Third Trimester Patient Education: Increasing Engagement

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Abstract

Objective: The purpose of this quality improvement project was to update third trimester patient education material and increase engagement with material between midwives and patients.

Setting/Problem: This project occurred in a midwifery practice in a large, urban, academic health center and research university. The existing third trimester education material was outdated and there was no structure in place to review it with patients. Research indicates patients should be provided with various teaching modalities to enhance learning.

Intervention/Aims: The third trimester packet was updated as a part of this project. Instead of having the medical assistant give the packet to patients, midwives gave patients the packet, creating an opportunity to review the information together. There were three specific aims: At least 80% of midwives to report updated material as "very helpful," at least 80% of eligible patients (27 weeks – 33 weeks) would receive the updated packet from the midwife**,** and at least 80% of patients who received the updated packet would review it with the midwife. Midwives were asked to respond to a survey after each clinic day that they provided the updated packet to patients, responding to both close-ended and open-ended questions.

Results: Overall, 87% of midwives reported the packet was "very useful," 74% of all eligible patients received the updated packet, and of those that received it, 89% opted to review it with the midwife. In the free-text responses, midwives expressed appreciation for the updated packet but also found it challenging to remember to give it to patients.

Conclusion: Overall, the updated prenatal education packet was well received by the midwives, however, it was challenging for them to remember to hand it to patients. When offered, patients overwhelming accepted the opportunity to review the packet with the midwife, suggesting they appreciate this learning opportunity. Moving forward, midwives should provide patients the

opportunity to review teaching materials together. It may be beneficial to have permanent copies in the exam rooms so that midwives and patients can review the material at any time, rather than just when the patient is provided with their own copy.

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Problem Description

Patient education is a fundamental component of patient-centered care. Health outcomes are improved when patients are informed and engaged in their care (Agency for Healthcare Research and Quality [AHRQ], 2020a). In the prenatal setting specifically, research shows patient education and health literacy lead to improved knowledge of pregnancy, birth, and the postpartum period (Freda, 2004; Schnitman et al., 2022). It also improves maternal satisfaction with care, promotes a sense of self-efficacy, reduces stress, and may reduce c-section rates and epidural use (Hong et al., 2021; Vogels-Broeke et al., 2022). It is well accepted that patient education is a critical component of quality healthcare, but it is less clear what appropriate, effective, actionable patient education looks like in the antepartum setting (Likis, 2009).

In the midwifery care model, shared decision-making plays an important part in providing care (American College of Nurse-Midwives [ACNM], 2016). Shared decision-making emphasizes patients' direct involvement in the medical decisions that affect their health which involves providing anticipatory guidance, effective communication, and weighing and balancing a patient's values and preferences (Agency for Healthcare Research and Quality [AHRQ], 2020c; ACNM, 2016). Often, this process includes decision aids or other written education material (AHRQ, 2020c). Most prenatal education is provided through dialogue and via handouts or leaflets (Grimes et al., 2014). While there is evidence demonstrating the effectiveness of decision aids specifically, there is little evidence regarding the utility of handout-style resources. Some data demonstrates that although written materials are distributed often, follow-up discussion or checking for understanding is rarely done by the healthcare provider (AHRQ, 2020c; Grimes et al., 2014). Indeed, the AHRQ states healthcare providers should not assume patients read the materials provided to them (2020b). Evidence shows that when written material

is provided to pregnant patients without explanation or checking for understanding, they are much less likely to engage with the material at all, suggesting printed materials should be used to support discussions with healthcare providers, not replace them (Stapleton et al., 2002; Grime et al., 2013).

In a midwifery practice set within a large academic health center and research university in the Northwest United States, pregnant patients are provided with a variety of patient education material throughout their pregnancy. Many of these resources are provided as handouts and decision aids while others are provided electronically. It is standard practice to provide patients with a printed "Third Trimester Pregnancy Education" packet (which will be referred to simply as "the packet" throughout this paper). The packet covers topics ranging from recognizing signs of preterm labor, Group B Strep screening, pain management options in labor, and instructions for finding a breast pump. However, a baseline assessment found the content poorly organized, outdated, and consequently not frequently used as a teaching tool during patient visits. There was also no standard process of asking the patient if they have read the material or have questions about it. Therefore, it was unclear how much of the content is read or understood by patients. Improving the third trimester patient education material was a multi-step process. The purpose of this project was to a) review the literature and determine the best mode of delivery for patient education (written, video, etc.); b) improve the quality and utility of the teaching material based on those findings; and c) assess the midwives' satisfaction with the updated material and encourage them to engage patients with the content when first provided to the patient. Future projects may focus on further increasing engagement and measuring patient learning and satisfaction with the material.

Available Knowledge

An extensive body of evidence regarding best practices around prenatal education does not exist. However, there is information available regarding best practices in general patient education that can be extrapolated to prenatal care. For example, the *Patient Education Practice Guidelines for Healthcare Professionals* is a robust, evidence-based resource for providers based on the education processes of assessment, planning, implementation, and evaluation (Health Care Education Association [HCEA], 2021). The guidelines support using a multi-sensory approach to patient teaching, i.e., a combination of written, oral, video, pictures, and hands-on-skills methods (HCEA, 2021). Additionally, multiple teaching strategies should be used simultaneously. For example, if giving oral information, a written handout should also be provided and referenced (HCEA, 2021).

In the prenatal education space, there are multiple publications that provide recommendations around when specific patient education or counseling should be covered. These include *Evidence Based Prenatal Care* guidelines by the American Academy of Family Physicians (AAFP) (Kirkham et al., 2005), the *Guidelines for Perinatal Care* by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (2017), and lastly the *Clinical Practice Guideline for the Management of Pregnancy* by the Department of Veterans Affairs (VA)/Department of Defense (DoD) (2018). All but the AAP/ACOG guidelines provide a level of the quality of evidence for each education topic. No dramatic variation in prenatal education recommendations was noted. None of the guidelines provide specific details around patient education modalities, but the VA/DoD guidelines, consistent with the HCEA

guidelines, do state that patients appreciate access to different forms of information (books, pamphlets, mobile applications, etc.) (VA & DoD, 2018; HCEA, 2021).

A few patient education studies have been conducted in the prenatal setting. A descriptive, cross-sectional quantitative, research study utilized an online survey to examine 171 expectant parents' preferences for education delivery methods as well as the perceived importance of various prenatal, birth, and postnatal topics (Kovala et al., 2016). Almost half of respondents, 47.5%, reported that they wanted to receive information face-to-face and 37.0% indicated they wanted to receive information both in person and online. Of the participants who preferred to receive information online or online in combination with in-person learning, 70.8% preferred to watch videos, and 63.2% preferred to read information online. A smaller percentage, 55.6%, indicated that they were interested in downloading a mobile app. There was a lack of diversity in this study, with most participants being white, female, and well educated. However, these findings are mostly consistent with results from a survey of 350 pregnant people receiving care in a large Australian hospital who indicated that the source of information they used most often and found most useful was discussion with their midwives (70%), followed by a booklet (61%) provided in the first trimester that covered a wide range of pregnancy related topics and care specific to that hospital (Grimes et al., 2014). Of note, the booklet was only provided in English and over half of the survey participants were primiparous, so it is unclear if multiparous individuals would report the same preferences.

The Australian and Canadian study findings are consistent with the primary finding of a more recent quantitative cross-sectional study of 1,922 Dutch individuals who indicated that their most useful source of information in early and late pregnancy was their midwife (91.5%), followed by friends and family (79.3%), websites (77.9%), and mobile applications (61%)

(Vogels-Broeke et al., 2022). Interestingly, this study examined participants' perceived trustworthiness of each information source and found that midwives were the most trustworthy, and while digital sources such as websites and mobile apps were used more often, respondents felt they were the least trustworthy. Also relevant to this project, the authors found that leaflets provided by maternity providers were used less often than peers, apps, and websites. Like other studies reviewed, study participants had a slightly higher level of education than the general (Dutch) population. Unlike other studies, there were more multiparous than nulliparous participants.

In summary, available guidelines inform which prenatal topics should be covered and when, as well as suggest using a combination of teaching strategies to ensure the best opportunity for patient learning (HCEA, 2021; Kirkman et al., 2005; AAP & ACOG, 2017; VA & DoD, 2018). The patients themselves report they value conversations with providers and glean valuable information and education from these interactions (Kovala et al., 2016; Grimes et al., 2014; Vogels-Broeke et al., 2022). Although written information is not the preferred mode of patient education, it proves to be effective especially when used in conjunction with discussion (HCEA, 2021).

Rationale

This project was developed using evidence from the available knowledge to create a packet and intervention that utilized best practices to support effective communication and provide anticipatory guidance for patients in their third trimester (HCEA, 2021; ACNM, 2016). This project followed The Institute for Health Improvement (IHI) Model for Improvement (MFI) methodological framework. The selected changes were studied using Plan-Do-Study-Act cycles (IHI, 2021). PDSA cycles allow the user to test and refine specific changes in the healthcare

setting on a small scale and then implement successful changes on a broader scale (IHI, 2021). This methodology was used to evaluate changes made to the existing third trimester patient education material currently used in the midwifery practice setting.

Specific Aims

This project's purpose was to produce an education packet that meets the midwives' satisfaction and to increase engagement with the content between midwives and patients. Three specific aims were developed to address these goals. The first aim was that 80% of midwives would report the updated material as "very helpful." The second was that at least 80% of eligible patients (27-33 weeks) would receive the updated packet from the midwife. The final aim was that at least 80% of patients who received the updated packet would review it with the midwife.

Methods

Context

There are nine midwives who regularly see patients in clinic, with a few per diem midwives who see patients in the clinical setting as well. One medical assistant (MA) and one registered nurse (RN) are dedicated to the midwifery service, but other MAs and RNs fill in when needed. Approximately 100 patients are seen in a week. Prior to the implementation of this intervention, the MA gave patients the packet at the 28-week or 30-week visit. The MA provided no formal explanation of what information was included in the packet. In a baseline survey of 11 midwives for this project, 54% of them responded they "always" reference the packet when talking to patients another 36% indicated they "often" reference the third trimester packet. However, multiple midwives also stated that they were unsure what material patients had already received, that there were difficulties with patient engagement, and inconsistent follow-up regarding the material. Even though midwives said they reference the material, it is unclear how

detailed or vague their reference to the material was. Because patients take the packet home with them and typically do not bring them to subsequent visits, there is little opportunity to review the content together. Lastly, 55% of surveyed midwives said that patients "rarely" mention written material provided to them, so it is unclear whether patients engaged with the material on their own. This may be partly explained by how each midwife manages their visits. There is variety in the style in how visits are conducted and there is no standardized manner of reviewing education material with patients. The intent of this project was not to dramatically change the way each midwife provides care but to improve the material's quality and make it more user-friendly for the midwives. The goal of the slight change in workflow was to facilitate engagement with the material between midwife and patient.

Interventions

First, the packet was updated and reorganized using already existing patient education material from sources like the American College of Nurse Midwives (ACNM), the Centers for Disease Control (CDC) and The American Academy of Pediatrics (AAP). A table of contents was created, and content was organized by topic. The updated packet material was approved by the midwifery practice manager who is also a practicing midwife. Over the course of three, three-week PDSA intervention cycles, three midwives at a time (eight midwives total across all three intervention cycles) were asked to give their patients the packet when they presented for their 27-week to 33-week visit, rather than having the MA perform this task. The midwife then offered to quickly introduce them to the material. See Appendix A for a timeline of the intervention cycles.

In the first PDSA cycle, midwives received an email reminder the night before their clinic shift to provide the packet to eligible patients. In the second PDSA cycle, the midwives

continued to receive an email the night before their clinic shift that reminded them to offer the patients the packet, they were also given suggestions about how to approach the review, for example highlighting the different sections of the packet, based on feedback from the first cycle. In the third PDSA cycle, midwives received email and text reminders and the MA was also asked to remind the midwife to hand out the packet. This change was based on feedback that it was challenging to remember to hand out the packet and a desire to have the MA involved. Packets were printed at the personal expense of the project director, by the midwifery program coordinator in the School of Nursing, and by the midwifery practice manager in the hospital.

Study of Interventions

The midwives participating in the intervention were given a survey after each clinic day (see Appendix B). Closed-ended questions were used to collect quantitative data measuring midwife satisfaction and engagement with the material. Qualitative data was collected via closed-ended and open-ended questions to solicit feedback on perceived barriers and areas for improvement. At the end of the third cycle, midwives were asked to complete a modified version of the survey used to collect baseline data for this project, to help assess for any potential increased engagement with material overtime (Appendix C).

Measures

The primary outcome measures of this project were to describe overall midwife satisfaction with the material, the percentage of patients who receive the updated material, and the percentage of patients who opted to review material with the midwife as a measure for engagement. Process measures included the number of 27-week to 33-week patients who were not offered the packet by a midwife participating in the project (i.e., number of times the midwife or MA forgot). Balancing measures include cost of printing new packets, any perceived

inconveniences noted by the MA or midwives related to the change in process for handing out the packet, any notable perceived increases in length of visit, and any perceived burden of completing the survey by the midwives.

Analysis

Survey responses were analyzed using mixed methods. Quantitative responses were reported as mean scores and run charts. Qualitative data was coded and analyzed for themes and overall impressions of the updated packet.

Ethical Considerations

There were a few ethical considerations with this project. The most significant consideration being that not all patients received the same material, as the updated content was trialed. Second, the updated material was made available only in English at the time of the intervention. Finally, the project director accessed visits via the Electronic Health Record (EHR) to determine which patients qualified to receive a packet. However, no patient data was collected or analyzed to complete this project. A request for determination from the university's institutional review board determined this project to not be human subjects research.

Results

Between October 5, 2022, and December 2, 2022, 41 patients between 27 weeks and 33 weeks gestation were identified as eligible to participate in this project. Two patients did not show for their visits; therefore, data was collected on 39 patients total. In the first PDSA cycle, midwives provided packets to 10 of 16 eligible patients (63%). On one day, the midwife forgot to hand out the packet. On another, the project director forgot to remind the midwife to hand out the packet. All 10 patients who received the packet opted to review it with the midwife (100%).

In the second PDSA cycle, midwives provided five of the seven eligible patients the packet (71%) and two of them (40%) opted to review the packet with the midwife. In both instances where the patient did not receive the packet the midwife forgot. No explanation was given why the patients did not opt to review the packet.

In the third PDSA cycle, midwives provided the packet to 13 of 16 eligible patients (81%) and all 13 patients opted to review the packet with the midwife (100%). Across all three PDSA cycles, 74% of eligible patients received the updated packet and 89% of those patients engaged with the material and the midwife. Visual representations of this data is provided in Appendix D.

When midwives were asked "Is the packet a useful education tool/effective complement to your discussions with patients?", 87% responded "the packet is a very helpful tool" and the remaining 13% said the packet was "moderately helpful." When asked "Do you feel more familiar now with the third trimester packet than you did previously?,"14% said their familiarity improved significantly, 43% of midwives responded that their familiarity had improved moderately, 7% said their familiarity improved minimally, 21% said they already knew all the content and their familiarity did not change and 14% said their familiarity did not change and they still do not know what is included in the packet. Midwives were also asked to indicate how much time reviewing the packet added to their visit. 82% of responders stated they spent up to five minutes reviewing the packet and 18% responded that they spent up to 10 minutes of the visit reviewing the packet.

Midwives also documented feedback they or the patients had about the packet and multiple themes emerged. First, the topic of pain management and/or specifically how to access TENS units came up four times. Second, appreciation and/or satisfaction with the packet was mentioned four times and finally, the challenge of remembering to give out the packet was

mentioned three times via survey and several more times via informal text or email. There were additional comments about how midwives used the packet, for example focusing on pregnancy material and not covering postpartum material. Midwives also proposed some ideas for how to further improve the packet, such as adding information about local pediatricians. All free form responses can be found in Appendix E.

Finally, eleven midwives (both faculty and per diem) participated in the presurvey conducted a few months before the intervention began and seven midwives participated in the post-survey one week after the last PDSA cycle ended. When asked "In third trimester prenatal visits, how often do you reference the third trimester education packet when talking to patients?" there was a 25% decrease in the "always" responses from pre- to post-survey (54% vs 29%), a 7% increase in the "often" responses (36%" vs 43%), and a 5% increase in the "sometimes" responses (9.1% vs 14.3%). When asked "How often does a patient specifically reference printed education material the midwifery practice has provided to them when asking you a question?" there was a 14% increase in the "often" responses from pre- to post-survey (0% vs 14%), a 3% decrease in the "sometimes" responses (46% vs 43%) and a 41% decrease in the "rarely" response (55% vs 14%).

Discussion

Summary

Overall, the updated packet was well received by the midwives. The first specific aim of the project was met with 87% of the midwives reporting the packet as very helpful. Also, in the free text responses, appreciation for the updates was noted on multiple occasions. The second specific aim was not met, less than 80% of eligible patients received the updated packet, with only 74% receiving it. Over the course of the three PDSA cycles, the percent of eligible patients

who received the packet increased, perhaps because of the increased number of reminders received and the midwives' increased familiarity with the process. However, it was evident from the free response that it was challenging to remember to give eligible patients the packet, rather than having the MA do it. When patients did receive it, almost all (89%) accepted a quick review with the midwife which met the third specific aim of having at least 80% of patients who received the packet reviewing it with the midwife. Of the three patients who received the packet but did not review it, two saw the same midwife, so it is possible that her invitation to review the material was less inviting than other midwives. Finally, midwives found that reviewing the packet took five minutes or less which is reassuring given time constraints were mentioned as a barrier to reviewing education material in the presurvey. The rationale behind this project's design was to provide multiple teaching modalities to patients to facilitate learning and to support midwives and patients in shared decision making. An overwhelming majority of patients opted to discuss the material with the midwife, demonstrating their appreciation of this opportunity to learn and engage with the midwife in this way.

The updates made to the packet according to available evidence are a significant strength of the project. Also, the midwives had the opportunity to refamiliarize themselves with the material and provide feedback, potentially motivating them to utilize the material with patients more regularly. Finally, measuring the number of patients who accepted to review the packet with the midwives demonstrated that they do want the chance to engage with education material with the midwives, rather than simply taking it home with them. This is valuable information for the midwives and should reinforce the importance of regularly offering multiple teaching modalities to their patients.

Interpretation

It is difficult to directly compare the results of this project with findings from the literature because in this project patient satisfaction and preferences around patient education were not directly assessed but were inferred based on the midwives' responses to the survey. Still, the midwives' responses to this project are consistent with the findings that patients appreciate or prefer learning from conversations with their midwife (Kovala et al., 2016; Grimes et al., 2014; Vogels-Broeke et al., 2022). Also, the design was consistent with the recommendation from the *Patient Education Practice Guidelines for Healthcare Professionals* to use multiple modalities to provide patient learning (HCEA, 2021).

Surprisingly though, a smaller percentage of midwives said they always review the third trimester packet with patients in the post-survey compared to the presurvey (54.5% vs 28.6% with the majority (42.9%) selecting "often" in the post-survey. Because the intervention in this project was to have midwives offer to look over the packet with patients, it was expected that this value would go up in the post-survey. There are a few possible explanations for this discrepancy. First, in the presurvey, midwives who did not end up participating in the project responded, and second, for midwives who did participate in the project, their responses may have been more reflective of their true practices in the post-survey compared to the presurvey because the project was more top of mind. The project may have made the midwives more aware of their usual practices and they may have more accurately responded to this question. Also, midwives were only asked to participate for three weeks at a time, they may not have referenced the packet at all, or much less often, when not prompted to do so. However, the percentage of patients who "rarely" mention patient education material as reported by the midwives decreased (54.5% vs

42.9%), possibly suggesting patients are bringing up questions about education material more proactively.

Overall, the workflow proposed in this project will not be sustainable moving forward and another strategy will need to be used to create the same opportunity for patient and midwife to review the third trimester packet together. Midwives are not accustomed to handing out patient education material and MAs are not accustomed or appropriately trained to engage patients with the education material they provide them. Different strategies should be trialed to determine the most streamlined way to support midwives in engaging patients with learning material. This may necessitate the MA proactively providing the midwife with the packet or having materials available in the exam rooms for midwives to use whenever they deem appropriate. Providing the content digitally could create one more opportunity for patients to absorb the material. Also, in the future, the same group of midwives should be surveyed before and after the intervention is implemented to measure quality improvement more accurately.

Limitations

First, because no patient specific data was collected or tracked intentionally, it is possible that a patient did not receive a packet in one visit but did receive it in a future visit, but both instances were recorded in the data. This means that the overall percentage of patients who received the packet might be artificially low. Also, there are instances where a midwives gave patients outside of the predefined gestational age range a packet or provided the packet to patients in group prenatal care. These patients were not recorded in the overall data collection. Second, the pre- and post-surveys were conducted anonymously, therefore it is impossible to know which midwives participated in both surveys and if their answers changed between the two surveys. This also made it impossible to accurately assess whether any quality improvement was

directly attributed to the intervention. Third, this project did not assess midwives' willingness to hand out the packet or understanding of why they were asked to do it. In effect, it is difficult to determine if midwives appreciated that the project's overall purpose was to enhance patient education by increasing engagement between patient, midwives, and the education material. Fourth, patient satisfaction with the packet and assessment of learning was not directly measured. Finally, printing the packet was more challenging than anticipated. The packet will need official approval by the university to be printed and distributed broadly to all patients in the midwifery practice.

Conclusions

The updated packet was well received by the midwifery team. The updated packet should be approved by the university so it may replace the old one. The midwives may be more likely to use or reference the packet now that it has been improved and many of them feel more familiar with it than they did before. However, the workflow used in this project will not be sustainable moving forward. A future quality improvement project could be to assess the best method for distributing the packet. It would be beneficial to better assess whether the midwives are willing to hand out the packet themselves and understand the purpose is to increase the opportunity to engage with the patient and the material, thereby enhancing patient learning. It may also be useful to create a few laminated versions that can remain in the exam rooms for midwives to reference at any time rather than just when the patient receives it for the first time. In addition, the packet could be provided electronically to reduce printing costs and meet the needs of patients who prefer digital content. Patients overwhelmingly chose to discuss the material with the provider making it imperative that the practice continue to prioritize multimodal patient education opportunities.

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Appendix A

Project Timeline

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-Mar
Finalize project design and approach (703A)			X					
Complete IRB determination and approval (703A)				X				
PDSA Cycle 1 (703B)				X				
PDSA Cycle 2 (703B)					X			
PDSA Cycle 3 (703B)					X	X		
Final data analysis (703B)						X		
Write sections 13-17 of final paper (703B)						X	X	
Prepare for project dissemination (703B)								X

Appendix B

Survey:

1. How many patients did you see today between their 28th and 32nd week of pregnancy?
2. How many of those patients received the updated packet and were offered a quick introduction to the material?
3. Of the patients who were offered a quick introduction to the material, how many accepted?
4. If you were unable to provide the packet to a patient, what barriers prevented you from doing so?
5. By how much time did the introduction of the packet increase the length of the visit, if at all?
    a. No added time
    b. Up to 5 minutes
    c. Up to 10 minutes
    d. More than 10 minutes
6. Do you feel more familiar now with the third trimester packet than you did previously?
    a. My familiarity has not changed, I still don't know all the content that's included
    b. My familiarity has not changed, I already knew most of the content that was included
    c. My familiarity has improved minimally
    d. My familiarity has improved moderately
    e. My familiarity has improved significantly

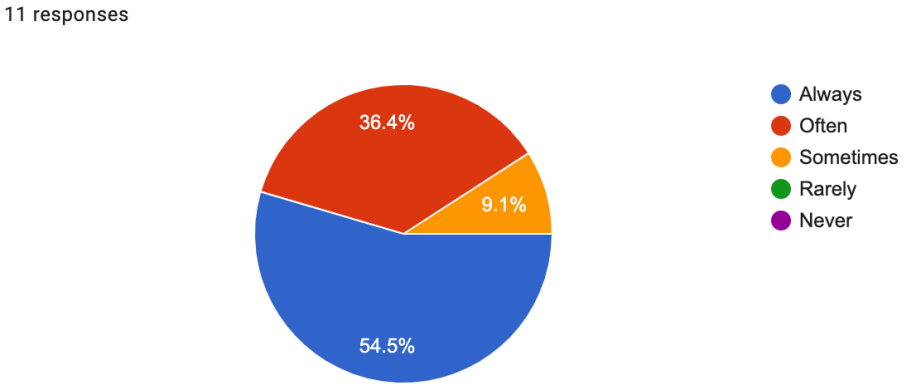
7. Is the packet a useful education tool/effective complement to your discussions with patients?
    a. The packet is a very helpful tool
    b. The packet is moderately helpful
    c. The packet is minimally helpful
    d. The packet is not helpful
8. What feedback do you have about the packet related to barriers of use, content, design, engagement strategies, etc?
9. What comments or questions did the patients have regarding the material?

Appendix C

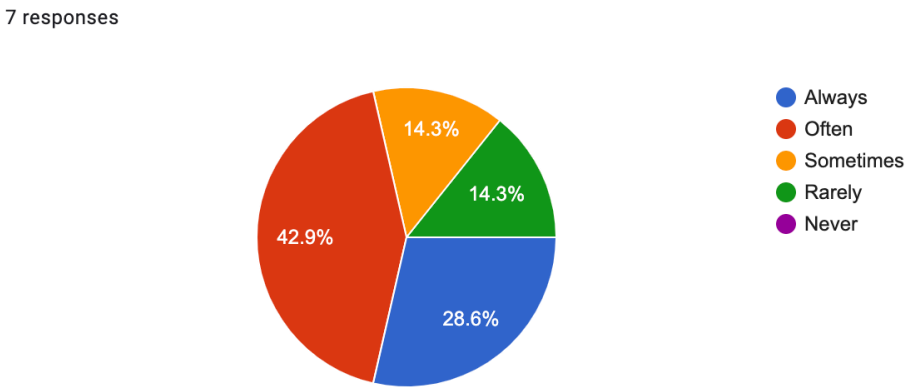
Pre- and post- intervention survey results from the midwives:

1. In third trimester prenatal visits, how often do you reference the third-trimester education packet when talking to patients?

Presurvey:

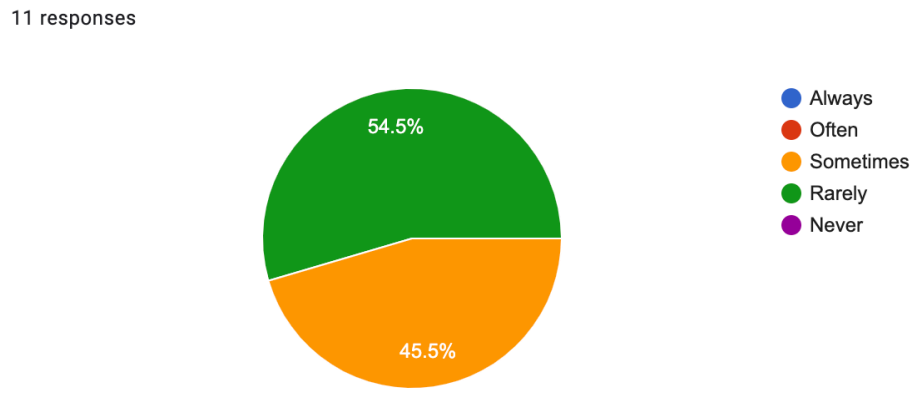


Post-survey:

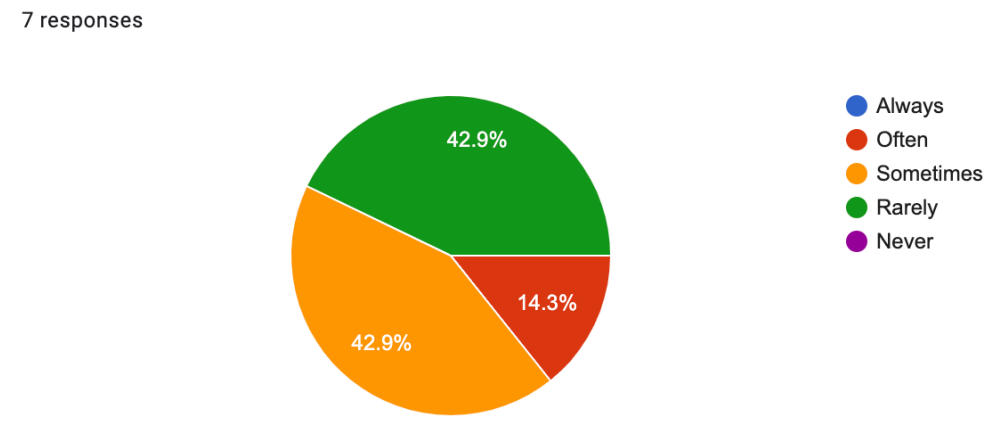


2. How often does a patient specifically reference printed education material the midwifery practice has provided to them when asking you a question?

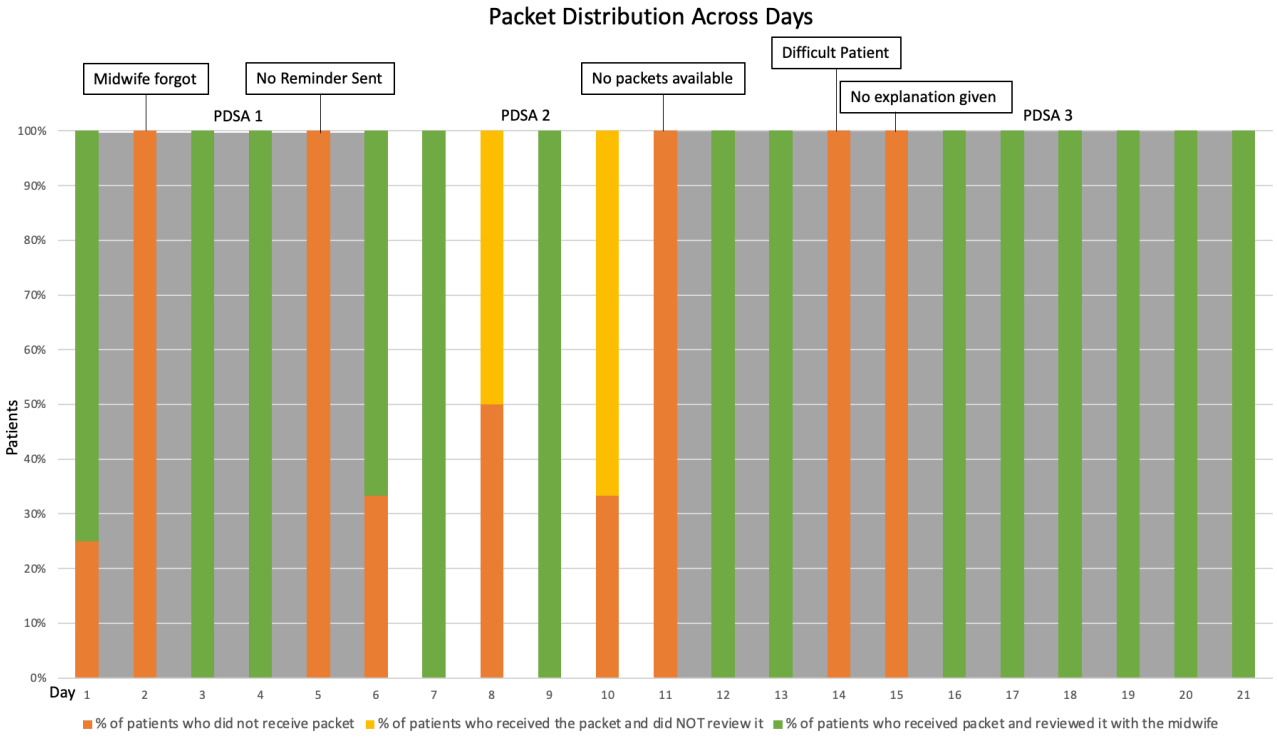
Presurvey:

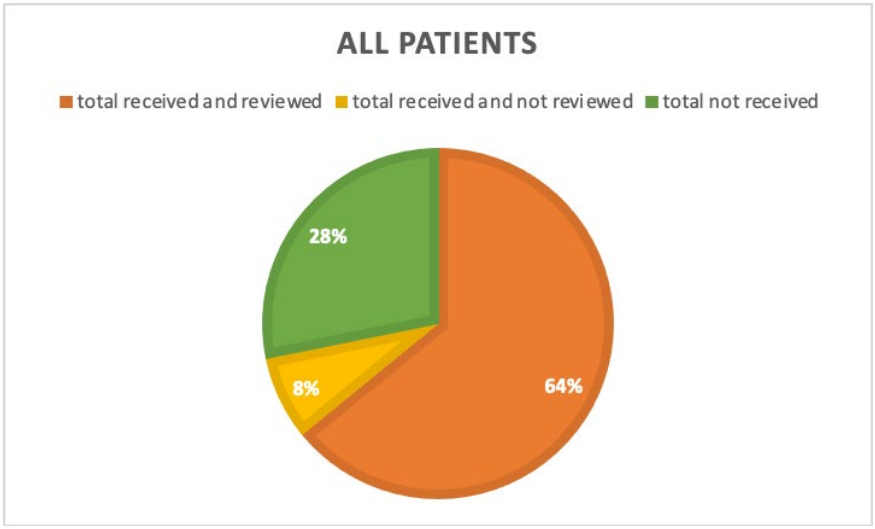


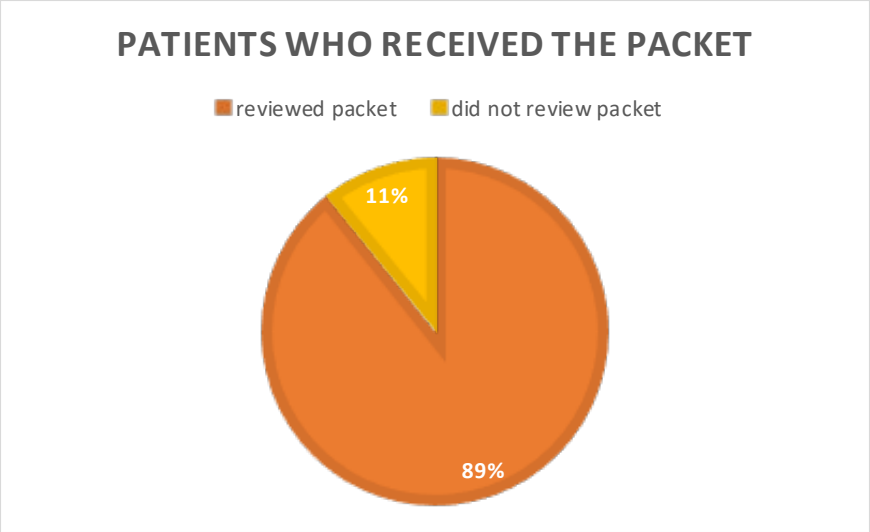
Post-survey:



Appendix D


Packet Distribution Across Days
Midwife forgot
No Reminder Sent
PDSA 1
PDSA 2
No packets available
Difficult Patient
No explanation given
PDSA 3
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Patients
Day
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21
% of patients who did not receive packet
% of patients who received the packet and did NOT review it
% of patients who received packet and reviewed it with the midwife


ALL PATIENTS
total received and reviewed
total received and not reviewed
total not received
28%
8%
64%


PATIENTS WHO RECEIVED THE PACKET
reviewed packet
did not review packet
11%
89%

Appendix E

What feedback do you have about the packet related to barriers of use (if you were unable to provide a patient with the packet, what prevented you from doing so), the content, design, engagement strategies, etc.?

- Forgot to give one it. Would be helpful if the MA would hand me it after rooming the patient, so I don't forget!
- I think the packet is well done but I do think a couple of the patients were a little overwhelmed with all the material. For discussion, may be we can break the packet up into two packets, one given at 28 weeks and another given at 32-34 weeks?? (just a thought)
- I tend to go over the current pregnancy related stuff in more detail, and spend less time on the postpartum stuff
- I forgot. I think the gestational age range is hard. I would be more likely to remember for every 32 wk visit. Or something like that.
- Biggest barrier after today is not able to change info to more accurate up to date info.
- No comments other then appreciation
- 31 weeks, had already received it and went through it. She is interested in the Ten's unit. How do I go about getting one for her?
- Overall I love the improvements on the packet, it is great!
- helpful to have something refer to and helpful topics patient can bring up

What comments or questions did the patients have regarding the material?

- I actually ended up giving it to 2 others (>36w) because they had questions about GBS/cervical ripening/baby meds etc and I was confident this material was in there (compared to the old packet).
- Going over the TENS unit page is awkward because we don't offer it.
- Where can they get a TENS unit.
- Might be helpful to have Childbirth and breastfeeding class options listed and Peds provider info – those are the two questions I get asked about a lot around this gestational age.
- One patient had questions about tools for pain management
- Thy all plan to read the packet in further detail and bring questions to next OB visit.