



**Medicaid HMO Providers' Perceptions of Barriers to Administering the
Healthy Start Prenatal Risk Screening Instrument to Florida Medicaid
Pregnant Women**

submitted to

Agency for Health Care Administration

by

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Introduction

For the past decade, Florida has increased its allocation of general revenue funds for improving and expanding maternal and infant health programs, which serve primarily Medicaid eligible populations, and has maintained an ongoing evaluation of services and outcomes. Significant expansions and enhancement of Medicaid services to mothers and infants began in 1991 with the enactment of the Florida Healthy Start program.* The intent of the Florida Healthy Start program was to provide comprehensive prenatal and infant care, including care coordination and psychosocial services, for all of the state's women and infants (Peredo and Jeffers, 1996). A large proportion of the population benefiting from Florida Healthy Start has been Medicaid recipients. In 1995, the University of South Florida College of Public Health analyzed Healthy Start Screening data and determined that among women identified as being at-risk for a poor pregnancy outcome whom agreed to participate in the Healthy Start Program, 70 percent were Medicaid recipients. A five-year trend analyses comparing maternal and infant health status indicators for Medicaid and non-Medicaid populations showed that a quarter of eligible women were not offered the Healthy Start Prenatal Risk Screen (The Lawton and Rhea Chiles Center for Healthy Mothers and Babies, 1999).

Parallel to the Florida Healthy Start initiative, the Florida Medicaid program embraced managed care as a strategy for achieving the state's goals of increased access, quality and cost containment. Florida, like other states, began converting from a Medicaid fee-for-service program to a Medicaid managed care program. A key concern of public health officials was the prevention of any reversal in the state's progress in improving birth outcomes due to changes in health care markets, financing or service delivery arrangements, and restructuring of health care organizations. A City MatCH survey (Peck and Hubbert 1994) notes that among responding health departments, there was a concern for the ability of managed care organizations to provide adequately for those most at risk and a fear that they lack the incentive to provide routine preventive services like prenatal care.

Aside from very general articles that discuss what Healthy Start is, and what it aims to do (e.g., Badura, 1999), there is little-to-none critical, academic literature that specifically addresses Healthy Start and the services it provides. An exception is Boroff and O'Campo's (1996) study of the Healthy Start program in Baltimore that found it had begun to increase the utilization of prenatal and pediatric care and improve birth outcomes. Studies of the types of services (such as home visits and care coordination) provided by Healthy Start suggest that they help reduce the incidences of infant mortality and morbidity (i.e., Buescher et al. 1991, Hobel, et al. 1994, and Kogen et al. 1994).

There is some literature that explores HMOs and their provision of services to underprivileged and Medicaid populations. Griffin, Hogan, Beechner, and Leddy (1999) examined the effects of a Rhode Island Medicaid managed care program on prenatal care utilization. They found prenatal care utilization to improve from 57 to 62 percent, and that Medicaid patients visiting

* Florida Healthy Start is a state-mandated and state-funded program. It should not be confused with federal Healthy Start, a program administered by the federal government, that targets its resources toward geographical regions in greatest need of intensive outreach.

private physicians were more likely to obtain adequate prenatal care than were those visiting other types of providers. Another study indicates HMOs can be more effective than fee-for-service providers in delivering primary and preventive care to Medicaid recipients (Piper and Bartels, 1995). However, Klinkman, Gorenflo, and Ritsema (1997) compared the quality of prenatal care provided via fee-for-service, HMO, and Medicaid providers; they found no significant differences between the groups, although they did find Medicaid patients tended to seek prenatal care later in pregnancy.

Much more prevalent are articles focused on how HMOs affect physicians work effort and satisfaction (Hadley and Mitchell, 1997), physicians willingness to participate in Medicaid managed care (Silverstein and Kirkman-Liff, 1995), and physicians perceptions of how managed care affects the way they practice medicine (Warren, Weitz, and Kulis, 1999). Hadley and Mitchell (1997) find that physicians affiliated with HMOs that have highly-penetrated a geographical area work fewer hours and see fewer patients per week than those in less-penetrated areas, however, they are less satisfied with their practices. They hypothesize that these physicians reduced satisfaction may come from erosion in their income, as well as HMO corner cutting incentives that may jeopardize care quality. They also suggest that since specialists length of visit with patients (in their sample) averaged 5.8 minutes “specialists may be cutting back on very brief follow-up or preoperative visits” (Hadley and Mitchell, 1997: 109). Warren, Weitz, and Kulis (1999) find that physicians participating in HMOs feel their clinical autonomy is compromised by managed care.

Silverstein and Kirkman-Liff (1995) note that HMOs must find providers willing to accept their reimbursement rates, as well as Medicaid patients. Generally negative attitudes about Medicaid patients (that they are disruptive to offices, don’t supervise their children, break appointments frequently, take more physician time, and are less likely to follow physician instructions) were correlated with limited (as opposed to full) participation among physicians who were affiliated with an HMO in that study’s sample.

While these studies have limited applicability to this research there are some potential implications from them. The finding that the relatively short period of time HMO specialists (such as ob/gyn) spend with patients suggests that certain procedures may fall through the cracks due to time constraints. Given this, perhaps within the scope of a prenatal visit the Healthy Start screen is seen as less important than other tasks that must be performed. Additionally, attitudes toward Medicaid patients may further influence the level at which providers engage with such patients. The perception that Medicaid patients are less likely to comply with physician directives, for example, may lead physicians to not offer the Healthy Start screening if they think it will be declined or ignored. These and other issues were taken up in this research.

Purpose of the Study

Florida State Statute 383.14 (64C-7, FAC), passed in 1991, stipulates that all pregnant women be offered the Healthy Start Prenatal Risk Screening by their health care provider at their first prenatal visit or at the earliest opportunity following confirmation of a pregnancy. However, the *Maternal and Infant Health Status Indicators for Florida 1997: Statewide Report for Medicaid Managed Care* (The Lawton and Rhea Chiles Center for Healthy Mothers and Babies, 1999)

showed that offering of the Healthy Start screen varied from 59-86 percent among Florida Medicaid HMO providers in 1997. The purpose of this study was to determine Medicaid HMO providers' perceptions of problems and barriers to administering the Healthy Start Prenatal Risk Screen, and to offer recommendations for improving their compliance.

Limitations

A limitation of this study is that only providers for whom a correct address was provided had an opportunity to participate in the survey.

Population

The target population of this study was Medicaid HMO providers of obstetrical services to women in the state of Florida. Providers included physicians, certified nurse midwives, and advanced registered nurse practitioners, among others.

Methods

The research protocol for this study was submitted to the University of South Florida IRB for exempt review and was approved. Additionally, the study was presented and explained by Patricia A. Gorzka, Ph.D., ARNP, at the December 1999 meeting of Medicaid providers conducted by AHCA. HMO representatives at that meeting gave verbal consent for participation. AHCA provided the names and addresses of Medicaid HMO providers of prenatal services; those data were received by The Chiles Center in February 2000. All duplicate names were removed from the initial list, resulting in a potential respondent pool of 1590. The research protocol entailed mailing a copy of the questionnaire and a letter explaining the study and requesting participation (see Appendix A) to providers of Medicaid HMO services to pregnant women. Potential respondents were informed that their responses would be kept confidential, and that returning the completed questionnaire was an indication of consent. Follow-up phone calls with respondents providing a name and telephone number were conducted in private offices at The Chiles Center. All identities of survey respondents were kept confidential.

Questionnaire

A 33-item questionnaire was constructed to assess potential problems and barriers that may be encountered by Florida Medicaid HMO providers in administering the Healthy Start Prenatal Risk Screening instrument. Question topic areas included demographic information about the practice facility, the HMO plans accepted by it, and the percentage of Medicaid patients served. Eight questions specifically addressed experiences with the screen itself, including when the screen is administered, how long it takes, who actually fills out the screen, and interactions with the local Healthy Start Coalition. The questionnaire included 17 Likert scale questions designed to assess perceptions about possible barriers to administering the screen. Question format consisted of selective response and one open-ended question. The Chiles Center faculty, AHCA, and Department of Health staff reviewed the questionnaire items for completeness and relevance. The initial and revised versions of the questionnaire were reviewed and endorsed by maternal

health practitioners David L. Darr, M.D., an obstetrician, and Cecilia Jevitts, Ph.D., a certified nurse midwife.

Data Collection

Each potential respondent was mailed a letter, a copy of the questionnaire, and a self-addressed, pre-paid envelope. Mailings were prepared in groups of approximately 400 with the first mailing sent 7 February 2000 and the last 17 February 2000. A reminder postcard was mailed March 20, 2000 to all potential respondents who had not yet returned a completed survey. Of the possible 1590 respondents, 206 were dead-ends (no forwarding address, no such address, additional duplicates found, and returned because the provider did not provide prenatal services), leaving 1384 surveys to reach a potential respondent. Of those 1384 surveys, 302 returned a completed questionnaire for a response rate of 21.8 percent.

Data Analysis

A total of 302 providers returned completed surveys. Frequencies for selected survey item are listed below.

Job Title	Frequency (Percent)
Physician	154 (51.9)
Certified Nurse Midwife	50 (16.8)
Office staff member	28 (9.4)
Other	25 (8.4)
Registered Nurse	17 (5.7)
Advanced Registered Nurse Practitioner	10 (3.4)
Licensed Nurse Practitioner	5 (1.7)
Senior Office Nurse	4 (1.3)
Licensed Midwife	3 (1.0)
Social Worker	1 (0.3)
Type of Practice Facility	Frequency
Single provider, private	109
Nurse-Midwife	36
Public health clinic	24
University-affiliated	15
Group practice, private	119
Hospital outpatient	15
Community health clinic	17
Other	16
Percentage of Obstetrics Patients Served	Frequency (Percent)
Less than 25 percent	50 (16.9)
25-49 percent	105 (35.6)
50-74 percent	89 (30.2)
75 percent and more	51 (17.3)
Are you a Medipass provider?	Frequency (Percent)

Medicaid HMO Providers Perceptions of Barriers to Administering the Healthy Start Prenatal Risk Screening
Instrument to Florida Medicaid Pregnant Women
Final Report: July 2000

Yes	212 (73.4)
No	77 (26.6)
Percentage of Medicaid Patients Served	Frequency (Percent)
Less than 25 percent	123 (42.0)
25-49 percent	90 (30.7)
50-74 percent	44 (15.0)
75 percent and more	36 (12.3)
Received educational materials from local Healthy Start Coalition?	Frequency (Percent)
Yes	246 (82.8)
No	27 (9.1)
Don't know	24 (8.1)
Received training from local Healthy Start Coalition?	Frequency (Percent)
Yes	183 (62.0)
No	66 (22.4)
Don't know	46 (15.6)
How would you rate your knowledge of the procedure to administer the screen?	Frequency (Percent)
Very knowledgeable	92 (31.0)
Knowledgeable	101 (34.0)
Somewhat knowledgeable	71 (23.9)
Not very knowledgeable	25 (8.4)
Not at all knowledgeable	8 (2.7)
When does your office administer the screen?	Frequency (Percent)
At the first prenatal visit	259 (87.8)
At a subsequent visit	17 (5.8)
Other time	9 (3.1)
We don't administer the screen	8 (2.7)
Who fills out the screen?	Frequency
Patient	154
Midwife	24
Social worker	7
Physician	22
Nursing staff member	127
Office staff member	13
Other	37
We don't administer the screen	7
Time needed to complete the screen	Frequency (Percent)
Less than 2 minutes	10 (3.6)
2-5 minutes	113 (40.5)
5-7 minutes	76 (27.2)
7-10 minutes	52 (18.6)
More than 10 minutes	28 (10.0)
How important is administering the screen?	Frequency (Percent)
Very important	107 (36.6)

Medicaid HMO Providers Perceptions of Barriers to Administering the Healthy Start Prenatal Risk Screening
Instrument to Florida Medicaid Pregnant Women
Final Report: July 2000

Important	107 (36.6)
Somewhat important	47 (16.1)
Not very important	19 (6.5)
Not at all important	12 (4.1)
Do you have any QA procedures related to the screen?	Frequency (Percent)
Yes	113 (39.1)
No	133 (46.0)
Don't know	42 (14.5)

Statement	Strongly Disagree n (%)	Disagree n (%)	Agree n (%)	Strongly Agree n (%)
Screen creates extra paperwork	13 (4.5)	51 (17.5)	159 (54.6)	68 (23.4)
Our office is adequately compensated	74 (27.6)	67 (25.0)	107 (39.9)	20 (7.5)
Receive follow-up from Healthy Start	27 (9.8)	60 (21.8)	147 (53.5)	41 (14.9)
Same questions as prenatal screen	5 (1.7)	27 (9.4)	177 (61.7)	78 (27.2)
Regular communication with HS coalition	39 (14.0)	87 (31.2)	122 (43.7)	31 (11.1)
We are not required to administer screen	81 (30.2)	112 (41.8)	67 (25.0)	8 (3.0)
Seldom screen non-English speakers	133 (48.0)	108 (39.0)	24 (8.7)	12 (4.3)
Patients won't give certain info for screen	20 (7.3)	131 (47.7)	103 (37.5)	21 (7.6)
Screen is required by state statute	10 (3.9)	54 (20.8)	53 (20.5)	142 (54.8)
Staff is adequately trained for screen	17 (6.0)	48 (16.9)	165 (58.1)	54 (19.0)
Only screen those we think will qualify	154 (55.8)	108 (39.1)	13 (4.7)	1 (0.4)
Screening takes too much time	70 (25.1)	130 (46.6)	56 (20.1)	23 (8.2)
Patients easily understand screen questions	13 (4.6)	57 (20.1)	193 (68.0)	21 (7.4)
Incomplete screens are returned to office	20 (7.4)	81 (30.1)	150 (55.8)	18 (6.7)
Screen helps us provide needed service	37 (13.2)	60 (21.4)	138 (49.2)	46 (16.4)
Could complete more screens if in Spanish	32 (12.6)	94 (37.0)	92 (36.2)	36 (14.2)
Patients don't need Healthy Start services	49 (17.0)	105 (36.5)	95 (33.0)	39 (13.5)

Findings

Survey Questions

Of the 302 returned questionnaires, over half (51.9 percent) were completed by physicians. Certified Nurse Midwives were the next most prevalent respondents (16.8 percent) followed by office staff members (9.4 percent), others (8.4 percent), and registered nurses (5.7 percent). The rest of the respondents included ARNPs, LNPs, senior office nurses, licensed midwives, and one social worker. The vast majority of respondents work in private single provider or group practices. The most commonly accepted HMO plans included United Health Care of Florida, Inc. (n=167), PCA Family Health Plan (n=151), and Stay Well Health Plan (n=148). Seventy-three percent of the respondents indicated they are also Medipass providers. Sixty-six percent of the respondents estimate the percentage of obstetrics patients they serve as a portion of the total in their practice as 25-75 percent. Most of the respondents (72.7 percent) said less than 50 percent of their client base are Medicaid patients.

Eighty-three percent of the respondents indicated that they have received Healthy Start educational materials from their local Healthy Start coalitions. However, only 62 percent said they have received training on administering the Healthy Start screen from their local coalition. Most respondents (65 percent) felt they were knowledgeable or very knowledgeable about the procedures for administering the screen. It appears that most providers do know how to properly screen: 87.8 percent administer the screen at the first prenatal visit, and most of the respondents indicated the patient and someone else (usually a nursing staff member) fill out the screen. Most respondents (71.3 percent) report the screen takes seven minutes or less to complete. Seventy-three percent of the respondents feel it is important or very important to administer the Healthy Start Prenatal Risk screen to their patients.

Respondents were asked to indicate the degree to which they agreed or disagreed with 17 statements regarding their experiences administering the Healthy Start Prenatal Risk screen; those results are displayed in Table 2. Respondents are about evenly divided on agreement/disagreement for the following: adequate compensation for doing the screen, receiving regular communication from the Healthy Start coalition, that patients won't give certain information asked for on the screen, that Spanish screens could help them complete more, and that most of their patients don't need the services of Healthy Start. Most of the respondents agreed that: the screen creates extra paperwork, it repeats questions asked in the standard prenatal record, incomplete screens are returned to their offices, the screen is required by state statute, their staffs are adequately trained to administer it, patients easily understand the screening questions, and the screen helps them provide needed services. Most respondents disagree that they seldom screen those who speak Spanish, they only screen those they think will qualify, and that the screen takes too much time to complete.

To better understand the trends indicated by responses to the scale items, an analysis comparing physician and non-physician responses was conducted. Physicians were 1.83 times more likely than non-physicians to agree that administering the screen creates extra paperwork (OR 1.83, $p=0.035$), and 2.32 times more likely to agree that completing the screen takes too much time (OR 2.32, $p=0.002$). Physicians were over twice as likely as non-physicians to disagree that they received follow-up from Healthy Start after referring patients for services (OR 2.37, $p=0.001$), and almost twice as likely to disagree that they receive regular communications from their Healthy Start coalitions (OR 1.83, $p=0.013$). Physicians were almost twice as likely as non-physicians to disagree that screens are returned to the office because they aren't filled out completely (OR 1.85, $p=0.016$), and over three times more likely to disagree that filling out the screen helps them provide needed services to patients (OR 3.28, $p=0.001$). Physicians were almost twice as likely as non-physicians to agree that most of their patients don't need the services offered by Healthy Start (OR 1.81, $p=0.013$), and three times as likely to disagree that their practice facility received training in how to administer the screen (OR 3.03, $p=0.0002$). Also, physicians are over three times as likely as non-physicians to have less than 50 percent of their patients from the Medicaid population (OR 3.36, $p=0.00001$). Physicians generally feel that administering the Healthy Start Prenatal Risk screen is somewhat important, while non-physicians generally feel it is important; ANOVA results indicate this difference in response is not due to chance alone ($F=17.12$, $p=0.0001$).

In order to examine potential differences in response by type of provider a General Linear Models procedure (GLM) was performed. GLM measures the degree of difference between group compared to the degree of difference within groups, controlling for group size. Providers were divided into three groups: physicians, midwives/ARNPs, and others. Results indicate a significant difference between physicians and midwives/ARNPs on four questions, and differences between all the groups on two questions. Midwives/ARNPs more strongly agreed that they received follow-up from their Healthy Start coalition than did physicians ($F=7.78$, $p=0.0005$). Midwives/ARNPs were also stronger than physicians in their disagreement that patients don't need Healthy Start services ($F=7.40$, $p=0.0007$). Physicians more strongly agreed than the other two groups that the screen creates more paperwork ($F=5.84$, $p=0.003$). Midwives/ARNPs and the other group more strongly disagreed the screen takes too much time to administer than did physicians ($F=10.13$, $p=0.0001$). Both physicians and those in the other category more strongly disagreed that more screens could be completed if they were available in Spanish than did midwives/ARNPs ($F=10.25$, $p=0.0001$). Also, physicians more strongly disagreed than the other two groups that filling out the screen helps them provide needed services ($F=14.10$, $p=0.0001$).

Because the numbers of respondents per region were not enough to conduct a statistical analysis, a limited descriptive analysis by Medicaid regions was also conducted. The only result of note was that respondents from area 10 (Broward) and area 11 (Dade and Monroe) had more no responses than yes responses to the question of receiving training on how to administer the screen.

Open-ended Questions

Respondents were asked if there was anything else they could think of that would make it easier to administer the Healthy Start Prenatal Risk screen, and were invited to write as long a response as they desired. Eighty-nine respondents chose to answer the question. Many of those responses were quite short, indicating that things were going well, that there were no problems, or cryptic, like the one-word response: "tracking." Twenty-three of those writing comments (26 percent) called for providing the screen in different languages, most notably Spanish, but Creole, Chinese, Arabic, Russian, and Portuguese were also mentioned.

Some respondents provided substantive suggestions to make the screen and administration process easier for them and their patients. Among the suggestions: print in black ink so it copies better, allow the bottom of the form to accept a stamp (rather than having to write each time), use a larger font size, provide a toll-free number for patient and provider questions, and move the consent section closer to the patient section (so they won't forget to sign it). A few also suggested providing incentives, samples, or gift certificates to encourage women to complete the screen. Another respondent suggested flagging Healthy Start participation in the Medifax system so providers would know their patient was taking part.

A number of respondents suggest rewriting some of the questions to make them more understandable. As one respondent wrote regarding question 4: 'all pregnant women are hungry... Do you have enough food in the house?' would be a better phrasing. One respondent felt a 'question regarding support of baby's father should be included in the screening

questionnaire. Lack of support (emotional as well as financial) should be viewed as a risk factor.’

Some of the respondents questioned the scoring system used on the screen. As one respondent pointed out: ‘it is difficult for patients to qualify unless they are black and unmarried.’ One respondent said: ‘I feel that we need to remove the statement regarding race, because if you are black you automatically score 2 points. What about people that are deserving of Healthy Start that are white or other nationality? Not all black clients are poor and needy.’ Others wondered why question 7 (In the last year, has anyone hit you or tried to hurt you?) and question 8 (How do you rate your current stress level? Low, medium, or high?) had no point values.

As is the case with this type of open-ended question, those who are critical were more likely to respond. About a quarter of the respondents were highly critical of the Healthy Start program itself, calling it ‘obsolete,’ ‘inefficient, ineffective, and expensive.’ Said one respondent: ‘This form is a complete waste of time for patients in a private practice... use the money to offer Medicaid to more OB patients or pay more for visits.’ Another said: ‘The problem isn’t the screen itself, it is the lack of services available.’ At least two physicians explicitly noted that the screen was redundant in light of the ACOG prenatal form they are required to fill out (this was also asked on the questionnaire). Other respondents complained about the lack of information they had to explain Healthy Start services to their patients. Many requested educational materials for themselves and their patients. A couple respondents requested someone get in touch with them to schedule a visit with their office to orient them about Healthy Start.

A few physicians seemed to be skeptical that Healthy Start had demonstrated proof of its claims to help improve healthy outcomes. One wrote: ‘the whole thing is a waste of time. We are already under a huge burden of paperwork and it does nothing to improve outcomes—show me the data!’ Another doctor wrote: ‘what database supports the concept that the questions select high-risk pregnancy outcomes? Should send to screeners evidence that screening via this form is a good predictor of pregnancy outcome!’ Another physician wrote: ‘this screen is more symbolism over substance. The reason for the high perinatal mortality rate is that this state classifies what are miscarriages in any other state as live births. The reason for the decline with the inception of the screen was that due to market forces, private providers started doing Medicaid. There is no evidence that the risk factors on the form predict what they claim. At the same time clear risk factors are omitted. This whole program is a farce and an intrusion into our practice.’

More specific criticisms were leveled at the screening process. Some respondents asked for some discretion in administering the screen in the hopes of saving time offering services to people who obviously don’t need them. Others seemed to suggest that their professional expertise was being questioned and usurped; said one CNM respondent: ‘I believe there are patients that would benefit but I think it is wrong that all women must complete this form as we are professionals trained to assess women at risk.’ Others had suggestions to make the process a little easier, suggesting a social worker fill out the form before a patient is even approved for Medicaid coverage.

Some respondents voiced frustration that even if they did follow the screening process, sometimes even that wasn't enough. One said: 'too often forms are returned for reasons that have no bearing on patient's need or care therapy delaying or denying much needed services.' Another noted: 'screens are being returned because pre-pregnant weight is not filled out. Nurses asked to estimate! I don't feel an estimation is appropriate. We give the information we can document.' Others requested regular feedback from their local coalition: 'follow-up on what Healthy Start does with [patients] would be helpful. As it is we get no feedback routinely and if we request feedback, the patient is required to sign a consent form even though we give the information freely. Makes for poor continuity of care between agencies.' Another respondent lamented the lack of available resources: 'you need more Healthy Start nurses to be able to provide the services. One of the biggest barriers to care is lack of transportation. Two of our clinics are rural and >30 miles from a hospital.'

Respondents were also asked to provide a name and phone number if they were open to talking more with the researcher about the screen. While a number of respondents provided this information, only those that wrote a response to the open-ended question that required further exploration were contacted. Attempts to get in touch with 20 such individuals resulted in six successful contacts. Those six respondents were each interviewed by phone for 15-20 minutes.

The first interviewee has been a midwife for 20 years, and a nurse "for a lot longer!" She said their office (a nurse-midwife practice) does the same kinds of referrals (WIC, parenting classes, etc.) as Healthy Start does. She said they receive a form letter as follow-up from Healthy Start and the only worthwhile information on it is the name of the care coordinator. While the form letter says they encourage the women to use the Prenatal Passport, Healthy Start often calls the provider to verify the woman has made a prenatal visit without even looking at the Passport. "It's not a cooperative effort at all; it's you have your information and I have mine." She would like it if the coalitions would "partner with us—help us help our patients." She feels Healthy Start does not seek provider input, and that there hasn't been much improvement in outcomes because information isn't shared with providers. She said that there is demand for smoking cessation programs, and that providers know smoking causes smaller babies, but they can't offer enough programs; "let's put some money where the problems are." Her overall perception was that Healthy Start is a way for the state to use funds, "to keep nurses who used to do care employed doing paperwork."

The second interviewee is an ARNP in a private group practice. She said that the word is out among teenager clients who come in with their friends for the prenatal appointment, to not do the form. When asked why she said their main complaint is that the Healthy Start people bother them: they come to the house and call too much. She is frustrated that they receive no feedback from their Healthy Start coalition except when the forms aren't completed correctly; she estimates that it has been 4-5 years since a Healthy Start representative has been to their office. She also expressed frustration that doing the form is an all or nothing thing; when she knows someone is truly not going to qualify and that they aren't interested in the program many times she ends up throwing out the form. She also claimed the county told them they wouldn't send them Medicaid patients because they weren't returning enough forms. She thinks a lot of resources are wasted when forms are returned as incomplete when a patient declines the services of the program. She also mentioned those who know they don't qualify or don't want the

services are hesitant to give demographic information and asked why the state is so adamant in trying to get that information. She felt more money should go toward helping women who need the services than trying to get complete information on women who don't. She felt the program could be improved by more communication with the Healthy Start administration, and by not making the form mandatory for those who don't need it.

The third interviewee is a certified nurse midwife who works in both a nurse-midwife and hospital outpatient practice. She had mentioned on her survey that it would be helpful if the screen were available in Arabic. She explained that because a university is nearby, their practice gets a lot of foreign students, especially Arabic women who don't speak English. Through translation she usually manages to get them to consent to completing the form, but she thinks they do it just to be nice. In spite of this, she said she would never refer one of them to Healthy Start, even if they could benefit from it, because of their culture: "they would totally freak-out." She said the perception among many women who are hesitant to fill out the form is that "big brother is watching me." She says if you are honest with them about what happens (that numbers get sent to Tallahassee), they become very cautious. She says that since she spends the time explaining to them about why it is something they should do, they can usually be talked into it. She is a member of her local Healthy Start coalition, and so was able to speak from the coalition's perspective. She said that their coalition had had a very hard time working with some of the area doctors' offices. They ended up hiring someone to be a liaison for them; a person who works like a drug rep visiting offices and bringing gifts. This tactic has worked a little bit, but they still encounter resistance from the providers.

The fourth interviewee is a licensed midwife who owns her own licensed birth center. She noted that most of their clients tend to be better educated and have a higher income so tend not to qualify, but sometimes someone does. She told of a young mother who had qualified for Healthy Start in one city who then moved to another city. The client contacted the birth center when her water and electricity were shut off, so they tried to get help for her. When they contacted the downtown Healthy Start office they were told to contact the Healthy Start office closer to the mother's home. When they contacted that office they were told Healthy Start could only help clients who were seeing providers affiliated with a particular hospital. The interviewee was frustrated because Healthy Start seemed unwilling to help when that should be their job. She suggested that there be a way for someone to approach Healthy Start even after having been screened as ineligible. She said sometimes when a woman is visiting the birth center for the first time she doesn't always trust enough to reveal potentially qualifying, shameful personal background details that come out in subsequent visits.

The fifth interviewee is a registered nurse who works for a public health clinic. In the section the providers fill out on obstetrical history is the word abortion. She mentioned some clients become very upset when they get their copy of the screen and see abortion marked when they actually had a miscarriage. The patients are concerned that it be registered that they wanted the pregnancy they lost. She suggested adding miscarriage as a category to that part of the form. She indicated their office has a pretty good relationship with the local Healthy Start coalition, although there was turmoil in the beginning. She said: "it's frustrating that monies don't increase, but the numbers of patients do." Even though 70 percent of their client base is Hispanic she would not want the screen translated. This is because the migrant workers she sees

tend not to be literate in Spanish so they don't comprehend the form if they have to read it. She said, "we even have to explain stress to the Hispanic population" so it is easier to just have someone translate it.

The sixth interviewee is a certified nurse midwife working in a public health clinic. She truly feels Healthy Start "is just a paper-trail, at least 99 percent of the time." She said: "you write referrals [for Healthy Start], then they go for financial evaluation and that is the last you hear of [the client]." She mentioned that many pregnant women come in for an initial appointment, then disappear until delivery, so they are sometimes difficult to keep track of. For a while her health department couldn't even get a Healthy Start nurse to find patients (once they were referred for services) because the nurses refused to go into those areas of town. She also said: "if we refer someone to Healthy Start for a special problem, we never hear what happens!" When asked about the health department's relationship with the local coalition, she said the members sometimes show up at staff meeting all dressed-up, "say hello, and then they are gone." She feels the Healthy Start coalition is trying, but that there is a loose link somewhere, and that clients aren't being adequately served. Part of the problem as she sees it is a delay in services: "if a patient has a problem now, getting her help 3-4 weeks later is usually too late."

Discussion and Interpretations

The results of this survey suggest that while the respondents in general feel administering the Healthy Start Prenatal Risk screen is important, there are certain administrative issues that make doing the screens something of an inconvenience. Respondents did not seem to think that conducting the screen took too much of their time, but it was clearly perceived as a redundant use of time. A majority of the respondents agreed that the screen creates extra paperwork and essentially repeats questions they are required to ask in the standard prenatal record. Furthermore, screens get returned to their offices if they aren't filled out completely. While this last item simply means the Healthy Start coalition offices are doing their job, some of the respondents questioned why screens were returned when only one thing was left unanswered on the screen. A more lenient attitude toward missing data on screens might lead to more women being referred for needed services.

Lack of knowledge about proper screening procedures does not appear to be contributing to the low administration compliance figures, since most screening occurs as required at the first prenatal visit, with both the potential client and a medical staff member filling out the screen. Additionally, a majority of respondents knew they were required to administer the screen, said they did not avoid screening non-English speakers, and did not only screen women they knew would qualify for assistance.

Responses varied regarding compensation for screening, communication with the Healthy Start coalitions, patients' willingness to reveal information, and whether or not patients really needed the services of Healthy Start. A negative position on any of these factors would likely negatively affect a provider's perspective on whether or not to administer the screen.

The analyses by provider type are instructive. Physicians were more likely to feel the screen created extra paperwork and that it took too much time to administer. While most of the

respondents agreed that the screen creates extra paperwork, most disagreed that it took too much time to administer. This suggests the need to address physicians' perception that the screen is time intensive. Physicians also seemed to disagree that they had regular communication with and follow-up on referred patients by their Healthy Start coalitions, although they disagreed that screens were returned because they weren't completely filled out, all of these are opposite the results in the sample as a whole. These results suggest physicians, as a group, may not have as much direct contact with Healthy Start coalition members as do other practice facility staff. Alternatively, physicians may be reacting to the suggestion in the question about returned screens that they have not completed the procedure properly.

The fact that physicians were more likely than non-physicians to feel that doing the screen does not help them provide needed services may be because fewer of their patients come from the Medicaid population. Conversely, it stands to reason that the non-physicians in this survey, who reported a greater proportion of Medicaid-insured patients as a percentage of their patients, were likely to see the screen as helping them provide needed services.

Respondents who answered the open-ended question provided additional clarification for some of the findings of the selective response questions. For example, 62.5 percent of those responding said screens are returned to their office when they are not filled out completely. In the written comments sections, some expressed frustration at forms being returned because they were missing one piece of information. While 68.4 percent of respondents felt they received follow-up from Healthy Start, some commented that they rarely heard from their coalitions. The phone interviewees echoed these difficulties, alluding to an antagonistic relationship between providers and the coalitions.

While only a fourth of the written responses called for translating the screen into other languages, about 50 percent of all respondents felt translating it would aid in completing more screens. Midwives and ARNPs in particular were more likely to agree that translating the screen into Spanish would help in obtaining more completed screens. One phone interviewee shed light on the ambiguous response to this issue by noting that translating didn't necessarily help with understanding, particularly among the illiterate. It may be in the interest of Healthy Start to consider making translated versions of the screen available for those providers who would like to use them.

Respondents were split on whether or not they had regular communication with their Healthy Start coalition. Some of the open-ended responses seemed to indicate that some providers were having little, if any communication with their coalition. Respondents generally agreed they and their staffs were adequately trained to administer the screen, however, only 62 percent said they had received training from their coalition. The requests for educational materials, visits from Healthy Start officials, and sharing of information with providers suggest the coalitions should examine ways to improve avenues for communication.

Some providers were quite adamant in their beliefs that the Healthy Start program itself is ineffective. This view was found in the agreement to the statements that the screen creates extra paperwork and asks the same questions as other forms, in the split response on the need for Healthy Start services, and was echoed in open-ended responses. Clearly some providers feel the

mandate to screen is an encroachment on the way they practice medicine, and some physicians' open-ended responses questioned the scientific basis for the screens. The Healthy Start program must find a way to change these perceptions or possibly face further declines in the numbers of women screened.

Recommendations and Conclusion

The responses of the providers indicate an overriding perception of poor communication between providers and Healthy Start coalitions. They also indicate, however, a desire to foster a climate more conducive to delivering Healthy Start prenatal services to the women who need them. It is imperative that the Healthy Start program explores ways to better communicate with providers. The following suggestions for improving the administration and assessment of the Healthy Start Prenatal Risk screen will hopefully streamline the process and ultimately result in more women being screened and referred for services.

Changes in Communication between Healthy Start coalitions and HMO providers

1. implement timely feedback mechanisms related to referrals
2. explore developing standardized tracking and feedback forms for coalitions to complete and share with providers on a routine basis
3. Provide information on the validity of the Healthy Start screen as a predictor of need
4. Conduct sessions with physicians, particularly, and other practitioners on the importance of non-medical interventions and supports for women whose score is high

Changes to the Physical Lay-out of the Form

1. print in black ink to aid photocopying
2. move patient consent area to just below the patient information section
3. increase the font size to aid readability
4. allow provider signature area to accept a stamp

Changes to Form Content and Scoring

1. provide scores for questions 7 and 8, or explanation for lack of scores
2. rephrase question 4 to ask: "Do you have enough food in your house for all household members to eat?"
3. consider adding a question that addresses the level of support of the father

Customer Service

1. provide a toll-free number for patient and provider questions
2. provide some type of incentive (i.e., samples, gift certificates) to encourage women to complete the screen
3. make available more educational materials

Changes in Form Administration

1. require local coalitions to track and report communications with their providers

One final note: it is critical that AHCA establish an accountability system within Medicaid Prepaid Health Care plan contracts to assure HMO providers comply with the state mandate to

administer the Healthy Start Prenatal Risk screen. Contractual language will make administering the Healthy Start Prenatal Risk screen subject to monitoring via chart audits and will further specify a standard for maternal and infant health care.

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