PATIENT EXPERIENCES

of Montana's Maternal Healthcare System

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MOMS
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Introduction

Patient-provider interactions significantly impact pregnancy and childbirth experiences [1]. Patients have widely reported poor treatment during the perinatal period, including disrespect, mistreatment, and a loss of autonomy [2, 3]. Considerable disparities exist in birth experiences and outcomes based on race, class, gender, and other aspects of identity [2]. Pregnancy marks a critical period for a person's health, and disrespectful treatment can cause mental and emotional harm that extends beyond birth [4]. Negative experiences influence future health-seeking behaviors, leading to long-term adverse health impacts [5]. To improve maternal health outcomes more must be done to adapt systems around the needs of patients and prepare providers to offer person-centered care.

Person-centered maternity care refers to "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all decisions [6]." Dynamics of patient-provider interactions, including provider attitudes and behaviors and the patient's involvement in decision-making, have a greater influence on birth experiences than medical interventions, the birth setting, and patient characteristics [7]. The positive impacts of person-centered care extend beyond patient satisfaction, contributing to improved mental and physical health outcomes [8]. Understanding patients' perinatal care experiences is vital to enhancing respectful, person-centered maternity care practices [3, 9].

Montana's Maternal Healthcare Experiences Study

The University of Montana Rural Institute for Inclusive Communities conducted a study on patient maternal healthcare experiences as part of a broader maternal health system needs assessment coordinated by the Montana Obstetrics and Maternal Support Program (MOMS). This needs assessment gathers information on Montana's maternal health system to identify areas of strength and need. The assessment focuses on the health system's capacity, delivery of services, and the experiences of the patient population.

The maternal healthcare experiences study included a statewide survey and interviews. We used two patient-informed, valid, and reliable scales to assess experiences of respectful care and decision-making. The Mothers on Respect Index [2] and the Mothers Autonomy in Decision Making Scale [10] were developed through a community-led participatory action research project in which a diverse group of childbearing people determined priority components of respectful care and shared decision-making. We used these scales to gather information on patient maternity care experiences in Montana. We also conducted semi-structured interviews and asked participants to describe their care experiences during pregnancy, birth, and postpartum. For a complete description of the study methodology, see Appendix A.

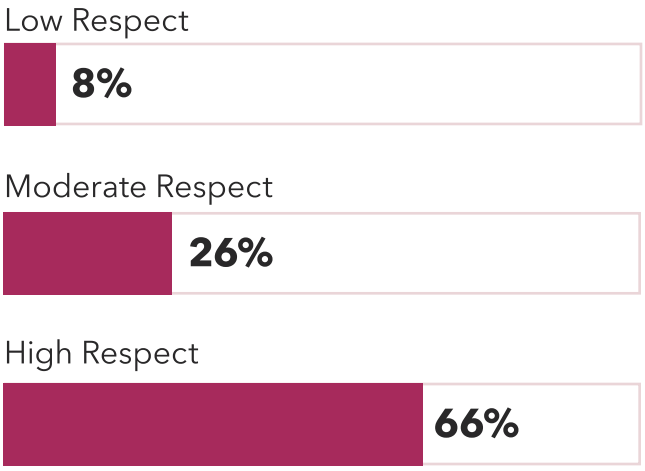
The study had 484 survey participants and 39 semi-structured interview participants. Participants lived in 41 of Montana's 56 counties, with just over half (54%) in rural communities. For a full list of demographic characteristics, see Appendix B.

Experiences of Respectful Care

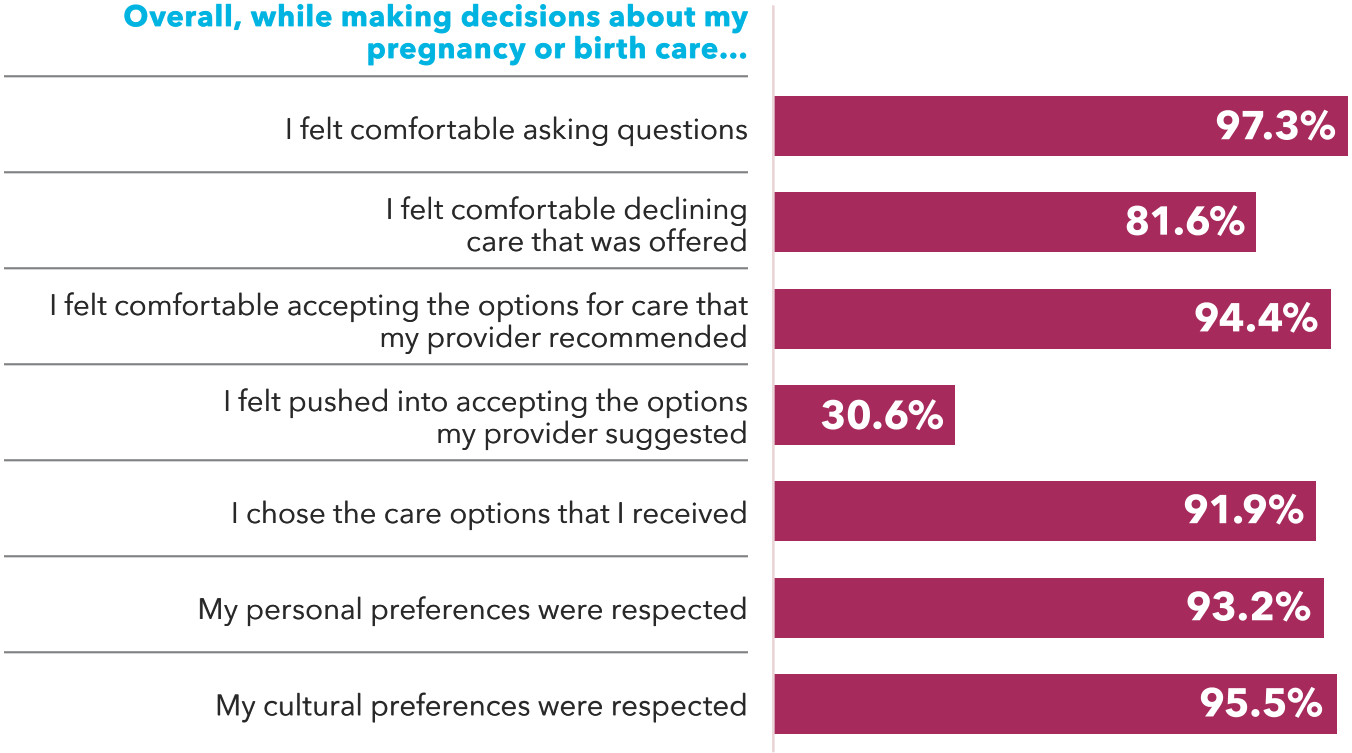
The Mothers on Respect Index measures respectful care through several core dynamics of the patient-provider relationship, including a patient's sense of autonomy and comfort in accepting or declining care and a patient's experience of discrimination in interactions with their provider [2].

The scale includes an overall respect score (low respect, moderate respect, high respect), based on the participants' responses to each item. In our study, participants reported experiencing high (66%) levels of respectful care with about a third (34%) reporting low-to-moderate levels of respect.

Figure 1. Participant Experiences of Respectful Care (Mothers on Respect Index) N=484



Respectful care involves creating an environment where the patient feels comfortable asking questions, sharing preferences, and accepting or declining care options.

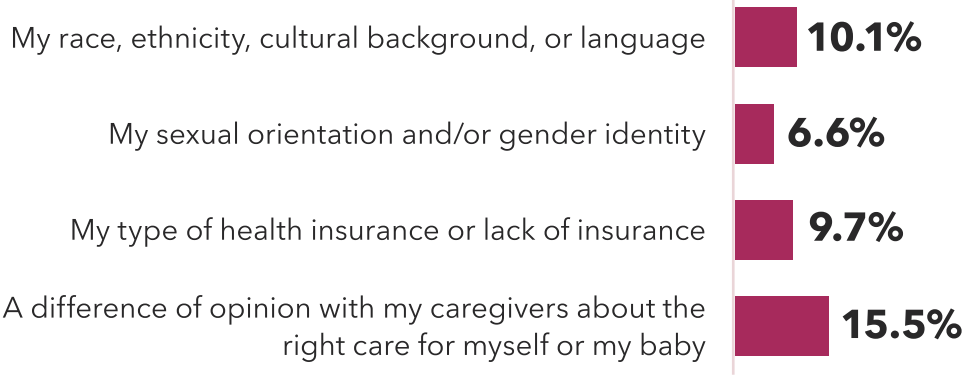


[1] We used the National Rural Urban Commuting Area Codes (RUCA) for counties to categorize responses as rural/urban. Zip codes were classified as small metro, micropolitan, and noncore. We classified noncore and micropolitan counties as rural and small metro as urban.

Respectful Maternity Care in Practice: *"I could tell that not all of them necessarily want you to have an unmedicated birth, but they supported me in my decision making. When I did decide to try the epidural, they supported me in that. They supported me walking around, doing squats, getting in the bath, getting in the shower. I just felt like every decision I made to try to progress my labor was supported, which was amazing."*

Respectful care involves treating all patients with dignity, recognizing their inherent worth and value, and seeing them as the leaders in their care.

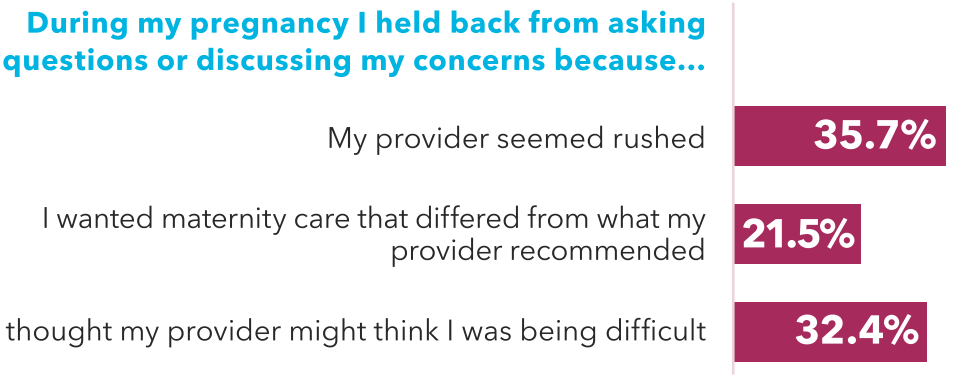
During my pregnancy I felt that I was treated poorly by my provider because of...



Opportunities to Improve Respectful Maternity Care: *"She asked me if we'd chosen a name and I said yes. And she said, "What is it?" And I said, "I'm sorry, I can't share it." And she was kind of weird and pushy about it. And she was like, "Oh, come on. I'm not going to tell anybody." And I was like, "I know. It's a cultural thing with my husband. You don't say it out loud until baby is born because your kind of jinxing it." So, I explained it and she was like, "Well, I don't know the people you know. You can just tell me."*

Respectful care requires a clinic environment that provides sufficient time for patients to bring forth questions and concerns. Establishing a strong patient-provider relationship supports patient-led care. When patients don't feel respected, they may avoid questions or hold back preferences to avoid potential judgement.

During my pregnancy I held back from asking questions or discussing my concerns because...



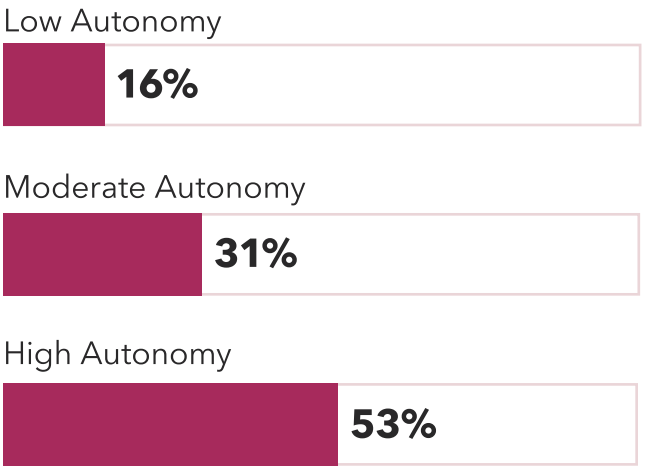
Respectful Maternity Care in Practice: *"I never felt rushed. I never felt like I couldn't ask a question. He always explained everything in a way that I could understand. It just made me feel more comfortable just knowing that he took the time to listen. It just made me feel heard. I felt like I was also in control of my care."*

Experiences of Autonomy in Decision-Making

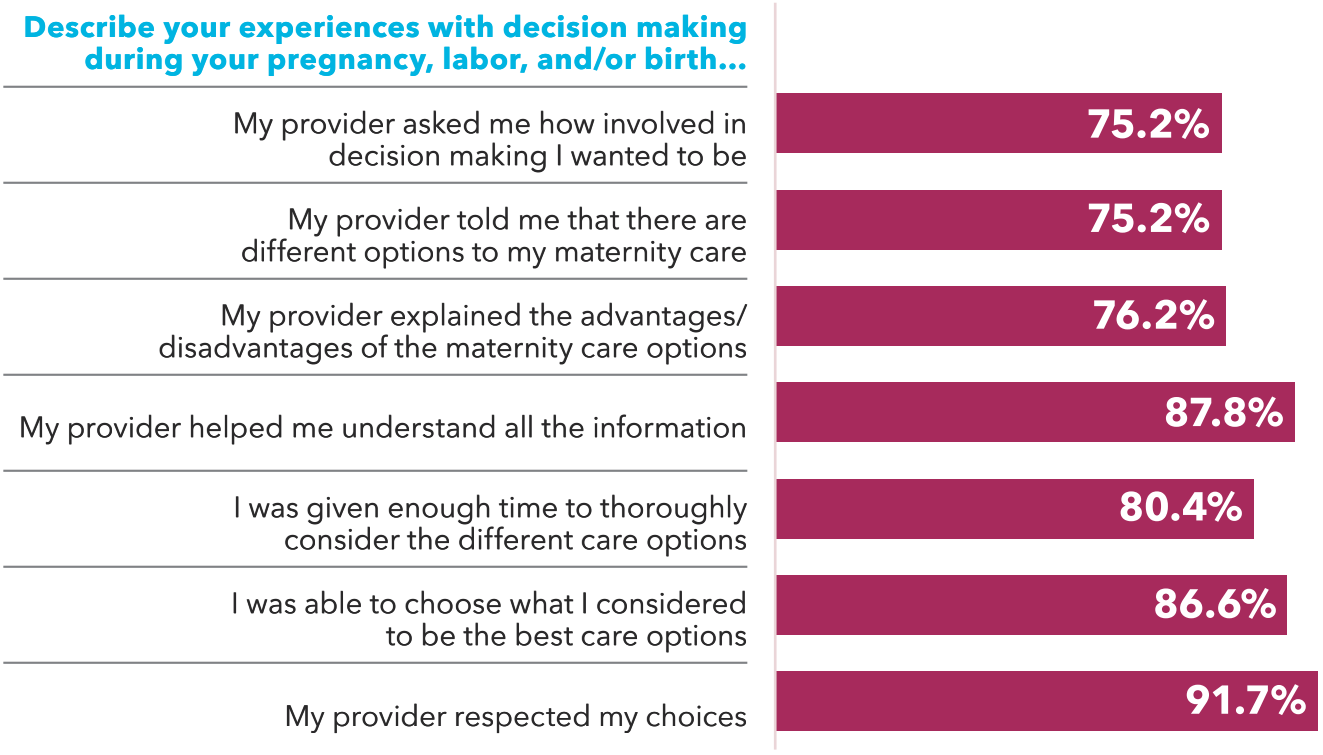
Involving patients in all decisions made about their care is central to person-centered respectful maternity care. The Mothers Autonomy in Decision-Making Scale measures components of the decision-making process, including the types of communication occurring between the patient and provider, and the patient's role in decisions about their care [10].

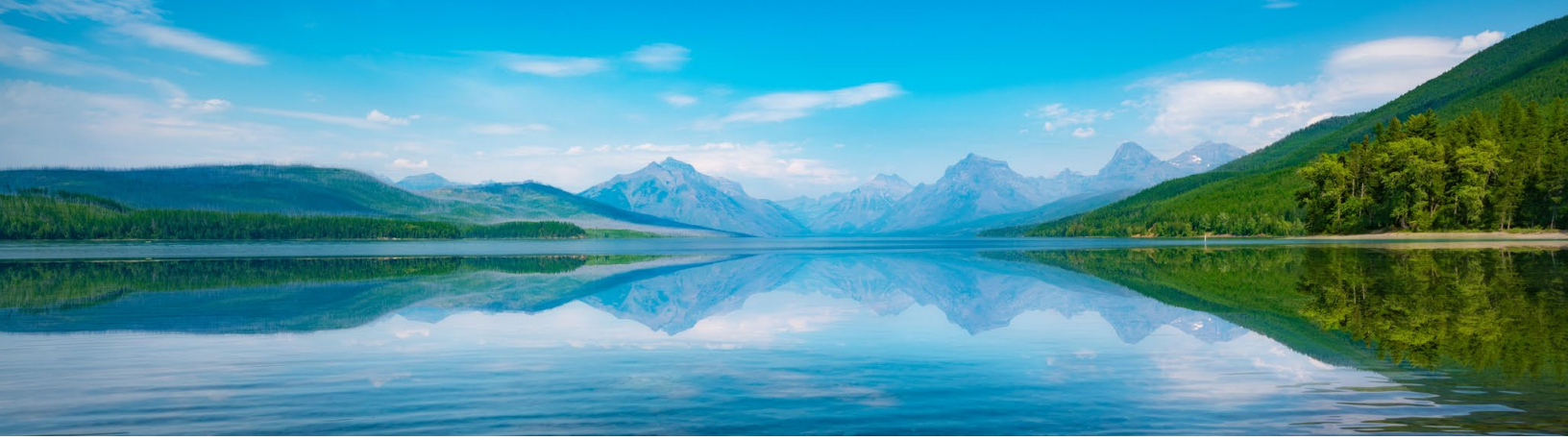
The scale includes an overall autonomy in decision-making score (low autonomy, moderate autonomy, high autonomy), based on the participants' responses to each item. Overall, about half (53%) of participants reported high levels of autonomy in decision-making, with the rest experiencing low (16%) and moderate levels (31%) of autonomy in their care.

Figure 2. Participant Experiences of Autonomy in Decision Making (Mothers Autonomy in Decision Making Scale) N=484



Respectful care involves a shared decision-making process where patients are provided sufficient information and time to fully participate in decision making. The patient makes the final decision which is respected by the care team.





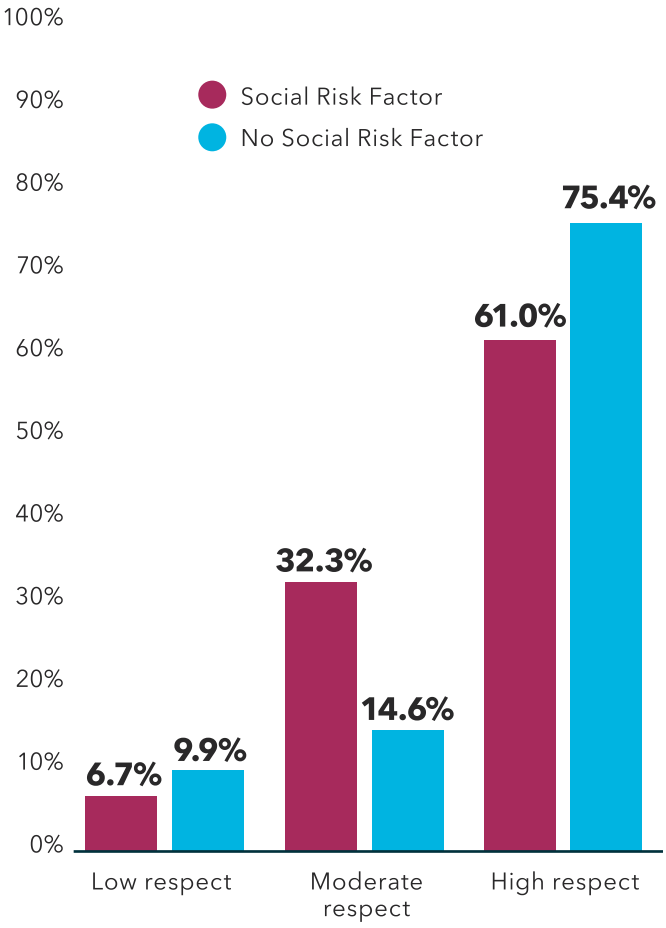
Respectful Maternity Care in Practice: *"If there was a question on what course to go, I was always given all the information where I could make a decision and they allowed me to make a decision. I would also ask what they would lean towards, like what their medical opinions would be on what we should do. And they were always very clear on what their recommendation would be. But if we didn't go with their recommendation, what the course of action would look like. So, I felt very comfortable. "*

The Impact of Social Risk Factors on Experiences of Respectful Care

We wanted to know if experiences of respectful care differed based on the presence of social risk factors. We included the Health Leads Social Screening Tool [11], asking about eight social risk factors (food insecurity, utility needs, housing instability, childcare, financial resource strain, transportation challenges, health literacy, and social isolation). Most (65%) participants reported having at least one social risk factor, with childcare (50%), social isolation (24%), and food insecurity (17%) reported the most. While access to childcare impacts families of all backgrounds, Health Leads asks specifically about the interaction of childcare and income issues.

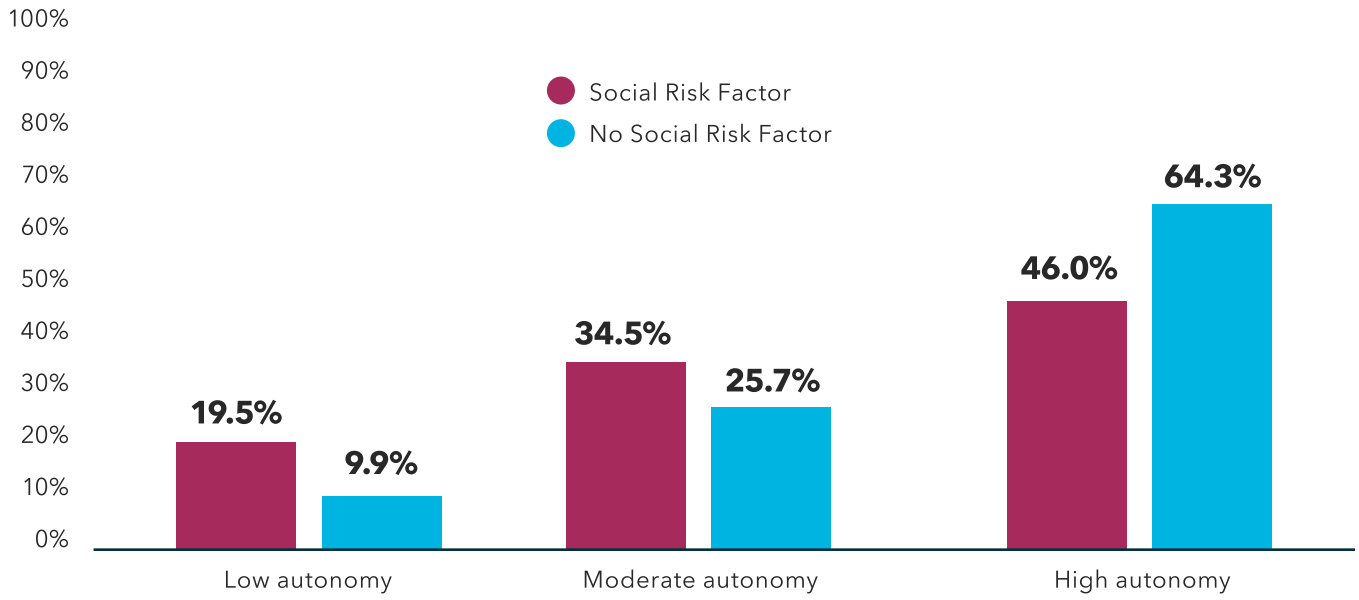
Participants with at least one social risk factor reported lower levels of respectful care and autonomy in decision making. These results align with national studies of respectful care, finding that socially marginalized populations can face discrimination and bias in healthcare settings, negatively impacting the quality of care [2, 12].

Figure 3. Participants with **social risk factors** are less likely to report high levels of respectful care. (N=484)



Opportunities to Improve Respectful Maternity Care: *"We had run into some financial problems where we were just behind. I asked them if there was anything I could do as far as a payment plan or if there was any sort of help at all, just so that I could make sure I stayed up to date with everything. They didn't help with any of that. They were just like, "Well, that's your problem. You have to pay it off, or that's it. There's no other support." I just felt alone."*

Figure 4. Participants with **social risk factors** are less likely to report high levels of autonomy in decision-making. (N=484)



Key Takeaways and Recommendations

Key Takeaways

- Participants reported high levels of respectful care, however reduced levels were associated with the presence of social risk factors. Socially marginalized populations may particularly benefit from respectful maternity care practices that acknowledge the role of bias and discrimination in the patient-provider relationship and quality of care [12].

- Participants reported moderate levels of autonomy in decision-making. Patient-led decision making is a critical component of person-centered care, especially during labor and delivery where changes in maternal and fetal status incite crucial decision points.

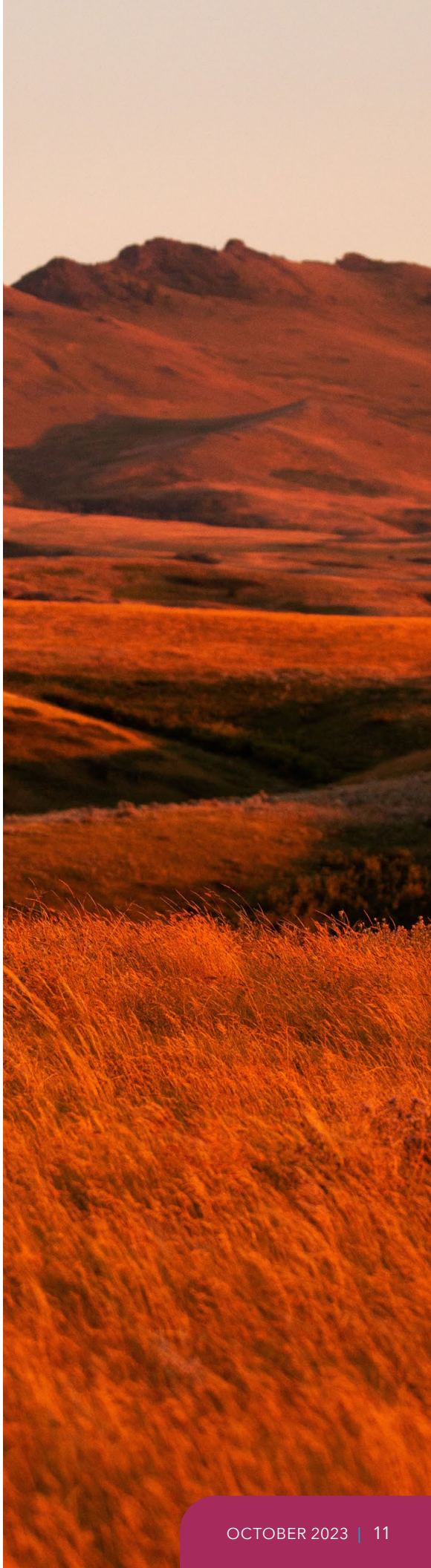
- Patient experiences must drive quality improvement efforts in maternal health, to ensure the maternal health systems meet patients' needs and desires for care. Centering patient perspectives in strengthening care delivery requires a formal process for gathering feedback.

Recommendations

- **Hospitals and health systems** can include the *Mothers on Respect Index* and *Mothers Autonomy in Decision Making Scale* in healthcare settings to gather timely patient feedback to inform quality improvement initiatives aimed at respectful patient-provider interactions.

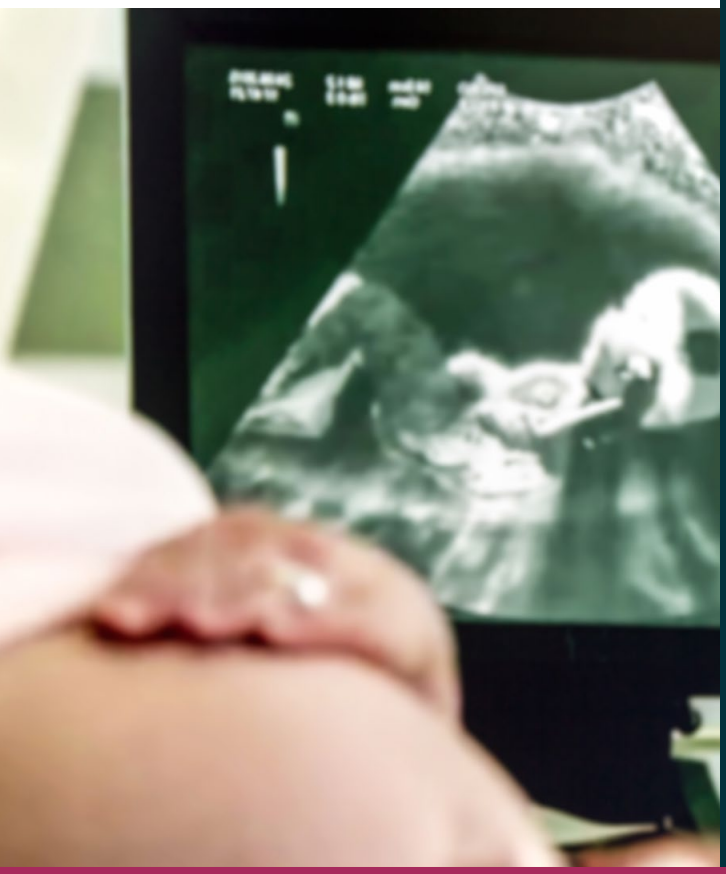
- **Healthcare providers** can engage in education and training focused on building awareness of how their background, experiences, and beliefs influence care delivery. Healthcare teams can adopt shared decision-making tools to support patient-centered communication and autonomy.

- **Community organizations** can build perinatal support networks for sharing information, resources, and building connections throughout pregnancy and postpartum.



Limitations

There are several limitations to this study. We used convenience sampling, a non-probability methodology, so our results are not generalizable to the population being studied. Convenience sampling also limits respondents from underserved populations, so these groups are underrepresented in our study. Survey recruitment occurred over social media, requiring access to smart phone or computer to participate. Despite these limitations, the study provides important information to help shape clinical practice improvements across the maternal health continuum.



Respectful Maternity Care Resources for Providers

University of British Columbia Birth Place Lab Respectful Maternity Care Tools. The Birth Place Lab has developed instruments to improve the evaluation of maternity care and measure respectful care in healthcare and community settings. The tools include the *Mothers on Respect Index* and the *Mothers Autonomy in Decision Making Scale*.

Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) Respectful Maternity Care Implementation Toolkit. The Respectful Care Toolkit provides evidence-based guidelines and recommendations for the provision of respectful maternity care across the maternal care continuum.

Safe and Inclusive Care Training Program This series seeks to improve perinatal care delivery through acknowledgement, respect, validation, and integration of patients' individual perspectives, cultures, identities, values, beliefs, and abilities. Health care organizations can include these materials in their learning management systems (LMS) to provide broader access to these materials for provider teams serving perinatal patients and families.

Appendix A

Methodology

Instrument

The Maternal Healthcare Experiences Survey included the Mothers on Respect Index (MORi) [2] and the Mothers Autonomy in Decision Making Scale (MADM) [10]. We measured respectful care with the 14-item MORi, a valid and reliable tool to assess the nature of patient-provider relationships and person-centered care. We measured patient autonomy in decision-making with the 7-itme MADM scale, a valid and reliable tool to assess the process of decision-making during maternity care. The MORi and MADM scale have been widely implemented to measure maternal health care experiences. Open-ended questions gathered further detail on experiences of respect and autonomy. We added additional items to collect information on patient sociodemographic attributes (race/ethnicity, education level, income), social risk, prepregnancy wellness visits, and birth location (home, hospital, birth center). We measured social risk with the Health Leads Social Screening Tool [13]. Health Leads includes eight social needs domains impacting patients' health based on findings from the Institute of Medicine, Centers for Medicare & Medicaid Services, and Health Leads [13]. We measured disability status with the standard set of six disability questions used in the American Community Survey. We created an online survey in REDCap and piloted it with community partners. The interviews followed a moderator's guide based on the survey. The University of Montana Institutional Review Board approved the study (120-22).

Data Collection

Data collection occurred from July 26, 2022 – October 15, 2022. The study targeted Montanans who have been pregnant in the last five years. We used convenience and purposive sampling methods. We recruited participants through social media platforms Facebook and Instagram via six custom images. The social media campaign included sponsored posts facilitated by the University of Montana Rural Institute for Inclusive Communities platforms. We also sent a postcard to all Montana Women, Infants, and Children (WIC) participants, totaling 8,800. Interview participants were recruited through the survey. People interested in participating in an interview contacted the research team to schedule. All interviews were conducted virtually over Zoom or on the phone.

Study Population

The current analysis includes 484 survey participants and 39 semi-structured interviews (average length 49 minutes). We omitted all survey responses without a zip code, with an out-of-state zip code, and an inaccurate zip code. Some respondents skipped questions, so the denominator varies across analyses.

Data Analysis

We used descriptive statistics to describe the sociodemographic attributes of the survey sample. We calculated the level of respect experienced score for each respondent based on the MORi. The level of respect score includes four categories very low respect (14-31), low respect (32-49), moderate respect (50-66), and high respect (67-84). We calculated the level of autonomy experienced score for each respondent based on the MADM scale. The level of autonomy scale includes four categories very low patient autonomy (7-15), low patient autonomy (16-24), moderate patient autonomy (25-33), and high patient autonomy (34-42). We combined the categories of very low and low respect and very low and low autonomy. For each MORi and MADM item we reported the proportion of participants that agreed with the statement. We categorized "Strongly agree," "agree," and "somewhat agree" into the category "agreed." We used the Health Leads Social Screening Tool to measure social risk. Health Leads collects information on food insecurity, housing instability, utility needs, financial resource strain, transportation challenges, childcare, and social isolation. We coded respondents with one or more of the social risk factors as 1; and respondents that did not report any of the social risk factors as 0. We used the National Rural Urban Commuting Area Codes (RUCA) for zip codes to categorize responses as rural/urban [14]. All interviews were recorded, transcribed verbatim, and analyzed in MAXQDA. We conducted a hybrid inductive/deductive process for coding and theme development. An interdisciplinary team of researchers coded the interviews and met regularly to discuss coding and resolve discrepancies in coding, reaching a final inter-coder agreement of 80.6%.

Appendix B

Study Demographics

Table 1. Sociodemographic Characteristics of Survey Participants (N=484).

Ages in Years	n (%)
18-29	137 (28.3)
30-39	296 (61.2)
>40	51 (10.5)

Race and/or ethnicity	n (%)
White	428 (88.4)
American Indian, Native American, Alaska Native	41 (8.5)
Hispanic/Latinx	26 (5.4)
Asian or Asian American	9 (1.9)
African, African American, or Black	9 (1.9)
Native Hawaiian or Pacific Islander	3 (0.6)
Middle Eastern or North African	3 (0.6)
Prefer not to answer	12 (2.5)

Gender Self-Identification	n (%)
Woman	469 (96.9)
Other Gender Identity*	11 (2.3)
Prefer not to answer	4 (0.8)

*Other Gender Identity: Genderqueer/gender nonconforming, Man, Transgender, Two-Spirit.

Income	n (%)
$0-24,999	59 (12.2)
$25,000-49,999	115 (23.8)
$50,000-74,999	112 (23.2)
$75,000-99,999	73 (15.1)
>$100,000	124 (25.7)

Education Level	n (%)
High School or less	58 (12.0)
Some College	152 (31.4)
Bachelor's	155 (32.0)
Graduate Degree/Professional	119 (24.6)

Rurality	n (%)
Urban	221 (45.7)
Rural	263 (54.3)

Social Risk	n (%)
Experience social risk indicators	313 (64.7)
Do not experience social risk indicators	171 (35.3)

Disability status	n (%)
Do not have a disability	383 (79.1)
Living with a disability	101 (20.9)

Table 2. Interview Participants Sociodemographic Attributes (N=39)

Age in years	n (%)
18-29	9 (23.1)
30-39	26 (66.7)
40-49	4 (10.3)

Race and/or ethnicity	n (%)
White	35 (89.7)
American Indian Alaska Native	6 (15.4)
Hispanic/Latinx	2 (5.1)
Asian or Asian American	1 (2.6)

Income	n (%)
$0-24,999	5 (13.2)
$25,000-49,999	4 (10.5)
$50,000-74,999	7 (18.4)
$75,000-99,999	7 (18.4)
>$100,000	15 (39.5)

Education Level	n (%)
High School	1 (2.6)
Some college	4 (10.3)
Post-secondary	34 (87.1)

Rurality	n (%)
Rural	18 (46.2)
Urban	21 (53.8)

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