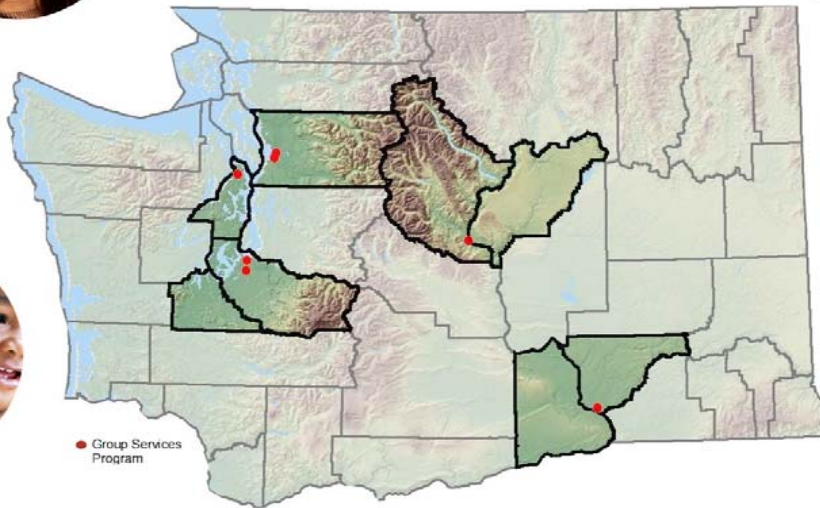
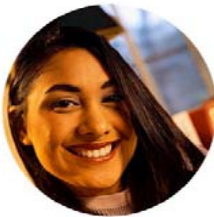


Group Services For Pregnant and Parenting Women

*An Exploratory Study
Appendices*



*Washington State Department of Social and Health Services
Management Services Administration
Research and Data Analysis Division*

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Pregnant and Parenting Women**
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Appendix A. Detailed Literature Review

The effects of group and individual prenatal care on gestational age and birth weight were analyzed in a prospective, matched cohort study of 458 low-income African American and Hispanic female study subjects split evenly between intervention and control groups.¹ All subjects entered prenatal care at less than 24 weeks' gestational age. The groups included up to 12 women scheduled to give birth at approximately the same time. Compared to individual care subjects, average birth weight was significantly greater ($p < .01$) for infants of women who received group care, particularly for infants born pre-term (2398 g vs. 1990 g; $p < .05$). The gestation period was also 2 weeks longer for group care patients who delivered prematurely than for individual care subjects with premature births (34.8 weeks vs. 32.6 weeks; $p < .001$).

The model used in the group care setting, the CenteringPregnancy® (CP) program, is based on assessment, education, skills building, and support in the integration of clinical and psychosocial care. A nurse midwife or obstetrician and an assistant, both trained in CP and group process, facilitate 10 group sessions. Each 90-minute session begins with weight and blood pressure measurement in conjunction with individual prenatal assessments by the practitioner, followed by discussion, education, and skills-building with respect to pregnancy, childbirth, and parenting. The CP program consists of a sequential curriculum of 10 session themes, but facilitators are trained to be flexible by addressing other needs and issues as they arise. Facilitators are also trained not to lecture to the participants, but rather to engage them in discussions about the following topics: (1) prenatal nutrition and fetal development; (2) common discomforts of pregnancy; (3) relaxation and labor; (4) family and parenting; (5) the birth experience; (6) decisions of pregnancy and developing a birth plan; (7) infant feeding; (8) postpartum adjustment; (9) new baby care; and (10) baby and mother care (including postpartum contraception).

In another evaluation of group prenatal care, researchers found that rates of low-birth weight (LBW) babies and pre-term births among pregnant teens who received CP group care ($n=124$) were significantly lower than for adolescents who received non-CP prenatal care ($n=144$; LBW: 8.9% vs. 22.9%, $p < .01$; pre-term: 10.5% vs. 25.7%, $p < .05$). Rates were also lower compared to adolescents who received no prenatal care ($n=233$; LBW: 8.9% vs. 18.3%, $p < .01$; pre-term: 10.5% vs. 23.2%, $p < .05$).² Compared to subjects receiving no prenatal care, a significantly higher proportion of CP subjects breastfed their babies (46% vs. 28%, $p < .02$) and had identified a pediatric provider at the time of discharge (79% vs. 52%, $p < .02$). In addition, 69 of 100 CP subjects who completed satisfaction questionnaires rated their overall satisfaction with the program a 9.2, on a scale of 1 (worst) to 10 (best).

The CP model was also the focus of a study involving 111 women—many of them Medicaid recipients—distributed across 13 racially and ethnically diverse groups, three of which comprised teenagers.³ Women who received group prenatal care used emergency departments significantly less than control group subjects did in the third trimester. Feedback indicated that 96% of women preferred receiving their prenatal care in groups. The author identified several

¹ Ickovics et al., 2003.

² Grady and Bloom, 2004.

³ Rising, 1998.

advantages of group care, including increased provider contact time (15 hours over ten visits in the group setting, compared with ten 10–15-minute appointments in an individualized office time). Provider discomfort with group facilitation, the need for large meeting spaces, and scheduling challenges were among the disadvantages noted.

A practicing midwife anecdotally described the prenatal care group she facilitates, noting that sessions take place every one or two weeks; last for 1–2 hours; typically include six pregnant women, one father, and three children; and focus on one topic at a time.⁴ The author highlighted the facilitator's role to help participants overcome their reticence and provide a non-judgmental atmosphere.

Results from a study comparing group and individual prenatal care for low-income black adolescents (n=65) suggest that intervention subjects attended sessions more frequently (11 vs. 6 visits), had longer gestational periods (39 vs. 37 weeks), and had a lower repeat pregnancy rate at 6 months and 2 years postpartum, compared to control subjects.⁵ In addition, relative to intervention subjects, control subjects reported significantly higher self-criticism scores and a significantly diminished sense of mastery about the labor and delivery process (p < .008). Peer support groups, facilitated by a nurse practitioner, involved health care activities (e.g., measurement of blood pressure, weight, fundal height, fetal heart tones, and fetal position), maintenance of one's own personal records, and discussion of prenatal education topics.

A 17-month randomized clinical trial compared home visits to hospital-based group visits after early postpartum discharge. The study included 1,014 low-risk mother and newborn pairs. One pair attended a 1.5–2 hour session, each comprising up to 8 mother-infant pairs, within 72 hours of hospital discharge; the other pair received home visits from a home health nurse within 48 hours of discharge. Group sessions, led by a registered nurse certified as a lactation educator, included a physical assessment of newborns and time devoted to breastfeeding, basic infant care, preventive education, and anticipatory guidance. One month prior to the study, the nurses received 20 hours of classroom instruction and participated in a 2-week preceptorship for breastfeeding instruction, newborn and maternal history, physical examination, and other postpartum anticipatory guidance. Although home visits were associated with higher maternal satisfaction, results indicate that comparable clinical outcomes were achieved.⁶ However, the costs of home and group visits were \$265 and \$22, respectively; making group visits a much more cost-effective option. Neither setting was associated with breastfeeding.

Three well-child group care studies ranged from six to fifteen months in duration, with study populations ranging from 78 to 210 subjects. Each group in one study comprised 3–5 predominantly white, middle-class, Mormon subjects, whereas the other two studies featured groups of six subjects with at least one high risk factor (e.g., poverty, history of child abuse).⁷ Groups in two studies were facilitated by a nurse practitioner;⁸ groups in the third study were

⁴ Whitson, 1993.

⁵ Hoyer et al., 1994.

⁶ Escobar et al., 2001.

⁷ Osborn and Woolley, 1981; Taylor et al., June 1997; Taylor et al., Dec. 1997.

⁸ Taylor et al., June 1997; Taylor et al., Dec. 1997.

facilitated by a pediatrician, a family physician, or a family nurse practitioner.⁹ The facilitators in the third study were neither specially trained nor advised about group-session content; facilitators in the other two studies implemented a curriculum of general parenting topics. Those two studies involved seven visits of 45–60 minutes each; clinicians/facilitators in the third study held at least three 45-minute group sessions with each subject during the six months of the study.

Results from one study indicate that significantly more well-child care visits were completed by intervention compared to control subjects. Intervention subjects also sought less advice between visits, spent significantly more time discussing personal issues, and spent significantly less time discussing the physical aspects of care than control subjects did. The time required for each subject was virtually equal across the intervention and control groups, as was satisfaction with care.¹⁰ The authors of the other two studies concluded that maternal interaction, child development, health utilization, health status, care compliance, and provider time were similar for intervention and control groups. However, in one study, a significantly higher proportion of children receiving individual care had emergency visits during the study period.¹¹

Five randomized, controlled studies examined diabetes care programs that varied with respect to duration (six months to five years) and number of participants (84 to 185). Groups ranged from 4–8, 9–10, 10–18, and 19–20 participants each.¹² Sessions were conducted in one of three ways: on a staggered basis (i.e., a 3-hour initial visit, a 2-hour follow-up visit after 2 weeks, a 1-hour follow-up visit at 3 months, and a 1-hour follow-up visit at 6 months),¹³ monthly for 2 hours each,¹⁴ or quarterly for 2 hours each.¹⁵ Groups in three studies were facilitated by a physician and a nurse educator or educationist;¹⁶ groups in a fourth study were led by a diabetes nurse educator, supported by two diabetologists;¹⁷ and groups in the remaining study were facilitated by a diabetes nurse and dietitian.¹⁸ The facilitators and the research teams in at least two studies were trained in group processes.¹⁹ Group sessions in each study focused on interactive learning rather than didactic instruction. Clinical outcomes for group care subjects were similar to or better than those for subjects who received individualized care. Self-reported knowledge, self-management behaviors/self-efficacy, problem-solving abilities, satisfaction with care, and quality of life generally improved for group care compared to control subjects.²⁰ In one study, post-intervention hospital discharge and utilization rates were significantly lower for group diabetes care subjects than for control subjects.²¹

An evaluation of a support group for new parents found that 94% of respondents to a two-year follow-up survey (n=92) reported that the group had been helpful to them, and 62% (n=61)

⁹ Osborn and Woolley, 1981.

¹⁰ Osborn and Woolley, 1981.

¹¹ Taylor et al., June 1997; Taylor et al., Dec. 1997.

¹² Trento et al., 2004; Clancy et al., 2003; Rickheim et al., 2002; Trento et al., 2001; Sadur et al., 1999.

¹³ Rickheim et al., 2002.

¹⁴ Clancy et al., 2003; Sadur et al., 1999.

¹⁵ Trento et al., 2004 and 2001.

¹⁶ Trento et al., 2004; Clancy et al., 2003; Trento et al., 2001.

¹⁷ Sadur et al., 1999.

¹⁸ Rickheim et al., 2002.

¹⁹ Clancy et al., 2003; Rickheim et al., 2002.

²⁰ Trento et al., 2004; Clancy et al., 2003; Rickheim et al., 2002; Trento et al., 2001; Sadur et al., 1999.

²¹ Sadur et al., 1999.

agreed that their child-care skills improved because of the support group.²² These groups of 5–8 members were facilitated by parents who took part in eight 2.5-hour sessions about birth experiences and parental stresses, along with two sessions about group process and communication. Group members were recruited through presentations to hospital-based prenatal classes, and by invitations extended three weeks after delivery. Members then attended two sessions, and the facilitator for each group arranged additional meetings for interested participants. Nine facilitators now lead 28 ongoing groups, including a “fathers only” group, a single mothers group, and a group for poor, underserved mothers. The groups do not have an established format; instead, members dictate content and direction.

Findings from a study of 118 Latino/a parents in rural communities indicate that participants in self-help parenting groups were satisfied with their group experiences.²³ Moreover, their knowledge of child development improved, as did their patience with their children, their coping abilities, and their communication skills. These no-cost groups are designed for parents seeking support from other parents experiencing child-rearing stress. They are facilitated by volunteers with training in basic parenting and group facilitation skills. Groups meet once or twice a month for 1–2 hours per session, and feature guest speakers or special topics.²⁴

A study to examine the impact of a group prenatal education/support program and group parenting program, both for minority teens, revealed that the percentage of repeat births among study participants was lower than the national average for teen mothers (15 vs. 22%). A majority of participants did not have a second birth until three to four years later, when they were no longer in their teens. In addition, 24% of study participants (n=80) were no longer on public assistance, and only one participant had been reported to the child welfare agency.²⁵ Study participants were 56% African American, 40% Latina, 2% Caucasian, and 2% other. Programs were offered to teens (17 years old and younger). A social worker in the Mount Sinai clinic made referrals, but participation was voluntary. The clinic social worker, also the director of health education, led groups with help from a parent educator, a pediatric health educator, hospital volunteers, and master’s-level students in health education. Each group, consisting of 10–15 teens, met for 1.5 hours per week. The prenatal group focused on pregnancy, labor and delivery, and early parenting skills, but topics varied according to the group members’ specific needs. The parenting group focused on child development, child safety, child discipline, relationships, education, and job seeking. Healthy snacks, transportation tokens, and “Baby Bucks” (which can be redeemed for infant care items like bibs, diapers, and socks) were provided to participants in both group programs. Trips to puppet shows, museums, and zoos replaced “Baby Bucks” as incentives in the parenting group after two years. Group members naturally transitioned from the prenatal group to the parenting group as dictated by their needs.

According to a study of mutual support groups for long-term recipients of TANF, participation in these types of groups resulted in enhanced parenting and social skills, improved self-esteem, and increased knowledge and self-sufficiency.²⁶ Over a six-month period, 23 adults and fourteen

²² Kagey et al., 1981.

²³ Wituk et al., 2001.

²⁴ http://www.kcsl.org/php_groups.html

²⁵ Rothenberg and Weissman, 2002.

²⁶ Anderson-Butcher et al., 2004.

children participated in two separate, open-ended groups meeting weekly for 1.5 hours. With support from an employment counselor or social worker, individuals receiving social services lead adult-group discussions of work strategies, parenting, and other social issues. The children's group focused on the development of life and social skills through everyday group activities. Qualitative interviews were conducted with nine women who attended the adult group for at least three months. Social service providers referred eight participants to the group; the other participant learned about it from a school flyer. One woman was Hispanic and eight were white non-Hispanic. All had children.

Participants felt that groups should be kept to a manageable size and driven by specific issues or concerns. They also identified four essential leadership attributes of effective group facilitators: (1) acting as a mediator/giving everyone the chance to participate, (2) the ability to "break the ice" and make everyone feel welcome, (3) creating a supportive, nurturing environment, and (4) demonstrating a willingness to obtain assistance for the group members. Under the theme of intragroup characteristics, participants reported the importance of feeling included and comfortable, and stated that comfort levels were negatively affected by lack of trust among group members, discussion of difficult subjects, or frustration with other group members. One-third of participants thought the group would be effective for anyone, while five others stated that it might not work for people who need professional help. Mutual support enabled group members to realize that some of their problems were not unique. Providing support to other members and feeling needed were also important to participants. Participation in the group reportedly relieved stress and resulted in positive attitude changes. Measurable outcomes included knowledge gains—particularly with regard to community resources and supports—and improved parenting, social, and problem-solving skills. A sense of empowerment, heightened responsibility, and enhanced self-esteem were also reported. Participants' families also enjoyed better spousal communication, and children who attended the children's program acquired new social skills.

Appendix B. Written Survey

INSTRUCTIONS: This questionnaire is part one of the two-part interviews we are conducting for the *Best Practices of Group Care for Prenatal Services* study.

1. Please provide the following information. Type your answers in the shaded areas.

Group care program name:
Organization name:
Address:
Your name:
Your title:
Length of time in your current position:
Phone:
Fax:
Email:
Website:

2. Type of organization (Click on box to select or deselect. You may check more than one)

- | | |
|---|---|
| <input type="checkbox"/> Non-profit | <input type="checkbox"/> For-profit |
| <input type="checkbox"/> Public | <input type="checkbox"/> Faith-based |
| <input type="checkbox"/> Coalition/consortium | <input type="checkbox"/> Other (Please specify) _____ |

3. When did your program become operational (Month/Year)? _____

4. Please describe the geographic area your program serves (i.e. CSO, county, city).

5. Describe the race/ethnicity of the population your program serves?

- | | |
|------------------------|-----------|
| White, non-Hispanic | _____ (%) |
| Hispanic | _____ (%) |
| African American | _____ (%) |
| Native American | _____ (%) |
| Asian/Pacific Islander | _____ (%) |
| Other | _____ (%) |

6. What percentage of your program participants are:

Under 18 _____ (%)?

Over 30 _____ (%)?

Single mothers _____ (%)?

7. What percentage of your program participants receive medical coverage through:

Medicaid _____ (%)?

Private insurance _____ (%)?

Other insurance _____ (%)?

Self-pay _____ (%)?

8. Describe the make up of your staff/volunteers:

Total number of program staff _____

of clinical/professional _____

of others _____

of volunteers _____

from community your program serves _____

of ethnic minorities _____

of bilingual staff _____

9. How many clients has your program served since its inception? _____

10. How many clients does your program serve each year? _____

11. Have you either performed an evaluation of your program or had one performed for you?

Yes No

12. Do you have any partners in this program?

Yes No

If Yes, who are they? (You may check more than one)

Hospitals Health centers Religious organizations

Schools Medical groups Public health departments

Coalitions/other community-based organizations

Other (Please specify): _____

Appendix C. Interview Guide

Program history and background

1. What is the target population your program intends to serve?
2. Why did you start this program?
3. What is the main purpose (or goal) of your program?
4. (Where applicable): How long did it take from the time you planned the program to the time it became operational? (Interviewer: If R asks what 'planning the program' means, say: "Whatever it means to you")

Client enrollment/outreach

5. Let's talk about how clients come into contact with your program.
6. How do your clients first learn about your group program? Is it from (Check all that apply)
 - a. Outreach worker
 - b. Word-of-mouth (family/friends/coworkers)
 - c. Marketing or advertising
 - d. Referred by a provider within your organization
 - e. Referred by other organizations/clinics OR
 - f. Some other source? (Please specify): _____
7. What is the primary source(s)?
8. Why are clients referred to your program?
9. Has client recruitment ever been a problem?
10. IF YES: Please describe the nature and extent of the problem.
11. How have you met those challenges?
12. Describe any outreach or educational activities that your program has implemented.
13. Do you conduct client needs/risk assessment at program entry?

During the course of the program?

IF YES: Please describe the assessment process, including issues addressed in the assessment, who administers it. (REQUEST ASSESSMENT PROTOCOL/TOOL IF AVAILABLE)

Group characteristics

14. Note: Q10, 11, & 12 are Not relevant to Centering Pregnancy, BTC, CHC La Clinica
15. In which trimester of pregnancy do most women enroll in your group program?
16. What is the average size of the group/class?
17. How long does each group session/class last?

18. Do you allow family members to attend groups/classes? If so, what is their role in the group?
19. Some programs assign clients to groups based on gestational age or the mother's age. What factors do you consider when assigning women to groups?
20. Since your program began, has the number of clients served increased, decreased, or roughly remained the same? (PROBE FOR THE REASON)

Program activities/curriculum

21. What credentials do the group leaders/class instructors have?
22. What training programs do the staff participate in? Is the training mandatory or optional?
23. Can you describe what a typical group meeting/class is like, e.g. how much time is devoted to instruction, group discussion, hands-on activities, etc.
24. Do you follow a structured curriculum? (ASK FOR A COPY OF THE CURRICULUM OR SAMPLE MEETING AGENDA)
25. What guides curriculum development? OR Do you have a conceptual model that guides your curriculum development? (IF YES: "Could you tell me about it?")
26. What issues are addressed in the curriculum? (Not for Centering P., La Clinica, PTA, BTC)

Check all that apply.

- | | |
|----------------------------------|------------------------|
| a. Nutrition | b. Exercise/relaxation |
| c. Childbirth education | d. Pregnancy problems |
| e. Infant care and feeding | f. Postpartum issues |
| g. Communication and self-esteem | h. Comfort measures |
| i. Family planning | j. Abuse issues |
| k. Parenting | l. Other |
27. What other services does your program provide? (INTERVIEWER: SKIP PREVIOUSLY MENTIONED ITEMS)
For example:
 - a. Help in obtaining medical care?
 - b. Personalized visits with a nurse, social worker and nutritionist?
 - c. Nutritional counseling?
 - d. Prenatal education?
 - e. Home visits?
 - f. Child care assistance for medical appointments?
 - g. Transportation assistance for medical/dental care?
 - h. Substance abuse treatment?
 - i. Interpretive services?
 - j. Breastfeeding support?
 - k. Family Planning/Birth Control information?

28. Pregnancies and childbirths are sensitive topics to many women, especially for the first time mothers-to-be. In general, how comfortable do your clients feel talking about these issues in a group setting? (Very comfortable, somewhat comfortable, Somewhat uncomfortable, or Very uncomfortable) Please explain.

(IF SOMEWHAT OR VERY UNCOMFORTABLE): What kinds of things do you do to help your clients feel more comfortable participating in the group discussion?

29. Do differences in clients, such as age, income, race/ethnicity affect interactions between group members?

IF YES, How do you address these differences?

30. Do you offer any incentives to encourage client participation in groups/classes? Please describe what incentives you offer.

Addressing client's concerns and special needs

31. What kinds of concerns/problems do your clients usually bring to the group/class? How do you address/resolve them?

32. Do you offer groups/classes for pregnant teens?

33. Teens and single mothers often face more challenges than other pregnant women. In general, how does your curriculum/program/class address clients' special needs?

34. Do you have classes/groups in languages other than English? What languages? How many clients participated in these non-English classes/group sessions each year (to date)?

Client retention

35. Do clients tend to complete your whole program?

36. What is the client drop out rate, if any? What are the main reasons clients drop out of the program?

37. How do you try to keep clients engaged in your program?

38. What were/are the primary reasons clients drop out?

39. Does your program help women remain connected after the group ends, and how?

Collaboration with community organizations

40. Describe the nature and level of collaboration your group program has with other community and/or public organizations (in addition to collaboration with health care facilities around medical care).

41. What kinds of services do these organizations provide?

42. How do you initiate and maintain linkages with community/public organizations?

43. Are you in contact with other programs similar to yours in other regions? How do you establish these contacts?

Care coordination

44. Do you provide information about clients' risk factors and ongoing prenatal services to their medical provider and to the labor and delivery staff? If so, please describe the process.

45. Please describe the nature and level of integration and/or collaboration your group program has with other health care organizations, including hospitals, health care centers, and insurance carriers. (Interviewer: For each type of organization, note length of relationship, other indicators of strength of partnership).

Evaluation activities

46. Describe any evaluations of the program, including data elements, mechanisms of data gathering, methodology, and outcomes selected.

47. What are program outcomes to date?

48. (Where applicable) How do you use the information you collect from program evaluation for quality improvement (QI)? For example: to identify problem areas, to establish improvement goals, to develop specific interventions, to monitor intervention effectiveness...

Your perspectives

49. What aspect(s) of the program/class did/do your clients find most valuable? What aspect(s) have been least valuable?

50. In your opinion, what sets your group model apart from other (similar) programs in the community?

51. In your opinion, what are the strengths of group models compared to traditional one-on-one approaches?

52. To what extent do you agree/disagree with the following statement? (Strongly agree, Agree, Neither agree nor disagree, Disagree, Strongly Disagree)

“Clients do better in a group setting than in a one-on-one model.”

PROBE: “Why do you say that?”

53. What sorts of training or technical assistance do you think would help your program staff do their jobs most effectively?

54. What do you think are the most important or essential skills needed for a group leader?

Example (Do not read):

- a. Confidence
- b. Professionalism
- c. Enthusiasm
- d. Compassion
- e. Inspiration (For others to change individually and for people to work together)
- f. Support
- g. Empowering
- h. Passionate Interest in Topic Facilitating
- i. Commitment
- j. Good Listener
- k. Network to Build Bridges (to varied community subgroups)
- l. Organizational Skills
- m. Other (Please describe)_____

55. How did you come to be where you are today as a group leader/class instructor?

56. In your opinion, how important do you think the group dynamics (client makeup) are to the success of a group/class you run?

57. In your opinion, what types of clients benefit the most from this program? (What characteristics of clients?)

58. In which aspects of a client's life or pregnancy do you think your program seems to make the greatest difference? (IF NEC., What do you think are the most important ways your program helps improve your clients' lives and pregnancies?)

(Do not read):

- | | |
|---|---------------------------------------|
| a. emotional support | b. improved nutrition |
| c. reduced smoking/drinking/drugs | d. reduced stress |
| e. improved knowledge about parenting | f. increased use of prenatal services |
| g. better prepared for labor and delivery | h. improved relation with family |
| i. better birth outcomes, etc. | |

59. What factors have contributed to the success of your program?

60. What have been the major barriers and challenges you have faced?

61. Has your program achieved everything you hoped for/wanted? What changes, if any, would you like to see incorporated into the program? Are there barriers to being able to make these changes?

62. Do you anticipate any change in your capacity to provide services in the near future (OR in the next couple of years)? If so, please describe anticipated changes, either increased or decreased capacity.

Closing remarks

63. What other topics or issues do you think are important that we have not already covered?

64. What is the most important lesson or message that we can learn from your program?

