MCHB/ DHSPS February 28, 2006 Webcast

Friendly Access:

Program Relevance for Healthy Start Projects

JOHANNIE ESCARNE: Good afternoon. My name is Johannie Escarne from HRSA's Division of Healthy Start and perinatal services. I would like to welcome you to the webcast titled Friendly Access, Program Access for Healthy Start Projects. I would like to make some technical comments to begin with. Slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speaker's presentation. You don't need to do anything to advance the slides. If you need to adjust the timing of the slide changes, match the audio by using the slide delay control at the top of the messaging window.

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We're very pleased today to have several speakers with us who will describe a quality improvement program dedicated to creating a culture of service excellence in Maternal and Child Health care and communities to improve consumers' access, use and outcome. Our first presenter will be Dr. Charles Mahan. He is a dean and professor at the College of Public Health Lawton and Rhea Chiles center. The next speaker is Dee Jeffers. Our final presenter is Miss Lo Berry. The project direct for the Central Hillsborough Healthy Start project.

We'll defer questions to the question and answer session following the presentation. However, we encourage you to submit questions via email at any time during the presentation. Please identify which speaker the question is for so that we can direct the questions appropriately. Without further delay we'd like to again welcome our presenters and the audience and begin the presentation. Dr. Mahan.

CHARLES MAHAN: Thank you, Johannie. Good afternoon, everybody. We really are pleased to be able to talk to you about our experience with the national Friendly Access program which is basically a program to improve customer service in Maternal and Child

Health care. I'm an obstetrician and I've been concerned and worked with customer service issues in my practices in Minnesota and Florida for over 30 years. And we had some really fine results. And when I headed up the state health department in Florida, we worked with the Disney people to try to improve the services at our county health departments. I'll mention some of that as we go along. It's hard to believe that the Friendly Access program is coming up on its 10th year of evolving and we really hope some of you will share our enthusiasm and interest for this concept and what it can do for -- especially populations that are chronically underserved or have trouble getting access to care. With that I'll move on and start talking about the program.

The -- back in -- 20 years ago Sara brown, who now heads up the national campaign to prevent teen pregnancy worked with the Institute of Medicine and a lot of experts nationally to come up with an overview of prenatal care and what was good about prenatal care in the U.S. and what was missing. They found that there was a lot of stuff missing, and that there were big problems with access to care. This monograph still has a lot of good information in it. If it's not on your bookshelf, it should be.

To start this off, based on my experiences and Dee's and Lo's and others that realized this was a big concern, we involved our faculty at the college of public health at USF into looking back at information that might underscore the need for improving customer service to make better access. The Institute of Medicine reaching mothers, reaching infants was the place we started. Dr. Albrecht, who is on our faculty, spent a year or so reviewing all of the English language literature about customer service and by the way, she started out

thinking that this idea wasn't going to make a very big difference and by the time she ended up reviewing all of this in a document called portal to portal, she not only was sold that this was a very important concept, but also emphasized to us that it's not just access to care. That if good care, customer service, reducing barriers is not taken into account, then retention of people in care is a big issue. By that we mean if we have a lousy structure set up in our community for people to access pregnancy tests and get into prenatal care or get on Medicaid and it takes them months to do it and many stops around the community, and they're tough enough to fight through that and get into the institution for prenatal care and have to wait six hours and find that nothing meaningful happened, they won't come back. It's especially true of teenagers and people that are very high risk like people that use drugs. So often our hardest to reach population is the first group to be turned off by barriers that we throw up by poor customer service. That document is available on our website and the -- at the end you'll get Dee's email and if you'd like to access that document, she'll be able to help you find that.

Crossing the quality chasm broke down the issues of quality in healthcare and spent quite a bit of time on the idea that if attention wasn't paid to customer service and making it easy for people to get care, that quality suffered. Also, of course, this plays into the fact that if it's difficult for people to access insurance signup like Medicaid, then everybody suffers because the doctor, midwife and hospital don't get paid. So there is a bottom line to this, too, for people that, you know, don't find it just a human effort to solve this problem. And then more recently, the Institute of Medicine talked -- put out a monograph called unequal treatment which really dealt with the problems we have with healthcare disparities

and outcomes. And really showed that we have a long way to go in the U.S. before we can say that we've even come close to making a dent in especially the difference between African-American outcomes and white outcomes. And as we look into it, a lot of the problem there is that different populations are treated differently by providers and people that are in the ladder of healthcare. I hesitate to call it a healthcare system because I don't believe we've ever had a healthcare system. And sometimes I'll slip and say that, but ignore it.

One of the things that we did to make sure that our funders understood what we were trying to do here was something that public health often fails to do. That's put a face on the problem. And so we had a video journalist who had done a wonderful series on breast cancer survivors, Beth Reynolds, work with us to get consent from people that had had problems with customer service and tell their stories. And she did in-depth interviews. Took pictures of the moms and babies and talked about their particular case. This is one that we'll very briefly present here and a quote from Sheryl who said it was like I had AIDS or something. They stood back from you and didn't want to touch you or something. We collected a lot of people who said they treated me like a dogs. I had babies at home. Went in for my ultrasound visit and had to wait eight hours even though I was the first one there. And things along that line that ring a bell with people in the rotary club because they're all experiencing this kind of service, too. Probably not to such a terrible degree, but they certainly understand that across healthcare today in the U.S., we've got some serious customer service problems, whether you're rich or poor. And so when we first started the concept of Friendly Access and started trying to put it into words, we used the words that

people gave us like, I didn't get respect. I wasn't treated with dignity. And a really big word that people are really searching for but often they don't say is, I had some problems and I did not see the compassion in my care that I would have expected to get.

Our initial partners and our funding partners in the program initially HRSA under Dr. Earl Fox and Doris Barnett. She died last year. She was one of the best minds in Maternal and Child Health and a good friend to all of us. And Earl and Doris, when we presented this concept to them, immediately saw the need from their work in Mississippi and Alabama, that this could be a very important component to making sure people got in earlier for care and stayed in care. And had better outcomes. So our initial funder to develop the concept was HRSA for two years. And we thank them for that and thank them for sponsoring this conference. And then Congress understood the idea and funded the idea, but Congress decided to put the money through the reproductive health program at the Centers for Disease Control and Prevention and so the major part of this work has come through a collaboration with CDC. Our research questions -- this was both -- this was a trial program to see if you could take a whole community that really wanted to improve these aspects of care, and does improving customer service increase access and utilization of health services?

We already said in the literature review we found that was an issue, so we wanted to see, OK, if we do a good job is it going to make a difference and will things get better? Then ultimately, not immediately, but down the road, does helping this process of access and utilization get you to a point where mothers and babies are healthier and have better

outcomes because they got good preventive care? So those are the two big research questions. They're pretty simple questions. But boy are they hard to do. So our mission of Friendly Access was to change the culture of Maternal and Child Health as Johannie said. And not only the care, but the whole community in ways that do the things we just asked in our research questions. One other thing I wanted to say before Dee comes up, because I slopped into her part, was that talking about HRSA, I sat on the national advisory committee, secretary's advisory committee for infant mortality for seven years, and that's the committee that oversees the federal Healthy Start programs.

And in one of the issues that I was concerned about that was brought up in the way the initial federal Healthy Start programs were set up and was discovered in the evaluations initially by mathematics was that the setup and the evaluation only focused on people that came to the federal Healthy Start programs for care. What we found in our early research was that the people with the serious access problems are the ones you never see. So what about those people? And we had to find out about them by going to big delivery hospitals in Florida and interviewing people that had no care at all. That's how you find out whether your system is really broken or not. I would now like to turn it over to Dee.

DEE JEFFERS: Good afternoon. It's really a great pleasure to be here and I want to thank Johannie and HRSA for having this afternoon. My job today is to give you an overview of the program that was implemented to help do the research, to answer the research questions that Dr. Mahan just shared with you. Before I do that, I wanted to add that this was really the brain child of Dr. Mahan. He is the state health officer, had completed a

long career in obstetrics and observed how healthcare was delivered. So he was the champion behind this because he wanted to change it. He realized that too many of the vulnerable populations of women out there really were trying to get into care but couldn't and once they got into care often the treatment was not such that would make them want to come back on a regular basis. Now, I need a little technical help here to make sure I'm changing these slides appropriately. I'm going to give you a little of the history of how the program was developed, how it was implemented, and then some of the findings that we found by demonstrating this project in the community that implemented it.

As Dr. Mahan just said we had a mission statement that we started out. This was developed by an interdisciplinary team. We had pediatricians, obstetricians, data analysis experts. Epidemiologists, representatives from HRSA and CDC which was great to have the diversity but it also made it difficult for consensus building and decision making but it did take us quite a while. We had a year of planning dollars, when we were first funded by CDC to implement the program it took us another six or seven months to finalize the program design. The mission statement was to change the culture of Maternal and Child Health care and communities in ways that improve community access, satisfaction and outcome. It's a pretty broad statement and not quite as focused enough. We have the pleasure of looking back and seeing what would you do differently? One of the things I would like to see us do differently is to change the statement to say that we want to create a culture of service excellence, not just change the culture but focus in and create a culture of service excellence which we'll explain later what we define service excellence to be.

In Maternal and Child Health and the community to improve our consumers' access, use and outcome. Our belief is that if we do improve access and change it in the way people can get in easily, make them want to stay, that would be a path to improve outcomes. This team spent months toiling over then what would the program model look like. Now, if you're seeing this on your screen it might be difficult to follow but it's a multi-phase that appears to be linear but actually there are steps somewhat sequential but often overlapping and sometimes repeating. But for designing the evaluation we did have components of the program with research questions at each step of the way. Phase one with the communities that were selected to be funded to do this had a coalition but we asked them to expand their coalition and I'll get into that but to partner with healthcare organizations and institutions that deliver care to set up what we call internal teams to work on issues within their institution. Who in the community needed to be trained and learn more about service excellence. The use of data in decision making and approach to strategic planning.

Very common in public health communities that are trying to change outcomes often use this path. But phase three is a little bit different. We took teams from communities down to Disney world to learn from the masters on customer service. They pride themselves in return visits because they make every opportunity to touch a customer what they call a wonderful wow experience. We wanted this mindset in our communities and we'll talk about that in just a few minutes. The next phase was an in-depth planning where you would take data that was collected back in the coalition formation and collecting data for

the baseline assessment and taking the data and turning it into interventions that local communities could use to change the culture of care and to address specific barriers that were identified by consumers.

Once those were implemented the plan is for the communities, then, to begin to monitor to see if consumers' experiences were changing and improving. If that then was linked to improved access, use and outcomes. We thought this would be about a 20-year research agenda but I think as we all see, sometimes your funding doesn't allow for that. But the story we have to tell is we did find communities that received the funds that we had available at the beginning of the project, did implement the program and they're continuing to do the work without our sustaining funds. They found their own to continue, which is very positive. So again let me start back at the point where we had fleshed out this program model. Not a lot of the detail was completed at that point. But given a very short time line and knowing we were being pressed by our funders to say what are you going to show that is different in three years? So we were trying to figure out the details, we went ahead and produced a guideline for communities to respond to with a vision of what we thought it would look like and did a call for nominations to identify communities that had existing Maternal and Child Health coalitions and strong partnerships that had demonstrated they had made a difference in their community.

Communities that had this coalition established would also know how to access and use Maternal and Child Health data. It took us about three months to get calls for nominations back. We narrowed a field of 70 down with a simple request for a brief description of why

your community would want to do this and what capacity you had to do it. Eventually, narrowed that down even further and invited about a dozen communities to do what we call a full application, which was quite extensive. So through a self-selection process other communities opted out. Out of the 12 we visited six communities and ended up with a cut in funding the first year and had to limit our funding only to three projects and a fourth one came on and funded themselves. I'll tell you about that community in a few minutes.

Those that we funded were Jacksonville, Florida. Indianapolis, Indiana, an east Tennessee, coalition that represented 16, 17 rural counties with Knoxville in the heart of it and Flint, Michigan. Of the four, three had Healthy Start projects. East Tennessee is the only one without a funded Healthy Start. The others did which we think strengthened the community's cam -capacity to do the work. We were in good stead. East Tennessee did demonstrate they had the similar capacity. What turned out to be a challenge for them, they were the only one with multiple counties and a large rural area to cover but we wanted to see how this model worked. It added a different component. We had strong partners that wanted to continue with us. We used some of our funding to support bringing representatives to many of our meetings from communities that didn't qualify for the funding but demonstrated a strong desire.

Those that continued with us were Phoenix, some phases of implementing the project with their own funding. Syracuse, New York, which is very interested in beginning some early steps in organizing. Des Moines, Iowa has expressed strong interest and would like to organize a project. We are now in touch with several other communities that have learned

more about it and are interested in taking the lessons learned here and implementing them in their communities. Now let me talk a little bit about the coalition and internal teams. I think we're all familiar. You almost can't get any money from the federal government if you don't have partnerships at the local level. And show a strong capacity and ability and history of working together in partnerships. What's often missing is a strong link back to the healthcare system at a high level. Often decision makers are not involved in process meetings and it's difficult access.

One of the conditions we set forward in this is that we wanted representatives from those who fund care, evaluate care and use care. We wanted consumers at the table, we wanted providers and you usually have providers but we wanted the heads of agencies to buy in if they would be involved. If they came together to change the culture of healthcare they knew internally they would have to do specific things to address any problems that were identified in our baseline assessment and talking to the consumers to find out what their perceptions of care were. I wanted to make that point how this project was different than most coalitions. Early in the process, we asked communities to do an enormous baseline assessment. We started out with a number of tools that we wanted them to use to collect data. But what we found early on with secondary data, one consistent source of data that they all could get their hands on was HIPAA and all the other constraints in doing research were secondary data, vital statistics birth records. Each community could get that. Some with more difficulty than others. But working with our experts in data analysis, we helped developed some formatting for the data so they could do a look to assess access.

The adequacy of care and how it was utilized and looking at outcomes. Ideally that baseline assessment should point to the next step of who you would be interviewing. Our goal was to identify the women that were having the most trouble accessing care and have the data to support that. Those that were obviously not utilizing it on a regular basis or coming in late and, of course, those women that don't get any care at all. Linking it to outcomes was important but was more important is the next step, taking the vital stats data and talking to the consumers. This is probably the most difficult but probably what yielded us the most information about our consumers and where we needed to target our interventions to change care was in extensive prenatal and pediatric surveys. We did approximately 800 surveys of pregnant -- new mothers immediately postpartum before leaving the hospital. And asked them about 104 questions. Some of them demographic but really probing questions about their perception of the care they received in particular items. We'll share some of the results later. I think it will be of great interest to Healthy Start projects.

There were cross cutting issues that we think are playing out in many communities. The pediatric was more extensive because you needed to get more demographic information both on the parent or the person bringing the child in for care. But they were adults bringing children in for care under five years of age. We had some with newborns and some toddlers and some early childhood years. The survey probed a little bit deeper. Now we knew who by a profile was not accessing care and who was not utilizing from the secondary data and luckily most of the surveys did target that group. So we learned a

great deal but it still didn't tell us some of the deeper questions. So the next phase was encouraging through training and providing some additional resources for the local communities to dig a little bit deeper and talk to the women themselves through focus groups and some more in depth surveys and using more qualitative experiences -- instruments. And that is about the last phase folks were going into before designing their interventions.

I would like to also share with you a little bit about Disney. We learned a great deal about this. Disney customer service training was our first experience as we developed the program. We sat down with the Disney folks to understand the mindset of a large, international corporation. The question was, how do they train and hold accountable and continue to make their staff deliver excellent customer services at every point of contact? We learned a great deal from them. A lot of people say this has no relationship to healthcare. They don't have the same problems. They don't deal with the same things. They don't have a large workforce. They aren't dealing with people with diverse backgrounds. What we found is absolutely the opposite.

That Disney employs hundreds of thousands of people across the world. They deal with multiple unions. They've got huge labor issues. But through what they call their loyalty chain, they have devised a way to make sure on the front line good customer service is delivered and they link it back that if employees know what to do and they're well trained, they will do it consistently. They need to be hired well, trained and then supervised and rewarded for good behavior and good performance. To do that, it takes a management

team that is supported by its leaders and they back it all the way up. They prove in their profit. They have the highest rate of return visit from families that save sometimes two, three, four years to come to Disney. They'll have a vacation there and have such a great experience they come back again. Most families are coming back for their second and third visits. We wanted to apply their techniques and their skills so that we could create the same type of environment so women would want to get into care early and once they've come in for care they'd say I'm coming back because I'm getting what I needed and I feel really good about it. That's as simple as that. That's why we chose Disney. What we learned, though, in the process that it's very expensive. It's $3,500 a person. We entertained taking 20 people for each community. You can imagine about $60,000 to take a full complement of folks down. Some communities matched that and took teams of 40. We had the capacity to do that. The training is very in depth. It's over three days.

People are taken into the Disney theme parks to see how services are delivered. You come back into the classroom setting and explore the Disney approach. Since then we came up with a book, I have to say I have an error here. There is a book called "9 1/2 things you would do differently if Disney ran your hospital." Dr. Mahan said I had the wrong title. Jot that down in your notes. Fred Lee. One of the curriculum designers for Disney he helped them translate Disney talk to healthcare talks. He was a little disappointed because Disney said they weren't going to take it on the road. He has created training materials. If you just Google Fred Lee go right into his own website. He not only has this book. He has DVDs and CDs you can get. You can apply it not just to hospitals but to healthcare. I encourage you to look at that resource. Following training

and then getting through all of the data, the early secondary data analyzed looking at the survey results, communities came together and discussed it and began to prioritize bringing consumers' voice to the table. What are the issues most critical to them? We'll share with you what we found across the site. This in some communities happened pretty rapidly. Some are better than others. Others are still using the data and developing more focused strategic plans on what they would like to do.

One thing we added that's unique. We tapped into a resource we have. Dr. Quinn, the director for the national collaborative and training for social marketing which you can find on the web if you'll email me, I'll make sure you get that contact, help us use social marketing which she says is using traditional marketing approach to helping to promote healthier behaviors and healthier products for folks and it's used across the country now in many public health programs. Dr. Mahan likes to quote it and saying what we're doing instead of all of us experts sitting around the room deciding what's good for people, we actually talked to the consumers and people that use our services or listen to our message and ask them what they think and what would work for them. Now, let's get into, I think, what might be of great interest to you, particularly those that are working on new concepts and interconception models of care. The four issues we found that resonated across the sites.

I'll ask Dr. Mahan to join me. Were unintended pregnancy. The data supports this. The content of care was weak. Continuity of care and multiple stressors. Charlie, you want to start with some of the findings that you'd like to share?

CHARLES MAHAN: Yeah. I think part of the content of care, getting people into care is one thing. But giving them something meaningful that really is going to help them get a better outcome in some prenatal care visits people don't get that both in private offices and in public clinics. Nothing important really happens. Patient education is the one thing that patients want the most. And that has to be well done and then they feel like they've had -- they want their questions answered. A couple of issues on content of care that were behavioral issues that were sort of surprising when we interviewed women was that 16% of them, this is across the four communities, nobody talked to them prenatally about birth control and planning the next pregnancy. I don't believe anybody should get up to labor and delivery without having decided what they were going to do about that after they had the baby. That should be on their prenatal chart. 12% were not offered an H.I.V. test. And that's malpractice in today's climate. And if somebody is not offered one or if somebody is offered one and declines it a lot of time needs to be spent to talk them into doing it because of the effects on the baby. The biggest one I saw in behavioral was 36% of women were not asked about domestic violence. Were not asked if they felt safe in their neighborhood. Was anybody hurting them. That's outrageous in today's climate also. Dee, you had some you were going to go over.

CHARLES MAHAN: It's very important, the unintended pregnancy. Nationwide, the CDD is making this a priority. For years we realized we're doing a terrible job when a woman has a three-pound baby or has diabetes and has problems during pregnancy, we take care of that pregnancy and then we drop her. 50% of Medicaid patients don't have a

prenatal -- a postpartum visit so if we just would focus on the people that had problem pregnancies and bad outcomes, and helped them the next couple of years, we would make such a big dent in our infant mortality and prematurity rates. Right now we're not doing that and I'm probably making some people mad out there that are doing it but most people aren't.

DEE JEFFERS: I would like to follow with some of the issues on continuity to care. We asked the question of women were they receiving regular care before they got pregnant. 47% had no form of regular care before getting pregnant. Once they were in care, 25% -- this is primarily a Medicaid audience that we talked to. 27% were not getting on WIC. The peed -- pediatric side had used the emergency room to take their child in at least once. Over 22% had gone in at least twice. Then following with some of the stressors that we found in the women, 10% of the women reported that either their partner or their husband, 10% were incarcerated or they themselves had been incarcerated during their pregnancy. And over 30% of them said that they had someone close to them die during their pregnancy. 30% reported -- or more reported that they were arguing more with their husband or partner. I could go on. We don't want to do a whole litany of research. I still think the one that surprised me the most was the 65% of women, though, that said they reported that no one had helped them find care for their babies. We have a real—

CHARLES MAHAN: That means they're walking out of the hospital not knowing who they'll take the baby to for care. That's terrible care. We always used to try to make sure that if it was a first pregnancy, the mother knew who the pediatrician was going to be

during the pregnancy and actually saw the pediatrician but certainly they need to know where to go when they leave the hospital. One other thing about unintended pregnancies that really shocked me was that 23% of the women in the four communities said that they didn't want to be pregnant then or any time in the future. And here they had a new baby. And so that's another failure of that. And one other word about continuity of care. We have found that it's very important no matter what kind of system you're in, for the patient to try to see the same provider all the time. Whether it's a nurse practitioner, midwife, Doctor, certainly they'll have to see a few other people but they need to know the name that Dee Jeffers is their nurse and that's the person they relate to.

DEE JEFFERS: You can see this certainly raised a lot of concern in the communities and what was nice they could validate the voice of the consumer. This wasn't experts assuming something. So we learned quite a good deal. It's a long survey and you have to be careful when it's administered and who administers it. They found a good person to look to are often the community outreach workers who work in the community with the women. They know how to pose questions, gain the trust of women so this could be another career path for a lot of our workers out in our Healthy Start projects. We're now in the process of condensing that down and have narrowed it down to 30 questions on the prenatal and 40 on the pediatric so they shouldn't take as long and we'll be able to make that available to the public.

I want to say another word about our project. Our intent was to create and build more capacity at the community level. I have to thank our two project officers who worked in the

four communities, Maureen Greer at Indianapolis is a wonderful consultant if any of you would be interested in contacting Maureen. And Ed Fever in our Tallahassee office were on the ground often working side-by-side. We used a quasi community research. We went in with a research agenda. Had a framework for a program but entered into a memorandum of agreement clearly defining the roles and expectations. Beyond that intervention design was up to the community. It was hands off. We asked that they use data, they use a planning process, that they do go through the basic training. We met with the projects at least four times a year during their years getting organized. A lot of this is out into the field. But once they looked at their own data, what the community decided to do, we were hands off and encouraged them to come up with their own research agenda, which they are doing.

One of the questions that was asked of us is that we talk about this, what does this mean for other MCH communities and particular Healthy Start projects? So we put together a few topics and we're going to ask Lo to come up in a few minutes and talk about her experience and what she thinks. We think it could be very applicable and useable because this recognizes that the culture of healthcare may actually impede our efforts to address racial and ethnic disparities. There is emerging research hinting that as women try to improve their health status and get more mainstream and come in for our services, we may be creating some of the stressors during their pregnancy that they need to avoid. The time signal to move this on. I think it offers an approach and tools for creating a culture of service excellence so if you really do find this is needed in your area, I think our tools have been pretty effective and what we've learned from our four community sites that

we would love to share with you. I think it inspires the communities to create a more positive, memorable experience for mothers and babies. It also facilitates communication between community healthcare and consumers. It uses both qualitative and quantitative data rather than oftentimes you have to rely so much on just the quantitative. It takes you beyond that. Using social marketing is another strength. And I think what is going to be very promising in the future is to be able to link to these other demonstration sites and build on their expertise and I'll be happy to share with you the contact if you'll email me. There is my email address and we'll bring Lo up.

LO BERRY: Thank you. Greetings. I'm Lo Berry and I have to admit this is a little awkward to me. I'll try to remember the look into the monitor they told me to look in. I want to say greetings particularly to my Healthy Start family and all the other kindred spirits in the Maternal and Child Health arena. Because of protocol I think I need to give some shoutouts as to our leadership, that's Marybeth and Beverly Wright and my project officer Johannie and our national board president beLinda. I'm always delighted being in the presence of these two, Dee and Charlie. They gave birth to the federal Healthy Start project in 1998. And myself and my staff really consider these guys as our god parents for Healthy Start. It's really particularly important when you talk about issues such as these that you feel you have people in certain positions that have your back. I can truly say these guys have had our backs and they've been great supporters of mine not just mentally and emotionally but also fiscally with our project.

It's not rock earth science for any of the Healthy Start community to know that incorporating a model such as the Friendly Access is really a core component of service delivery. You know every time I hear a sad story about how one of our moms are treated when they go into access care I take it very personally and it is very hurtful. Every time I hear about how respectful one of our moms were treated, you know, that also brings joy to my heart. So this is not news to any of us. I think the bottom line for us is that it's critically important how you treat people and how people perceive that you treat them. I believe that our community, meaning the federal Healthy Start community, we get it and that we recognize that maltreatment, ill treatment are all poor -- are all indicators of poor health outcomes. To paraphrase what Dee and Charlie said a few minutes ago I think some key elements to remember in a model like this is you must love the people. You've got to be passionate about the advocacy and the fight and struggles of your work. You have to know what you're talking about and you have to be willing to serve and be good stewardships of that servitude.

Our project is excited because we got to play an important role in this conception of Friendly Access. I want to real briefly tell you about some of the roles we play. One, we provided some consultation for the Friendly Access staff team. We sort of validated the genuineness of the project and added credibility to Charlie and Dee's information in their effort. I remember going to one of the sites when one of the ladies from the community pulled me aside and said I really was wondering, you know, if there were any black folk in that community. So I think we added credibility as well. Two, we were participants in the selection process of the sites. This was particularly exciting to us because it gave us an

opportunity to help identify what we call inclusive communities. The willingness to address underlying issues that communities had that promote poor health outcomes.

Third, we participated in the Friendly Access Disney training and have incorporated, of course, some of the guiding principles in our model of care. Four, we've made ourselves available for strategic planning in these communities and we enjoy doing that. We have contributed, of course, what we call to the mindset in our own community. We're really happy that our local system of care is in -- and our coalition has expressed interest in actually utilizing the friendly aspects model in our community of healthcare. As you see here, in all of our projects in the federal healthy start project, of course, have to address the five core components of services and we know that. In addressing the core components of services these are some of the key elements that you see here with the healthy start model. I don't think these elements are strangers to most of you who are listening. But we embrace a professional and a paraprofessional staff. We actually believe that building community capacity is essential for changing the health outcomes and health behaviors in long term ways. And we hire indigenous folks to be service champions. We have people who provide emotional support with our moms during birth and delivery process and we have indigenous outreach workers. We believe culturally competent staff is important. Another element is the health advocacy and education.

Another is the health literacy which Charlie talked about. The patient education and the provider's education and how they deliver that information. High consumer involvement, broad based partnerships. We like to say that our partners is extensive and people laugh

about it all the time. We say we have everybody and their mama at the table here at this community and we really believe it's important to share the liability but also the responsibility of a good health outcome. So I won't go in detail but as you see here it's very broad-based from our community stakeholders, our residents, to our educational institutions, our hospitals and other agencies in our community. Lessons learned. We have many, many lessons learned. The one that we like to tell people to keep in mind when you're doing an effort such as this is to address and remember these, poverty and you can't really have a conversation in honesty and not address that poverty is a psycho social determinant of a poor outcome.

Trust, cultural competency, embracing the community when you're coming in there. Looking at the demographics. Knowing what those community strengths are and reminding them always that they have a choice in participating or not. And honestly research and evaluation as community empowerment tools and the participants as research partners. This is how I'll end. This is Healthy Start consumer who started with us four years ago. We -- the managers get mentors. Carla was my mentee. She had twins prenatally. She's a mother who epitomizes moms that we work with all the time. She has every social ill you could think of. Carla became the co-chair of our community consortium and was so for two years. In December she completed the University of South Florida in social work and now one of our case managers. So we're really happy to have Carla with us.

I just want to end by giving you a quote from Dr. Debra Austin, who actually attended the Disney experience. And she said to leave with y'all the most important lesson learned at the Disney institute training was the importance of orienting employees and staff in the common vision of the organization. And all Disney employees, whether they work in the laundry or the corporate offices learn who Walt Disney was and how he is and how his collaboration built the organization that they are now a part of. She says that one of the most important aspects of the trust and respect is valuing the opinions and perspective of the employee. For example, we heard the story of a mechanism being used in a laundry that was designed based on the recommendations of the employees. When I left the Disney institute, I immediately thought about how little many of the child center employees knew about Lawton Chiles and how he and his collaborators came to make reducing infant mortality one of the state's priorities and I thought about how important it is to continually tell the story both of the assets and liabilities of the community we serve as well as how all of our employees are part of a national commitment to improve MCH outcomes. Thank you.

JOHANNIE ESCARNE: Thank you, Charlie, Dee and Lo. I guess you guys did such a fabulous job I haven't received any questions. Unless the audience would like to send in some questions now. Or if the audience here in the room has any questions. Or if you guys had anything else you wanted to add to your presentation. I'll give it a minute or two.

DEE JEFFERS: While we're waiting. Is this on? I wanted to just take a minute to tell you a little bit about each community and what they're doing. I think we failed to include that. In

Indianapolis, they use their data in such a compelling way that it was instrumental in getting the passage through their state legislature for a Medicaid waiver for family planning. We thought that was pretty astounding. They also received some additional funds from the public health department to work on their issue that they had the highest rate of all the communities in not accessing WIC. We've been instructed to work on that. In east Tennessee they have rallied around and held a number of trainings and are beginning to work on how they're going to pull this off in multiple counties without any further funds, which is extremely difficult in their community because the resources are so lacking. But they continue on without staff.

Flint, Michigan, has received enough funding to go for another couple of years and are developing their strategic plan and going to focus on reducing unintended pregnancies as well. They have a mock children center an ideal clinic that has completely renovated the way they offer services and have adopted the Disney model and now have the MOT take five moments where every employee spends five minutes every day finding some way to make a memorable moment for a client. They have a lot of other things they're doing there to make services very customer friendly. And then our friends in Jacksonville, Florida had a four-pronged project that they're getting the March of Dimes to pick up. One is educating women about how to access Medicaid. They have a lot of problems with getting women enrolled. Also with transportation and working with their city bus system to improve not just more lines but how consumers are treated on the buses. They found out some of the behaviors of bus driver was a real deterrent. Women didn't like to get on the bus to come for care. Just a taste of some of the strategies. And again we're writing this up. By the end

of the summer we'll have a little manuscript prepared for dissemination on the successes of each community. It will be available free.

JOHANNIE ESCARNE: Thank you, Dee. Do we have any other questions? I do have one question. How do we get access to these materials that will be coming out?

DEE JEFFERS: Give them my email. Somebody wants to be in contact. You can also Google the Chiles Center.org,

JOHANNIE ESCARNE: The specific question was the 9 1/2 things you would do differently if Disney ran your hospital, how would you get access to that one?

DEE JEFFERS: I could Google Fred Lee. It comes up immediately how to get his materials and his books. You have to order it online. It is not available in the bookstores.

JOHANNIE ESCARNE: OK. Thank you. Another question, was how will the information be disseminated, the information that you're gathering?

DEE JEFFERS: Through a public -- one, we do hope to have publications but like I say short of any publication in journals on the research we plan to publish a manuscript that will have lessons learned. The history of the project. Lessons learned and an overview of what the projects were doing. We're preparing that now. It will be out by this summer. We'll make sure all the federal Healthy Start projects get a copy.

JOHANNIE ESCARNE: Thank you. Do we have any other questions? Well, I guess you guys gave such a fabulous presentation that that's it for today. On behalf of the Division of healthy start and perinatal services I would like to thank our presenters and audience for participating and also thank the Center for Advancement of Distance Education School of Public Health for making this technology work. Today's webcast will be archived and available in a few days on the website mchcom.com. We encourage you to let your colleagues know about this website. We look forward to your participation in future webcasts.