

**NWX-BPHC**

**Moderator: Tracey Orloff  
September 13, 2011  
1:30 pm CT**

Coordinator: Welcome. Thank you very much for standing by. At this time all participants are in a listen-only mode. To ask a question during the question-and-answer session please press star then 1 on your touchtone phone.

Today's conference is being recorded. If you have any objections you may disconnect. And now I'd like to turn the call over to Ms. Esther Paul. Ma'am you may begin.

Esther Paul: Thank you all for joining us for the Bureau of Primary Health Care Enrichment Series for Grantees. My name is Esther Paul and I am a Public Health Analyst with the Office of Training and Technical Assistance Coordination at BPHC. I have served as the coordinator for this call and would like to take this opportunity to welcome you to (unintelligible) session.

Today's session has been convened to draw your attention to the significance of maternal and child health in public health practice and to emphasize the importance of recognizing and addressing persistent health care disparities. We are fortunate to have with us a distinguished panel of experts who will enrich this call due their diverse public health experiences.

Mr. Jim Macrae, the Associate Administrator for the Bureau of Primary Health Care, HRSA will provide you opening remarks for this call. After Jim, Dr. Jamal Gwathney, the Clinical Advisor for the Northeast Division of BPHC will give us background information on maternal and child health care disparities.

Then Dr. David de la Cruz, a Captain in the U.S. Public Health Services and recently promoted to Branch Chief of the Healthy Start Program at Hereford Maternal and Child Health Bureau will speak to us about HRSA programs addressing maternal and child health disparities.

Following Dr. de la Cruz, we will hear from Ms. Jeretha McKinley, the National Program Replication Manager for HealthConnect One which is one of the pioneers of the community-based doula model and her sub-grantee. After you have heard from Ms. Jeretha McKinley you will hear from Mr. Doug Smith, a Chief Executive Officer for Greene County Health Care Incorporated, a BPHC-sponsored community health center in Snow Hill, North Carolina. He will tell us about the exciting changes that Greene County has implemented in its community through their community-based promotora program.

In addition to the speakers here, I have with us Mr. Israel Garcia from the BPHC Office of Special Populations and Mr. (Babak (unintelligible) who is the BPHC Project Officer for Greene County Health Care Incorporated and we are thankful to them for their presence. I am also thankful to my director, Ms. Tracey Orloff, who is here from the Office of Training and Technical Assistance Coordination. And at this time I'd also like to thank the Office of Quality and Data for providing us with the necessary information for this conference.

So without further ado, I hand the conference over to Mr. Jim Macrae. Thank you Jim.

Jim Macrae: Thank you. And thank you, Esther for organizing this call. We really appreciate it and a huge thank you in advance to our presenters today. I think you really will enjoy their presentations because they have a lot of great information to share with you.

We are very excited about today's call because we are focusing on maternal and child health. And this is a very important area for all health centers across the country. I think that most of you are aware that almost a third of the patients that we see nationally are kids ages 0 to 18 years old. And I think something that we don't always recognize is that we also delivered more than 250,000 babies last year through the health center program.

So we have a big impact on both maternal health as well as child health. And I think even more importantly we know that just from our experience in working in health centers that focusing on health early and focusing on good health care early and making sure that kids start off on the right (unintelligible) can have an impact on people's lives throughout their entire health journey that they have.

So really starting early with good health is critically important because good health early has a big impact on whether your health is good later on. So we really see that as something critically important for all of our patients but in particular for our youngest ones.

In addition we also know that prenatal care is critically important and that there is no substitute for getting people into prenatal care early. But I think even more importantly -- and I know we'll hear this a little bit from our

maternal and child health colleagues -- it's not enough just to get women into prenatal care in that first trimester, we really need to make sure that women, and in particular pregnant women are in even before they get pregnant. So they actually have a health home that helps them even before they make the decision to become pregnant and then helps them throughout the whole life course.

Because it's not enough just to focus on prenatal care, we have to focus on everything. So we're really excited about today's call and we really appreciate, again, all of the speakers.

In particular, we're very excited that our colleagues on maternal and child health bureau are here as well as our colleagues from the doula program as well as one of our health centers to actually speak about some of their successes in terms of dealing with maternal and child health issues.

As we know there are lots of ways to address maternal and child health. One that we have been very interested in, excited about, talking about recently has been the whole text4baby initiative. We know right now that over 85% of Americans own a cell phone and over 72% of cell phone users send or receive text messages. So the National Healthy Mothers, Healthy Babies Coalition decided to provide a creative response to high infant mortality by launching text4baby. And HRSA is really proud to be one of the key partners in that coalition.

In particular text4baby provides pregnant women and new moms with information to help them care for themselves and their baby. It provides accurate text-length health information and resources in a format that is personal and timely using technology they know and use. We know firsthand

at many of our health centers that our patients actually use cell phones in terms of communication.

The good news is that registration for text4baby is simple and the messages are timed to the woman's due date. So once the baby is born the mother can text in an update with the baby's birthday so she can keep getting messages throughout the baby's first year.

In particular we know many health centers have been able to take advantage of this technology. But we really encourage all health centers to utilize text4baby because of the early success we've seen with this effort to make a huge impact in terms of women's health and our kids' health.

In addition we have seen that there are lots of opportunities for us to work across our different bureaus to really focus on some of the key areas that we have in health centers. We have made a big push in the last several years around getting women into prenatal care in that first trimester and we've seen some significant improvement in terms of that. We're up to almost 70% of our pregnant women are seen in the first trimester. And this is great but we still have some room for improvement.

We also continue to make sure that the babies that are born at our health centers are below birth weight. The latest data that we have is that the percentage was 7.4, which is lower than the national average of 8.2% and in particular given the populations that we focused on is a great achievement but again there's more that we can do.

In addition we've made some significant efforts to try to improve the immunization rates of our children. The most recent data shows that 74% of our kids at health centers receive all their recommended immunizations by

their second birthday. Again, a big improvement over the last several years but again, room for improvement.

We really believe that through our collective efforts together, and in particular sharing best practices we can all do better in terms of our performance around maternal and child health. In particular, there's also been a new initiative around home visitations which is a new program within HRSA and I think our colleagues again from Maternal and Child Health will speak to it.

We actually have two grantees that will speak in particular about two initiatives that we think will make a big impact in maternal and child health. In particular our colleagues speaking about the doula program and its importance in terms of promoting good maternal and child health as well as a promotora program that has done significant efforts around outreach in terms of getting women into care early on.

We will share their success with you and you'll have the opportunity to ask them many questions. Lastly I just want to say that I again appreciate all the efforts to set up this call. This has been something that we've been talking about for a long time and we really see it as again, a natural partnership between our Bureaus but most importantly a key area for us to focus on with our health centers. There is so much we can learn and share with each other and I really appreciate again the opportunity to kick this off today.

So with that I will turn it over to Dr. Jamal Gwathney to walk you through some of our activities. Thanks Jamal.

Jamal Gwathney: Thank you Jim. I really appreciate everyone being here. Again, my name is Jamal Gwathney. I am a family medicine physician. I've worked in the community health centers in Wilmington, Delaware and in Washington, D.C.

for a little under ten years. And my love for maternal and child health began early in medical school and I delivered babies all through my community health center time so this is a near and dear topic to me.

I'm going to go over a kind of overview of maternal and child health and give you some background. If you're following along with the slide, I'm on slide six now.

And why is maternal and child health important? As Jim alluded to there are a wide range of conditions that affect maternal and child health and that these conditions have been and will continue to be a priority in the public health of America. As Jim also alluded to it will predict the health of future generations as well as communities and the health care system as a whole.

I'm on the next slide, seven now. We need to focus on prevention in the issues of maternal and child health. We need to focus on access and quality. And that's where we want to incorporate patients in the medical home meaning for use whether you're accredited, recognized or certified. In any quality initiative you want to incorporate that into your health centers.

And again focusing on before and even between pregnancies as Jim alluded to or stated that those are really important times to improve the health not only the mother but in preparation for the child. These issues will help address and prevent morbidity and mortality as we go forward, as we move forward.

So slide eight, late December 2010, Healthy People 2020 announced their new format on a new initiative and over-arching goals with a focus on the social determinants of health as well as implementing resources. I won't go through the actual goals there therefore your documentation for later, reference for later. I do want to encourage you to look at it, look through them and look at

the measures that I'm going to go through, just a couple of measures right now.

Slide number nine, morbidity and mortality. I want to focus on the reduced low birth weight and very low birth weight in the Healthy People 2020 goal obviously is one of our clinical performance measures here in the Bureau of Primary Health Care. So we're already collecting data on that and should be trying to implement interventions to decrease those low birth weight data.

Pregnancy, health and behaviors. Again, increasing the proportion of pregnant women who receive early and adequate prenatal care. Prenatal care beginning in the first trimester. We're again, collecting that information already. So the Bureau is in line with other national initiatives as well.

And we're looking at pre-conception. This slide definitely deals with the pre-conception, the inter-pregnancy timeframe where an increasing proportion of women of childbearing potential with intake of at least 400 mcg of folic acid from fortified foods or dietary supplement. This is key. This is one thing that we can do as health centers to improve the early or congenital malformations that may come from a neural tube defect that come from folic acid deficiency.

So if we could increase the number of women who are actually on folic acid before they get pregnant, that would be great. Because most women don't realize that they're pregnant until four or five weeks pregnant and the most important time for actually getting folic acid is in that first four to five weeks. So this would be a great initiative that you could put in your QI, QA plan for increasing those dietary supplements.

Infant care, trying to increase the knowledge about back to sleep, or encouraging breast feeding. And then health services and you're incorporating

the newborn screening for assurance that those newborn screenings for our children have been done. That was slide 13.

Currently on slide 14, these are some end factors that influence pregnancy and childbirth. Age, pre-conception health status is very important. Poverty. Race and ethnic disparities. And mortality. All these are significant and but a significant portion of low birth weight and pre-term births don't have any risk factors associated with them at all.

So it's important to not focus in on just these particular risk factors. You want to implement your measures for all of your pregnant moms, all of the pre-pregnant women and then you can, if you have additional services, focus those on a particular high risk area.

This slide, number 16, I want to draw your attention to the pregnancy related conditions: gestational hypertension as well as eclampsia which is having seizures after high blood pressure and swelling and weight gain. And as you can see these two pregnancy-related issues the rate for non-Hispanic blacks are almost twice as high than the Hispanics. I'm going to keep making that differentiation as well as I'm going to allude to that in the future.

Number of maternal deaths per 100,000 live births. Again you can see non-Hispanic blacks is the social or the ethnic group that is highly affected by maternal mortality. So recognizing disparities in maternal and child health. Our goal is to improve outcomes for all but again we need to focus on particularly African-Americans as you've seen in the previous slides.

The leading cause of death for both white and black women are embolism, hemorrhage and pregnancy-induced hypertension. And obviously pregnancy-

induced hypertension can be most effectively treated if we diagnose it and attend to it properly while women are pregnant early on.

Slide number 21. More than 500,000 babies in the United States are born prematurely each year. That's one in eight babies. That's a significant amount. Pre-term birth is defined as less than 37 weeks gestation. Infants born premature are obviously at risk for hearing defects, vision defects, intellectual learning disabilities as well as behavioral and emotional problems throughout life. And then you also have to consider, factor in the emotional and economic burden to the family as well.

This slide, similar issues affecting infant and child health. Social demographic factors, physical and mental health of the parents and caregivers, maternal health. Similar factors that went into the maternal morbidity and mortality.

Slide 23. So low birth weight among infants. This slide here you will see the marked difference between the non-Hispanic blacks at 13.7 per 1,000 live births compared to whites at 7.2 and Hispanics at 7.0. Low birth weight is the number one cause of neonatal mortality meaning death before the first 28 days. So this is an important factor to try and hone in on and try and decrease those low birth weight rates.

This epidemiologic paradox that I had alluded to before where these factors of low socioeconomic status, late entry to prenatal care, comorbid diseases, lower education have all been identified as factors for why African-Americans have such high rates of low birth weight, maternal mortality for the same risk factors are similar for Hispanic population. And as you can see the Hispanic rates are much lower, sometimes twice as low as African-Americans.

So there's not a clear reason why that is. There are many hypotheses as to why this happens. Maybe it's some genetic factors. Maybe there are issues regarding the immigration of maybe more healthy Hispanics from other countries and so that kind of skews your data as to why they have lower incidences of these conditions as well as potentially more familial interaction in pregnancy and pregnant women in their lives.

There might be more interaction between moms and grandparents and pregnant moms. So there are a lot of different hypotheses but when you're focusing, obviously when you're focusing on an area or an ethnic group, African-Americans would be your choice based on these data. But this is a paradox that we have not found a clear answer to as of yet.

Slide 25. Infant mortality in the United States has been on a substantial decline over the last century or two. It's been stable since about 2007 at about 6.8 deaths per 1,000 live births. The leading cause of infant mortality is with congenital malformations and then followed by short gestation or low birth weight. So again the short gestation, low birth weight are things that we can actually do things about. Congenital malformations are usually genetic in nature. We can't do much about that except for some of the neural tube defects and things like that.

So if we can focus on certainly the short gestation and the low birth weight that would be a big boon for us. Mortality rates for again the - I'll skip that last section there. Slide 26, you will see the infant mortality rates. And again you'll see the clear difference. Non-Hispanics blacks have 13.8 and then the Hispanic and white down at 5.6, 5.7. So clearly more than twice the rate there.

Social determinants of health are very influential as we talked about. And trying to decrease the racial and ethnic disparities in infant mortality which are

significant for African-Americans as we have seen. We want to address family income, education attainment in the household members, health insurance coverage.

So this kind of leads into integrating public health and primary care as well as social health. So whatever you can do to collaborate with your public health department or any other community organizations that will also address those social determinants of health can go a long way to improving the overall health of our pregnant women and children.

Only 57% of the United States have access to a medical home and we know that children without a medical home are nearly four times as likely to have unmet needs; and three times more likely to have unmet dental needs as well as less likely to have had preventative health care in the past year. So again, patients in a medical home and other quality initiatives can help meet these needs for all of our patients.

And homeless populations are a special population that might need special attention. One of our speakers that does deal with our special populations, the migrant seasonal farm workers, but also homeless populations are the special population within the Bureau of Primary Health Care that the Office of Special Population Health has resources and technical assistance directed at these and other special population areas. So definitely use them if you serve patients in those particular special populations.

Slide 30. Addressing disparities in maternal. If you want to engage along a life-long discussion of across the full spectrum of a mom and child's life with the patients and their families as well. You want to again -- as Jim talked about -- preconception health initiatives are essential as more than 50% of

pregnancies are unintended or unplanned. So that would be key to improving the health of our moms and babies.

Maternal and child health. I'm certainly going to let Dr. de la Cruz talk more about the maternal and child health programs and I will end there and turn it over to Dr. de la Cruz.

Jim Mcrae: This is Jim. If I could just add one thing. I think one of the things that we really are trying to do much more and will continue to do more is really sharing our experience in the health center program with our comrades in maternal and child health. I think one of the things that we really see is a big benefit of today's call is to hear a little bit from David in terms of what's going on there.

But I think even more importantly we're planning to share more and more of our information and resources because we know you all have asked for and we need to provide some of those resources that are available in our sister Bureau and we'll make sure those are available. But I think even more importantly just hearing what resources are available and what can be done in terms of making an impact and there have been some tremendous strides made in a variety of different areas. And really again, I appreciate David, you taking the time to be here today.

David de la Cruz: I'm happy to be here. Thank you. Thank you for the invitation. I've been with HRSA for almost 12 years. Before that I was with Georgetown University's Graduate Public Policy and stood on the faculty down there. So I've been in the MCH community for a while and it's really an honor and privilege for me to be here. So thank you for extending the invitation to me.

I'll start with sort of an overview of the infant mortality rate Jamal talked a little about this before. You'll see that it's definitely on a downward trend in the U.S. and clearly headed in the right direction. The next slide however, shows that compared - even though we're heading in the right direction in the United States we still have a lot of work to do if we compare ourselves to other industrialized countries.

We - the latest study came out showed that we're actually ranked 41st in the, amongst industrialized countries and actually that is - even that is headed in the wrong direction. The last time the study was done we were at 39. So we are being passed by other countries even though the United States clearly spends more per capita on health care than other countries.

So next slide. So let's look a little closer within the U.S. about infant mortality. In 2007 you'll see in this slide that the overall infant mortality rate is number of deaths of a live birth before the first birthday per 1,000 live births. So overall, 6.75 in 2007 and you'll see the white non-Hispanic was 5.63.

But as Jamal said there is clearly some huge disparities if you look at the - across the different races and ethnicity's of the mother. Blacks, African-American non-Hispanics have a 2.36 times higher rate of infant mortality than whites. American Indians and Puerto Ricans also have higher than whites. So clearly some attention needs to be focused on the disparities between the races.

So the next slide, Jamal talked a little bit about this also. This slide compares the neonatal versus post-neonatal so neonatal is the first 28 days after birth. The post-neonatal is the 29th day to the first birthday. So in all cases the

majority of deaths occurred in the neonatal period. The one exception being American Indians, but that's pretty close.

You'll also see that there's also disparities not just neonatal or post-neonatal but also across races and ethnicities. The next slide Jamal again alluded to this. The effect, how does IMR relate to the length of gestation you know, pretty dramatic, pretty clear that if the child is born before its 37th week of gestation the IMR is 178 per 1,000 live births.

It seems clear that there's something that happens there between the 32nd and you know, right around the 32nd week. Technology seems to have caught up with us a little bit and we're able to keep alive more of those births. You know, if you can just get them to the 32nd week. However, there is 16.2 is still, you know, extremely high rate of IMR and this has some policy implications as far as cesarean section, voluntary cesarean sections, you know, even before the 44th week you still have an infant mortality rate that's clearly too high.

So the next slide, congenital malformations is the highest cause of death followed by short gestation or low birth weight. You'll see the light blue is the year 2000 and 2007 is the next year is the dark blue. So the other causes are SIDS, maternal complications or unintentional injuries.

So the trend seems to be staying the same. You know, nothing really, those five causes have stayed the same over the past decade or so although it does look like they're trending upward. You know, more are dying from low birth weight, more are dying from maternal complications and unintentional injuries.

So what is Maternal and Child Health doing about this? What is one of the programs that Maternal and Child Health Bureau focuses on or funds is Healthy Start. And that was established in 1991 under the first George H. W. Bush administration and has since grown through several administrations 20 years ago from 15 projects to today there is 105 projects in 39 States, D.C. and Puerto Rico. And some of the community health centers actually have a Healthy Start program so some of you on the phone may be familiar with Healthy Start. Hopefully you are.

We focus on the highest of the highest risk individuals in the highest risk communities. When it started back in '91, 97% of the women we served, probably even more than that were African-American. Now we're seeing those numbers go down and have a higher number of -- it's still predominantly African-American -- but we have more and more American Indians and Tribal Nations coming in. We have six projects along the U.S./Mexico border and we're also starting to focus a lot more on migrant farm workers and people in the Appalachian mountain region.

So next slide. What is Healthy Start? It's simply just an initiative to reduce the rates of infant mortality and to eliminate health disparities by improving perinatal outcomes. We make grants, a five-year-program project funding program. And the only eligibility criteria is you have to have 1.5 times the national average of infant mortality. That's the main eligibility criteria.

Next slide. The goal of Healthy Start is to improve health access and outcomes with high-risk women and infants. Like I said we are in the highest risk communities focusing on the highest of the highest risk women and infants. And we promote healthy behaviors and reduce the causes of infant mortality.

So how do we do that? Again we want to reduce infant mortality but we also want to eliminate perinatal health disparities. We implement a variety of innovative community-based interventions. We also want to ensure that every participating woman and infant and their family -- and by family we're pretty generous of who we include in Healthy Start -- it's the partner of the pregnant woman, it is anyone who we believe can influence the health care of that community.

As Jim said earlier, it's not just enough to have a healthy baby born to a healthy mother but it's also important to bring that healthy baby and woman back into a healthy environment and healthy community. So we include fathers, grandparents, siblings, whoever the community thinks would have the greatest impact in the health care. We also have strong linkages with local and state perinatal systems.

So next slide. So the core service components, how do we - I mean how does Healthy Start implement the program? Well we do it through these core service components. But we always say if you've seen one Healthy Start site you've only seen one Healthy Start site.

Each one is unique and different and that's because from the very beginning we believe that the community itself knows better about what will work in the community better than we would. So although we give them these components of outreach and client recruitment, case management, health education, end of conception care, depression screening and referral, how they implement those components is up to them. We leave a lot of discretion to the community to implement them in a way that they think will have the biggest impact.

So, next slide, we also have four core system components that are more at the system level, a higher level. They have to have a local health system action plan and that's where they work with their community health care system or business community or just local leaders in their community and try to effect health care at a greater level.

They have to have a consortium. A consortium is a governing body or some sort of advisory board made up of program participants but also key leaders in the community, health care community as well as business community. Anyone who the program or community feels can influence the health care of the people being served.

We also know that federal funds may go away at any time so we have a strong component of sustainability. We don't think any Healthy Start site could probably stand on its own but we sure would like to see, without any federal funding, we haven't reached that point yet but we have seen a lot of projects be able to find a partner to pay for parts of their services so they can shuffle their funds elsewhere. And also there's collaboration with Title V.

So like I said what are some of the requirements. I won't go through these. Really they need to be able to work within the larger community. It's a gap-filling program. So we don't want Healthy Start to come into a community and provide services that are already being provided. You know, with limited funds they should partner with other organizations.

Next slide. They need to establish and maintain a system of care that makes comprehensive perinatal care understood and available to the people they are serving. Really what that means is that they need to include the community and by community I also specifically mean the program participant in their own health care plan.

But they also have to be capable of obtaining and using data to improve care and evaluate their impact especially in this day and age. It's not enough anymore -- maybe 20, 15 years ago we were able to go in front of Congress and say, you know, we're saving baby's lives you know, who doesn't love babies and moms -- now we have to be much more clear about the effect that we're having, much more data driven.

and we do in the Maternal and Child Health Bureau have universal performance measures, discretionary grant information system and also the Title V information system where a variety of performance measures are collected and reported every year. But as I said earlier the variation that we allow the projects to have also leads to challenges in overall project-wide evaluation.

So while we know that we are making an effect in the communities that we serve it's very difficult to make any sort of universal statement about what Healthy Start is doing because the way that one program may implement a component is very different from another program. So the evaluation is challenging but we are coming up with some interesting information.

So I'll end on some of the accomplishments of Healthy Start. So as I said before not only are we serving the highest risk communities but we're outreaching to the highest of the highest risk women in those communities. A lot of our programs are almost at capacity so when they outreach they don't just unfortunately aren't just able to take just any woman or any family but really have to make the tough decision of serving the highest of the highest risk women.

But having said that, in 2009 the total infant mortality rate nationwide was 6.42 but in our Healthy Start projects and mainly our Healthy Start program participants it was only 6.0. And 13 Healthy Start projects have reported no infant deaths from the year - for the three-year-period 2007 to 2009 and another eight Healthy Start projects have reported no infant deaths for the project period of 2008 to 2009.

So we believe we're clearly making a difference in the communities we're in. Even with the 1.5 time infant mortality rate eligibility criteria we're only serving 105 communities. There are over 105 communities in the United States that would meet that eligibility criterion. So what we're trying to do now is come up with some overall effects and overall components that seem to work the best and try to replicate those or make them more generalizable to other communities even without receiving Healthy Start dollars.

So I'll stop there but I am excited to pass this along to our next speaker who is one of our partners with Healthy Start and with our division who will talk a little bit about the doula program that we help fund.

Jeretha McKinley: Thank you Dr. de la Cruz. You've done a lot of my work for me. A lot of the components of the community-based doula program are also components of Healthy Start and they definitely are our partners in this work.

HealthConnect One is a community-based program that provides technical assistance. And I'm just going to thank all of you for the opportunity to speak with you today about our program. So travel with me to a time when this program was first conceived.

HealthConnect One was busy with breastfeeding peer counselor programs that were born out of an acknowledgment that breastfeeding could make a

difference for all families but there was the health disparity primarily among the general population and African-American communities - particularly communities of color.

The peer counselors that we began to train and employ for breastfeeding work were telling us on a regular basis that they could inspire higher initiation rates, longer breastfeeding duration and help mothers feel more successful if a counselor was actually with the mother when her baby was born. At the same time Chicago-based philanthropist Irving Harris was looking to enhance the early child development work which was based on research, because the research said that starting at birth, at the time the baby was born was not quite early enough.

The research was showing that we needed to begin prenatally, similar to the same thinking that other experts on the call had mentioned. The ideas of these stakeholders were the sparks that were needed to conceive this community-based doula program. The program was nurtured early on with assistance from a Robert Wood Johnson grant.

And national replication of the program began several years later in Albuquerque, New Mexico with funding from a Healthy Tomorrows grant. This program is still growing and works - we work with programs in over 44 sites and 16 States. HealthConnect One has been recognized by SPRANS, the Special Projects of Regional and National Significance through HRSA with funding as a leadership institute for community-based doula programs.

We participated in the first cohort which was a two-year project and are currently serving in the second cohort of six sites. These six sites are around the country and you can see them listed further down in the slides, on slide 65.

The community-based work that is going on has a number of positive results. Fewer complications during birth, decreased rates of C-section, increased breastfeeding rates, decreased costs. And I'm sure many of the community health centers around the country are really interested in finding out how to either save money or reduce costs.

There are a number of programs that are affiliated with the HRSA grant that I'd like to specifically highlight. And one is in Pittsburgh, Pennsylvania. East Liberty Community Health Center has a community-based doula program affiliated with an organization called Birth Circle. Birth Circle has been doing doula work for a number of years and is now focused along with us on serving those women and their families who are at particular risk for the poor outcomes that have already been mentioned on the call today.

The other site that I'd like to highlight is in a rural setting. It is in Cherokee County, South Carolina and it is affiliated with ReGenesis Community Health Center, a federally qualified health center that is serving a broad base of families in the area. And they're affiliated with Birth Matters, another doula program that we're happy to be working with.

I'd like to highlight for just a moment some of the outcomes that HRSA identified for all - well HealthConnect One identified - through outcomes for all of the sites. Eighty-nine percent of all infants participating in the project of all six sites in our first cohort 2008 to 2010 had a medical home, 89% of them. Eighty-four percent of the women participating had ongoing source of primary and preventive health care.

Only 1% of the infants among all the live births to the project had very low birth weight and this is below the Healthy People 2020 baseline of 1.5%. The neonatal mortality rate was zero per 1,000 live births and again the baseline

is 4.5% for Healthy People 2020. Seventy-six of the post-partum women initiated breastfeeding within the first 48 hours after delivery and 98% of the pregnant and post-partum participants were screened for depression.

Again, these are some of the measurements that HRSA requires for us to collect and the program sites are doing a fantastic job with those outcomes.

I want to just give you just a little bit of background about why this program is unique. A community-based doula is a trusted member of the target community similar to the promotora program that is going to be described in a few minutes. From early pregnancy until at least six months post-partum she provides emotional and physical support, linkages to services, home visits and labor support, breastfeeding education, parenting and life skills, and again unique to this program she is always valued with salary and supervision.

So where many of the community-based organizations, community health centers are concerned about limits in her practice and scope and standards, they are always supervised and there are very clear limits to what the community-based doula does.

Again I want to let you know that HealthConnect One as a doula leadership institute provides an array of resources including a Web-based data collection tool that provides a lot of resources for how not to forget things you're supposed to talk with your family about during a home visit. And then how to document your successes.

And last but not least again I want to just reiterate again our outcomes for exceeding the HRSA Maternal and Child Health common objectives and they're listed on the last slide along with a photo of some of the folks that have been involved in this project over the last four years.

And thank you again for all of your time and attention to the concerns of mothers and babies across our country. I'll now turn the program back over to our next speaker.

Man: Well Ms. McKinley we wanted to thank you very much for that great information. Your programs are doing a lot of great work and we appreciate that. We will take questions after this next session but we wanted to introduce Mr. Doug Smith, a CEO for Greene County Health Care and he's going to talk about the outreach and promotora program that he's implemented there.

Doug Smith: Good afternoon everybody. Greene County Health Care is a federally qualified health center in Snow Hill, North Carolina. We serve people from about 10 counties in the eastern part of North Carolina. We have applied to both NCQA and CMS for recognition as a medical home and we're already recognized by Medicaid as a pregnancy medical home.

On any given year we serve approximately 30,000 patients with medical, dental, medical family therapy and enabling services. About 60% of our patients are farm workers and their families. The next slide you can see some statistics that are quite interesting. Greene County Health Care is the left column, North Carolina the center column, National is the right column.

As you can see in most cases Greene County Health Care is doing close to the North Carolina and National averages. Like the first row for women having first prenatal visit in the first trimester; we're sort of in-between North Carolina and the National ones in low and very low birth weights. We're doing better than either North Carolina or the National statistics in two-year-olds fully immunized. And a little worse in terms of percentage of women with Pap tests.

These statistics are actually very encouraging because 60% of the people that we serve are farm workers and their families which is a traditionally hard to reach population and one reason that we're able to reach them is through the outreach promotora program that we have here. Our outreach workers and promotoras provide a number of different services depending on the needs of the patients and the family that we're working with.

It could be health education, it could be health education about pesticides, it could be something that's closer to maternal and child health, prenatal care. It could be case management; it could be care coordination including transportation if needed. We try and connect these families to a medical home and if they're close to Greene County that would be us. But certainly if they're a long distance away it may be another community health center or another place.

And we try to connect them to whatever resources they believe that they need. Our outreach workers also do a fair amount of screening so that we can help determine the needs of the individuals. Back in 1996 when I came to Greene County Health Care, they served somewhere around 100 to 150 farm workers. Largely if something really acute was going on and one of the local growers happened to bring them to us, it was almost accidental that they got to us.

And that was the case despite the fact that there's close to 20,000 farm workers in this area. At that period in time they had no services that they could go to really. I mean there were not health departments that had any bilingual people. Greene County Health Care didn't have any people who were bilingual. There really was no source of care for those individuals.

By 2000, once we had started the beginnings of an outreach program with the assistance of the state of North Carolina we were up to 2,500 farm workers and last year it was over 17,000. Each time that we've done an expansion on a new side or an expansion of services we have incorporated hiring more outreach workers in going to a larger service area that's been built into all of our applications.

One of the other reasons for the success for the program is that we do provide comprehensive medical and dental care, behavioral care with our medical family therapist and we have a lot of partnerships with a lot of other organizations. So we just can't do this all of ourselves. We have pediatricians, we have an OB/GYN for the prenatal care, other family physician/internist mid-levels for other patients.

And we have the ability to track all of our clinical outcomes that we feed back to the providers for quality assurance. So when a farm worker family or the mother or the children come to us we can identify what their needs are and then either within our own organization or by working with our partners we can help to satisfy those needs for them.

The next slide lists a number of the partners that we work with from the various health departments, the County Memorial Hospital. Obviously in a number of cases we need specialists. We've seen many people who haven't had medical care or haven't had dental care in their entire life. So some of those things are past our capabilities and really require the intervention of a specialist right away.

The next slide is just a visualization of how we see a health care home working. The outreach workers and promotoras are a strong portion of the coordination for the farm worker families that go between all those little

arrows that link the circles together. That's the outreach workers. That's what they're doing. They're putting all those pieces together and also the cultural competency portion.

At this point about 50% of our staff is bilingual. And all of our outreach workers and promotoras are bilingual and virtually all bicultural. That's how we try to look at fitting those pieces together. I'll be happy to take questions later on.

Jamal Gwathney: Excellent. Well thank you sir. We really appreciate this great information. Our programs are doing a lot of great work out there in the communities. I think now we will open it up for questions. Operator, if you would assist us in that, that would be much appreciated.

Coordinator: And thank you very much. Now if you would like to ask a question please press star then 1. Please un-mute your phone and record your name clearly when prompted. Your name is required to introduce your question. So again star then 1 and one moment please. Just one moment please. Our first request is from (Sara Shields). Your line is open ma'am.

(Sara Shields): I this is (Sara Shields). I work in a community health center in Worcester, Massachusetts and this is a great presentation and review. Thanks so much. I have a question. I never heard the term pregnancy medical home before. Could you elaborate on what that means and how one moves towards becoming that?

Doug Smith: Well it's a program that CCNC and Medicaid in North Carolina operate. So I'm not sure that it's available in any other state other than the state of North Carolina. CCNC in North Carolina has a number of care coordinators that are on their staff.

They have a care management model; they refer to it as a medical home model. But basically we provide the medical home and they provide some care managers. In this particular case the care managers are focused around pregnant individuals.

And in other cases with CCNC the care managers are working on expensive patients. People who are frequently into the ERs. But in this case they're focused on the pregnant patients. And they help us find resources and connect our pregnant patients to resources that they may need.

(Sara Shields): Thank you.

Coordinator: Again, please press star then 1 if you might have a question. And (unintelligible) at this time is for (Mike Connell). Your line is open, sir.

(Mike Connell): Yes, Doug you might not know the answer to this but the rate of breastfeeding is related to pregnancy interval and determines the pre-term labor rate. Do you know what the incidence of breastfeeding is in your population?

Doug Smith: No. Not off the top of my head. I'm sorry.

(Mike Connell): Okay. Well we have a high rate of it here. We're just over the mountains and we have a CenteringPregnancy clinic and there's a very high rate of breastfeeding and a very low rate of low birth weight infants.

(Sara Shields): What is your rate? Can you share that with us?

(Mike Connell): It's under 6% but it's not that large of a numerator yet. The breastfeeding rate is 95%.

(Sara Shields): Wow. And Jeretha do you have any data on that?

Jeretha McKinley: I agree that all of the rates would be different. And depending on your community, in some areas particularly urban areas, the breastfeeding rate particularly among certain ethnic groups, African-Americans, the number would be 2% when we started the program. So 100% improvement would only be 4%.

Whereas in other sites, for instance in an area where we have migrant health workers the migrant health promotion project that's along the Texas/Mexico border, their breastfeeding rate is already 100% and they already have low birth weight, I mean, have great outcomes when it comes to birth weight. They don't have low birth weight babies but they do have a high rate of gestational diabetes which then is a factor for inappropriately high birth weight babies. So, yeah, I mean every community has its own challenges.

(Sara Shields): Thank you everyone.

Coordinator: And at this time I have no further questions in queue.

Jamal Gwathney: All right. Thank you everyone. In closing I just wanted to maybe give out some resources for health centers to go to, to try and improve their maternal and child health interventions. Actually my slide number 32, I believe it was lists the Maternal and Child Health Library at Georgetown University. It's a great resource.

Bright Futures, of course, from the American Academy of Pediatrics and the Maternal Child Health Bureau combined to create Bright Futures. The Office of Minority Health and Health Disparities will obviously give you information

on all of minority health issues but certainly has information on maternal and child health as well. As one of the grantees just mentioned, Centering Pregnancy, the American College of Nurse Midwives has a position paper supporting Centering Pregnancy which is group pregnancy visits which is evidence-based and has increased the rates of breastfeeding, decreased the rates of pre-term birth, increased prenatal knowledge or increased their readiness for labor and delivery.

So Centering Pregnancy is another resource that you might think about incorporating into your health centers. And then obviously text4baby is something that we want to highly, highly promote. And ACOG, the American College of Obstetrics and Gynecology are all great resources to help you as you're trying to improve your maternal and child health interventions.

With that I will conclude the session. Anything else?

Esther Paul: Operator, do we have any more questions?

Coordinator: No, I have no further questions at this time.

Jamal Gwathney: Thank you everyone for your participation today. Have a great day.

Coordinator: And thank you everyone. As you heard, conference has concluded and so all lines may please disconnect.

END