

# Group Prenatal Care

Strength in Numbers  
Jessica Brumley CNM PhD



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## Objectives

- ▶ Identification of the Components of Centering Pregnancy
- ▶ Understanding of the Strengths and Limitations of Centering Pregnancy
- ▶ Strategies for implementation of group prenatal care
- ▶ Potential Pitfalls in Implementation



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- ▶ History of Prenatal Care
- ▶ Review Evidence to Support Group Prenatal Care
- ▶ Essential Elements of Centering Pregnancy
- ▶ Other models of prenatal care
- ▶ Review of Change Management model
- ▶ Review results of VIP Group Prenatal implementation at USF
- ▶ Obstacles encountered
- ▶ Strategies for success



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## History of Traditional Prenatal Care

- ▶ 1902 Ballantyne “Manual of Antenatal Pathology and Hygiene”
- ▶ 1903 1<sup>st</sup> Edition of Williams Obstetrics did not have any information on Prenatal Care
- ▶ 1967 Williams had just 12 pages on Prenatal Care
- ▶ 1996 Gabbe has over 200 pages on Prenatal Care

Prenatal care effectiveness and implementation. McCormick & Seigel 1999.

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## Prenatal Focus

- ▶ Maternal mortality
  - preeclampsia detection
- ▶ Infant Mortality
  - Preterm birth and low birth weight prevention
  - Birth Defect Detection
- ▶ Improved rates of preterm birth and low birthweight among women with more prenatal care spurred the push for public policy to improve access to prenatal care.

Alexander & Kotelchuck (2001). Assessing the role and effectiveness of prenatal care: History, challenges and Directions for Future Research. Public Health Reports (16) 306-316.

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## US Birth Outcomes

Despite increase in prenatal care utilization PTB and LBW have increased

	LBW (%)	PTB (%)	Infant Mortality rate/1000 live births
1998	7.5	11.6	7.2
2008	8.2	12.3	6.6

March of Dimes Peristats

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### Key Components of prenatal care

USPHS Expert Panel on the Core Content of Prenatal Care (1989)

- ▶ Risk Assessment
  - History
  - Physical Exam
  - Lab Tests
- ▶ Health Promotion
  - Counseling to Promote Healthful Behaviors
  - General Knowledge of Pregnancy and Parenting
  - Information on Proposed Care
  - Interventions to Reduce Psychosocial Risk

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### Challenges to the Establishment

- ▶ Expanded focus from just the woman and fetus to the infant and family
- ▶ Beyond basic medical needs
  - Psychosocial
  - Environmental
  - Family
- ▶ Encouraged rethinking of frequency and timing of visits
- ▶ Shift in focus on pre-conception and early pregnancy education and counseling as well as postpartum and unintended pregnancy prevention
- ▶ Inclusion of promotion of parenting skills

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### Healthy mom, baby, and family



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## Traditional prenatal care

- ▶ First visit 30 to 45 minutes during first trimester
  - Complete history, physical exam, laboratory testing, risk assessment, education
- ▶ Monthly visits until 28 weeks gestation
- ▶ Biweekly visits from 28 to 36 weeks
- ▶ Weekly visits from 36 weeks until delivery
  - Follow up prenatal visits are 10 to 15 minutes
  - Weight, blood pressure, fundal height, fetal heart tones
  - Laboratory screenings when indicated
  - Education

Total Time Spent in Prenatal Care around 2 ½ hours  
This does not include check in, waiting or check out.

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## CenteringPregnancy

» A MODEL FOR GROUP PRENATAL CARE

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## Centering Pregnancy

- ▶ Group based prenatal care including assessment, education and support
- ▶ 8 to 12 women
- ▶ Similar gestational age
- ▶ Meet in a group space
- ▶ Meeting time 90 to 120 minutes per session
- ▶ Meetings are pre scheduled for entire pregnancy
- ▶ Meetings follow the course of prenatal care
- ▶ Check in and check out rarely required



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There are 15 elements which define the Centering model of care:

- ▶ Health assessment occurs within the group space.
- ▶ Participants are involved in self-care activities.
- ▶ A facilitative leadership style is used.
- ▶ The group is conducted in a circle.
- ▶ Each session has an overall plan.
- ▶ Attention is given to the core content, although emphasis may vary.
- ▶ There is stability of group leadership.
- ▶ Group conduct honors the contribution of each member.
- ▶ The composition of the group is stable, not rigid.
- ▶ Group size is optimal to promote the process.
- ▶ Involvement of support people is optional.
- ▶ Opportunity for socializing with the group is provided.
- ▶ There is ongoing evaluation of outcomes

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Prenatal Care in a group why?

- ▶ Efficient use of time
- ▶ Community building
- ▶ Promote active problem solving
- ▶ Opportunity to create social changes
- ▶ Positive peer influences
- ▶ Groups are fun!



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Centering Pregnancy Design

- ▶ First visit is an individual visit. The concept of group prenatal care is introduced
- ▶ Women are group based on month of expected date of delivery
- ▶ Groups consist of 8 to 12 women and begin at 16 to 20 weeks
- ▶ Group meets
  - monthly for 4 sessions
  - Biweekly for 6 sessions
  - Postpartum reunion visit 1-2 months postpartum
- ▶ Additional individual visits can be scheduled as needed

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## Centering visits

- ▶ Women present directly to group and bypass front desk
- ▶ 30 to 40 minute check in and provider assessment
- ▶ 60 to 70 minute formal circle time or facilitated discussion
- ▶ Wrap up
- ▶ Time for socializing



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## Self Care

- ▶ Self Weigh In
- ▶ Self Blood Pressure
- ▶ Document in chart
- ▶ Able to follow own health status
- ▶ Hands on
- ▶ Encourages transparency



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## Physical Assessment

- ▶ Physical assessment occurs within the group space
  - Provisions for privacy can be made
- ▶ Questions are encouraged to be brought back to group
- ▶ If individual time is needed it can occur after the group session



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## Self Assessment Sheets

- ▶ Opportunity for Self Reflection
- ▶ Guides discussion during group sessions
- ▶ Promote Goal Setting
- ▶ Topics vary
  - Normal discomforts of pregnancy
  - Nutrition
  - Breastfeeding
  - Comfort measures for labor
  - Relaxation
  - Plans for parenting
  - Contraception



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## Education

- ▶ Occurs within the facilitated group session time
- ▶ Questions are put out to the group
- ▶ Guidelines for each session are provided but are flexible
- ▶ Group sessions do not take the place of child birth preparation classes
- ▶ Guest Speakers can be invited to discuss topics.
  - Examples include a nutritionist, lactation consultant, pediatric provider, physical therapist
- ▶ Field Trips
  - Tour Labor and Delivery

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## Support

- ▶ Group stability
- ▶ Leadership consistency
- ▶ Time for socialization
- ▶ Refreshments



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### 10m AIMS FOR THE IMPROVEMENT OF HEALTH CARE

- ▶ Safe: avoiding injuries to those we are intending to help
- ▶ Effective: providing services based on scientific knowledge to all those likely to benefit and refraining from providing services to those not likely to benefit
- ▶ Patient-centered: care that is respectful and responsive to individual preferences, needs, and values, and letting these values guide all clinical decisions
- ▶ Timely: care that reduces waits and harmful delays both for providers and recipients
- ▶ Efficient: care that avoids waste of supplies, equipment, ideas, and energy
- ▶ Equitable: care that does not vary in quality because of personal characteristics such as gender, ethnicity, geography, socioeconomic status

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### Traditional vs CP Group Care



Review of the Evidence

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### Original Pilot Data

- ▶ N=111
- ▶ 96% preferred group prenatal care
- ▶ Women in CP groups were significantly less likely to use the ER in the third trimester (p=0.001)

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### Prospective Matched COhort

- ▶ N=458
- ▶ Minority women of low SES from 3 public health clinics
- ▶ Compared birth weight and gestational age of women in Centering Pregnancy group and traditional prenatal care
- ▶ Women in CP groups had higher birth weights ( $p < .01$ ) and even preterm infants had higher birth weights ( $p < 0.05$ )
- ▶ Cost of care was not different

Ickovics et al. 2003 Obstet Gynecol 102: 1051

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### Pregnancy outcomes from RCT

- ▶ N=1047 Low SES mostly Black women
- ▶ Women assigned to group were less likely to deliver preterm as compared to traditional care (9.8% vs 13.8%) and there were no significant difference in age, income, education or parity
- ▶ This is equivalent to a 33% risk reduction (OR 0.67, 95% CI 0.44-0.99)
- ▶ Results were greater for black woman (10% vs 15.8%) (OR 0.58 95%CI 0.38-0.92).

Ickovics et al. 2007 Obstet Gynecol 110(2):330-339.

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### Other Outcomes from RCT

- ▶ Less likely to have inadequate PNC ( $p < 0.01$ )
- ▶ Better prenatal knowledge ( $p < 0.001$ )
- ▶ Felt more ready for labor and delivery ( $p < 0.001$ )
- ▶ More satisfied with care ( $p < 0.001$ )
- ▶ Higher breastfeeding initiation (66.5% vs 54.6%,  $p < 0.001$ )

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## Women's perspective



McNeil, Velved, Dolan, Siever, Horn & Tough (2012). Getting more than they realized they needed: a qualitative study of women's experience of group prenatal care. BMC Pregnancy and Childbirth 12:17.

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## "I wasn't alone" – A Study of group prenatal care in the military

- ▶ "I was iffy about going in it - I'm not really a person that talks about things going on with me...I was surprised that so many women were going through the same things I was. For example, we talk about the tenderness of your breasts—you know, sometimes you can't even touch them, and you sure don't want HIM touching them—so many women were going through it too...you just don't discuss these things with people, not even friends."
- ▶ "I felt much freer to voice my opinions during the labor then I think I would have if I hadn't gone through the group. That was very different, especially in the military system. A lot of time you feel lost and don't have empowerment. The group definitely gave that to you—it made you feel like you could get something done."

Kennedy et al. (2009). Journal of Midwifery and Women's Health. 54(3) 176-182.

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## Women's experiences

- ▶ Positive
  - Education and "Understanding"
  - Relationship with provider
  - Being with other women
  - Behavior change/Empowerment
  - Normalization through sharing
- ▶ Negative
  - Physical exams in group space
  - Rushed during exams
  - Limitations of relationships with other women

Novick et al. 2011 Qualitative Health Research 21(1) 97-116.

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## Provider Perspectives

- ▶ Increased opportunity for education and support
- ▶ Acknowledged that women seemed happier and wanted to come to care more
- ▶ Women seemed to appreciate not having to wait
- ▶ Challenges with implementation such as appropriate scheduling, recruitment and medical record access
- ▶ Challenges for provider to develop group facilitation skills and "give up" one on one time with client

Klima et al. 2009 Journal of Midwifery and Women's Health 54(1) 27-34.

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## Provider Transition

- ▶ My current practice is just fine
- ▶ Thinking about giving CP a try
- ▶ Anxiety and stress about a new model of care
- ▶ Confidence and empowerment with group: Actively engaged in new behavior
- ▶ Looking to the future: Committed to the CP model and wanting to sustain change.

Baldwin & Phillips 2011 The Journal of Perinatal Education 20 (4) 210

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## Administrators perspective

- ▶ Improved waiting time issue
- ▶ Women were more enthusiastic
- ▶ Recognition to clinic
- ▶ Women were more engaged in prenatal and pediatric care
- ▶ Challenges scheduling issues with walk ins and overbooking during group time
- ▶ "Taking a provider away for group hinders clinic flow"

Klima et al. 2009 Journal of Midwifery and Women's Health 54(1) 27-34.

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# Change Management Strategies

»» Courtesy of J&J  
STTI MCH Leadership Academy  
Carolyn Miller

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## Challenge the Process...

Model

Inspire

**Challenge**

Enable

Encourage



Adapted from J&J's Change Integration Process

Maternal-Child Health Nurse Leadership Academy 2

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## The Change Integration Process

Make it Real → Make it Work → Make it Last

Define Business Goal & Future State	Create an Environment for Change	Plan the Change	Execute & Improve	Integrate & Sustain
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Source: J&J's Change Integration Process 36

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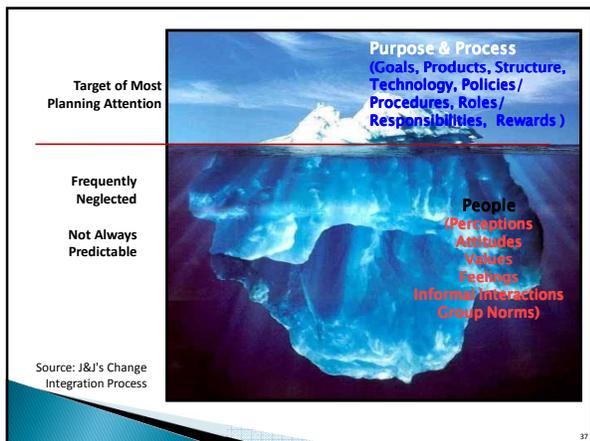
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## Model adaptation

- ▶ Groups typically consist of 5 – 7 women.
  - VIP groups are smaller due to space restrictions, high partner participation rate and practice volume/interested rate.
- ▶ Group space allows for self BP and weigh in.
- ▶ Physical assessment occurs in exam room adjacent to group space.
  - This allows for greater privacy but is also more time consuming.
- ▶ Groups last 90 minutes. 30 to 45 minutes of physical assessment and 45 to 60 minutes of facilitated discussion.
  - 90 minutes is same as 15 minutes per patient x 6 patients
  - Most groups are scheduled at the end of the day so as not to delay individual patients if group runs over.
- ▶ Refreshments
  - Brought but rarely used possibly due to more compact group time.

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## Model Implementation

- ▶ Several meetings with clinic staff and administrators were used to discuss implementation and promotion
- ▶ Women are offered VIP Group Care by New OB visit provider (usually CNM)
- ▶ Name and MRN of women are placed on list in Nurses office
- ▶ Women are contacted by Group Director to confirm interest and register for first visit.
- ▶ Women who present to first group session are then registered for all subsequent sessions.
- ▶ After check in at front desk women present directly to the group room. There is no unused (waiting room) time.

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## Results

- ▶ A new group is started on average every other month based on numbers interested.
- ▶ Groups consist of 5 to 7 women on average
- ▶ 80 women have participated thus far.
- ▶ Most often cited reason for missing a group session is work scheduling conflict.
- ▶ 2/62 preterm delivery (1 spontaneous and 1 severe IUGR)
- ▶ 61/62 were breastfeeding at postpartum reunion
- ▶ 17/22 gained within IOM guidelines for weight gain in pregnancy.
- ▶ 30% C-Section rate

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## Evaluations

### What I liked best about my prenatal care...

- ▶ "being around other pregnant women"
- ▶ "the handouts that were given and the different people that came in and talked to the group (breastfeeding)"
- ▶ "quick response time to my questions (via calling or email)- comfortable in the group setting -Jessica rocks!"
- ▶ "group discussions, hospital visits, lactation consultant"
- ▶ "being with a group of other expectant mothers and sharing each others progress."
- ▶ "meeting the other women and seeing every one grow week to week"
- ▶ "the communal environment"

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## Challenges Encountered

- ▶ Resistance to Change
- ▶ Room Changes
- ▶ Busy clinic
- ▶ Waning interest in recruitment
- ▶ Changes in responsibilities

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## Strategies for Success

- ▶ Don't be a lone wolf
- ▶ Empower others to act
- ▶ Taylor to your target audience
- ▶ Recruitment
  - Ideally by the provider facilitating the group
  - Start early consider asking at first contact

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# Centering Pregnancy

» A valuable tool to teach prenatal care

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## Centering Pregnancy: a valuable adjunct to Obstetric resident training

- ▶ 4 UCSF OB/GYN Intern resident were trained to facilitate CP groups.
- ▶ Groups were co-facilitated by a CNM or OBGYN
- ▶ Residents were surveyed and concluded Centering was feasible and valuable
- ▶ Residents were more likely to view themselves as the primary care provider
- ▶ They developed leadership, communication and group facilitation skills.
- ▶ They had sufficient time to offer education

T. McLean (Resident) 2010 CREOG/APGO Abstract

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## Resident Perspectives

- ▶ “Traditional clinic is a needed training ground to learn the basics of prenatal care, but it was within centering that I learned the art of caring for pregnant women”
- ▶ “...I built a sense of responsibility for the patients given the enhanced continuity. If I missed something...the bucked stopped with me.”

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## The future

- ▶ Increase the number of providers able to facilitate groups
- ▶ Training staff in co-facilitation
- ▶ Promotion of group model to the community at large
- ▶ Use of the group model to educate future health care providers



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