

The Community-Based Doula Program Initiative - The First Project Period

MCHB / DHSPS Webcast, April 26, 2011

JOHANNIE ESCARNE: Good afternoon, I'm Johannie Escarne from HRSA's Division of Healthy Start and Perinatal Services in the Maternal and Child Health Bureau. On behalf of the division I would like to say welcome to this webcast titled "The Community-Based Doula Program Initiative - The First Project Period". Before I introduce our presenters today I would like to make some technical comments. Slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speaker's presentations. You don't need to do anything to advance the slides. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window. A 12 second delay typically provides optimal performance for the audience. We encourage you to ask the speakers questions at any time during the presentation. Simply type your question in the white message window on the right of the interface, select question for speaker from the dropdown menu and hit send. Please include your state and organization in your message so that we know where you're participating from. On the left of the interface is the video window. You can adjust the volume of the audio using the audio control slider which you can access by clicking the loudspeaker icon. Those of you who have selected accessibility features when you registered will see text captioning beneath the video window. At the end of the broadcast, the

interface will close automatically and you'll have to opportunity to fill out line evaluation. Please do so. It will help us improve our technical support.

Today we have several presenters with us. Angela Hayes-Tolliver, Senior Project Officer in the Division of Healthy Start and Perinatal Services, will introduce our presenters. Angela.

ANGELA HAYES-TOLIVER: Thank you, Johannie. Good afternoon. As Johannie said I'm Angela Hayes-Toliver, Project Officer working with the Community-based Doula program in the Division of Healthy Start and Perinatal Services. Today on the webcast we will hope the participants will gain an understanding of the value added from enhancement of a community based Doula program that's being provided through the use of Federal funding; understand the importance of the provision of training and technical assistance from an experienced Community-based Doula leadership institute; gain knowledge regarding program implementation in an urban setting as well as a rural setting; and be able to reflect on strategies for implementing programs in your own communities.

Let's start off by defining what is a Doula. The word Doula comes from the ancient Greek and refers to a trained and experienced woman who provides continuous physical, emotional and informational support to a woman before, during and immediately following childbirth. With a Doula a woman is never left alone during the labor and birth. This program is geared to providing grants to three urban and three

rural communities to support community based Doula's as well as providing one community-based Doula leadership institute to provide outreach, training, technical assistance, quality improvement and cross sided evaluation services through the urban and rural community based Doula programs. The community based Doula program identifies and trains indigenous community workers to mentor pregnant women during the months of pregnancy, birth and immediate postpartum period.

Doulas provide culturally sensitive pregnancy and childbirth education, early linkage to healthcare and social services. Labor coaching, breastfeeding education and counseling and parenting skills while fostering parental attachment. They're required to follow ethical standards and provide the highest quality labor support to birthing women and their families. The community-based Doula leadership institute also provides training and technical assistance, including culturally sensitive pregnancy and childbirth education, skill development, to provide early linkage to healthcare and social services. Labor coaching, breastfeeding education, counseling and parenting skills development including fostering parental attachment.

The target audience for the Doula service for our grant is the first time mothers. Particularly young women, women with language barriers and women from low income backgrounds who have a higher risk of prematurity, infant mortality, low birth rate and poor maternal outcomes and they also be dealing with higher rates of substance abuse, child abuse and neglect and difficulty with maternal attachment. The community-based Doula program generally engages first-time mothers as early in

pregnancy as possible and continues services through at least six months, which is approximately 26 weeks postpartum. But optimally one year postpartum.

The first project period is started September 1st of 2008 and ended August 31st of 2010. During this period again we had three rural grants, three urban grants and one technical assistance center.

Today you will hear from the technical assistance center provider and from one of the rural and one of the urban grants that participated in the first project period.

Additionally, all three of these grantees were successful in competing in the current project period which started September of 2010 and goes until August of 2013.

It's my pleasure to present to you the speakers today. Our first speakers will be Rachel Abramson the Executive Director for the HealthConnect One from Chicago, Illinois and Jeretha McKinley the National Program Replication Manager from HealthConnect One in Chicago, Illinois, this is our community-based Doula leadership institute. Our next presenter will be Lizette Pacheco, the Regional Director for Migrant Health Promotion from Texas who will provide us an urban view and our final presenter is Tia Demery, who is the Doula Program Coordinator for Georgia's campaign for adolescent pregnancy prevention in Atlanta, Georgia. I will now turn the speakers over to Rachel.

RACHEL ABRAMSON: Thank you, Angela. This is Rachel Abramson, the Executive Director of HealthConnect One. We were granted for the first two years of the community-based Doula funding the grant as the leadership institute and I would like to talk to you about our experience during those two years. HealthConnect One slide please.

HealthConnect One's work began in 1986 with breastfeeding peer counselor programs. We were one of the first states to implement peer counselor training and placement which expanded statewide in the 1990s. We consulted with best start on developing the USDA loving support and loving support through peer counseling program and have been working with breastfeeding peer counselors in Illinois and other states since that time. We expanded the peer counselors role really through the leadership of the peer counselors to include birthing support and the extended community-based Doula model in the mid-1990s. This model was piloted in Chicago between 1996 and 2000 with a four-year quasi-experimental evaluation which showed positive outcomes for three agencies serving pregnant and parenting teens. Over the past 25 years, we've been able to document strong positive outcomes of community-based support with associated cost savings, very important for the sustainability of all of our programs. And we have focused on targeting racial and socio-economic disparities in perinatal outcomes. Our programs have resulted in fewer complications during birth and less intervention, lower rates of C-section births, increased in breastfeeding rates and improved infant health, with associated decreased costs. Next page.

How did the community-based Doula project happen. How did this happen? MCHB took the leadership two and a half years ago to conceive and guess Tate a national community based Doula model. The Doula model was well-known and there were a growing number of community-based replication sites around the country. It was still a new model for many people. The first HRSA RFP included funding for the six program sites, as Angela mentioned and a Doula community-based leadership institute to provide anticipatory guidance, technical support, a reporting mechanism and a network for mutual support. It was felt that leadership was needed both to facilitate the definition of a common vision for the program for all six sites and to monitor the progress towards the goals that were identified. It was felt that it's not enough anymore to carry out six similar programs. We had to be able to make the case for an evidence-based model that was successful and that proved its worth. Next slide, please.

Why was this necessary? The status of maternal and child health is not improving in this country and in many ways families are facing increasing challenges. Our population is more poor and more diverse every day. And almost half of the babies born in the United States are on Medicaid. I think that's an amazing statistic. Almost half of the babies born in the United States are on Medicaid. So we know that low income women, women of color and younger women, are at risk for poorer health, educational and social outcomes and for increased health risks for themselves and their babies. We also know that our MCH programs are siloed, few programs provide

a continuum of care. They're often quite associated from each other. I know there are program folks on the phone and we know that we may provide services for our participants and then we lose them to another program, to a clinic, to the hospital, when they're ready to birth their babies. And we may not get them back again. So thinking about continuity of care and access to care, we also know that there has been limited access to community health workers for birth, breastfeeding and early parenting. We know that local agencies value community health worker programs, community-based programs that really address issues of access and health disparities. But often it's difficult to get the funding for these programs or if they can fund them, it's difficult to sustain them. So there was a clear need for a community health worker provide to support maternal and child health needs with a national focus and a plan for sustainability. Next slide. That says HC One five essential components and I will turn this over to Jeretha McKinley.

JERETHA MCKINLEY: Thanks, Rachel. So we come to the place where we're discussing the foundation of this program. When the RFP came out, each grantee initially proposed its own program design. Designed especially for its own community, it's own strengths and needs. And it was a responsibility, then, of the leadership institute to establish a basic foundation for the whole cohort of six sites. For which they would have to adhere. So once the grant was provided for the six sites and the leadership institute, which became HealthConnect One, we then provided this base for evaluating the effectiveness of the model. How did they make up that foundation? I'll go through some of those with you now. Many of you on the phone may be familiar

with them. You can find them on our website, www.HealthConnectOne.org and, of course, they're listed on your slide there. Usually when I'm presenting these, I have everyone raise their hand and you have your hand raised and I start out with the thumb. That thumb represents the first essential component, which is very important, particularly to this grant. Where all of the six sites were expected to use indigenous health workers. Employing women who are trusted members of the target community. And this one piece sets it aside for many other programs that serve low income women or women of color in that the actual community health worker, the community-based Doula, is a member of that community. Then if you look at your hand and you go to your baby finger, we usually associate that with number five. And that is valuing the Doula's work particularly with a salary.

So thanks to MCHB and their foresightedness, they made sure there was funding available to pay the community-based Doulas a salary or at least pay them for the work that they were doing because they realized the benefit not only to those women, but also to the economic base of the community and ultimately to the best outcomes for the program because it's much easier to monitor someone's work when you're paying them rather than when they're volunteering. Supervision was vital to this program. Many birth Doulas discuss how difficult it is to do this work alone. And through our over 10 years of experience with this work, over and over and over again it's been shown to us how valuable having the support of a supervisor is and I'm sure that Lisa and Tia will talk more about that when they do their presentation. And then that support that adds onto the supervision and salary includes continuing education

and keeping up with their credit hours for things, a career ladder, relationships for referrals, etc. All of that is very important in the fifth essential component. Now, if we go to our other fingers on our hand, we begin then with two. Now, number two also makes our model that we're using for the community-based Doula initiative really different than many others because it extends and intensifies the role of the birth Doula. It starts early in pregnancy with weekly or at least twice a month visits with the family early in pregnancy.

Getting to the birth by the -- continuing through the birth to about two hours post birth at the hospital. Really consistent visits in the first few weeks after the family is home with the new baby. And then following through, as Angela said, through six months postpartum and optimal lie through the first year. The intensity of weekly or more than weekly home visits really sets this program apart from many others. The third essential component is collaboration. That you've already shown by your participation in this call, it's a diverse team approach so that everyone is welcome to the table and, in fact, their experience is valued. The fourth is the learning that goes on during the training is experiential learning. Our curriculum is provided for this -- through this grant to each of the six sites where they can do their own training from a cultural and community standpoint where it can be used most effectively. This -- it's important to make sure we include them as experts in their own community. Next slide, please.

The leadership institute. The leadership institute was charged with a number of responsibilities. Angela has laid most of them out but I just want to give you a few

more examples. In providing the program implementation plan and evaluation, we were charged with coming up with some common objectives and measures. And so we invited our six other grantees to the table to help us define what we could agree to in terms of those common objectives as well as how they would be measured. What kind of numbers were we looking for? So one, for example, that we looked at was the percent of pregnant and postpartum participants screened for depression. And we all agreed that that was very important and so the measure for that was 100%. And having these objectives set out in the beginning helped each of us to begin working on that and looking at how we could improve if we seemed to -- as time went on to make sure that we were making adequate progress.

The second was that we provided technical assistance to each of the six sites and the cohort. Again, based on a response to their needs as well as to the things that we felt they needed. And I'll give you one example. One of the things that we asked them to do was to evaluate their agency's performance of the five essential components. How well were they meeting each of those five essential components and then we individualized our technical support to them based on their strengths and their needs. Of course, we provided the templates. As I said curriculum, templates like an invitation. An example of an invitation to a stakeholder's meeting or a form for collecting information. The leadership institute conducted an orientation early in the grant. It was a surprise to many of our grantees because usually they get about a six-month time period to plan and we invited them right away so it was within weeks of them getting their letter that we provided the orientation. I think we started in

September and we met in the D.C. area in December of that orientation. The leadership institute, in response to the grantees' requests, provided Doula training for all but one of the sites which is G cap which you will be hearing from later on but all five were provided with a Doula-certified course by our certified trainer. We provided training of trainers for those agencies that were ready and willing to move forward with the curriculum. And then we provided additional workshops as needed for those that requested them. Our web-based data collection tool is what we're all excited about and we provided that web-based tool and offered it to all six sites and both migrant health and G-cap who are on the call today. We'll talk more about using that tool and we were pleased with that outcome. And then, of course, assessing and reporting progress of the cohort. Next slide.

So we know that every community has layers and layers of stories. I'm not going to tell any, but I'm sure that you know some of them. And we know that just like every family is different, these communities, these programs and these stories are very different. But people like us on the outside are thrilled with these stories but we really can't see how they're making a difference until we see the program outcome. We need to see the numbers. What is the story? Well, as you'll be able to hear as we further go on, we'd like to thank our sites that we worked with over the last two years because their stories and their numbers is what made the difference. We appreciate what each of the following partners, organizations and communities contributed to this work. We all benefit from their gifts and again we say thank you to access community health network, Chicago, Illinois, Georgia campaign for adolescent pregnancy prevention

Atlanta, Georgia. Migrant Health Promotion, Brownsville, Texas and surrounding area. Mille Lacs band of Ojibwa, Onamia, Minnesota. St. Louis, Missouri, and New Mexico's program. And so what did we learn? We learned -- next slide, please.

There are unique challenges for established sites that are, of course, different than those of newly created sites. And so as we move through those first two years, we begin to create services and technical assistance that were specific to the needs of both new and established rural and urban. And, of course, we learned that the preparation time for newly-created programs should be built into the grant.

HealthConnect One is always on the fast pace and so we appreciated being slowed down a little bit to assist the whole cohort in moving forward in a way that is beneficial to all. So I'm gonna now ask that we turn to the next slide and I'll turn it back over to Rachel.

RACHEL ABRAMSON: Okay, thanks, Jerry. We are very proud to say that we exceeded the 2008 objectives and performance measures that we had set for ourselves that HRSA sets common performance measures for all of their funded projects. And our outcomes for medical home for babies and ongoing primary and preventive services for women, low birth weight and very low birth weight and neonatal mortality rate were all better than the objectives that were set for us. So we're pleased that we were able to show that. I do want to say -- and echo Jerry when she spoke about the web-based data collection system. That we really have found that a single data collection system is an essential part of a multi-site national program. It is very

difficult to compare data and outcomes collected in different ways from different sites and we just can't afford to carry out our programs anymore without the ability to measure our success and advocate for continued funding. So having that system was very important.

We are proud to say that in almost every area we exceeded the common objectives set at the beginning of the project. We had 100% of the children in the program with the medical home. Actually, we had 83% of postpartum mothers initiating breastfeeding in the first 48 hours of birth and when we first discussed the subjective with the cohort at the beginning of the project, people just weren't -- just did not believe that we could get to 50% or 75% because they were serving communities for which breastfeeding really was not the norm. So getting to 83% was a big success, really, a big win for all of our sites. There actually is an error in this slide. The 18% of C-sections was the number for the second cohort. We actually were closer to 25% C-section rate in the first cohort. We spent quite a bit of time getting started. It is still significantly lower than the nationwide average of 33% of C-sections. What it took to get these strong cohort-wide outcomes was the leadership institute facilitating the designing of common objectives and the development of a common vision for the project among the six sites. Leadership institute knew that each individual community wanted to show off their good work so as Jerry described, we developed a framework for choosing the common objectives for the entire cohort. We facilitated a process of thinking about where we all wanted the group to go and the group agreed in December of the first year of funding, agreed on seven common objectives. And again we also

monitored the MCHB performance measures required of all MCHB-funded projects and exceeded those. So they say that if everything is a priority in Maternal and Child Health, then nothing gets done, I think the leadership institute was critical in making sure that priorities were clear and that everyone owned them and stayed focused on them. That the cohort stayed on target and was making progress toward the primary priority objectives. The leadership institute made sure that there was documentation of how well we were making progress and if we were not, we helped the grantees to problem solve and refocus. And as you'll hear from the program grantees, they were very creative in how they used their own specific local resources to solve their specific challenges. Next slide, please.

We're really proud that we developed an exemplary high-level, very active national community-based dual advisory board which has served as an expert advisor to the project and helped develop evaluation strategies and outreach and public education around the community-based dual model. As Jerry mentioned, we're proud that we responded to the needs of the sites providing the certified birth trainings to sites when they requested them even though that really was not our original plan, it totally made sense to do that at that point in the development of the project. And we're proud of our national recognition by AMCHP, the national Healthy Start association, CityMatCH and other groups around the country. We're also really proud that HealthConnectOne took on a giant. We're a small group of people who have really made a huge difference in the lives of families across the country. And also in the way we in the country look at supporting birthing families in underserved communities. We took on the traditional

ways of providing care to low income women and women from diverse communities, which did not necessarily serve them well, and we were successful in showing that there are different models of birthing support that positively impact birth outcomes. That was a real win for us and I think it was a win for the entire group of grantees. And we're also really happy that we've had a chance to Doula this process and help the programs that were in the first two years and the programs that are yet to come. Like a Doula, the leadership institute needs to be there so that the programs can be successful. And next slide, if you'd like more information, you can contact Jerry McKinley, our national program replication manager. Her email is on that slide. And check out our website again. There is a lot more information there about community-based Doula and some of the other work we do at www.HealthConnectOne.org.

Thanks and Angela, back to you.

ANGELA HAYES-TOLIVER: Thank you very much, Rachel and Jerry for providing that insight on the leadership institute and how such a critical place you are making in this whole process. I would now like to go to our next speaker, Lizette Pachero from the Migrant Health Promotion from Texas who will share with us a rural program for the community-based Doula. Lizette.

LIZETTE PACHECO: Okay. Well, first of all thank you. It is a great pleasure for me to share what we're doing in the Rio Grande valley with our rural Doula program. So let me start with our first slide and talk to you all a little bit about what Migrant Health Promotion is all about. So Migrant Health Promotion have helped farm workers and

border communities live healthy lives and train them to be leaders in their own communities. We have four locations, one in Michigan, Ohio, Washington, Florida and Texas. Our mission is that using the we provide sustainable community development to farm workers, migrants, border and/or other underserved or isolated communities throughout the nation. Throughout increased knowledge and skill building individuals and families will be empowered to live healthy lives. Next slide, please.

Some Migrant Health Promotions program provides Doula support services to pregnant women living in rural areas in the Rio grand valley. It forms the southern most tip of Texas and includes Cameron, Starr, hid all go and Willacy counties. We provide services in Cameron County. The program is composed of two Doulas and myself, which I am the program director for the Amor de Madre program. Second slide, please.

So we believe that there are four essential components to best practice and we use this component with all our programs at Migrant Health Promotion. The first one is the community outreach worker. We feel that we have culturally sensitive educators from local communities that provide health education. Women that are trusted in their communities, they are very familiar with the areas that they're working in. They've previously worked there with other programs and they are also paid for the work that they do out there. We also believe outreach is very essential. Door-to-door contact with residents of local colonies. We utilize flyers, community organizations to recruit our participants. They hang door hangers when they're out in the community to recruit

participants for Doula services and participate in prenatal classes. We also strongly believe in education. We use the March of Dimes curriculum for our education sessions. We do activities to increase knowledge and participation in our groups. And, of course, another one of our very, very important components for best practice is data collection. We collect information from participants to analyze our birth outcomes, satisfaction with programs and also to monitor our program goals. Next slide, please.

In this slide you will be able to have an idea of how our outreach takes place. We have our Promotoras that go out that provide birthing education in the communities. They're out there doing outreach and door-to-door. You'll be able to see how they're out in the rural areas. We also utilize a mobile unit from valley Baptist, which is one of our local hospitals. And we go out with that, we take the unit out to the colonies, to the rural colonies where they do screenings and also provide free pregnancy tests when out there. This is another way that we outreach also for participants. As well as for referrals of any other needs that our people might have. Next slide, please.

Our education consists consists of prenatal classes. These classes are informal. They are either provided in a group and facilitated by our Doulas. The focus of the classes consist of the importance of prenatal care, classes are developed by the curriculum developed by March of Dimes. We encourage first-time moms as well as women with small children to participate. There are five sessions and they're provided with a certificate of completion at the end. We encourage also women who have small children to participate because that way they get to share their birthing experience or

parenting experiences with our first-time moms and we have found that to be very helpful to them as well. Next slide, please.

We accommodate our classes based on the needs of our community and our moms. We go to health centers and we also are out in the communities outside, under trees, anywhere where we can provide them and make it easier for them to access this education which we feel is very, very important to them. During the classes we cover the importance of prenatal care, we cover the importance of eating healthy, caring for their babies, breastfeeding, SIDS, shaken baby syndrome and the big day, what will happen the big day when you have your child. What are we going to do and how is the Doula going to be there to help you go through this process? Next slide.

When our participants are approached by our Doulas, I would say 100% of the time our participants haven't accessed any prenatal care. Because they're afraid. They aren't familiar with the resources that are out in the community due to the fact that they live in very rural areas where they also lack transportation. And that is something that we've been really working on to help them access transportation and access prenatal care. So we establish medical homes for all of our participants when we meet them, we start from establishing medical home, assisting them in applying for Medicaid or perinatal CHIP, whatever they might qualify for. They're all encouraged to breast feed their infants which is why, as I previously mentioned, we cover the importance of breastfeeding when we're providing them the prenatal education. And we've also gone in together with community partners so that we could accommodate the moms that are

willing to breast feed their babies as well. And I will talk to you more about how we have engaged with community partners and how they've helped us be very successful in advocating for breastfeeding. We also have a very good rate on our vaginal births. Our Doulas provide a different kind of techniques with our participants when they're in the hospital and this helps in increasing the likelihood of them having a vaginal birth as well as a memorable experience, which is our ultimate goal. Of course, for them to breastfeed afterwards. Another great outcome that we've been blessed with is also utilizing the HealthConnect One. Our leadership institute database software. We track our progress, we track our goals, we track how we're doing and it really facilitates us when it comes to reporting. Aside from -- aside from the database we've also -- we also have our participants attend the conferences that are organized by HealthConnect One, which to me are very helpful for our Doulas because it serves as professional development for them as well as mastering their skills. I feel that every time they participate in them they learn something new. We come back with new ideas as how we can, you know, better serve our rural communities. They also come down -- we have someone who comes down on the first night and visits with us and she gets to see where our communities are, how rural they are and how are Doulas are out there really working and really providing this fabulous support to our first-time moms. And how they also share with her the -- you know, the wonderful stories and how pleased they are with the Doula program. So we are very fortunate to have HealthConnectOne as part of our technical assistance team. Next slide.

So during our reporting period we were able to provide Doula support services to first-time moms and we provide services to 45 of them. We provided 180 referrals. We also provide -- if they're not first-time moms, we could also provide only case management to them. So this is where the referral and all this linkage comes in. We established medical homes for all of our participants. We had 43 of our participants breast fed. We had 39 vaginal births and we had five cesareans and these were due to medical conditions which we believe that if it wouldn't have been because of these participants had a Doula, they wouldn't have known about their health conditions, which some of them were high blood pressure, gestational diabetes and H.I.V.. So these cases were -- they had to be cesarean due to their medical conditions. 128 women participated in prenatal classes and 46 healthy infants were born including one set of twins. Next slide.

So we've done different things, yes. We have encountered barriers, but I am excited to share that we've over the years we've been able to overcome some of the barriers. We've improved our relationship with providers. Down here in the valley, Doulas weren't -- providers weren't very familiar with Doulas so at first, yes, they were a little -- not very willing to accept the Doulas to go in with our participants to their appointments but I'm happy to say right now we're working very, very close with two providers which are private providers and they are seeing our participants there at their facilities. We also -- we have -- we've established very good relationships also with our hospitals. We attend the nurses' meetings just -- since there is constantly a rotation of nurses, we attend their meetings to educate them on the importance of Doula and the role of a

Doula during labor. And we've also, as being part of the Healthy Start consortium we're part of their breastfeeding committee where we've gone and approached different restaurants here locally and we've encouraged them to become a breastfeeding friendly establishments. We've been very successful with that. We've placed stickers outside the establishments which just says that they are breastfeeding friendly establishments and right now we're also in the process of going to the daycares and also encouraging them to make an area breastfeeding friendly area so when our moms take their children to childcare, they are also -- they also are encouraged there to go during their breaks at work or for them to breast feed their babies, their infants. Next slide.

So some of our accomplishments in our programs are that one of the hospitals where most of our women deliver they have placed a sign in the entrance that reads, visitors are limited to partners, spouse or significant other, grandparents, the child's birth coach, which is where we come in. So this to us is something very nice and very exciting because in this particular hospital, I mean, the Doulas can actually go in there and they are very welcomed by the nurses because they've seen the change and the support that they provide the participants. And then you will also see we have most of the -- we have mostly males that are owners of a lot of the restaurants and they've been very, very supportive about also breastfeeding so they've also allowed us to place the stickers in their restaurants and we provided them with cover-ups that were also made just to facilitate the women. You know, many of our women, we hear that they don't want to breast feed because they feel they'll lose out an going out with their

family to eat out and things like that. When we approach these restaurants we do let them know what we're doing and why we feel it is very important for our breastfeeding moms to also have that opportunity to go out with their families and enjoy breastfeeding as well. And another of our major accomplishments is that our participants, 100% of our participants call our Doulas when they're ready to go to the hospital. And the two people that you see there are two of our Doulas, Maggie and Alba. So basically that's it. If you would like to know more about our program my name is -- you can contact me at you have my phone number. And I would be more than willing to share with you many more successes to our program. Thank you.

ANGELA HAYES-TOLIVER: Thank you, Lizette for sharing some of your accomplishments and the wonderful work that you are doing in the communities with us. Our next presenter is Tia Demery from the Georgia campaign for adolescent pregnancy prevention in Atlanta, Georgia. I would at first like to apologize to Tia and to you, the audience, because Tia's slides are not available at this time. They will be available, I understand, after the presentation. You will be able to download them. But I know that Tia has very special information to share with us about her urban program that she leads. So I will turn this over to Tia and again, I apologize for the slides not being available.

JOHANNIE ESCARNE: Actually, Angela, before Tia starts, the slides are available for download right now. They're just not going to be seen in the slide window as she

presents. So if the audience would like to follow along with Tia you can download her slides on the website www.mchcom.com.

>> Thank you, Johannie.

TIA DEMERY: Okay, thank you, Angela and Johannie. My name is Tia Demery and I am from Georgia Campaign for Adolescent Pregnancy Prevention in Atlanta, Georgia. We normally shorten that name and say G-CAPP because it's a mouthful. If you hear that I'm talking about our organization. Let me start off by saying who we are. G-CAPP is a statewide teen pregnancy prevention organization. Our mission is to eliminate teen pregnancy in Georgia. We have a goal of reducing the pregnancy rate by 15% by 2015. We often replicate, educate and advocate. We've been known to replicate programs, indicate community. Advocate for public policy initiatives to support healthy children, youth and families.

What is a community based Doula? A Doula for us is a woman from the community sensitive to cultural norms provides emotional and physical support, linkages to services, labor coaching, breastfeeding education, parenting and life skills. Our Doulas have been doing this for quite a while and they provide that and more. The purpose of our Doula program is to improve birth outcomes. Decrease unnecessarily medical interventions like C-sections and things like that. Increase mother/child bonding. Increase breastfeeding and increase postnatal health among infants. Our G-cap program is made up a little different than other agencies. We partner. We

received the replication from HealthConnect One and we subcontract with families first, Inc., also in Atlanta. We have four paid Doulas. They're housed out of family first office. They work solely for families first and G-cap manages the program, the finances, as far as granting and things like that for families first and they're providing direct services where we're providing supervision of the program as a whole. So our Doula program is partnership among two agencies. Our Doulas are actually extensively trained through HealthConnect One and DONA. They also receive training through families first and G-cap attending different trainings and conferences throughout the world. So we provide them with ongoing training throughout the year from many different agencies.

Who we serve. We serve first-time mothers and we serve those mothers in south Fullerton county and east Atlanta decal be county. We service African-American and Hispanic populations. Not to say we wouldn't service any other ethnicity that comes in but that's mainly our target population. We are able to do that because we also have our Doulas who are from the community so our Doulas are able to service their own communities so we have two African-American Doulas and two Hispanic Doulas and we have a lead Doula who is bilingual so she's able to act as a supervisor and was as a backup Doula on either side. It's helpful that we have that. We often receive our referrals from schools, clinics, other community agencies. But the biggest part of our referral base comes from word of mouth through our clients and previous clients that we've serviced. That is our biggest, biggest referral source. HealthConnect One has been so gracious to help us with hands-on technical assistance. They're always

available to provide training. They provide the initial orientation once your program is replicated, they provide ongoing training, annual training so you as -- when you have Doulas come on you contact them and they will actually provide whatever training that your agency needs. They kind of fit it according to what is set up for your target population that you're trying to service.

We also have received wonderful services from our Doula databases. Which we are extremely excited about it. Our Doulas love the database. They can enter the client information from prenatal, post partum, labor and delivery and able to communicate back and forth with the supervisor and the supervisor can leave them notes and the site director can upload the data and export information about all the clients that have prenatal information or all clients under labor and delivery. So it's really easy and very helpful for our Doulas to be able to come back and enter in information so they can see the type of services and what they're providing for their clients. We also receive from HealthConnect One staff development and conferences. They provide a breastfeeding and beyond conference every year that gives our Doulas wonderful knowledge and increases their skill set. So that is something that they always look forward to attending every year because they learn a great deal from HealthConnectOne. We're extremely proud of our achievements and outcomes that we have had together.

And I'm just gonna go over only the September 2009 through August 2010 data. We serviced 80 women throughout this period and we had 65 births. Our C-section rate was 9% during this time, which we're really ecstatic about. Of course, we want it lower

but that was really great for us. Our breastfeeding of initiation rate was 69%. Our Doulas really work hard with our women on breastfeeding and skin to skin contact. It's something that we pride ourselves on because they're very, very passionate about that. We have 80% skin to skin percentage rate. We had a 3% low birth rate which is really outstanding. And we had a zero percent very low birth weight. We're really proud of those statistics that we have with our agencies, which meant our Doulas were doing really good, hard work throughout our agency. One challenge that we seem to have come across as the years go on is that clients have multiple issues that are not related to pregnancy and services of a Doula. And some of those issues can range from sexual abuse, lack of housing, depression, unhealthy relationships.

Our Doulas often go beyond the call of a Doula as we often say around here, which can mean stress for the Doula because that Doula is actually having to take on a lot of issues its than pregnancy services and that's where our lead Doula comes in to provide Doula services so she is there to have hands-on to help that Doula throughout that process. We often have to refer some of our clients out for certain services like counseling or assisting them with housing, things like that. So it's really hard getting clients in that have multiple issues to work with because the main Doula role is providing prenatal, delivery and postpartum care. They can go on a visit and something occurs to where now that particular client may be evicted from their home and so then prenatal education becomes okay, now we have to find somewhere for you to live. So that's a lot of that going on lately where the Doula seems to have many

roles from Doula to counselor to social worker to mother to sister. She has many roles here between families first and G-cap.

A best practice for us is that we are culturally diverse. Our women are from the community and we are able to service our Hispanic and African-American population. When we started that seemed to be the highest population of needing the more services for pregnancy going on in the community. Our Doulas are from the community and able to provide the services in their own languages which our clients love so they don't have to -- our clients don't have to use a translator. They can communicate with that particular Doula and the Doula that is assigned to that client, their backup is that same way so if it's a Hispanic mom, or a Hispanic Doula is servicing that mom her backup is a Hispanic Doula so the client can get all their services in their own language without any type of problems or hesitation. They can feel very comfortable being in their own setting. Often our Doulas see our clients in the mall, the stores, walking down the street so they know their Doulas and they're very comfortable in calling them day or night. Which is wonderful even after we in services, the relationship is so great they still call and invite them to birthdays or high school graduations. So the bond is so strong between our Doulas and their clients. It is really amazing. Community changes as a result of a Doula, one of the things we do, our Doulas provide also information on birth control. So we've actually been able to delay some of our repeat pregnancies that we've had since the young ladies that are in our program.

So in addition to prenatal and postpartum, labor and delivery education we're providing them with birth control education so they're knowledgeable on what they need to do so they can prolong the second baby so if they're in school, finish school. If they need to get a job, things like that to stay on the right track. Also, we pride ourselves in helping young ladies return to school. We know a lot of times that some of the girls that we get may want to drop out of school because they're pregnant or they just had a baby. Our Doulas are very great in working with the client to either enroll them in school, help them return in school, or G.E.D. to get a high school education or the G.E.D. program and job readiness. They're really good about having a baby at an early age if they're a teenager does not stop your life. You can go on and do things. So they are very, very good coaches in not only pregnancy but also after you have the baby. We've been able, because of the HRSA funds, we've been able to increase services to first-time mothers which is a community change for us. Because we haven't always serviced just first-time mothers. This is great for us because we can get those moms in and we try to get them as early as possible so we can provide longer services for the mother and her family.

What we've learned. HealthConnect One provides technical assistance and they increase our knowledge through their orientation and annual training and conferences. The Doulas are able to connect with each other, increase their knowledge and skills, and it's very important because Doula work is very maternal and very togetherness so working with HealthConnect One it's a constant source of energy to connect other Doulas with other Doulas and provide technical assistance and hands-on because it

just comes across that we know they care about our Doulas and what they do and it's very important for the Doulas to know that they're cared about because their job is extremely hard. 24 hours a day and they need an extensive amount of support. We have a wonderful relationship with HealthConnect One and our HRSA funds provided us with a great opportunity to increase our services to first-time mothers through the grant funding we were able to increase our referrals that we received through the clinics and the hospitals and the schools and be able to increase our caseload of moms we're able to see. So that was really wonderful for us to receive that. And also the last thing we learned is that going beyond the call of a Doula is extremely hard. Being a Doula, a counselor, a mother, an educator, a big sister. Sometimes even a translator for some of our clients Doulas have to -- the client is going to the hospital and the hospital only communicates with the Doula and so the Doula is translating back and forth can be extremely hard and stressful for both client and the Doula. So we've learned that our Doulas have many roles, wear many hats and need a great deal of support from our agency. So if you would like more information about Georgia campaign for adolescent pregnancy prevention or families first, you can email me at Tia@gcapp.org or our website is www.gcapp.org or you can call me.

ANGELA HAYES-TOLIVER: Thank you, Tia, for that very informative presentation. And your accomplishments and your challenges that you still have had. I want to thank all of our presenters for this presentation and the valuable information that they have shared and I am going to turn it over to Johannie now. For the rest of the program.

JOHANNIE ESCARNE: Yes. Thank you, Angela. We have now entered the question and answer portion of our webcast. The first question we have is for Tia. For the GCAPP program what are the breastfeeding initiation rates among your African-American clients and how do you overcome barriers and encourage African-American women to breast feed?

>> Okay. Wow. Well, actually among the two populations they're about half and half. Our Doulas are awesome when it comes to providing breastfeeding education. They explain -- it's like the barrier for our African-American young girls is with growing up with a culture where it's not looked so fondly upon. So giving -- getting that information from someone that looks like you because they understand that that is okay to understand that but having them try. Most times if they say okay, if you try it for like one day and then -- try it for three more days. That sometimes those girls that get that information by the time they finished the first week how did it go for the first week and then it went okay. Try it for another week and so those that are not so wanting to breast feed, you kind of have to take them day-by-day. Before you know it they've breast fed for a whole month. They kept saying breast feed for the next day, the next day. Talking to some of their friends who have breast fed and knowing it was okay, I got through it. It didn't hurt like some people said it would hurt. So it is more of a day-to-day thing on some of the young ladies who are very opposed to breastfeeding but they keep constantly at them and provide them in information about how great it is for the baby to receive breast milk and once they learn that it is really healthy for the baby

and the baby reduces the illnesses and things like that, then they're more prone to say I'm going to try. That's all that they'll say. If you try, then it starts at trying that they've been doing it for like three months.

JOHANNIE ESCARNE: Thank you, Tia. Does anyone want to add to that answer or I'm trying to give a couple of our audience members some time to type in their responses. So if anyone else has anything to add to that response or any other final comments you would like to make, you can do that at this time.

RACHEL ABRAMSON: This is Rachel Abramson. We have seen at HealthConnect One that both the Doula programs and our breastfeeding peer counselor programs show extraordinarily high rates of breastfeeding when you have a stable program with peer-to-peer support, supervision and focus on where the community health worker should be putting her time. We have seen over and over again in African-American as well as other racial and ethnic groups that breastfeeding rates -- breastfeeding initiation rates can go to 80%, 85%. With the support of a peer. As Tia mentioned and described so beautifully. So I think that we know what is needed to increase breastfeeding rates in communities where they're low. And it's clear and clearer that important to invest in this really critical maternal and child health strategy for prevention of chronic disease and obesity.

JOHANNIE ESCARNE: Thank you, Rachel. Next question. This is also for Tia. Does your lead Doula take on a full client load and do you offer her a pay differential?

>> No, she doesn't take on a full load. She is mainly as a backup Doula for the backup Doula. There have been cases where all of our Doulas are out having births and she is the only one left so she will then take on that particular case as far as delivery. But she does not take on a full caseload. As a supervisor she does get a pay difference and it really works well with us just because she is able to be the backup for both of our communities. So she is able to service African-American backup because she is African-American but she is also serving as our Hispanic backup because she's bilingual and accepted in both communities which works very well for us. If there is a case where she has to take on a caseload, it may be like one or two because something may be going on with a Doula. If a Doula has to go in the hospital or something like that to help out the other Doula she may pick up something but nothing on a regular basis where she is carrying a caseload.

JOHANNIE ESCARNE: Thank you, Tia. This question is for either -- any of the presenters. Have you seen your breastfeeding duration rates in the past six months increase? Does anyone want to tackle that question?

>> Duration rates in the past six months?

JOHANNIE ESCARNE: Yes, have they increased?

>> I can answer that. This is Lizette. Ours has. I feel that I guess as Tia has mentioned and as we all have, support is the key to all of this. Our first-time moms having that support. Yes, they have WIC, which they also provide support to them. But I think over the time that we spend with our participants they establish this real close relationship with us and they call us whenever they have any problems, you know, breastfeeding or latching and things like that. So I -- we have seen how the breastfeeding has increased with the participants that are enrolled in the Doula program.

>> Thank you, Lizette.

JOHANNIE ESCARNE: This question is also for anyone. What are some of the challenges that you have experienced in the first years of the program?

>> Jerry, you want to take that one?

>> Can you say it again? Repeat the question.

JOHANNIE ESCARNE: What are some of the challenges that you have experienced in the first years of the program?

>> Okay. We talked a little bit about some of those. I want to be respectful of the person's question so I hope I'm providing what they are looking for. But from a

leadership point of view for all six of the sites all together as from an aggregate point of view, some of the challenges for some of the newer sites. I'm kind of mentioned this was outreach. So because the program -- the service of a community-based Doula was not well-known or understood in a community, in those early months, even up to 18 months of a program, outreach is a significant challenge because you have to explain the program. Now, I know that there are some people here, for instance, that are from Washington State and Doulas are not an unknown there. They are very well-known, very well respected. So you might not have that same challenge. So again, that's where the leadership institute comes in and kind of individualizes the support that's necessary where a new site in a more traditional community might not have the - all of the benefits to a more enlightened or experienced community. They might need a little more time, for instance, for something like outreach or as Lizette mentioned, maybe getting to a point where you know who your allies in the medical profession are. It takes you a little while to get to that point and so, you know, things like that. Just general, again, relationship building is really important.

JOHANNIE ESCARNE: Thank you. How is the DONA training that Doulas receive differ from typical Doula training and what is the process for training the trainers for community-based Doula work?

>> Okay, I'll take that one, too, this is Jerry again. So the curriculum is developed based on a more global approach to learning. Where learning is spread out over a long period of time. And has lots of practice involved. Supervised practice. So our

curriculum is built around lots of discussion and practice in the class and then a significant amount of out of class practice. When I say significant, there is attendance at breastfeeding series, an attendance at a labor support class series. Observations of home visits. Observations of births, observations of clinic visits. So there is -- it's very extensive compared to the course that DONA would provide, which requires that the participants have already done a lot of these activities prior to coming to the course. And books, texts have been read in preparation for the course and then the course is a three-day very brief overview of each of a number of topics like pregnancy and labor and labor support and special situations, whereas each of those topics is a whole session of three hours, for instance, in our curriculum. Or it might be two sessions, or in the case of labor it's four sessions. For our curriculum versus the DONA three-day weekend. So for the -- in the first cohort, because they were trying to ramp up their speed of their course they asked us to come in and do the three-day DONA course and we did that for most of the sites and after that they've been able to access the curriculum if they want it.

JOHANNIE ESCARNE: Thank you, Jerry. Where do you find funding for the training of your Doulas?

>> I'll take that one. The Federal funding from HRSA included funding for the six sites and funding for the leadership institute. So it was seen -- the training of the Doulas was seen as part of the package and I think we need to think of training and technical assistance as part of the package for replication and for expansion of this model. So,

you know, it was already funded. The leadership institute provided whatever training was necessary and I think it was tremendous foresight to make sure that was part of what happens. I know and I suspect the person who asked the question has a lot of experience with training being the last thing to be funded. But in this case at least for the federally funded Doula programs it's not. For Doula programs who are replicating the community-based Doula model with HealthConnect One we also write the cost of a training fee into the budget when we work with sites so that they can think about funding the entire package again with either one or multiple sources of funding. So the training again is an essential part from the beginning. We've seen a variety of funding sources for community-based Doula replication. Some public/private partnerships, the public monies can be early Head Start. Healthy families, Healthy Start, a variety of local programs that provide Maternal and Child support and include community based Doula or integrate community-based Doulas as part of that program and often an agency will start out a program with some private funding. So if you're working with local funders or national funders, there is quite a bit of interest in this right now. We're in a tight funding environment but we're also at a time when funders and policymakers are looking at the value of investing in maternal and child health support programs and family support programs so I think it's important to make the best case you can for this investment, including the training and the support of the Doulas because you want to make sure that the program will be sustained.

JOHANNIE ESCARNE: Thank you, Rachel. Are Doulas in your programs like typical Doulas initiating contact in the third trimester or sooner? If sooner, when?

>> Tia. For our program, initially early on we began Doula work was in the third trimester but now our Doulas are seeing them before. It depends on the Doulas' caseload and our waiting list and how far along the client is. It will depend on when we're able to actually assign that client. So if we get someone -- I get a referral and that young lady is six months pregnant compared to someone who just found out their pregnant the mom to be -- the six-month will be put with a Doula sooner than the one that just found out. But we normally keep a waiting list of maybe four or five people at a time. So that we're rotating trying to get young ladies off the waiting list. It just depends on how far along she is but we do try to see them sooner than the third trimester for us.

>> This is Rachel. Tia gave you a great example of practical program management. The difference between the model and the ability of the organization to serve the population. So the community-based Doula model says that you begin services as soon as possible, as early as possible during pregnancy. Basically as soon as the pregnant woman connects to the agency you begin Doula services with assessment and home visiting and other center-based support. But you can see how difficult it is when the funding that you have doesn't allow you to serve all the women.

JOHANNIE ESCARNE: Thank you, Rachel. Lizette, do you have anything to add to that response? Okay. The next question, does anyone include the Doulas in home visitation programs staff education?

>> This is Lizette, what was the question, I'm sorry.

JOHANNIE ESCARNE: Does anyone include the Doulas in the home visitation program staff education?

>> I'm kind of confused by the question. Do you mean staff education as -- you mean the actual home visiting education portion as a part of their education?

JOHANNIE ESCARNE: I would think that's what they mean but I'm not sure. I just read what they wrote. If you think--

>> Part of that is the HealthConnect One that we talked with you about, making a home visit, what you need to do. How to approach the clients and the community. All of that is a part of the HealthConnect One training that they provide. HealthConnect One literally takes you hand in hand, step-by-step on what you need to do from the beginning to the end. From getting referrals from outreach to getting referrals to once you have the referrals to what you should do with a client when you go home, what is too much to ask on the first day? What is not too much to ask on the first visit? So each step-by-step from beginning to end so they do provide that in the training, if I'm answering the question correctly.

JOHANNIE ESCARNE: Thank you, Tia. Okay. I think we're coming onto the end of the program but I have one more question. Are the participants paying or is insurance being billed for the Doula services?

>> I can answer to that one. This is Lizette. Our participants do not pay for anything. We do -- they don't pay us for the Doula service. As I mentioned in the presentation, we do assist them in applying for any insurance that they might qualify for to pay for their delivery and for their prenatal visits but on our end we don't charge them anything at all.

>> Thank you, Lizette.

ANGELA HAYES-TOLIVER: This is Angela. I'm the program person. It wasn't the intent for the participants to have to pay for the Doula services. That was not the intent of MCHB's program.

JOHANNIE ESCARNE: Thank you, Angela, for that program note. Okay. Well, on behalf of the Division of Healthy Start I would like to thank you for participating in the webcast and also like to thank our contractor the Center for the Advancement of Distance Education at the University of Illinois at Chicago School of Public Health for making this technology work. Today's webcast will be archived and available in a few days on the website www.mchcom.com. We encourage you to let your colleagues

know about this website. Thank you and we look forward to your participation in future webcasts.