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Promising Practices from the March of Dimes' Reducing Disparities in Premature Birth Program

ELISSA SCHULER ADAIR: Thank you. Thank you, Kelly. Good morning. How is everyone this morning? It is great being here. I am a first time AMCHP attender.

And when I saw workshop I took it very seriously and am planning to put you to work. I am also planning to give you an opportunity to shop a little bit through some of the promising strategies that this exciting program has identified. And hopefully you'll return to the communities in which you work and live with some new ideas and some new practical strategy implementations.

But you're also a guinea pig for us. Part of what this project is trying to do is to create some tools that can be useful in the field. So in playing through some of our workshop activities, obviously this is not a complete tool, we're trying to get some feedback from you all as well as to what kinds of things people are going to find most useful when they are trying to implement or refine programs to reduce disparities in premature birth.

This CDC funded project reducing--the March of Dimes' Reducing Disparities in Premature Birth Program has a number of aims. To promote safe motherhood for minority women before, during and after pregnancy. To eliminate racial and ethnic disparities in maternal health outcomes. To reduce adverse reproductive outcomes. To build relationships with state health departments and/or state coalitions and local affiliates. And to strengthen systems of services for minority women across their life span.

Given this ambitious list of goals, we created a program structure that uniquely fitted our institution, the March of Dimes, which you are aware has chapters in every state as well as in Puerto Rico. We created a mini-grant application process, opened it up to chapters who had existing partnerships that they wanted to build on to reduce disparities in premature birth. And in this competitive process collected--selected six chapter pilots. The locations of these pilots are California, South Carolina, Illinois, Florida, Pennsylvania and Texas. The first five of these programs really had to do with implementing consumer activities on the ground. And those are going to be the ones I'm going to be talking about today.

Texas is a very unique program. The Texas chapter has made the decision that they want a better process for evaluating the impact in terms of birth outcomes that their chapter grant funding is having in the communities. So what they chose to do is to use mini-grant funding to support the development of an evaluation infrastructure and technical assistance arm to their chapter grantees. It's very

exciting and I regret that I will not have the time to go into it today. I'm really focusing on the first five that did consumer related activities.

So one of the really unique things about being part of this multi-site process and I certainly will not do justice today to each of the five programs about which I'm talking is that it really created and opportunity to facilitate communication and collaboration, not just within chapters which had a program person from the March of Dimes collaborating with a community partner but also across chapters. So we took the AMCHP Promising Practices model very seriously. You're in a Promising Practices presentation. We don't have any final answers. We're moving towards that. But there were a lot of continuous improvement loops built into this multi-site process. They included conference calls. In our first year, this program started in September 2005, we held four conference calls--three conference calls. We have just had our most recent conference call in this our second year last month.

We conducted site visits. I went to each of the chapters, had an opportunity to meet with staff, providers, partners. I also had the chance to interview some consumers in some locations and observe activities. We held an in-person meeting in September at our offices in White Plains and had two representatives from each of these programs come to participate in about a day and a half of talking about the finding that they had after their first year of being in the field and also to address some of the bigger questions that their program designs raised.

So there's really been a lot of opportunity for collaboration and process improvement.

The key program strategies that I'm going to address today and it's important to remember that this is a preview. We anticipate in four to six months having a much more complete publication that we will disseminate to AMCHP members. So keep your eyes open for this. This is definitely a plug and a teaser to get you involved and invested in the longer product. But the key program strategies, among others, that I'm going to talk about today is raise community awareness, improve patient provider communication and trust, increase individual knowledge, encourage positive health behaviors, provide social support. By social support I mean both emotional and practical support. And the support was provided in multiple ways, sometimes by working with family members to increase the support already existing in a woman's network, but it also added peers and mentors to women's networks as well. And finally to address psychosocial barriers to change.

So I'm going to begin talking about community awareness and social marketing. As you know, the March of Dimes does social marketing very well and this is a project about which we were particularly proud that worked very collaboratively. Illinois was one of the locations that federal funds were dedicated to to reduce disparities in premature birth. The name of this project is The Closing the Gap Project. March of Dimes is but one of a number of state and city and private

partners involved in this project. It's located in Chicago in two neighborhoods, Englewood and Austin. These communities are African American communities.

They created a series of intense images with community input, meaning they used focus groups to develop these campaign products. And they are really intense images. There's a picture of an infant casket in a hearse. There's a picture of a baby whose name is Terrell. Baby Terrell in a NICU incubator with tubes being cradled in what is clearly a male parental hand. So you get both the technical aspects of being in a NICU as well as the size difference in that image. And finally it took advantage of a local celebrity named Common who's an R&B artist and also a hip hop artist and put his image on things as well.

It was planned as a sequential campaign beginning with signs and symptoms of preterm labor, moving into messages related to prenatal care and SIDS and is finally moving into an individual risk reduction action steps phase. These mass media campaign images were complimented by neighborhood outreach and included a community led health educator component that was staffed with community health educators who had formal training using a structured curriculum. That was multi sessions. The cream of the crop of those who participated in the training were offered part-time jobs. And as you can see the campaign materials included things like postcard and then wallets as well for really, you know, one-on-one street and neighborhood outreach.

Two projects really focused on faith based outreach. The first was in Pennsylvania entitled Love They Neighbor and the second was in California, entitled Health Mothers, Healthy Babies. One of the things that was very clear in working with the faith community projects is how the March of Dimes and their faith based partners really felt that they had a clear alignment of goals. When they talked about it they felt that their community ministry as faith--in the faith based setting really matched the kinds of community outreach messages and public education initiatives that were important to us. So the goal was to serve those in need and encourage a healthy lifestyle, body, mind and soul.

In Pennsylvania there was a group of communities--a group of community churches in Norristown, Pennsylvania, which is outside of Philadelphia. It included African American and Hispanic churches. And of course the implementation was slightly different in the different locations. There were health programs where experts were brought in on specific topics to work with faith based groups that were already meeting for other purposes. And it also included individual mentoring, particularly in the Hispanic program, a mentoring mommy program as well as the nurse who was in charge would do monitoring of blood pressure and weight. There were also walking clubs associated with this project.

In California, the Healthy Mothers, Healthy Babies project used a watch one, do one curriculum format and they also were prepared for all sorts of circumstances, be they Power Point presentations, or one-on-one tabletop notebook

presentations of a curriculum that really walked individuals and groups through what it meant to have a premature baby.

And they did it in a very visual way as well. They would present a beanie baby so people would get a sense of the size of a premature infant. And one of the very striking things about this is they really worked to make it a multiplying community initiative. In some ways it came out of work that one of the curriculum developers did in Nigeria where she had seen the way that health education information is replicated in grassroots communities.

So there was a watch one, do one curriculum format where someone would get up and do the presentation and then an audience member would be picked on to demonstrate just how easy it was for them to then go on and reiterate the information. That project is currently active in the Antelope Valley in there--which is a section of L.A. that's a little--it's not--as well as in south central L.A. where they're working with some churches there.

Another project in Florida that worked very closely with the state department of health was related to group prenatal care. As many of you who are familiar with centering pregnancy know, the purpose of group prenatal care is to deliver prenatal care in a group setting to women who are of similar gestational age and it occurs over a number of 10 sessions.

The Florida Department of Health was faced with birth outcomes that were continuing to worsen but they were looking and realizing that they had done over the years a good job of getting women into prenatal care. So it was not an issue in their minds of access. It was a matter that the prenatal care people were receiving wasn't resulting in the birth outcomes that they had hoped they would. So transitioning to a group prenatal care setting where there would be the added group dynamic to encourage women to adopt healthy behaviors as well as a format that breaks down some of the barriers between patients and providers was very attractive to them.

Florida worked as a team and a number of before the March of Dimes came into the picture with mini-grant funding to come up with a curriculum and protocol that had been bought into by the various stakeholders in Florida. This was implemented through a number of county health departments. And we supported both the training and some technical assistance during the implementation. In terms of prenatal group care, all elements of traditional care are included. Women are assessed individually by providers and they're often pulled in and out of group so that that can be done.

South Carolina built on the group prenatal care model and decided that it could also work for group interconception care. Their group entitled Strengthening my Foundation Brick by Brick had the goal of helping parents of preemies to reduce their risk factors before their next pregnancy. Participants determined the

discussion content. It really takes advantage of group dynamics so that the agenda for the next session is determined in the current session. And they'll make decisions if nutrition is going to be their focus, domestic violence, et cetera.

One of the things you'll notice, just like in California, the importance of having visual clues to what was trying to be accomplished. So this group used cardboard building blocks to represent metafile risk factors. And people would come in with their block that said remember to take your vitamin everyday. And they would build on individual action plans in this very concrete foundation building block way. This was facilitated by a nurse who created follow-up to individual action plans.

So let me just review quickly some of the psychosocial barriers that the different sites encountered when implementing their programs. The psychosocial barriers encountered and these are from the perspective of the consumer. There are certainly provider psychosocial barriers as well, but I'm focusing on consumer ones at this point. Hearing conflicting messages from trusted sources, and I can't attitude and lack of hope, fatalism, God made this baby and God will take care of it, feeling like you already know and don't need instruction and being stubborn, resisting health information. One of the consumers I spoke to said I was just being hard-headed. So they're really, you know, having that attitude was something that people talked about as well. In parenthesis are the sites in particular where these psychosocial barriers were raised by staff and consumers.

Of course another thing that absolutely comes up are system gaps. There's a lack of individual and community information. There's inappropriate and inadequate care. There are cultural disconnects with providers. There's a lack of provider to provider linkages for consumers, transitions on and off publicly funded services caused problems as well as the lack of coverage for undocumented Hispanic women.

So as I mentioned, this is just a preview. There is more to come. The next steps for us are testing of community planning tools, and upcoming publication of promising practices. This was just a tidbit and replication to additional chapters in subsequent years. Once again, this is year two continuation funding for up to five years. We just began our second year in October of 2006.