Innovative Perinatal Education Management Service

Developing a Family-Centered, Hospital-Based Perinatal Education Program

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Abstract

The development of a family-centered, comprehensive perinatal education program for a large, urban hospital system is described. This program was developed in conjunction with the building of a new women's center and, although the authors were fortunate that several opportunities for educational program development were linked to this project, many of the steps taken and the lessons learned can be helpful to anyone desiring to develop a similar program. This article relates perinatal education to the principles of family-centered maternity care, outlines the criteria for a quality educational program, gives rationale for this type of program development, and offers practical suggestions for starting or enhancing a perinatal education program within a hospital system.

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In the spring of 1997 Kennestone Hospital in Atlanta, which is part of the WellStar Health System, contracted with a women's health consulting firm to help them identify their philosophy of women's care, build a new women's center, and develop educational programming for women and their families. Kennestone Hospital is one of three hospitals in the Atlanta WellStar Health System that offers maternity services. These three hospitals account for over 8,000 births a year. Part of the project was to develop a comprehensive program of perinatal course offerings for expectant and new parents. In the fall of 1997, a coordinator for perinatal and family

education was hired and given the challenge of developing this program. The purpose of this article is to share what was learned in this development, encourage others who might have a similar opportunity, and report the successes and challenges that were encountered.

Historical Background

Prior to 1997, the childbirth education programs at Kenestone Hospital were minimal and did not meet national standards for quality childbirth education programs. A 7-week childbirth series was offered, which consisted of a 2-hour class on each of the following topics: (a) childbirth preparation for labor, (b) relaxation techniques and a tour of the maternity care facilities, (c) postpartum and cesarean birth, (d) breastfeeding, (e) vaginal birth after cesarean birth, (f) siblings, and (g) newborn care. The number of participants in these classes was not limited and classes were held in a large auditorium. When relaxation techniques were practiced, participants had to lie down in the aisles of the auditorium. While there was nothing wrong with the information that was offered, the 2 hours spent by one noncertified instructor and the 1 hour spent by a certified instructor with 30+ couples cannot be compared to the 15 hours of time now spent with a Lamaze International certified instructor who teaches a group of no more than 12 couples. Hospital tours had as many as 70 people attending, with one instructor as guide. The class handouts were sporadic and of inconsistent quality. Instructors were not given feedback regarding improvement of their class content or presentation skills.

The Development of a Family-Centered Perinatal Education Program

It was recommended that the perinatal education program be redeveloped to reflect the family-centered principles being adopted by the new women's center. What does a comprehensive, family-centered perinatal education program look like? It places an emphasis on consumer information, health-enhancement, and family autonomy—all foundations of family-centered care (Bia-sella, 1993; Nichols and Zwelling, 1997). It offers a complete spectrum of educational opportunities for the childbearing family and is based on the Principles of Family-Centered Maternity Care developed by Celeste

Phillips (Phillips, 1994) (See Table 1). Several of those principles relate specifically to perinatal education:

- *Childbirth is seen as wellness, not illness (Principle #1).* This principal is basic to perinatal education, for the goal of most childbirth educators today is to promote the concept of wellness in childbirth classes. Women are presented with a view of pregnancy, labor, and birth as normal physiology and part of a healthy life experience. Comfort measures and coping strategies are taught to support this philosophy of wellness.
- *A comprehensive program of perinatal education prepares families for active participation throughout the evolving process of preconception, pregnancy, childbirth, and parenting (Principle #3).* By offering a selection of courses for all members of the pregnant woman's family—courses that begin before the pregnancy occurs and then continue throughout the pregnancy and after the birth—the hospital is demonstrating its commitment to a philosophy of family-centered education.
- *The hospital team assists the family in making informed choices for their care during pregnancy, labor, and birth and for postpartum/newborn care and strives to provide them with the experience they desire (Principle #4).* One of the primary roles of the childbirth educator is to be an advocate for the pregnant family, informing them of all their choices and the advantages or disadvantages of each. This awareness begins during classes in the prenatal period and then, it is hoped, carried out throughout the inpatient childbirth experience.
- *The father and/or other supportive person(s) of the mother's choice are actively involved in the educational process, labor, birth, and the postpartum and newborn care (Principle #5).* Since family-centered perinatal education can strengthen communication and decision-making skills, the hope is that families will utilize these skills to increase the quality of interaction between themselves and with their health care provider.

As program development got underway in the fall of 1997, a number of criteria were identified by the new coordinator as being critical for contributing to a quality

Developing a Family-Centered, Hospital-Based Perinatal Education Program

Table 1 Principles of Family-Centered Maternity Care (FCMC)

In each of the definitions of FCMC, emphasis is placed on the integral role of the family. Key points of the philosophy of family-centered care are summarized in the following ten principles of operation developed by Phillips + Fenwick.

FCMC Principle #1

Childbirth is seen as wellness, not illness. Care is directed to maintaining labor, birth, and postpartum and newborn care as a normal life event involving dynamic emotional, social, and physical change.

FCMC Principle #2

Prenatal care is personalized according to the individual psychosocial, educational, physical, spiritual, and cultural needs of each woman and her family.

FCMC Principle #3

A comprehensive program of perinatal education prepares families for active participation throughout the evolving process of preconception, pregnancy, childbirth, and parenting.

FCMC Principle #4

The hospital team assists the family in making informed choices for their care during pregnancy, labor, and birth and for postpartum/newborn care, striving to provide the family with the experience they desire.

FCMC Principle #5

The father and/or other supportive person(s) of the mother's choice are actively involved in the educational process, labor, birth, and postpartum and newborn care.

FCMC Principle #6

Whenever the mother wishes, family and friends are encouraged to be present during the entire hospital stay, including labor and birth.

FCMC Principle #7

Each woman's labor and birth care are provided in the same location, unless a cesarean birth is necessary. When possible, postpartum and newborn care is also given in the same location and by the same caregivers.

FCMC Principle #8

Mothers are the preferred care providers for their infants. When mothers are caring for their babies, the nursing role changes from performing direct newborn care to facilitating the provision of care by the mother/family.

FCMC Principle #9

When mother-baby care is implemented, the same person cares for the mother and baby couplet as a single-family unit, even when they are briefly separated.

FCMC Principle #10

Parents have access to their high-risk newborns at all times and are included in the care of their infants to the extent possible given the condition of the newborn.

"Principles" – December 1997

Phillips + Fenwick

program. These criteria were based on her previous professional experience as well as from published recommendations (Association of Women's Health, Obstetric, and Neonatal Nurses [AWHONN], 1993, 2000; Haire, 1975; International Childbirth Education Association [ICEA], 1999; Lamaze International, 2000; Phillips, 1994, 1996) and can be seen in Table 2. We are proud to report that each of these criteria has been implemented in WellStar Hospital's educational programs in the following ways:

- *Courses encompass the entire childbearing year.* All families will not take advantage of all course offerings. However, to provide family-centered perinatal education, the opportunity must be available at all times during the childbearing period to meet the needs of those who are interested. This is one reason why we created a series of different types of classes offered at varying intervals so that it is possible to enter into the curriculum at the beginning and continuously take classes on various topics related to a particular time in pregnancy. Course offerings do not "end" until approximately one year after the birth of the baby.

Table 2 Standards for a Family-Centered Perinatal Education

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- Courses offered encompass the entire childbearing year.
 - In order to meet the changing needs of families during the childbearing year, educational offerings include early pregnancy, mid-pregnancy, and late pregnancy classes, as well as postpartum and parenting information.
 - The long-term emotional significance of the childbearing experience is addressed in all courses.
 - Classes reflect the cultural needs of the participants.
 - Class size facilitates the group process, with an ideal size of 6–10 couples and a maximum of 12 couples.
 - Teachers utilize a variety of teaching strategies during each class to meet the needs of different types of learners.
 - The Lamaze class series for first-time parents includes at least 12 hours of instruction with emphasis on skills practice (especially positioning and relaxation), comfort measures, and class discussion.
 - Classes include discussion of consumer rights and responsibilities for making informed choices based on knowledge of alternatives.
 - Family input and evaluation of class content and process is actively sought and used to improve classes.
 - Childbirth instructors are certified.

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- *In order to meet the changing needs of families during the childbearing year, educational offerings should include early pregnancy, mid-pregnancy, and late pregnancy classes, as well as postpartum and parenting information.* A series of classes was developed: (a) a preconceptual health course, called “Can We, Should We?”; (b) an early pregnancy class, called “Now We’ve Done It!”; (c) a mid-pregnancy course, called “Decisions, Decisions, Decisions”; (d) the Lamaze course, called “Here We Go!”; (e) a postpartum support group for mothers called “Mom’s Connection”; (f) a breastfeeding course, called “So *That’s* What They’re For!”; (g) two newborn courses, called “Newborn Care and Behavior: What Do We Do With Her Now?” and “Newborn Care and Behavior: Intellectual and Emotional Care of the Newborn”; and (h) a parenting course, called “Parental Adjustments.” We also purchased the franchise for a course called “Boot Camp for New Dads.”
- *The long-term emotional significance of the childbearing experience is addressed in all courses.* As part of the Lamaze International certification experience, candidates become familiar with important references regarding the significance of the childbearing experience to women and families. While this does not occupy a large portion of the curriculum, an acknowledgment of this concept should permeate every class and every interaction the instructor has with every family. An unspoken recognition by the hospital system also exists, as evidenced by the resources allocated to making this normal life event a special memory for families.
- *Classes reflect the cultural needs of the participants.* The population of the counties served by the Well-Star Health System is composed of approximately 30% Hispanic families. Many of these families are

undocumented aliens who are not eligible for Medicaid. To serve them, many barriers such as transportation, cost, language, and partner support must be overcome. We were fortunate that one of the childbirth educators is a bilingual labor and birth nurse, and she offers the only Lamaze classes taught in Spanish in the greater Atlanta area. The workbook and handouts used for classes have been translated into Spanish, and a Spanish labor video was purchased as well. Two Hispanic educators teach the newborn care class and the breastfeeding class is translated into the Spanish language. Tours of the labor and birth areas are conducted once a month in Spanish and hospital signs are in both English and Spanish. To assist families who speak other languages in any of the other classes taught in English, a device is available that is composed of a headset worn by the one who is translating and ear buds worn by the ones who are listening. Theoretically, this allows any class to be attended by any family, regardless of their native language.

- *Class size facilitates the group process.* The instructor-to-family ratio is dependent upon several factors. The first step is to identify whether or not there is a national recommended standard set for a particular course. For example, both Lamaze International (2000) and AWHONN (2000) recommend a class size of 6 to 10 couples (12 to 20 people) for a Lamaze childbirth course, with a maximum of 12 couples (24 people). We have found it best to set the upper limit at 10 couples, to leave room for those who, for one reason or another, need to be fit in later. However, since our enrollment stays full and we want to accommodate everyone who makes a request, we generally have 12 families in each class. A second consideration related to class size is the teaching strategies employed to achieve the

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learning objectives of the class. This is discussed in more detail below.

Available sites can also affect class size. Classes are presently offered at four locations, and there is a plan to add two more in the future. The obvious benefit to the families is the opportunity to attend childbirth classes closer to their homes. But having multiple community sites also helps the hospital system, for it takes some of the pressure off the room utilization problem and creates a positive presence for the hospital in the community. However, it is important to schedule one class of the series at the hospital. This will prevent confusion related to finding the hospital, parking, and the admission process when the family arrives in labor. A tour should be conducted before this class so that the families become comfortable with the environment where they will give birth. As the program grows, it is important to allow for an adequate number of classes and instructors so that families will not have to attend elsewhere to receive their educational needs. The ultimate goal is to educate 25% of the families who give birth at WellStar facilities. With a soon-to-be-reached annual birth rate of approximately 10,000 births per year, this would necessitate 2,500 families, which would necessitate approximately 250 to 300 class series per year.

- *Teachers utilize a variety of teaching strategies during each class to meet the needs of different types of learners.* The sharing of factual information (lecture) is the simplest level of teaching and can be effective with high instructor-to-family ratios. Meaningful group discussions are best managed if the size of the class is not too large. The mastering of at least the introduction of psychomotor skills is the next most time-consuming level. The changing of attitudes can be the most challenging topic of all—it demands the most time and individual attention and requires the most highly skilled instructor. Therefore, such a challenging topic justifies the lowest teacher-to-family ratio.

For example, the newborn care class #1, which deals with information regarding newborn characteristics and the psychomotor skills necessary to care for a newborn, is team taught and has a ratio

of 1:6 (i.e., two instructors for 12 families or 24 people). Half of this class consists of hands-on practice with newborn-like dolls that are given to each family at the beginning of class so that they can “care for” their baby the entire time. This represents a woefully inadequate attempt to instill some reality into the minds and hearts of these expectant parents. A final example related to size is our birthing center tours. One instructor is able to meet the needs in that situation of 20 to 25 people.

- *The Lamaze class series for first-time parents includes at least 12 hours of instruction with emphasis on skills practice (especially positioning and relaxation), comfort measures, and class discussion.* All our childbirth educators are asked to incorporate the teaching strategy of “Labor Stations” (Zwelling and Anderson, 1997) in their Lamaze course. This strategy is one in which the practice of relaxation and massage, breathing techniques, and various positions for labor and birth is integrated into all content presented throughout the entire 2-hour class, as couples move from one “station” to another in the classroom. In fact, one of the five classrooms in the new women’s center is devoted to this teaching strategy: The room contains a birthing bed, bedside tables, rocking chairs, mats, and bean bags—all of which create the stations.
- *Classes include discussion of consumer rights and responsibilities for making informed choices based on knowledge of alternatives.* Although the thread of informed choice is woven throughout the entire curriculum, the skills of decision-making and communication are a major emphasis of the second trimester course, “Decisions, Decisions, Decisions.” The inclusion of the popular class on pharmacological pain management, titled “Everything You Wanted To Know About Epidurals, But Were Afraid To Ask,” bears witness to the belief that families can be trusted to make the choices best for them if given accurate information concerning reasonable options in a nonjudgmental and respectful atmosphere. In addition, parents are given the “Pregnant Woman’s Bill of Rights” and the “Pregnant Woman’s Responsibilities” in their course notebooks (Haire, 1975). A member of the staff has also translated these documents into Spanish.

- *Family input and evaluation of class content and process are actively sought and used to improve classes.* Obtaining feedback from the families who come to classes and from the instructors who teach them is of utmost importance to the continuing progression of the program. Many of the evaluations are class specific (i.e., questions are included that we hope will illicit opinions and feelings directly related to the class content and their instructor). This information must then be analyzed and acted upon by the coordinator to be of any benefit. After each class or course series, the instructor reads the class members' evaluations. Then, she herself is responsible for completing an evaluation form. Her evaluation includes plans for changes in response to the class feedback and her own assessment. Parent and teacher evaluations are reviewed at the time of the instructor's yearly evaluation. A peer review process is also planned for the future, as well as a post-birth evaluation that may take the form of a postcard.
- *Childbirth instructors are certified.* A decision was made by the administration of Kennestone to support Lamaze International certification for interested and qualified staff. This decision was made after careful evaluation of both local and national certifying organizations. To date, 15 professional women have been certified and 18 more are in the process. A few other previously certified childbirth educators from the Atlanta area have also been hired. This means that there is a perinatal educator staff of 37 Lamaze Certified Childbirth Educators (LCCEs).

There are other aspects of developing a large perinatal education program that are influenced by a family-centered approach. These include curriculum development, scheduling, class environment, quality control, standards setting, and customer satisfaction. Although Lamaze childbirth preparation forms the nucleus of the program, many other types of classes exist that, when offered, allow families the choice of a well-rounded experience. An in-depth community needs assessment is invaluable to identify the classes desired by families. In our area, several different families and their corresponding needs stand out: the adoptive family, including the birth mother; the family experiencing a multiple pregnancy;

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the family who has experienced a loss; the Hispanic family; and new fathers. These were special families identified as needing to have courses developed to meet their educational needs.

Curricula for these courses can be created in several ways: developed by staff, such as the Lamaze course; modified from existing programs, such as the newborn course that was modified for adoptive parents; offered through collaboration (a liaison was formed with Nancy Bowers, the founder of the "Marvelous Multiples" program, to offer classes at our hospital); or purchased (a franchise for "Boot Camp For New Dads" program was purchased and included the training for three fathers to be the "drool sergeants" to facilitate the course).

The registration process for all these courses should be family-centered as well. The attitudes of the staff who register families are critical. The manner in which parents are treated during the registration process will set the tone for how they will be treated in classes and as an inpatient. An excellent registration service can also provide essential communication to the education staff regarding class enrollment and demand. Weekly updates are received by E-mail, which allow us to forecast our needs and add classes and instructors to teach the classes before families are turned away. Any special needs or requests are accommodated if possible. Those who conduct the registration are kept "in the loop" regarding departmental information and decisions. Specific questions are included in our class evaluation forms regarding the ease of the registration process. Then, this information is passed on to the registrars, who receive an abundance of sincere praise and feedback when their extra efforts have made a difference to a family. Once in a while, a pizza lunch meeting can go a long way to promote communication and a sense of teamwork.

The environment in which classes are held is also an

important family-centered consideration. The appearance of the facility when families enter, the size and comfort of the classrooms, the comfort of the furniture, and amenities such as restrooms, break areas, and refreshments all give a critical impression. If people are not physically comfortable, they will find it difficult to learn. People make assumptions based upon environment. If the room is too small for the number of families, if the room is dirty and has uncomfortable, hard chairs, or if the visual aids are not current and professional, it can be concluded that the system considers money more important than the comfort and learning experience of the families it serves. Conversely, if a family walks into a classroom with relaxing, gentle music playing, sees bright, positive posters and pictures on the walls, and notices rocking chairs, labor balls, mats, body pillows, bean bags, and a labor/birthing bed available for their use, they are likely to feel that their learning experience is important to the hospital system. A location that offers convenience, free parking, and safety also gives important messages to consumers. Classes need to be offered frequently enough to meet the demand and during times of the day and days of the week that are convenient for the families. The length of the class is important, too. For example, the 3-Saturday, Lamaze series is quite popular because it meets the needs of families who want to accomplish the course in 3 rather than 6 weeks.

Quality assurance is achieved by working to develop an educational program that meets the standards of professional organizations such as AWHONN, ICEA, and Lamaze International. All educational materials, handouts, visual aids, and equipment should be of the highest quality. Instructors should be certified. And an evalua-

tion process must be in place to evaluate both the courses and the instructional staff at continuing regular intervals.

In summary, a comprehensive perinatal education program is an integral part of any service that is philosophically based upon the principals of family-centered care. It provides many opportunities to positively interact with and impact families during a peak experience in their lives. And it attracts families to other services offered by the hospital system. It is a primary way to send a message of caring and competence that could strongly influence women as they make future decisions regarding health care for themselves and other family members.

Rationale for Program Development

Why should a hospital system consider a major perinatal education component as part of its family-centered focus? While it is clear that there are benefits to the expectant and new family, are there benefits to the hospital system as well? Families seem to be pleased with their birth experience when five concerns are addressed: (1) the support from another human being, (2) relief from pain, (3) the assurance of a safe outcome, (4) labor attendants who accept the woman's philosophy and personal behavior, and (5) appropriate bodily care (Phillips, 1996). Perinatal education can help to clarify, modify, or even initiate these expectations in a positive way. This approach empowers families to make choices they can live with and feel proud of, through the promotion of communication and decision-making skills and the realization of their personal goals.

A comprehensive educational program creates an opportunity to interact with and impact a family from the time before pregnancy begins to approximately one year after birth, even if that family is formed through adoption. It promotes health care choices through an awareness of options. And, finally, it can promote loyalty from the family to the health care system and the professionals who helped them become informed consumers. It also increases customer satisfaction and enhances positive outcomes, factors that are of major concern to hospitals in today's health care environment.

How to Begin: Suggestions for Development

How should a family-centered, perinatal education program be developed? We identified the following as im-

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portant areas to address in developing the educational program:

Assessment of Market and Community Need

Four focus groups from the community were interviewed to assess their educational interests and needs. The groups included women of childbearing age that were Kennestone Hospital consumers; women of the same age group who were not Kennestone Hospital consumers; a group of middle-age and older women who were Kennestone Hospital consumers; and another group of the same age who were not Kennestone Hospital consumers. Their discussion led to the development of a menopause group, a resource library and education center, and features such as on-site health screenings, flexible center hours, 24-hour unlimited family visitation, and greater staff accessibility for the patient by cell phones.

Securing Administrative "Buy-in"

Meetings were held with the administrative staff in the hospital system who had the most "stake" in the quality and success of the program, and the proposal for a comprehensive educational program was presented. The physical and emotional benefits of education to the hospital's consumers were discussed. If families have a positive birth experience because they have been educated, they are more likely to return to the same hospital for subsequent births or for other health care services. Although administration is interested in the welfare of their consumers, they are primarily interested in knowing how an educational program will benefit the system. The following points were addressed: An educational program (a) enhances the image of the hospital in the community, (b) increases the number of potential patients coming to the facility, (c) provides "frontline" marketing, (d) decreases costs by improving outcomes, and (e) increases patient satisfaction.

It is important to do your homework prior to this meeting. Review the literature to cite studies or clinical articles that document the benefits of family-centered maternity care and perinatal education. We recommended the development of a task force to be involved in the planning of the program. The task force should represent all areas of perinatal nursing, childbirth education, medicine, marketing, and the community. This

allows a number of people to be involved and enhances "buy-in." The task force met regularly throughout the planning process and was very helpful in generating ideas and helping with implementation. Because we were involved in a major building project and change process, the consulting firm that had been hired provided continuing education seminars for the hospital nursing staff that supported the concepts that would be presented in the childbirth classes. This was very helpful, for an education program is more successful if the hospital staff feel they are included and involved. After several meetings, we had achieved administrative buy-in and we were on our way.

Certification of Instructors

We wanted to "go for quality" in the development of this new program, so we wanted all our educators to be nationally certified. One of the consultants working with us presented a comparative analysis of the available national certification programs (cost, length, quality, national recognition, outcome) and ways the program might be funded. The childbirth education task force chose to affiliate with Lamaze International and to support the certification process for the nurses who were interested in becoming childbirth educators. We held two recruitment teas—one on a Sunday afternoon and one on a weekday evening—to inform interested professionals about the Lamaze International certification program and the subsequent role of a childbirth educator at Kennestone Hospital. We also invited hospital nursing staff and professionals from the community to attend. Once the childbirth educators were selected and had begun their certification process, they were required to attend four monthly 1-day workshops taught by one of the consultants working with our building project, who by coincidence was also one of Lamaze International's faculty. We were fortunate that we had this additional opportunity to offer our staff, for in most situations the certification process is more self-directed. The educator candidates then also attended the required 3-day seminar, which was part of one of Lamaze International's university programs but was held on site at our hospital. Kennestone Hospital had committed to pay all of the childbirth educators for their time in attending all of these seminars, a commitment that showed unprecedented support of their belief in the long-range benefits

of perinatal education. The funds for this endeavor were obtained from both the Kennestone Hospital Foundation and the Kennestone Human Resources Department, because the money was not available in departmental budgets for this purpose. The foundation raises money for various projects for the hospital system; a new women's center was an attractive project for them. The human resources department at Kennestone gives tuition reimbursement to staff for up to \$1,000 per year. Normally, this reimbursement is not given until after the employee has taken the course and successfully passed; however, for this project, the human resources department agreed to grant the money in advance.

We also sought and received a great deal of support for the childbirth educator candidates from the local Atlanta Chapter of Lamaze International. These experienced LCCEs served as sponsor teachers and welcomed the candidates into their classrooms to observe and act as student teachers. We were grateful for the commitment and support of these teachers in mentoring new childbirth educators. As other certification programs become available, such as perinatal bereavement, postnatal, and parenting, the hope is to involve the staff in those programs as well.

Marketing

In our situation, the marketing of the new women's center and of the perinatal education program was most often done together. From billboards to the newspaper to the radio, Atlanta heard that there was a new place and a new way to have a baby. This created a huge amount of curiosity about what was going on and when tours were offered. People came in droves! Whether perinatal education had been mentioned in a particular medium or not, it was always a main attraction of the tours—we helped many mothers on and off the labor balls! We also had beautifully prepared written information prominently displayed, so families could take it to read at a later time.

We also needed to market (and “sell”) our new perinatal education program to the physicians. We used a variety of approaches to gain their support. Many were simply glad that we (the hospital system) were taking the responsibility for the education of families and that standards were high. Other physicians needed to meet one-to-one with the program coordinator to discuss their

fears that the education would be extreme and would create unrealistic expectations and eventually dissatisfied customers. While a lot of misconception regarding Lamaze preparation still persists, most of the physicians seemed satisfied once they were given information about the quality of Lamaze International certification, the Lamaze philosophy, and the resources that had been committed to the program. Physicians were also able to tour the center and see the classrooms and materials ready and waiting for their patients. An evening in-service program was offered for the physicians, demonstrating the classroom's labor stations that would teach positioning for labor and birth. We even helped a number of physicians on and off labor balls!

Marketing for our program also takes place with the distribution of the “Perinatal Information Notebook,” which is given to every family. It was created by the perinatal education department and contains information not only about education offerings but also about pregnancy health, labor and birth, nonpharmacological and pharmacological pain management, mother and baby discharge forms, car seat safety, breastfeeding, and immunizations. This notebook is given to the physicians' offices to be distributed to each mother on the first or second prenatal visit. Our marketing department did a wonderful job in promoting the important services of perinatal education and the new women's center. They won many awards on a national level for their efforts. In fact, some days, when there is a need for another instructor and room so another Lamaze series can be added, it seems that they may have outdone themselves! Be careful what you wish for—if you have a good marketing department, you might actually get it!

Financing

There are a number of ways that revenue can be managed for a perinatal education program (Biasella, 1995). We were very fortunate that the start-up costs needed for our program were created as part of the large building project for our women's center. There was a great deal of synergy present because of this project and that definitely released some purse strings. People wanted to be a part of the project and to be recognized for their contributions. Significant one-time gifts were made by the hospital volunteers and alliance groups, the hospital foundation, and individuals in the community. While most of this money

did go into the building itself, some was contributed to perinatal education. For example, the program manager and coordinator chose the artwork for the classrooms, making certain the pieces represented mothers, fathers, and children of various cultures. The audio-visual equipment was purchased from contributions and included four slide projectors, five overhead projectors, five TV/VCRs, an LCD projector and laptop computer for Microsoft PowerPoint® presentations, a video camera, and a complete sound system. Almost \$40,000 was spent on typical childbirth education supplies such as posters and teaching aids. If you ever find yourself in this enviable position, make sure that you have someone who will bargain with purchasing agents to make the best use of the resources you have. Community sources such as March of Dimes will often provide funds to begin education programs for those populations they have been identified as being under-served and whose perinatal outcomes are poor. If a program is successful, they may also be interested in its maintenance.

Once things are up and running, get to know the financial officer who is assigned to your department. He/she may be able to help you with operational budgets and Medicaid reimbursements, as statutes vary from state to state. Become cognizant of the budget cycle for your system and keep a "wish list" of what you need to maintain and increase the program; be sure you have rationale for why you need something. Items that may enhance quality and promote positive outcomes will be considered more favorably than those that do not. Learn the "fair market value" of what you are offering. This can help to justify an increase in what you charge for a class and, therefore, an expenditure you want to make to enhance its value. Fair market value is nothing more than what others are charging for the same service. Be careful that you are comparing apples to apples. For example, if the typical charge for a childbirth series in your area is \$85 and you are charging \$90, it looks as if you have the higher fee, until you compare the fee on an hourly basis. If others give 12 hours of instruction instead of 15 hours, or if the instructor-to-family ratios are higher, you are the bargain, not them. If you are presently charging less than what a preparation for childbirth series in your geographic area typically costs and you want to justify a major expenditure such as a professionally produced Lamaze workbook for each family, present the increase in projected revenue to the financial

officer and he/she can add the same amount to a sub-account so you may buy your workbooks.

You should have a clear idea of the perceived financial goal for the program. Is it to break even or is it to make a profit and, if so, how much? You will use this information to make decisions regarding instructor-to-family ratios. Providing your own handouts versus purchasing or creating your own major materials such as a workbook is an issue that needs to be decided based on the financial goals of the program and your available talent. If you are contemplating creating your own materials, be sure to take into consideration whether or not you have people qualified to do a professional job and the time they will need to be paid to do it. Childbirth classes can be profitable, even when you subtract the direct costs such as instructor salaries and nonreturnable supplies and indirect costs such as support staff and coordinator time, reusable supplies, room and AV usage, utilities, the cost of curriculum development, etc.

People whose job is to oversee the utilization of a limited amount of resources need to know that an investment in perinatal education, while a worthwhile thing to do, will not be a financially irresponsible decision on their part. It is up to you to convince them, using their terms and way of looking at things. A useful approach could be to couch your proposal in terms of pros versus cons and make certain that it is supported by data whenever possible. For example, some of the pros of a strong hospital-based perinatal education program from an administrator's point of view might be the following: consistency of information; the existence of services such as marketing, referral and registration, and environmental services; the potential appeal to health care providers; the creation of a database of those who have been educated and those who have not; customer loyalty; and the goodwill created when staff who take care of families also do some of the prenatal education. Some cons might be the cost of creating and maintaining the program, the

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space and other amenities necessary to do a quality job, and the appearance of competition with those health care providers who already have their own classes in place.

Recruitment of a Coordinator and Staff

A comprehensive perinatal education program requires a full-time coordinator that must be selected with care. Begin the process by writing a job description that outlines expectations and asking the compensations officer of the human resources department to assign a job grade to the position. Lamaze certification, a strong background in perinatal education, a personal philosophy that embraces family-centered care, and administrative experience are definite requirements. The role of the coordinator is a demanding one. She should possess strong interpersonal relationship and organizational skills, for she must deal with the requests and frustrations of the educators and keep track of class scheduling, staffing, and all the materials and teaching aids. Ancillary staff to support the coordinator's position will be crucial during both the start up and maintenance of a program. Job descriptions that will allow the hiring of people required to provide support services should be written, approved, and graded before the program begins. This provides clear expectations to be set and minimizes frustration. Ideally, policies should also be in place at the onset of a program. Without these, it becomes difficult to enforce expectations that have only been verbally addressed.

When allocating full-time equivalent (FTE) hours to the perinatal education department, it is important to remember the FTEs required for nonteaching as well as teaching positions. The creation of new curriculums and the revision of existing ones, the creation of the calendar for courses, and the scheduling of instructors to specific series and OB tours are all functions that can be delegated to talented individuals, as needed, if there are available FTEs to do so. The education program at WellStar was allocated 7 FTEs. Two FTEs were used for one full-time coordinator (to develop and manage the program) and one of the perinatal educators (who received 0.5 FTEs to develop and manage the newborn courses, 0.2 FTEs to develop and manage a high-risk course, and 0.3 FTEs to develop and manage a grief program). The 5 remaining FTEs were used for the educators.

Lessons Learned

As with any new endeavor, we learned lessons as we went along. The job descriptions and contracts that were written for the first group of childbirth educator candidates were not as clear and concise as they needed to be, which resulted in some misunderstandings. This has since been corrected with the second group of educators. The childbirth educators are expected to teach for a period of 2 years in exchange for the financial support the hospital provides for the completion of the Lamaze International certification program. It is now also required that they be willing to teach at more than one location and to teach at least six Lamaze series per year and conduct hospital tours on a rotating basis. The creation of a pool of 35 Lamaze certified educators is a lot of work. Before a system decides to go about meeting its needs in this way, the commitment of resources, not only direct (financial) but also indirect (staff time), must be considered. However, the benefits of having so many highly qualified educators, many of whom are also taking care of families during and after birth, are considerable and certainly worth the effort.

Goals for the Future

As the program grows and we look toward the future, we have several goals in mind. We would like to host an annual conference on family-centered perinatal education for childbirth educators and maternity care professionals in our region. We want to enhance the evaluation process currently being used to measure outcomes. In addition to the evaluations we obtain from class participants, we also require the educators to conduct an evaluation of their performance and the participants' evaluation responses after the completion of each class series. This process should give the instructor a chance to accomplish two things: (1) reflect upon her own impressions of how the class went and what she might do differently next time, and (2) analyze the comments of the class participants and formulate a behavioral response. This process not only assures the perinatal education coordinator that the instructor has read the evaluations and given the responses some thought but also provides what is often the best plan for addressing family concerns. We will continue to make changes in

the curriculum based upon the data from the parent evaluations.

As the number of our families who have been through our educational programs grows, we intend to collect data regarding pregnancy, childbirth, and postpartum outcomes. We will look at this information from both a general and an instructor-specific point of view. The WellStar system utilizes a "paperless charting" software, the Hill-Rom WatchChild™ Obstetrical Information System. This is a potentially valuable tool that could give powerful information regarding the differences between prepared and unprepared families. For example, since all vaginal exams for dilatation and effacement are graphed beginning with admission, if it is hypothesized that prepared women come to the hospital later in labor due to a lower anxiety level and a greater ability to utilize nonpharmacological methods of pain management, this data could be collected. Even an hour less of inpatient care would represent significant savings for a hospital system. A perinatal education program within a large health care network such as WellStar's would benefit by the opportunity to collect this type of outcome data.

The time and effort that went into the development of the perinatal education program at WellStar has been rewarded in many ways, but we felt particularly proud when we were awarded the status of being a Lamaze International approved provider in the summer of 1999 (Lamaze International, 2000). Just as it would have been impossible several years ago to foresee all that has been accomplished in program development at Kennestone Hospital and within the WellStar system, it is equally impossible to know what lies ahead. It is an exciting challenge.

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Study Finds School-Based Prevention Programs Can Be Cost-Effective

For every dollar spent on the Safer Choices program, \$2.65 will be saved on medical and social costs, according to a study published in the *Archives of Pediatrics & Adolescent Medicine*. Safer Choices is a school-based intervention program designed to reduce the incidence of STDs and unintended pregnancy among high school students.

Wang L.Y., Davis M., Robin L., et al. (2000). Economic evaluation of Safer Choices. *Archives of Pediatrics & Adolescent Medicine*, 154(10):1017-1024.

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