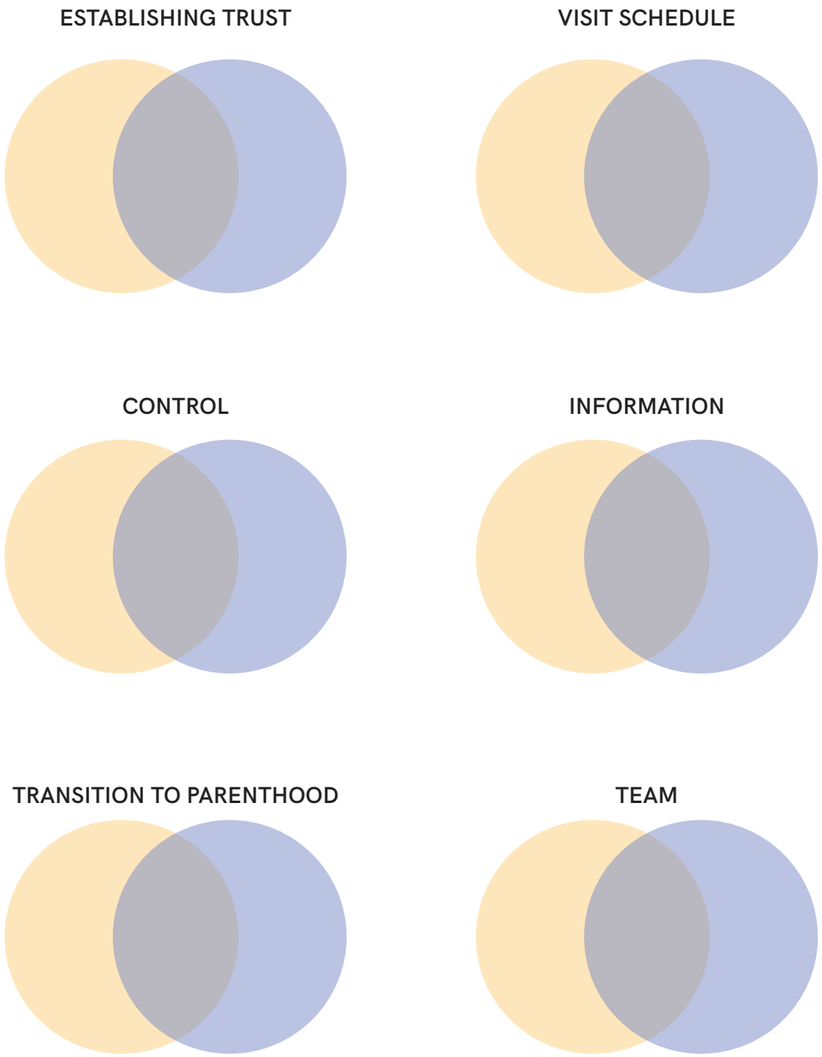
Beth Israel Deaconess Medical Center | epam | CONTINUUM

How can we make prenatal care better for parents and providers?

Side-by-side views from providers and patients and areas of opportunity

Joanna Luo, Alison Kotin, Sandra Hwang, Rebecca Pinn, and Natasha Polozenko
EPAM Continuum

in collaboration with Dr. Eva Luo, Dr. Toni Golen, Dr. Neel Shah, and Michele Hacker
Beth Israel Deaconess Medical Center
Obstetrics-Gynecology Department



Introduction

Why redesign prenatal care?

Background
The current model of prenatal care can be traced back to the beginning of the 20th century. Dr. John William Ballantyne spent his career studying and characterizing some of the greatest "fetal hazards" and ways to treat mothers to avoid them. He wrote an article in 1899 on "Antenatal Therapeutics," arguing that much could be done antenatally to improve maternal and fetal outcomes. This body of work, along with the work of others, led to the first maternity hospitals and ultimately the creation of the field of prenatal care. Ballantyne's goal: "the removal of anxiety and fear from the minds of pregnant women, the treatment of pregnancy disorders, both minor and major, the promotion of normal labor, the reduction of stillbirth and maternal death rates."

The burning platform for change can be highlighted by the fact that the US is one of the few countries where the maternal mortality rate is rising; patients will be able to receive more customized care with improving technology; and as we emphasize shared decision-making, patients are seeking greater control towards an "ideal" birth experience. This was our starting point:

The opportunity is to redesign the prenatal care service delivery system for providers to give every future pregnant patient a care experience tailored to their unique needs.

The Collaboration: Project Joy
In a unique collaboration between EPAM Continuum and Beth Israel Deaconess Medical Center (BIDMC) OB-GYN Department, designers, clinicians, and researchers came together to take a fresh look at the current and ideal states of prenatal care.

Approach
We used the human-centered design process because it enables us to uncover deep insights about the patient and provider experience.

Starting with qualitative interviews, we spoke to a total of 12 mothers who have received their care at BIDMC and 12 providers who work at BIDMC. We developed a structured discussion guide protocol and stimuli in order to understand the functional and emotional needs in the pregnancy experience.

The 12 mothers that we interviewed were experiencing different stages of pregnancy. The majority were postpartum and had the ability to reflect on their experience as a whole. We spoke to a number of second- and third-trimester mothers to get a snapshot of their experience. These interviews were conducted both on the phone and in-person in their homes.

The 12 providers ranged from nurses (postpartum and labor & delivery nurses), midwives, generalists, faculty attendings, private attendings, community attendings, and maternal fetal medicine attendings. At the end of interviews, we used case examples to understand how each provider approached patient care.

All of these interviews were transcribed and analyzed to identify themes, insights, and opportunity areas. (All of our participants' identities have been masked in this document to honor their privacy.)

Opportunity Areas
In this document, we share six specific areas of opportunity as highlighted by both patients and providers. The juxtaposition of the patient and provider perspectives helps us understand the emotional complexities of the current pregnancy experience.

We framed these areas as questions to direct idea development. These opportunities are available to anyone. However, we believe that providers have a tremendous opportunity to deliver better prenatal care by redesigning the experience through the lens of these six areas.

PATIENTS

I want to be supported by someone who understands me and reassures me.

Patients want to feel known, from prenatal to birth to postpartum. When caregivers share information, anticipate needs (proactively provide services like lactation consultants), and remember preferences, patients feel reassured.

All patients have different preferences and personalities. While some want to share everything about their personal lives, others are fine with keeping it strictly professional or clinical. No matter which personality patients have, they are all looking for interactions that inform the doctor about who they are. Whether they are personal facts, like a death in the family, or clinical facts, like Guillain-Barre syndrome, patients are looking for providers who know about their situation, so they can feel reassured about their care.

Little things can make or break the experience for patients. Positive or negative moments within the ecosystem of care can affect a patient's entire perspective of the experience. In a one-size-fits-all pregnancy care model, consistency and customization of care at the individual level is necessary to build and establish trust between providers and patients.

When her brother passed away, her doctor noted it in her file. "I got a nice room. It really touched me… I felt like I was in a suite… Expected that my family was going to be at the delivery. Felt like I was in a hotel. That was extra and that was really nice."
— Mother M, **Postpartum**

"**One of them clearly had never looked at my chart and didn't mention my gestational age. Didn't know anything about me…**I have a history of Guillain-Barre syndrome, so I can't get the flu vaccine. And every single time that I went, they shamed me about not being vaccinated for influenza—every single time I went—and that I was putting my baby at risk…"
— Mother A, **Postpartum**

"**I would always tell her about my personal life and get her advice.** Like if I had a fight with my boyfriend. When I was fighting with my boyfriend, I punched the wall, and I told her what happened. She just told me that anger isn't going to get you anywhere. Anger will be more negative towards you. If I do again, I need to calm down, drink more water."
— Mother L, **Postpartum**

"She's brilliant. She's always been so friendly, and her bedside manner is really good. **We had a nice first appointment, it didn't feel rushed.** She really cares about her patients."
— Mother B, **Third Trimester**

1. ESTABLISHING TRUST

PROVIDERS

The clinical and educational care I provide is important, but I'm overextended and patient logistics limit time.

Some providers seek common ground with their patients, relate to them on human terms, and build a relationship that feels emotionally close so that patients feel comfortable.

However, providers' time is often limited by administrative tasks such as documentation, scheduling, or billing.

A faculty attending with 30 years of experience used to see the same patients from prenatal appointments to delivery. "You just knew absolutely everything about your patients. They could literally call and leave a message with their first name and their voice, and I knew exactly who they were and what had gone on in their last two pregnancies, the name of their husband, name of their kids, what they liked to do in their free time. It was just less busy, and you followed people all the way through."

"**[Midwives] know how you sleep, and we know the name of your dog, and we know what your mother-in-law's like.** If you can't sleep, I wanna know why. Who you are and who you're living with impacts your health."
— **Midwife T**

"I had a patient that is a doctor, an oncologist… She drove an hour and a half to see me for 20 minutes… she really wanted to see me. These are highly educated people, who still don't quite get it. **She is getting reassurance. We spend more time talking about my children than we talk about pregnancy.**"
— **Maternal-Fetal Medicine (MFM) Attending**

"I would say that if you have a challenging psychosocial patient with an extensive history, then you have time constraints. That's challenging."
— **Midwife S**

"Pregnancy's a vulnerable time…**The more you get to know somebody, the better the relationship is, the better the care is. When things go wrong it makes it an easier conversation to have.** Whether it's a miscarriage, or something tragic that happens in their lives, or diagnosing depression which is really common amongst our patients dealing with violence in the home or in the community.
— **Community Attending P**

How can we…

provide patients **reassurance** and **meaningful interactions** without requiring more time from the provider?

Patients are looking for reassurance from a medical professional to know that they are okay and that baby is okay. When providers establish and build knowledge about their patient, they are able to provide more meaningful interactions with their patients. Do these patient-provider touchpoints need to be in-person appointments?

What level of interactions will help patients feel reassured? And how much interaction is needed without creating more work for providers? With the development of group prenatal care or alternative forms of communication between providers and patients, e.g. text messaging or online messaging portals, will patients feel like they are getting the care that they need from their providers?

PATIENTS

I want to see my doctor when I feel I need them the most.

Many patients talked about the lack of touchpoints with their provider at the beginning of their pregnancy, when they have the most questions, fears, and physical discomfort.

Patients who talked about a desire for "peace of mind" at the beginning either wanted to know if they were in fact pregnant or they wanted to make sure the baby was okay.

The end is as challenging as the beginning. Most patients do not know what to expect from their postpartum experience, and waiting six weeks for a standard postpartum visit can feel too long. A postpartum patient who experienced postpartum depression felt "like I had everything I needed, which is part of why I didn't tell anyone how I was feeling. I felt like I should be able to do this. People who don't have family close by or have husbands who take off from work are fine. I thought I might be able to do this, and I didn't tell anybody because I had a lot of shame around it. Then it got worse. Then you are not using the resources that you have, and I felt guilty about it—so silly. It's so different and so many feelings."

"Intense nausea began in the first few weeks after conception. **That was a really, really challenging time because you don't meet with your OB or the person who does your first appointment [a nurse practitioner] until eight to ten weeks**… [About postpartum] I feel like six weeks is TOO LONG! I was glad to see the physician sooner… **Both of my pregnancies had complications, so it's hard for me to think about what an uncomplicated pregnancy would be like, if I would hypothetically need more or fewer visits.**"
— Mother T, **Postpartum**

"Now it takes longer for you to be seen. You used to go right away. Having to wait till eight or ten weeks is really scary. **It's a mental thing. There is nothing that can be done, but I would rather be seen by a doctor right away so that if there are any issues…Gives you peace of mind to be seen earlier…**I would change the number of visits. More at the beginning. Less at the end, check in remotely."
— Mother M, **Postpartum**

"**Unknowingly, I fell into a depression.** I was not enjoying being in a relationship with his dad. I just wanted to be home and didn't want to be in the outside world."
— Mother N, **Postpartum**

"I see [my doctor] constantly, she is always there to help. **I see her every month. Since you see someone for so long, you start to trust them over time—the frequency."**
— Mother L, **Postpartum**

2. VISIT SCHEDULE

PROVIDERS

I'm locked into seeing my patients based on the schedule of the pregnancy, not the emotional or postpartum needs.

The one-size-fits-all model is applied to every pregnant patient. Although parents appreciate frequent contact, many may not need as much prenatal monitoring or as many visits as standards dictate. How to strike a balance between reassurance and unnecessary care? Some attendings talked about alternative forms of care, for instance centering, group care, or telehealth, for patients who are experiencing a a pregnancy that requires less monitoring.

The American College of Obstetricians and Gynecologists recently decided to call the three months postpartum period the "fourth trimester" and talked about the need for follow-up care to happen sooner, to make sure that the transition is more seamless. A few providers talked about the challenges of knowing what to do in this period of the patient's care.

"Patients think we are providing a tremendous medical service… **There's other ways to do that than coming to my office…Patients would not find that as acceptable. Because they don't quite understand what exactly we are doing with them.** If they knew that it was really some preventative healthcare, some education and everything else could be done without talking to a doctor…You come to the office to do some stuff, but why do I need to be sitting in a room for 15 minutes to do this to them every four weeks?"
— **Maternal-Fetal Medicine (MFM) Attending**

"After discharge from the hospital, the next appointment is in six weeks and a lot can happen in six weeks. **A concern that is at the forefront of a nurse's mind is mental status and postpartum depression, especially in the era of social media. Mothers are feeling the pressure to have an Instagram-perfect pregnancy and postpartum experience, and when they feel overwhelmed, or feel as though they aren't measuring up, they are susceptible to different kinds of mental stress.**"
— **Postpartum Nurses**

"A two-week postpartum visit is super important. We see all of our patients at that point…So to improve postpartum depression pickup: screen for family violence, help with breastfeeding, adjustment/social things that come up with a new baby. **So even our straight-foward patients will have a two-week postpartum visit.** Most of our patients come. We also do a six-week postpartum visit. We do the Edinburgh depression screening and so do the pediatricians who are just down the hall."
— **Community Attending P**

How can we…

create a patient schedule to align care for both **clinical and emotional** needs **during and after pregnancy**?

A combination of both clinical and emotional drivers should determine the schedule or journey that patients are set on.

Can we break the one-size-fits-all model to accommodate more personalization without creating an overly complex system for providers? Thinking about Michael Porter's value-based model of care, we should consider what works with what patients want from their experience to improve patient outcomes. We could also learn from community clinics like Bowdin and South Cove about what makes their experiences successful.

PATIENTS

I want a sense of ownership over my pregnancy experience.

Although patients can't "control" the pregnancy experience, they want to know what can happen and the choices that they will have available. They want this information in terms that they can understand.

While some patients go with the flow and some want to dictate the terms of their experience, the majority of patients appreciate providers who presented them options or had a conversation about their care, especially regarding delivery expectations.

For example: for some patients, having few medical interventions makes a "better" pregnancy experience. They were heavily influenced by stories that they had heard from their own mothers or in the news, and believed that if "women have been doing this for thousands of years" they could, too.

Other patients welcome as much medicalization and are highly engaged in the scientific evidence behind recommendations.

"The story that my mom told: she has four kids… she had C-sections. She talked negative about it. I have friends who have had C-sections. [This is] the stuff that just scares you. **I'm like, I hope I don't have to experience the pain of the cutting you.**"
— Mother K, **Second Trimester**

"At 32 weeks the placenta has moved up. **'If it doesn't move you'll need a C-section.' I prefer not, but if that's the case, whatever.**"
— Mother P, **Postpartum**

"**I want to go natural,** but because I was in labor for two days [for a previous pregnancy], they induced me very late at night." It was harder for her to recover.
— Mother Q, **Third Trimester**

"It helped that the doctor who ended up doing the C-section, she really sat down with us and answered all of our questions. **I wanted to make sure that she was really up-to-date on what was going on with the pregnancy. That there would be no surprises in the OR.** I guess we decided to do it because we felt really comfortable with her. It felt like we were in good hands."
— Mother T, **Postpartum**

"**It's just a personal thing, honestly. I think I want to know I can do it—that I have the strength to deliver vaginally.** But realistically, as long as the baby's healthy, it's okay. I tend to put a lot of pressure on myself, and have high expectations of myself, so I struggle with that."
— Mother B, **Third Trimester**

3. CONTROL

PROVIDERS

I need patients to accept they can't control everything in their pregnancy and their child's birth.

Some providers talked about the challenges with patient populations who need to "let go" of a need to control or plan for their birth experience and be open to a variety of possibilities at every stage. Similarly, providers also discussed patients on the other end of the spectrum who defer all decisions to the provider.

Different types of providers will approach patients in different ways: some attendings talked about proactively setting up longer appointments to discuss the details together, and others discussed working to better understand the roots of patient preferences and gently explain the drawbacks.

Still other providers told us that cultural beliefs and word-of-mouth among friends and family members often influence patients' attitudes towards medical interventions such as epidurals or vaccinations.

"**The baby is not reading the birth plan, but if [the parents] have particular ideas of what they would like to happen or not happen, I have a very long visit with my patients at 35 weeks where I go over**: when to call, when to go, hospital consent form. It takes over 30 minutes for that visit and the GBS test when they visit and run through all of their questions related to L&D."
— **Faculty Attending A**

"A lot of people worry about the epidural. **There are many who readily want one. [For some] it's not necessarily that they don't want it, but that there are lots of strong family feelings**… So I spend a lot of time trying to address this."
— **Community Attending C**

"In medicine, the patient is always right… **You can't tell patients they're wrong. You need to figure out why they came to the conclusions/decisions they have. They're right in their head, [but they need to] let me figure out why they came to that conclusion, [and] then tell them why I disagree.** Then they'll actually hear me and feel like I support them."
— **Faculty Attending F**

"**Women are scared of pain, and a lot of people are terrified of C-sections, and they think it is the worst thing that could happen.** I've seen so many of them. I am not sure where it comes from. I**t's not a failure!**"
— **L&D Nurse P**

How can we…

give patients **meaningful options** and **realistic expectations**?

How can providers carve out time in the prenatal schedule for education and counseling on options that patient's can gain control? How can providers reframe the "birth plan" as a document to facilitate a conversation about options and control?

Providers should find areas where patients can make meaningful decisions so that they know what to expect, especially in delivery. There's a large amount of anxiety around how delivery works. Because it's a such a mystery for patients, providers should proactively address the topic. Should there be a list of options for providers to cover? Such a list might alleviate patients' fears and help them feel more confident about the experience.

PATIENTS

I gather information from a variety of sources, and I believe I know which information to trust.

Patients vary widely in how proactively they seek information about pregnancy and what sources they trust most. Differences in approach depend less on generation and more on personality and the presence of an active support network.

Some patients, particularly those without any active support network, prefer going directly to the doctor for questions. Among these patients, those who are less proactive do lean heavily on clinicians as their source of trusted information.

Patients with large, active support networks are likely to turn there first. Among these patients, those with strong existing beliefs about how to approach their pregnancy may feel less of a need to seek out other sources of information, including the doctor.

Many patients reach for digital resources to queue up questions for the doctor or to supplement the advice they receive from their support network. These include a wide array of baby-tracking apps or Google. Patients noted online information is tempting, but can be confusing or alarmist. "Getting off the internet" has helped some manage anxieties, but apps that are "curated" or vetted sources are valuable between provider visits.

Mother K doesn't have a strong group of friends that she goes to to discuss her issues; however she does crave facts and information, so she directs almost all her questions to her doctor. **"All my concerns I go to the doctor…I call him all the time."**
— Mother K, **Second Trimester**

"**I check over six pregnancy apps daily for updates** on what the baby's doing this week, about development, the systems that are forming, good foods to eat, exercise you can/can't be doing.
— Mother B, **Third Trimester**

"Honestly, if I have questions, I call my mom first. She bottle-fed me and my siblings, too. The next is my friends— I have a ton of friends with babies. The next is Google, which I try to avoid. **The last resort is calling the doctor, but I haven't yet.** I didn't have anything serious enough to call my doctor. I wasn't bleeding or anything."
— Mother P, **Postpartum**

"If I had a question, I would Google it. I go to Google for everything. During pregnancy I would search every pain… then when I had a pre-natal visit, I would ask. **You can't always rely on Google.**"
— Mother L, **Postpartum**

"Experience and being a doctor are more important. But **this app helps to reinforce what you are getting**."
— Mother M, **Postpartum**

4. INFORMATION

PROVIDERS

I want to provide accurate information, but I need to focus on care.

Providers recognize that patients are not always receiving accurate information, noting the influence of unreliable online sources and urban myths passed down through generations. At the same time, providers must prioritize the tasks that surround patient care, leaving less time to interface with the patient, let alone educate.

Midwives and postpartum nurses emphasize that the more parents can learn (from trusted sources), the better prepared they will be. This translates to better pain management and easier deliveries. Midwives in particular highlight the importance of building a relationship as a conduit for effective education.

"The biggest challenge is staffing and balancing getting my task list done (vital signs, labs, getting medicated, checking perineum, assessment on baby), while still allowing enough time for education for the parents. **It's hard to multi-task… you can't do postpartum education whilst breast feeding.**"
— **Postpartum Nurse L**

"I think we are there to give accurate information, but patients are coming in sicker and come with a lot of medical problems that need to be managed. Nowadays, I am worried about giving enough time. **You have to get a lot accomplished in a little amount time. I just think that everything is way busier [than it used to be]**."
— **Faculty Attending A**

"You get this wide variety of people who are in a very 'It's in God's hands, whatever happens, happens' passive approach to things. There's a lot of it in immigrant populations. Whether it is because that's their culture in their homeland, or because they're in a foreign country, they don't ask a lot of questions. **I think part of what's challenging and fun is trying to empower patients and get them to be engaged in their own care.**"
— **Community Attending P**

"People can only listen to so much. If you've only been to a doctor's appointment you only hear half of what's said. Y**ou plant the seeds.... [and over time] the relationship develops; we're really good at building relationships.**"
— **Midwife T**

How can we…

educate patients with **relevant and accurate** information **without burdening providers**?

Patients are seeking information everywhere and self-vetting what is a trusted source or not. The influx of information inputs is only increasing with the use of digital tools, including websites, apps, and social media.

More than ever, providers have a critical role to play in educating the patient in a way that is digestible and translates into positive action. At the moment, this is in direct conflict with the constraints that providers face, leaving them forced to find creative ways to find time to educate their patients.

PATIENTS

I am overwhelmed about how parenting and work life will fit together.

For most parents, financial necessity requires that they return to the workforce after their baby is born. Some look forward to an opportunity to re-define themselves again as people, separate from their identity as parents, while for others the prospect of separation from their baby feels overwhelmingly difficult.

The postpartum parents we interviewed identified returning to work or school as a major source of anxiety and ambivalence, and few had a concrete plan or schedule for re-entry into the workforce.

For the parents who most wanted to return to work or school, finding childcare and healing physically and emotionally from labor, and in some cases postpartum depression, were major barriers. While all reported talking to their providers about managing depression and physical symptoms after delivery, none of the parents we spoke with had people in their lives equipped to coach them through returning to the workforce.

"I was in the vet tech program at school, [and] it was competitive. **I want to continue. I don't know when, but I'm worried about that because I don't know.** The school part worries me."
— Mother L, **Postpartum**

"**Work is freedom away from kids. I cannot be a stay-at-home mom (that is a real job).** I like to be in the work force. But, I really love being a mom. Being able to work allows me to want to be with my kids. If I was home all the time, I would want to be away from them."
— Mother N, **Postpartum**

"Of course, I want nothing more than to stay home forever, but it's just not in the cards for us… I was overwhelmed with everything. My partner called my best friend. **I was sobbing to her about my anxieties about work. And then I got an extension on [my work] leave, and I felt better immediately getting the feelings out.** Then I thought I should have done it immediately. I was trying to keep it together."
— Mother E, **Postpartum**

"In America, I feel like the culture, it doesn't support women that are pregnant all the way… For example when you give birth you only get six weeks [parental leave], what are you supposed to do after that? **So you're supposed to take your baby at six weeks and give it to somebody else to take care?**"
— Mother S, **Third Trimester**

5. TRANSITION TO PARENTHOOD

PROVIDERS

My priority is to address the clinical health of the patient and baby.

Providers, especially those who are also parents, recognize their patients' anxieties around next steps after their babies are born. While patients in the hospital tend to be hyper-focused on their physical symptoms, and providers are of necessity focused on preparing them for labor & delivery, providers reflected a growing awareness that parents also need support in preparing for life after delivery.

Helping patients gain perspective on their own priorities, and understanding and managing their anxiety around work, finances, and childcare, are key functions which providers are not always equipped to manage or fulfill, unless they can draw on personal experience.

"In prenatal care in the office, there's nothing that prepares you. It's all about the pregnancy or the delivery to some extent, but nothing [regarding] what happens after that…. **All this time taking time for natural delivery, you should be preparing to be a mom!** That's the hard part. The labor is the 'easy' part."
— **L&D Nurse P**

"Remember how much time you spent preparing for your wedding? … but it lasted six hours. But the whole point is, you are going to be married to this person, hopefully, for decades, and that's what it is all about. Then I go over that it's the same thing like having a baby. **Obviously the birth part is part of the process, and obviously maybe the favorite day of your whole life, but at the end of the day you are going to be parents.**"
— **Faculty Attending A**

"The other issue is: how much postpartum maternity leave do they have? Many go back to work right away. **We are trying to learn more about how they plan and think about childcare.** We are trying to find a way to probe more and have patients think about it more before they deliver. In order to consider alternative plans and see if they are better for their lives."
— **Community Attending C**

"MFMs are particularly bad at the postpartum period. We accept it when the baby is delivered alive and the mom is okay…**Yeah, okay. We will take care of her during postpartum, but we are not good at it. There's so many other sick patients waiting for us.**"
— **Maternal-Fetal Medicine (MFM) Attending**

How can we…

better **equip providers** to help patients **transition into parenthood**?

While all prenatal providers acknowledge that pregnancy is more than just delivery of a healthy baby and healthy mom but instead a transition into parenthood, providers lack the training and support to help patients navigate this transition. What additional resources can providers use or refer patients to to better prepare patients for becoming a parent?

What resources or guides can we provide for providers to help them address this emotionally stressful period of time?

PATIENTS

I want to know who is on top of my case.

Patients value consistency, and feel more secure in their care if they see familiar faces and get to know individual providers well over time. While providers have done a good job preparing patients to expect a new, and possibly unfamiliar, team during their labor and delivery, inconsistencies during routine visits and unexpected changes can cause anxiety and confusion.

Patients quickly become frustrated if they feel they have to repeatedly "tell their story" to new providers who don't know them yet, and assume that little coordination takes place behind the scenes. When a provider takes time to get to know a patient and can demonstrate continuity of information sharing, patients feel reassured that their input is valued and are more comfortable with the care they receive.

"[Regarding the computer notation about a swab discharge test:] **It's important to me because it just takes worry away that they're doing the same steps as they did the first time.** I don't want them to do different stuff, and then it's in the back of my head: 'Woah, they didn't do that stuff the first time,' or 'They're not doing it now?'... A part of me feels like they don't understand where the worry is coming from. Even though they do, it's like they're not trying to fix it."
— Mother K, **Third Trimester**

"She [the MFM] and my OB both said: 'You will be monitored monthly and then more frequently to make sure growing okay'... When I came back and it was a different physician, another MFM, who went over my scan with me, [and] saw a clear picture! It looked good...That was startling to me because it wasn't what I was told before. I said to him, 'Are you sure?' Because my first daughter was small gestationally. And he was like: 'I am recommending that you don't come back.' **Two different physicians, [and two] conflicting opinions. I guess different people just have different approaches**."
— Mother T, **Postpartum**

"[In the] middle part of my pregnancy, I felt very weak - they were hard [times] for me. **Different faces and different nurses every time I got the IM Progesterone shot.**"
— Mother N, **Postpartum**

"When she was on vacation, one time. She referred me to one of her colleagues. Okay. **It felt different, weird. It wasn't the person I see every month**."
— Mother L, **Postpartum**

6. TEAM

PROVIDERS

I want my patients to feel supported but their care requires multiple providers.

Providers note that the system of care for prenatal patients has changed over time, with less consistency across visits for patients and more of a team approach to providing care. While providers recognize that care from a consistent provider is key to building trust and reducing anxiety, this is rarely possible.

From logistical challenges of fitting prenatal visits into patients' schedules, to providers' shift and on-call schedules, to the unpredictability of labor, few factors within the current prenatal care system support this model. While providers support each other, communicate, and often go to extraordinary lengths to track patients across multiple institutions and specialists, these efforts remain largely invisible to patients.

A community attending mentioned, "We work really hard with the MFM division to improve access for our patients including them making appointments for our patients and letting us know so that we can contact patients with our onsite interpreters rather than MFM often does which is calling and leaving voicemail messages in English, which may not be paid through the end of the month. Big improvement in the last two to three years."

"When I first started, we saw our patients for every visit and rounded on our patients. Then we scheduled the C-sections, and there was an assumption that you would be there. **Whereas now, your patients are most likely taken care of by multiple providers.**"
— **Faculty Attending A**

"I think it's also hard because there are certain limitations with the system that we work in. I'd love to be able to deliver my own patients, and I am on-call for two days, but unfortunately she is not 41 weeks until the weekend. **It's hard when you can't accommodate patients for many good reasons. There's a lot of logistical factors.**"
— **Community Attending C**

"[Access to a team] is what the BI means to me... I could not do that by myself. I have these three people right outside for me. There are layers and layers. **I will tell them: 'I am glad that you are in my village.' It takes a village to have a delivery. I am doing that with that posse of 20 people ready in a snap.**"
— **L&D Nurse F**

"Being a product of Beth Israel, when I first got [into my practice], **I emphasized open communication and making sure that patient safety and communication come hand in hand.**"
— **Private Attending B**

How can we...

assure patients the various providers **know their situation**?

At the end of the day, patients wants to know that someone is familiar with the details of their case. Right now, it is not clear to patients who their care team is, and they are left uneasy. Providers on a care team communicate and coordinate with other members of the team, but patients are unaware of this collaboration.

How can we give patients visibility into who is taking care of them and assure them that the details of their case are constantly being communicated within the care team?

Project Joy
In a unique collaboration between EPAM Continuum and Beth Israel Deaconess Medical Center (BIDMC) OB-GYN Department, designers, clinicians, and researchers came together to take a fresh look at the current and ideal states of prenatal care.

Learn more about our project here.

Beth Israel Deaconess Medical Center (BIDMC) OB-GYN Department aims to provide outstanding, compassionate patient-centered care, educate future leaders, and support research to improve health outcomes in obstetrics and gynecology, all in an innovative and progressive work environment. As a non-profit, academic institution, BIDMC OB-GYN Department embeds quality and safety into the DNA of all processes in the department with a keen eye towards opportunities for systems improvement to address the greatest challenges of today.

EPAM Continuum is a global innovation design firm. Our work is informed by the needs, desires, and aspirations of people: customers, patients, citizens, and those who make our client organizations work. Together with BIDMC, we strive to improve the lives of mothers and medical providers who work hand in hand to bring new lives into our world and to preserve and protect the lives for which we care every day. To learn more about our approach, please visit us at our website.