals and objectives along with a list of recommended actions to work towards improving rates of early prenatal care.

To address some of the recommendations related to access to early care, nine (9) agencies in high risk areas were identified and awarded grant funds to implement evidence based programs that focused on improving access to early prenatal care. The agencies included six Maternal and Child Health Consortia, two federally qualified health centers and one community based agency and were all operational by 2010.

Evidence based models used included Patient Navigators, Centering Pregnancy, and Doulas. The Patient Navigator model is a model first created in the chronic disease arena, utilizing community members educated about prenatal and postpartum care. These projects are targeted in communities with poor pregnancy outcomes. The patient navigators assist the women and their families through the various health and social service systems. Centering Pregnancy is a model that provides prenatal care for low risk pregnant women entering care in the same gestational age in a group setting. The women in the group take responsibility for their prenatal care and receive health education via an experienced facilitator. The Doula model educates community women who serve as mentors, labor coaches/ birth companions and provide services to low risk pregnant women in the target community. Doulas are very supportive of the initiation and support of breastfeeding.

While all sites used an evidence based model, every site did not use the same model and some employed more than one approach. In Year 1, several approaches were attempted to assist in the recruitment of women into early prenatal care. One grantee proposed a social networking model that was not as effective as expected in the target community. This agency redirected funding to a Doula model in Year 2. Another agency had proposed an integrated model using a medical home centered at an FQHC with referrals for interconception care at a family planning agency and home visiting at a maternal and child health consortium. This agency redirected funding to a patient navigator model in Year 2. Consolidation of the maternal and child health consortia from six to three during Year 2 and 3 of the project period created an opportunity for multiple models in each consortium. The northern region currently has implemented the patient navigator and the Doula models. The central region has implemented Centering Pregnancy and Patient Navigators. A community based model that also included free pregnancy tests was initially used in the southern region however they have moved toward a Patient Navigator model during Year 2.

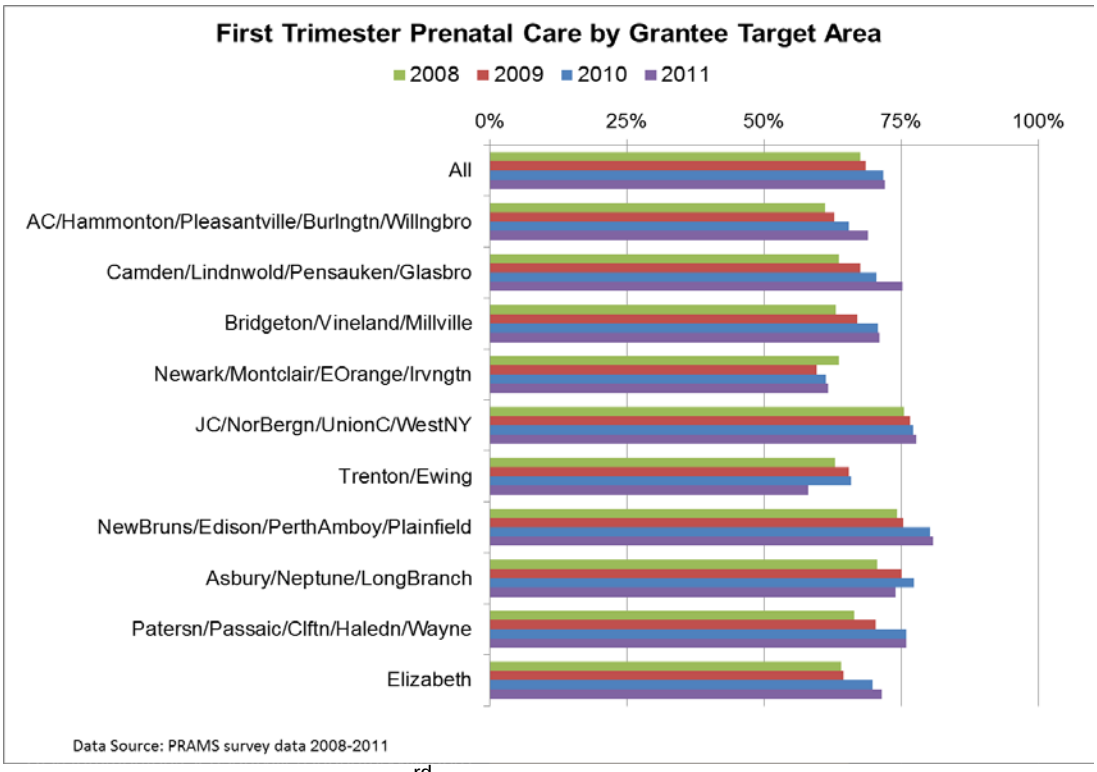
All grantees held Advisory Groups or Consumer driven Focus Groups. During these meetings, barriers to accessing prenatal care were identified by consumers. Insurance/Medicaid issues were identified as a barrier with the main hurdle being the lack of awareness about eligibility criteria for immigrant women. Inconsistencies in information provided by County Medicaid offices and delays in processing presumptive eligibility were also identified. The remaining barriers identified focused on language, homelessness, domestic violence and lack of transportation.

The table below shows Prenatal Care Access target areas by rates of Early, 3rd Trimester/No and Adequate Prenatal Care as measured using Pregnancy Risk Assessment and Monitoring Survey (PRAMS) data. The table covers the periods of 2008 before sites received the initial funding through 2011. All but two (2) of the target areas showed improvements in early prenatal care and many sites showed declines in late or no prenatal care. The Newark target area was the only high risk area that showed no improvements in prenatal care adequacy.

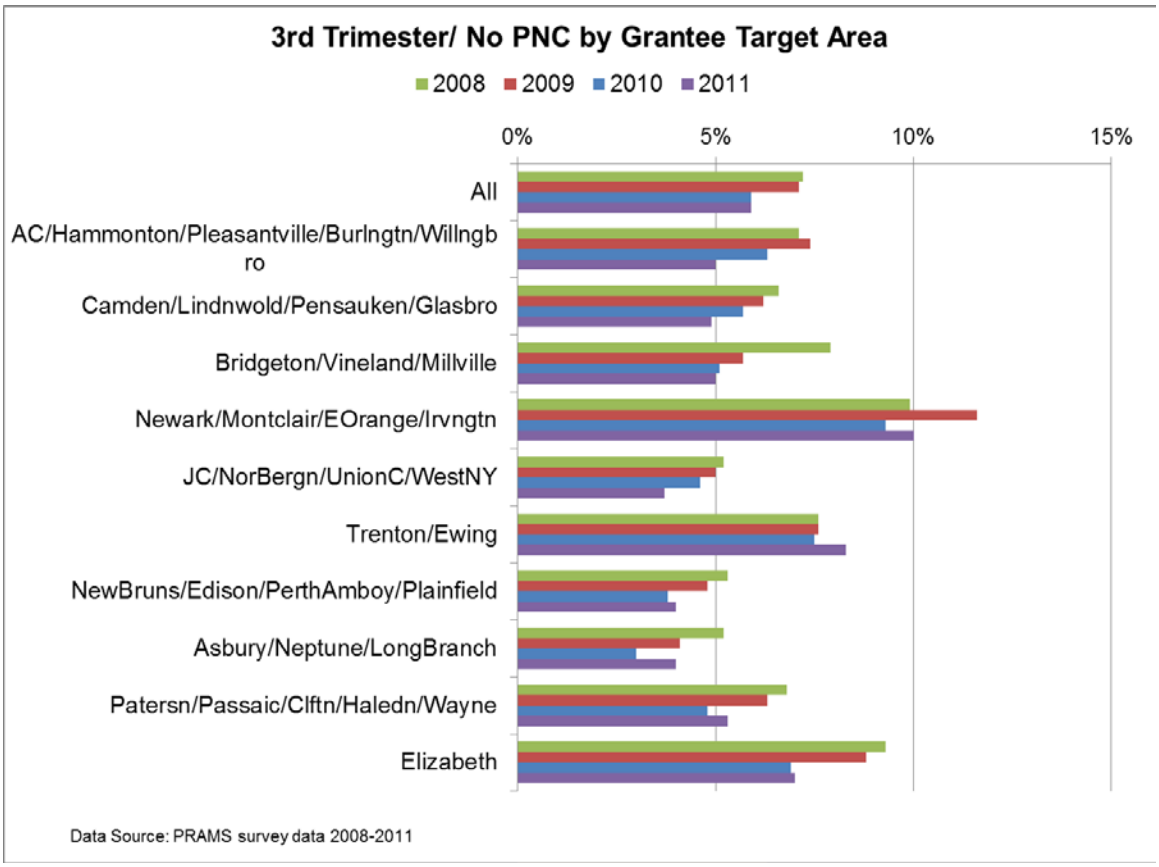
PRAMS 2002-2011 Annual Files
Timely PNC by Grantee Target Area

	PNC 1st trimester				PNC 3rd trimester/none				PNC adequate			
	2008	2009	2010	2011	2008	2009	2010	2011	2008	2009	2010	2011
All	67.50%	68.60%	71.80%	72.00%	7.20%	7.10%	5.90%	5.90%	56.20%	57.10%	59.20%	59.30%
AC/Hammonton/Pleasantville/Burlngtn/Willngbro	61.10%	62.80%	65.40%	68.90%	7.10%	7.40%	6.30%	5.00%	51.40%	52.00%	54.90%	57.30%
Camden/Lindnwold/Pensauken/Glasbro	63.70%	67.50%	70.50%	75.30%	6.60%	6.20%	5.70%	4.90%	40.60%	45.60%	39.40%	41.70%
Bridgeton/Vineland/Millville	63.10%	67.00%	70.70%	71.00%	7.90%	5.70%	5.10%	5.00%	41.30%	47.60%	50.90%	43.60%
Newark/Montclair/EOrange/Irvngtn	63.70%	59.60%	61.30%	61.70%	9.90%	11.60%	9.30%	10.00%	54.40%	50.80%	55.10%	54.10%
JC/NorBergn/UnionC/WestNY	75.50%	76.60%	77.20%	77.70%	5.20%	5.00%	4.60%	3.70%	61.50%	62.40%	63.70%	64.00%
Trenton/Ewing	63.00%	65.50%	65.90%	58.00%	7.60%	7.60%	7.50%	8.30%	60.70%	63.50%	64.00%	62.40%
NewBruns/Edison/PerthAmboy/Plainfield	74.30%	75.40%	80.30%	80.80%	5.30%	4.80%	3.80%	4.00%	66.50%	67.70%	70.30%	72.90%
Asbury/Neptune/LongBranch	70.60%	75.10%	77.30%	74.00%	5.20%	4.10%	3.00%	4.00%	67.10%	68.50%	71.00%	71.00%
Patersn/Passaic/Clftn/Haledn/Wayne	66.50%	70.30%	76.00%	75.90%	6.80%	6.30%	4.80%	5.30%	58.40%	60.80%	62.90%	62.30%
Elizabeth	64.00%	64.50%	69.80%	71.50%	9.30%	8.80%	6.90%	7.00%	49.10%	47.90%	51.30%	53.50%

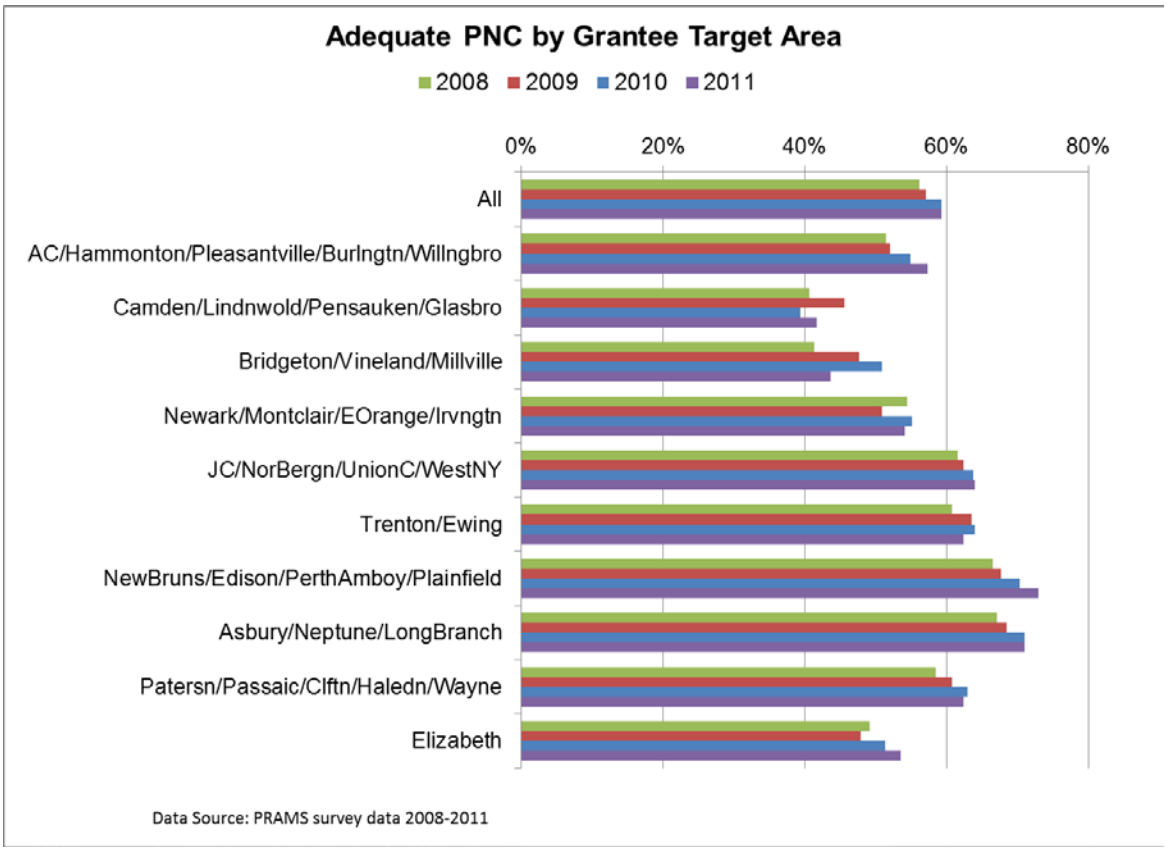
The graph below shows first trimester prenatal care rates of mothers in nine (9) early access target areas from 2008 through 2011. Most areas showed improvements since 2008. While Newark and Trenton target areas did not show sustained improvement across all four years, Trenton showed improvement in 2009 and 2010.



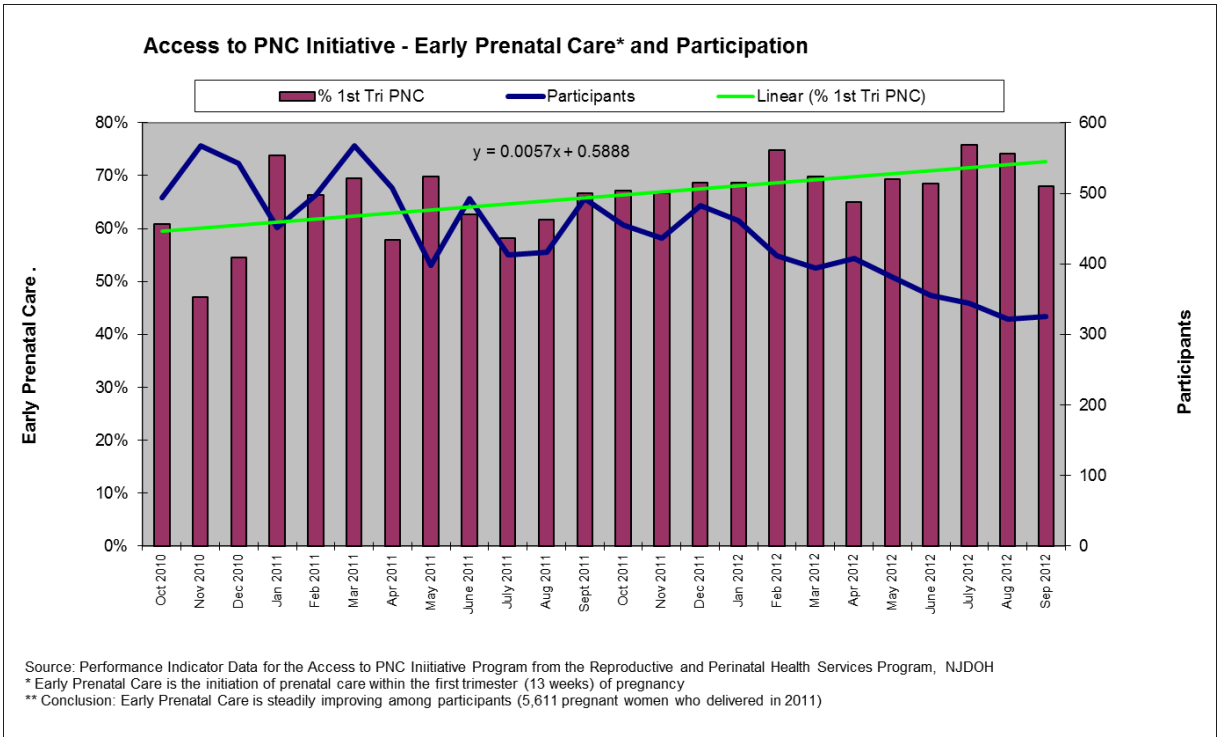
Late prenatal care defined as 3rd trimester care and no prenatal care were grouped together in the chart below. The expected reduction in these rates was observed in most target areas. However, Newark and Trenton areas did not show the consistent declines observed in the other grantee target areas. Trenton's rates of late and no care increased in 2011 from their 2008 lows while Newark's rates were slightly higher for that same time period.



All grantee target areas experienced improvement in the adequacy of prenatal care except Newark. Newark's rates of adequate prenatal care remained basically unchanged from those found in 2008. While the level of improvement varied across the 4-year period, each of the target areas had 2011 rates that exceeded the 2008 rates.



Data from the PNC initiative program below shows prenatal care rates by paticipant level over the 2-year period the program has been operational. The highest rates of program participation were found during the early months of the program. Rates of 1st trimester PNC have trended upward throughout the life of the initiative despite declining enrollment.



Source: Performance Indicator Data for the Access to PNC Initiative Program from the Reproductive and Perinatal Health Services Program, NJDOH
* Early Prenatal Care is the initiation of prenatal care within the first trimester (13 weeks) of pregnancy
** Conclusion: Early Prenatal Care is steadily improving among participants (5,611 pregnant women who delivered in 2011)

FINDINGS

Most target areas showed improvements in early access to prenatal care and adequate prenatal care along with reductions in late/no prenatal care. Whether the improvements are due to the additional resources in those target areas or the specific evidence based models used in areas showing improvement remains to be determined. While Newark and Trenton target areas did not experience the same level of improvement even with the additional resources, an examination into the specific evidence based models that worked in other target areas may be helpful in revising program features in those areas.

Early and adequate prenatal care has a long established history of benefits to pregnant women and their infants. By focusing on ways to insure that program features meet the unique needs of a community, we can better address the challenges to improving early and adequate prenatal care in these target areas.