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Megan: Hello, everyone and welcome to today's webinar, Using the Doula Model for Resource for Case Management. I'm Megan Hiltner and I'm with the Healthy Start EPIC Center, I'll be moderating today's webinar. We have approximately 60 minutes set aside. The webinar is being recorded. The recording, along with the transcript and slides, will be posted to the EPIC Center website following this webinar.

Before I introduce your great speakers for today, I have a couple of announcements, just more housekeeping reminders. We want your participation. So at any point in time, if you have a question or a comment for the presenters, please track them in at the bottom left-hand corner of your screen. We will only be taking questions via the Chat function and we will be taking questions following the presentation today. If we don't get to all your questions, we will be including them in a Frequently Asked Questions document that we'll post to the EPIC Center website following the webinar. Also, you'll be asked to complete an evaluation survey at the end of this webinar, so please take a moment to complete it. We really do appreciate your feedback.

So now let me introduce your wonderful speakers for today. First, Ms. Jeretha McKinley. She's the National Program Director for HealthConnect One. She has more than 30 years of public health experience with government and nonprofit organizations, including Healthy Families, WIC programs in numerous states and a number of city and state departments of health. She's internationally recognized for her work on developing worldwide standards for training and breastfeeding and has a great deal of expertise in peer-based community outreach programs.

Your other speaker for today is Ms. Rachel Abramson [SP]. She's the Executive Director at HealthConnect One. Ms. Abramson is a master's prepared nurse and an international board-certified lactation consultant, who has provided leadership for HealthConnect One since 1986. She was the founder of the Chicago Breastfeeding Task Force and was project director for the four year collaborative Chicago Health Connection Doula Project. She also has extensive experience in breastfeeding promotion and management, maternal and child health, community-based health services research and nonprofit administration and is the author of numerous articles on community issues in maternal child health. Both of these speakers have national and international honors and awards for their work and expertise, have a

great deal of expertise, particularly regarding Doula. So without further ado, I'm going to turn it over to you, Rachel, to begin the presentation.

Rachel: Well, thank you. Jeretha and I wanted you to see what we look like, so we're not just different-bodied voices this afternoon. Jerri [SP] and I have been working together for more than 25 years. I am in Chicago and she is in Atlanta. So let's get started. This is the image that often comes to mind when we mention community-based doulas. The doula supporting the mother during birth, a very warm image. Birthing support has been shown to shorten labor and decrease C-section rates and increase breastfeeding. All really important outcomes for Health Start. But the community-based doula model achieves much more than just improved immediate birth outcomes. Today's webinar will focus on the role of case management in HealthConnect One's community-based doula model and the impact that can be achieved in Healthy Start programs with this model.

The community-based doula program is not just a birth-only program. Community-based doulas are outreach workers, home visitors and case managers. So today, we'll be talking about examples of how this model can enhance Healthy Start programs and then we'll respond to your questions at the end. Our objectives today are to identify important functions of case management, to identify positive outcomes of community-based doula programs and then talk about how community-based doula programs can help fulfill case management objectives.

First, let's name who we are, who's in this virtual room. We know that we're speaking across the country to a diverse group of Healthy Start program directors, supervisors, case managers, outreach workers, doulas and other frontline health workers. We're hoping that you'll all bring your perspectives to this conversation and engage in questions and at least virtual discussion in the second half of the presentation. We want it to be specific and get a better sense of who you are through a poll.

Megan: With this poll, I'll just help give you all some instruction about how to weigh in. We'd like to know if your Healthy Start program has a doula program. So click on the radio buttons there, on the actual screen, Yes or No. Whether your Healthy Start program or site has a doula program. It looks like we've got 12 responses at this point in time, 13. We'll give it another second or two. Okay, it

looks like three-quarters of the folks on the webinar do not have a doula program, report that they don't have a doula program. That will be great information for you all to have as you share more.

Let's do another poll, folks. Same process. My Healthy Start site has a home visiting program, yes or no. If you'll use the radio buttons then weigh in, that'll be great. All right. It looks like we have a total of 18 responses. It looks like the majority of folks do have a home visiting program, almost 95% of folks.

All right, one more poll, everyone. I have heard about HealthConnect One, yes or no. Use the radio buttons. It looks like . . . oh, you all are at pros at this now. All right. It looks like the majority of folks have not yet heard about HealthConnect One. All right, so Jerri, I'll turn it over to you to continue with the presentation, with those poll results, keeping those poll results in mind.

Jeretha: Thank you, Megan. Hello, everyone. Again, this is Jeretha McKinley, my nickname is Jerri. Just in case it's easier for you to pronounce. So I'm going to move ahead. With the information you've given us, most of you are doing home visiting. But there are other components that we'll be discussing that deal with case management that also include those who do not have a home visiting program.

Case management is clearly an essential component of Healthy Start. But the term "case management" can be used in many different ways, as you can see from the slide. It's described in many ways and can have a variety of different components. So what is case management in Healthy Start? As you read the next couple of slides, you will see that of course, coordinating all of these efforts is easier said than done. With today's budget pressures, high case loads and dramatically changing healthcare systems, it is tremendously important that it's coordinated. That we realize it can be difficult, providing accessible care to families in underserved communities. Home visiting advocates, of course, are dedicated.

I noticed yesterday, an article that trended on Twitter, for those of us who follow Twitter. It was posted by HuffPost Politics with the hashtag #HomeVisiting and it was titled This May Be The Most Effective Anti-Poverty Program in America. As you can see, business folks, political folks consider home visiting programs valuable and that they save money.

So how do we save money? By making time. One of the most valuable lessons we've learned through our 25 years of managing cases was our breastfeeding program and of course, with our community-based doula program, is that caseloads need to be managed appropriately. A case manager should never be assigned more than your maximum caseload.

All of us have goals, of course, and whether we are program participants or we're program staff, even if we're federal Healthy Start staff or JSI staff members, we all have goals. HealthConnect One's community-based doula model can be one vehicle to help you achieve those goals.

Community-based doulas are community experts. They're advocates. They're counselors and health educators, just like many of you. Because community-based doulas are community experts, they really make an impact. As I'm talking, if you come up with any questions or concerns, we try to be general, but you can begin typing your questions into the chat box at any time. Any questions that you have about what we're discussing and we'll be happy to answer them in the second half of the session.

So if home visiting is working for you or even if you're doing some other form of case management, why would you add labor support? Maybe you can give us some ideas about why you would want to have labor support in the chat box. Healthy Start programs integrate doula support for a variety of reasons. One might be recruitment and retention of participants. Other reasons might be dealing with participant isolation or language barriers. Community-based doulas act as a healing balm. They act as translators and confidence builders for families during this transitional period, often where the hospital is seen as a foreign place. Community-based doulas make the difference in the transition from hospitals to home.

So how have we at HealthConnect One kind of come up with what works in terms of community-based doula programs? I'm just going to give you . . . this is time for our little exercise break. Let's play a little game. For those of you who want to play, if you raise your right hand, we have five essential components, just like the fingers on your hand. Now, your thumb . . . if you'll stick your thumb up like a thumbs up sign, is number one. It's one of the things that makes our program and our model unique.

We employ women who are trusted members of the target community many of whom were born into a home visiting program or at least wish they had. They know all the ins and outs of that community, all the restrictions, all the traditions. They know what works in their communities. The community knows them and trusts them.

Now, I'm going to skip down to a few more slides and if you still have your hand up, you can put up along with your thumb, you can also put up your baby finger. That's a special little sign I'll explain later. This also makes our model unique. Valuing the doula's work with supervision, salary and support.

Like most Healthy Starts, of course reflective supervision is an important part of supporting the case manager while they support the families. For example, when cases are closed, it's valuable to conduct exit interviews with the case managers, just like you would a family. I know that times are hard when it comes to money. But if you have questions about how this can be funded, we'd be happy to talk to you about those particular concerns.

Okay. So our next slide then after you have up your thumbs and your baby finger, the two symbols that say, "Hello, have a nice day." The next one would be our second essential component. That component is to extend and intensify the service. Like Healthy Start, again, we provide home visiting during pregnancy, but also during labor and for months after the baby is born. Working with the family to do home visits often, so that their needs are met. Collaboration with the community, of course, is important as in Healthy Start and that's a hallmark of your work.

Last but not least, before our fifth, is facilitating experiential learning using popular education. Training, of course, is critical. The community-based doulas have extensive classroom time. They also get over 80 hours of practical experience. During training, they observe home visits, birth and classes. They practice recruiting, making phone calls and documenting their work on the data collection tool. I can't over-emphasize again, number five, valuing the community-based doulas, home visitors work with salary supervision and support. Now, Rachel is going to continue our conversation.

Rachel: Thank you, Jerri. So as in Healthy Start, evaluation of programs is very important. We know that case management and home visiting programs, all of our

programs are accountable to the community that they're serving. Not just to the federal mandate. So outcomes need to be collected and reported back to the community.

Our first pilot of this model from 1996 to 2000 documented dramatic outcomes in a team population. The outcomes of the community-based doula pilot relate directly to Healthy Start outcomes. Lower C-section rates, when babies are born naturally, mothers are more ready for the challenges of mothering. They don't hurt as much. They can take care of their families earlier. They can hold their babies more comfortably. They can take the baby to the doctor. They're less stressed.

Breastfeeding mothers and babies are healthier and the risk of SIDS or sudden, unexplained infant death is significantly decreased. More positive birth experiences and more comfortable parenting help the mother concentrate her energies on this baby and plan for her own life and her family's growth. So these kinds of outcomes, this kind of experience help Healthy Start to help families feel positive and powerful.

HealthConnect One has had a more recent opportunity than 2000 to analyze outcomes from four years of federally-funded community-based doula programs. We've shared those back with stakeholders, funders, potential partners in the past year. The outcomes in the report called "The Perinatal Revolution" were similar to those we found earlier. Again, important for today's Healthy Start priorities, particularly the emphasis on breastfeeding outcomes.

So we know that the longer a mother breastfeeds, the healthier she and her baby will be. As in this slide, for Hispanic mothers, in particular, the duration of breastfeeding, the length of breastfeeding, protects her and her baby from the risk of diabetes, which is high in Hispanic communities. As you can see in this slide, Latina women with community-based doula support had double the rates of breastfeeding at six months, compared to a comparison group of women without community-based doula support.

Exclusive breastfeeding is giving nothing but breast milk, no cheese, no juice, no water, no cereal, just breast milk. Again, exclusive breastfeeding gives the most protection for both mother and baby, from chronic disease and obesity. You can see in this slide that Hispanic mothers had almost five times the rates of exclusive

breastfeeding at six months than the comparison group. Again, the purple line shows the outcomes of the mothers who did have community-based doula support.

Our story is the same with African-American mothers, as with Hispanic mothers. Those who had community-based doula support had significantly higher breastfeeding rates at six weeks, three months and six months, almost double the rate of mothers in the comparison groups at six months. Really, a great accomplishment.

Then we saw that in spite of disparities in initiation and duration, African-American mothers with community-based doula support had four times the rate of exclusive breastfeeding at six months. Again, this is protective for both mother and baby against obesity, hypertension and heart disease, which are all significant risks for the African-American community.

Most important for our programs, the data showed which program factors led to the strongest outcomes. For example, it took six or more prenatal visits to achieve those outstanding breastfeeding outcomes. So starting the program sooner, meeting with a community-based doula more frequently and having her attend the birth led to better outcomes. The meaning for us is that the length and the type of relationship developed with a client, the intensity of the relationship is key to the outcomes.

Breastfeeding outcomes weren't the only outcomes we looked at in this study. Immediate birthing outcomes were also improved with community-based doula support. In this case, C-sections were significantly lower with the support in the program than the comparison group from the planned study.

We were very glad to see that 73% of newborns had the chance to be skin to skin with their mothers in the first two hours after birth with community-based doula support. This practice significantly increases breastfeeding success. These were only a couple of samples of the outcomes that were impacted by community-based doula support. They also included high rates of access to medical care and referrals for other medical and social support and decreasing in other interventions during labor.

We know that cost-effectiveness is a big demand of case management programs. Same for community-based doula programs. We do see over and over, concrete cost savings in the outcomes of our programs. From fewer costly interventions during labor, reduced length of stay in the hospital, over $500 a year in cost savings from breastfeeding versus formula feeding. Estimates of between $300 and $1,400 saved just in the first year after the baby's born in public health costs from illnesses that were averted from healthier babies and more breastfeeding babies. So we see that community-based doulas clearly enhance case management and improve the outcomes in the same kinds of communities that are served by Healthy Start.

We intentionally kept our presentation rather short so that we could engage your questions and your comments and get a sense of what's going on for you on the ground in terms of both case management and your interest in community-based doula programs. So if you could take your time now to check your questions into the chat box.

Megan: So Ms. Jeretha and Ms. Rachel, there is a question in the chat box. That question is "Can you describe the doula training program and expectations for caseload?"

Jeretha: Yes. This is Jeretha. Hello, how are you, [inaudible 00:27:30]? The training is based on a curriculum that we developed based on experiential learning. Kind of respecting the information that the learners bring to the table. It does have a content portion with lots of facts and figures and things.

But we found that many of the participants come to the table with lots of information already. We share that around the table, what they've learned in their community. How the information that they get from a textbook compares to the experience they have with their clinics and hospitals, etc. What does parenting look like in their community versus what they might read in a book? We share all of that.

Then as they take the course, they have an opportunity to go out into the community and observe how childbirth education works in their neighborhood or what a breastfeeding class is like. They often find that many of those services or

courses do not have good access or may not even be available. They may have to create them on their own.

But it gives them a better actual sense of what's going on in the real world. They observe home visits. They observe birth. The way that they're learning is assessed is by a set of competencies that they must achieve before they finish the course. The curriculum is DONA approved. But it must be used by a DONA approved trainer in order to be acceptable as their course for DONA certification, if that's the question. I hope that I've kind of answered the question. It's kind of lengthy, but . . .

Megan: I think you did. But I think the other piece to that question was around expectations for caseload. Are there expectations for caseloads?

Jeretha: Yes. Because there are many visits over a long period of time, sometimes up to nine months, also, there are extended intensive visits, our case load is small. So compared to Healthy Start visits now, the way it's crafted, you have less face to face contacts expected. Perhaps over a shorter period of time, depending on their risk or community needs and therefore, you might not see the participant as much. It might be face-to-face and phone calls that are accepted. Our case loads are very small. Depending on the need and the community usually at the absolute max of 17 or 18. The longer the family is on the caseload, of course, the fewer the visits that are necessary. So you can have more families.

Megan: How long is the course?

Jeretha: The course is 20 sessions and we never suggest that it's less than ten weeks long. It's an extensive course.

Megan: A follow up about that, what about price?

Jeretha: We suggest that every community defines what their need is and what their resources are. So we don't put a cost on it. Most of the communities that we have worked with, there has been no fee. They have sound funding to support the community-based doula's training with a stipend and their work, again, with a salary.

Megan: That's great. Another question. "How does supervision work? Are supervisors 'on call' for the duration of the long labor or labor starting at night or on weekends?"

Jeretha: Yes. Our supervisors are on call. And not just on call for backup, but also on call for questions. It's another reason why, again, case management is so important. The home visitors are only assigned families at two births per month. So that there's less opportunity for them to be doing births constantly. It's two births per month. If one comes early, you might have three. If one comes late, you might have three every once in a while. But you're not going to have five or six births in a short period of time. That also makes it a little bit different from a birth doula program where you don't have as many home visits and other meetings and other chats that you have to attend to.

Megan: Another question that came in . . . thank you so much, Jeretha, for that detailed explanation. Another person is asking to sort of revisit the general points you made earlier about why doulas are so effective at improving delivery outcomes. So if you could give a little more detail about why are doulas so effective at improving delivery outcomes?

Jeretha: Rachel, you want to take that one?

Rachel: It's a short question, but it's a complicated answer. There are physiological reasons, psychological reasons and, we believe, even evolutionary reasons for the impressive outcomes of doula support. For human mothers, the presence and support of another woman during labor is very powerful. It may go back to evolutionary issues. We see that in cultures where an experienced woman is present during birth and breastfeeding, mothers tend to do better. This may be just how we're wired to go through these important transitions in our lives with the support of other women.

We know that the doula's skill in natural birthing techniques is very helpful in shortening labor, in avoiding medical intervention. With the physical and emotional techniques that they are taught and they learn experientially are very useful in helping physiological labor to advance. We also see that without that support sometimes unnecessary interventions can sort of lead to a cascade of more interventions during labor and then leading to C-section or other issues. It's both

for skill of the doula, the relationship that she's developed with the mother and the simple presence of a supportive woman.

I want to just make sure that you understand that this relationship has been going on for months before the birth. We have a mother who's going into the hospital which, for most of us who have had that experience, is a scary experience. For a woman who faces language barriers or perhaps treatment that is not respectful, it's an even more frightening place. To have someone with you who has been with you for months. Who has developed your trust and you really believe that she will be there for you for the entire time is a very powerful thing.

Megan: Thank you, Rachel. That was a really wonderful explanation. Like you said, a short question, but a complicated answer. Another couple of questions. "Has the community-based doula program led to any sustainable funding?"

Jeretha: I'll answer that question. This is Jerri. So community-based doula programs, when vetted in a program that also has sustainable funding, and the term "sustainable" is kind of difficult. But I'll use sustainable to mean a program that's already well-established. One of our sites is an Early Head Start site. So they vetted community-based doula into their Early Head Start home visiting program. So in that regard, it is sustainable.

If it were to be vetted, for instance, in Healthy Start and Healthy Start was considered a well-established program, then it would be sustainable once it's vetted in that program. If, on the other hand, you are trying to find ways to . . . as I was reading the question, I noted things like reimbursement from insurance. We have had community-based doula programs, in this case, to participate with insurance reimbursement.

One of them, in fact, was a site that was included in the Perinatal Revolution white paper analysis. Also, a grantee from the Maternal Child Health Bureau for the community-based doula grant. Before they got involved, they were getting insurance. The problem was, as the program continued and the outcomes were fantastic, the insurance company decided to change the conversion rates for reimbursement. So they started out with an equitable reimbursement, but because of no fault of their own, that reimbursement rate changed.

That's something that our whole community, everybody on this call and all the people that work in birth and all the people that work in pregnancy and home visiting, we're all battling, trying to figure out how do we get folks to value this work and value the outcomes in a financially viable way? Great question.

Megan: I think you did . . . you kind of responded to both of the questions that have come in around billing insurances for services. So I think that it sounds like you also gave a good resource that folks could look back to the Perinatal Revolution document that you all showed earlier and read more about that, that case example. Am I correct that that's where they can go and look with that?

Jeretha: There is some more information there. We don't go in-depth, though, on the insurance piece. There is a discussion of sustainability, though.

Megan: Okay. So another follow up question about community health workers. "Would it be possible to build a program of community health workers who are also doulas by adding a doula training component to an existing community health worker training program that's available to us?" That person is saying that's from state-funded NCH programming.

Jeretha: That one is a longer question and a very brief answer and the answer is yes.

Megan: Great. Another follow up question about contact information. "So can we get contact information for accessing a doula program trainer?"

Rachel: Yes, you can. I will advance to the slide. Just so you know, we made a slide with references in case any of the participants want to print it out later and have a list of references. But here is our contact information. Both our website, Jerri's the national program director and she's the first contact for interested programs. My contact information is there as well.

Megan: Great. The individual that asked the question about the community health worker training to thank you for the answer and they were wondering if additional information on how to add a doula program component to their existing community health worker program could be provided? Should they follow up with you directly and get that information or is there additional processes that you can share?

Jeretha: Sure, we'd be delighted to assist you and there is additional information on our website. So if they would go to our website and look under the Programs tab, look under Community-based doula, there's additional information and an application and some other stuff that might be helpful. But they can always e-mail me or call me. I'll be happy to work with folks. I love Healthy Start. I look forward to talking to you guys.

Megan: Wonderful. Folks, we have a few more minutes. Are there any other questions that anyone would like to ask before we wrap things up? While we wait for a moment or two to see if anyone else has any burning questions, let me just do a quick reminder to everyone on the webinar about some other upcoming webinars that we have scheduled through the EPIC Center.

On April 28th, from 3:00 to 4:00 p.m., there's a webinar on reproductive life planning. On April 30th, from 3:00 to 4:00 p.m. Eastern time, there's a webinar on centering pregnancy and centering parenting. On May 5th, from 3:00 to 4:00 p.m. Eastern time, there's a webinar on quality family planning recommendations in Healthy Start. To find out about any webinars upcoming or to register for any other webinars, you can go to the Healthy Start EPIC Center website or you can register through the EPIC Center training alerts that come out on the Listserv.

There are a couple more follow up questions, so let's go back to the Q&A box. "Is there any data on pregnancy spacing with this model?"

Rachel: I'll answer that one. This is Rachel. In our pilot project, which focused on pregnant and parenting teens, we did see a significant lengthening of the space between pregnancies, particularly for the young teens. So yes, there is and that is the [inaudible 00:44:56] reference on the reference slide.

Megan: Thank you. "How have doulas been useful in helping moms attend postpartum health visits?"

Jeretha: Okay, I'll answer that one. So one of the great things about this particular model for managing cases, unlike many of the others, is that you have consistent contact with the family. Many times, what happens otherwise is the mother leaves the hospital, she goes to stay with her aunt or some other relative or the baby's

grandparents and we lose touch with her, until about six weeks, seven weeks postpartum.

Because this particular model is so intensive, particularly around the birth period, the community-based doula never loses touch with the mother. So there's the constant goal setting and reminding and keeping up with appointments and following up and educating and supporting for all of those appointments. In fact, that's one of our greatest outcomes is it's over 90% compliant for postpartum visits.

Megan: That's great.

Rachel: That's both mother and baby visits.

Megan: Another question that I think is an important one for Healthy Start [inaudible 00:46:32] too is "What techniques have you found to help retain families in the program?"

Jeretha: I'll go again and thank you, Rachel, for backing me up on that one. Because the relationship begins really with developing trust, it's less so collecting information and more developing trust in the beginning. Now, we end up with a lot of information. We have one of the few databases that has over 800 indicators in the database. We collect lots of data, but we start out developing the relationship and people are much more open to sharing other contact information, their schedules and all of those kinds of things, letting you know when they're really feeling like a visit and when they'd like to reschedule, being open and honest.

So there's quite a bit of collaborating between family and home visitor that goes on. That helps to retain the participants. Sometimes, even the father will call the doula and say, "I don't know what's wrong with her. She's yelling and hollering at me. Can you come over here?" Because the mother is having a little bit of baby blues or she's frustrated that things aren't exactly the same. She's having a hard time adjusting to the change. Other family members will engage with the community-based doula.

So it helps to retain the families over a much longer period of time than we generally see. There's not this, "I'm only going to use you for right now because I need you, but then when I'm done with you, we won't have a relationship anymore." Those relationships continue.

In fact, one of our doulas that a film was based on still has relationships with some of the young people that she attended their birth and their parents and can tell you right now, "So and so is in high school. They're doing really great." Those relationships continue.

Megan: Great. Another question that has come in to the chat box. "Has there been any push back from OB providers in regards to the community-based doulas?"

Jeretha: One of our, probably, best [SP] projects that's also included in the white paper, is located along the border of Texas and Mexico. There's an OB there who was probably our greatest champion in the area. Because for him, he recognizes the value, the extraordinary value of the work that the community-based doulas are doing in that area. He speaks up for them and about them on a regular basis.

One of the biggest things that we do in our training is to help the community-based doulas understand what their role is. So they know their role and they know their limitations. So we have very few in our program among the folks that we trained, we have never seen a backlash from providers, even OBs, who once they get to know the program, that they complain about it. They really like it.

Megan: Great.

Jeretha: We're not trying to be OBs.

Rachel: We're not trying to be nurses, either. This is Rachel. I would say also that part of the development of the community-based doula program is engaging stakeholders to talk about what services already exist in the community, what challenges birthing families face, what the priority issues are, both medical and other issues, and also to talk about engaging stakeholders, including the providers. So including the physicians, including the nurses, all three shifts at the hospital and making clear what the program is for, what the boundaries are and how important it is to work together. That's also part of the program development and we find that it works really well. It takes time, but it does work.

Megan: Well, there doesn't seem to be any other questions in the queue. So with that, Rachel and Jeretha, thank you so much for sharing your knowledge and information about the community-based doula model with us today on the webinar. We really appreciate it. We will post this webinar recording with the slides, as well

as the link to the white paper that's been referenced in this webinar on the EPIC Center website. So go back and look for that.

Folks on the webinar, thank you so much for your participation. We hope to see you on another upcoming webinar soon. That concludes the webinar presentation for today. Thank you all, again and have a great day.