

Common Evidence Based Challenges in Maternal and Child Health

*The Intervention Works but Not for the Intended Problem
The Case of Prenatal Care and Low Birth Weight/Prematurity*

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**The Intervention Works But Not For the Intended Problem:
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**The Intervention Works But Not For the Intended Problem:
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OVERVIEW

The purposes of this case study are to:

1. *Identify the key characteristics of this type of evidence-based challenge and the problems that fall into this challenge category,*
2. *Discuss potential courses of action when dealing with this type of challenge,*
3. *Identify strategies to overcome the challenge,*
4. *Identify recommendations for action that might apply across programs/interventions.*

This case study was developed for use in ***Leadership, Legacy, and Community: A Retreat to Advance Maternal and Child Health (MCH) Scholarship and Practice***. The Retreat was hosted by the MCH Program at the University of Illinois at Chicago School of Public Health, in Chicago, July 2008. This is one of four case studies developed for the Retreat. We encourage you to use this case study, as well as the others, to engage in a group dialogue around the many evidence-based challenges we face in our work related to MCH.

Each case study was designed to be used in a 3-hour workshop that may include two full-group discussions and two rounds of small group discussions. In the initial whole group discussion, you may choose to discuss the characteristics of this challenge and how to know when an agency/organization is experiencing this challenge. You may also choose to generate a list of issues/problems that characterize this type of challenge (Purpose #1). We encourage you to follow-up this discussion with 2 rounds of small group discussions (8-10 people per group). Each small group discussion should be 30 minutes and focus on a different set of questions designed to address and achieve purposes #2 and #3. Lastly, you may conclude your workshop/discussion with a large group discussion to identify recommendations to address this particular type of challenge across interventions/problems, purpose #4. All discussions can be guided by the set of **Discussion Questions on page 7**. The questions provided for each round are to be used as guides to focus the discussion, with an eye toward having the focus be distinct but complementary across rounds. ***If you identify other key questions for that round's focus, that is wonderful.***

Disclaimer: We believe that these case studies will produce insightful and useful information. Therefore, we encourage you to share any information and recommendations/strategies that you identify with the UIC Maternal and Child Health Program. With your permission, we will post this information on our website at www.uic.edu/sph/mch. Please contact Kris Risley at kyrisley@uic.edu.

Note About Working With This Case Study

As a participant in a discussion about this evidence based challenge, we ask you to take a look at your colleagues and note the different disciplines as well as the different generations present and be willing to learn from, discuss, and create with all participants. Whether you have a lot or a limited amount of experience with the particular issue on which this case is based, you have much to offer in helping the field of MCH identify a process to address this type of challenge.

The Intervention Works But Not For the Intended Problem *The Case of Prenatal Care and Low Birth Weight/Prematurity*

Early 1980's: In the early 1980's, the evidence suggested that lack of access to prenatal care was the major barrier to the success of prenatal care as a strategy for improving adverse pregnancy outcomes in vulnerable populations.

1985: The Institute of Medicine report, *Preventing Low Birthweight* finds that for every \$1.00 spent on high risk maternal care, \$3.38 is saved in high-risk newborn costs.

1988: The Institute of Medicine report, *Prenatal Care: Reaching Mothers, Reaching Infants* finds that the #1 barrier to increasing access to prenatal care is financial although other major barriers are cited: system barriers, organizational barriers, and cultural and personal barriers.

1986-1990: Policy response to the IOM Reports is the expansion of financial access to prenatal care through Medicaid. Expansions are incremental and states often go beyond recommended federal limits.

As a result of the Medicaid expansions, financial access to prenatal care appears to have led to increasing rates of first trimester entry into prenatal care although disparities remain between racial/ethnic groups. At the population level, despite increased first trimester prenatal care entry, low birthweight and preterm birth rates begin to rise for all groups except African-Americans (declines seen by AA begin to reverse in 2001). In addition, evaluation articles from this period demonstrate that although the Medicaid expansions appear to have increased access to prenatal care, except for a few studies, there has been no substantial effect on rates of low birthweight and preterm delivery.

While the evaluation of the Medicaid expansions suggest that increasing access to prenatal care has at best an equivocal effect on reducing rates of preterm delivery and low birthweight, it is also clear that prenatal care is an established intervention that all higher income women have access to and expect to be available.

Although both the population data and the evaluations of the Medicaid expansions call into question the efficacy of expanding access to prenatal care, it is unclear that the logic model on which the Medicaid expansions were based was completely thought out. While the Medicaid expansions provided access to prenatal care for higher low-income women, they did not ensure any new services for the poorest and most vulnerable women who already had Medicaid coverage. In addition, the Medicaid expansions did not pay for "outreach" to find women who could benefit. In fact, many low-income women enter prenatal care and only then find out they can get Medicaid coverage for this care. Importantly, there are now increasing numbers of very low-income women who no longer (after welfare reform) automatically have Medicaid coverage when non-pregnant. In addition, although some women enter prenatal care early, they often go on to receive less than adequate prenatal care based on visits. It is clear that new strategies and approaches with respect to prenatal care as an intervention are needed if prenatal care is to remain a viable intervention.

There is some data to suggest that enhanced prenatal care (a concept which was also supported through the Medicaid expansions of the 1980's/COBRA 1985) that includes additional components such as case-management, and/or home visiting, and/or increased health promotion

content, etc. appears in some situations to have a positive effect on reducing adverse pregnancy outcomes. In addition, specific components of prenatal care appear to positively affect pregnancy outcomes (e.g., smoking cessation, nutritional support); and, some completely different approaches to prenatal care delivery are just beginning to show positive results (e.g., Centering Pregnancy).

While prenatal care has waned in popularity as an intervention, there has been an increasing focus on preconception and interconception care. There is also increasing attention to well-woman care across the lifespan and acknowledgement that healthy women have healthy babies. Many advocates, policy-makers and MCH professionals are claiming that prenatal care is too late; nine months is not enough to reverse a lifetime of exposures and to ameliorate chronic health conditions. Consequently, funding and focus is emerging for preconception and interconception care.

Discussion Questions

Whole Group Discussion (30 minutes) (Purpose #1)

- What are the key characteristics of this type of problem (evidence-based challenge)?
- What other programs/interventions/problems fit this profile?

Round I (30 minutes): **Given the mismatch between the problem and the intervention, what are our *Course of Action* options?** (Purpose #2)

- What are the ramifications of continuing the program/intervention in its current form?
 - In terms of achieving health goals?
 - In terms of professional credibility?
 - In terms of public expectations?
 - In terms of ethics, social justice, moral obligations?
- What are the constraints to abandoning the program/intervention in its current form?
 - In terms of achieving health goals?
 - In terms of professional credibility?
 - In terms of public expectations?
 - In terms of ethics, social justice, moral obligations?

The Case of Prenatal Care and Low Birth Weight/Prematurity (continued)

- What are the pressures for/against the program/intervention?
 - How do we assess the strength and importance of those pressures?

Round II (30 minutes): **Given the mismatch between problem and intervention, how can we reframe the intervention within a new paradigm** (Purpose #3). For example, in this case,

might the objective to increase access to prenatal care benefit from a redefining of “pre”-natal care to include preconception and interconception care?

- What are some other ways to think about the program/intervention’s usefulness, based on the science/evidence?
- What would be involved in re-aligning the program/intervention within the context of the current public health focus (for example, for prenatal care, within the current focus on pre/interconceptional care) to achieve its potential?
- If re-alignment isn’t possible, are there alternative models or delivery system changes within the larger framework of the intervention (prenatal care) that can be tested to generate support for the intervention?

Whole Group Discussion (45 minutes): **Given what we have learned from this case, how can we take what we’ve learned and apply it to other programs/interventions that fall into this challenge** (those identified in the beginning of session) (Purpose # 4)

- Given the challenge presented today, what are the recommendations/approaches to addressing the challenge that are universal in nature (ie, apply to other issues/programs that fall into this challenge)?
- How do we advocate for an intervention that has waning support from stakeholders, but has fundamental support (as a right of a population) from other stakeholders?
- How do we terminate support for interventions that are weak but have large stakeholder communities?
- What is the role of the MCH field in meeting this type of challenge to evidence based practice?
 - Practice professionals?
 - Academic professionals?

DISCUSSION GUIDELINES

The Ultimate Purpose of this Session is to **Identify Global Recommendations and Strategies to Address this particular evidence-based challenge**. The guidelines presented below were adapted from the World Café model: www.worldcafe.com.

- 1) **Focus** on what matters!
- 2) Contribute your thinking.
- 3) Speak your mind and heart.
- 4) Listen to understand.
- 5) Link and connect ideas.
- 6) Listen together for insights and deeper questions.
- 7) Have fun!

Our assumption:

You have within you the wisdom and creativity to confront even the most difficult challenges. Given the appropriate context and focus, it is possible to access and use this deeper knowledge about what's important – the lives of the women, children, and families you serve.

FACILITATOR INSTRUCTIONS

Initial Whole Group Discussion: Discussion Questions, See Page 7

1. **Main facilitator introduces the Case and leads the participants into a group discussion that addresses purpose #1 (See page 4).** Main Facilitator also reviews World Café guidelines prior to beginning any discussion (See page 8).
 - i. **Facilitator identifies a participant** to take notes on flipcharts for any discussions involving the entire group. (The note-taker should pay special attention to comments resulting from the question: What other health status problems/issues fit this profile? [we will return to this question in the final group discussion]).

NOTE: You may use additional note-takers to keep up with group discussion.

ROUND 1: Discussion Questions, See Page 7

Ask each Small Group to identify 2-3 Take-Home Messages from this round that they will then share with the entire group.

2. **Main facilitator asks participants to break into small discussion groups of 8-10 people.**
3. **Main facilitator asks each table to identify an individual to facilitate the small group discussion for that round (*table facilitator*).**
4. **Main facilitator asks each table to identify a *table note-taker* who will take notes about the discussion.**
5. **Following the completion of that round (25 minutes), main facilitator asks each *table facilitator* to share the 2-3 take-home messages that were identified from the round.** This should last no more than 5-10 minutes.

NOTE: EACH DISCUSSION SHOULD LAST APPROXIMATELY 25 MINUTES AND BE FOLLOWED UP BY A WHOLE GROUP DEBRIEF THAT LASTS NO LONGER THAN 5-10 MINUTES.

ROUND 2: Discussion Questions, See Page 7

6. **Main facilitator asks individuals to move to a table with new people for the Round 2 discussion.**
7. **Main facilitator asks each table to identify a new individual to facilitate the small group discussion for that round (*table facilitator*).**
8. **Main facilitator asks each table to identify a new *table note-taker* who will take notes about their discussion .**
9. **Following the completion of that round (25 minutes), main facilitator asks each *table facilitator* to share the 2-3 take-home messages that were identified from the round.** This should last no more than 5-10 minutes.

Final Whole Group Discussion: Discussion Questions, See Page 7

The purpose of this final session is to identify several, tangible strategies/recommendations to address this particular type of challenge. They may be related to practice or academia.

10. **Main facilitator leads the entire group in a discussion to address the final Whole Group Discussion questions (See page 7).** Please leave about 45 minutes for this section.
 - i. Identify a note-taker to take notes during this session.

NOTE: You may choose to take a 10-15 min break between rounds 1 and 2 or round 2 and the final discussion.

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