

HEALTHY BIRTHS INITIATIVE

Interview & Observational Data Report

Submitted to:
First 5 LA

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I. INTRODUCTION

In 2005, First 5 LA retained the National Health Foundation (NHF) to assist in evaluating its Healthy Births Initiative (HBI). Products from NHF's evaluation activities during HBI's first implementation year include reports concerning both quantitative and qualitative data. This report presents the findings from the analyses of qualitative data gathered through observations of and interviews with HBI participants from various levels of this multi-layer, multi-strategy initiative.

Together, this information provides a context for the quantitative data being gathered and reported through HBI's data and case management system. This context includes the perceptions of and expectations for HBI and its various strategies of a broad range of participants; it includes the views of health leaders throughout Los Angeles County, Best Babies Collaboratives' (BBCs') administrators, the case managers working for organizational members of the BBCs, and pregnant and parenting women receiving case management services through the BBCs, as well as findings from observations of the Service Planning Area (SPA)-based Healthy Births Learning Collaboratives (HBLCs). The report covers the first round of data collection and therefore all the information presented should be viewed as baseline. The interview instruments and observational guidelines have been designed to be built upon in future years, when analyses and discussions would emphasize outcomes.

This report consists of four distinct parts. This brief introduction is followed by a summary of the major findings and their implications. Next the detailed findings are presented, and the report ends with a description of the data collection and analysis methods used.

II. MAJOR FINDINGS & IMPLICATIONS

This section presents what were the most common opinions, concerns and issues identified through NHF's interviews and observations. Opinions and issues from each group interviewed--Health leaders and BBC administrators, case managers, and clients--and from observations of the HBLCs are presented in five sub-sections. The major findings in each sub-section are numbered with their related implications bulleted beneath.

A. HEALTH LEADERS

1. HBI's design and approach were highly regarded by health leaders, but they wanted to better understand how its component parts fit together and what the HBLCs and BBCs are expected to do and accomplish.
 - Several of these health leaders want to be ambassadors for HBI, but without sufficient and accurate information, they cannot. The Los Angeles Best Babies Network's (LABBN's) communication challenge is to give them this information simply and succinctly.
2. The two most common critiques about HBI are the absence of a public education campaign and what is seen as First 5 LA's apprehension about pre-conception care despite evidence of its impact on birth outcomes.
 - Because it has no overall public education campaign, the success of HBI-related policy work could be limited. Simplifying information about the complex and highly emotional issues surrounding discussions of poor birth outcomes among different ethnic groups requires the expertise of policy communications specialists. Health leaders perceived First 5 LA as exactly the kind of organization that should be supporting work on this issue.
 - First 5 LA's apprehension about pre-conception care has, presumably, resulted in HBI's inter-conception care focus. Given the importance of pre- and inter-conception care to HBI achieving its goals, it seems that First 5 LA is not fully supporting its Initiative.
 - In addition, several health leaders suggested that the ultimate test for HBI, and crucial to its eventual success, is how well it is integrated with other First 5 LA Initiatives both programmatically and fiscally.
3. LABBN was highly valued, particularly its inclusive and collaborative approach, and because of this approach, the names "LABBN" and "Network" are becoming conceptualized as much more than simply LABBN's Board and staff.
 - If the "Network" can expand and all participants remain informed and "on the same page" on issues and policies, LA County's entire perinatal service system will benefit. In particular, the system could benefit from being recognized as having an infrastructure that allows the community to work with academic centers.
4. The Perinatal Summit Proposed Action Plan 2005-2007 (Action Plan) includes recommendations that address the most important issues facing perinatal health in Los Angeles County. Unsurprisingly, health leaders not responsible

for implementing these recommendations tended to think this would be “simple” or “easy” for several of them. However, those responsible for implementation have identified several unanticipated challenges. There was complete agreement that recommendations #s 1, 4, and 5 will be extremely difficult to implement.

- Because the recommendations address chronic problems in the perinatal health field, their successful implementation could directly affect HBI achieving its goals. Without First 5 LA’s unequivocal and long-term support, these recommendations may not be implemented and HBI’s goals may not be achieved.

B. BBC ADMINISTRATORS

1. While some BBCs thrived almost from the beginning of the planning phase, others did not and were still not functioning when the implementation phase began. This was because relationships vital to sharing resources and progression towards the common goals had not been fully developed.
 - First 5 LA and LABBN might want to review whether and how to maximize the success of the “undeveloped” BBCs. Technical assistance is needed on various issues. For example, team building, leadership development, and perhaps more direct intervention by LABBN is also required.
 - Future funding of collaborative activities could be improved by having a more detailed understanding of existing community networks. With such information, funding could support processes that build upon existing relationships rather than forcing collaboration.
2. Only one BBC had actively marketed itself thereby significantly increasing its visibility to local governments and businesses. Other BBCs knew such recognition is important to achieving long-term changes in local perinatal health policies and have attempted to “brand” themselves despite objections from some key partners (see #4 below). These BBCs explained they did not have sufficient resources or expertise to be successful.
 - BBCs wanted First 5 LA to focus some media resources on them by launching local public service announcements.
 - BBCs also wanted First 5 LA and LABBN to train staffs in all the Collaboratives on publicity and media relations.
3. Most BBCs had established channels for laterally disseminating information about available services and resources in their communities. In two BBCs, these channels have penetrated beyond their own staffs to staffs at non-member organizations.
 - To leverage BBC funding beyond BBC grantees, First 5 LA and LABBN might want to expand the communications models to other BBCs.
4. BBCs, and sometimes individual organizations within them, disagreed on whether these Collaboratives should be promoted as distinct participants in the local continuum of care; as one stated “ultimate success [of the BBC] depends on whether or not the women think this collaborative is a good idea.” Others argued that their clients should be seamlessly integrated into the existing system of care.

- This is a basic philosophical disagreement. Lack of a common understanding about funder expectations could severely hinder future communications.
5. Administrators from all the BBCs reported that the Data Collection and Reporting System (DCAR) is useful in sharing detailed client information, making inter-organization referrals, and reporting to First 5 LA. They also valued the web based case management, seeing it as a collective, and therefore unique, data source and believing it will reduce workload if it can be fully integrated into existing organization systems. Data from this system, along with population data, should be able to be used to assess whether HBI's long-term goals have been met.
 - First 5 LA must continue to be actively involved in assuring this data system achieves its full potential. This will require continued process improvements, data quality monitoring, and ongoing introductory and "refresher" trainings.
 - LABBN faces considerable staffing challenges if it is to provide technical assistance to all BBCs on how to constructively monitor their programs, raise funds, and educate local stakeholders.
 6. BBCs recognized and valued LABBN's role as the HBI central coordinator; they reported its most important role is to facilitate cross-BBC communications.
 - The BBCs and HBI would benefit from LABBN conducting a thorough assessment of various BBCs' successes and failures and establishing ways for them to communicate both in general and about specific issues. For example, by hosting meetings (issue specific and educational) and by facilitating mentoring relationships both within and across BBCs.
 7. Most BBC and HBLC interactions were limited. While a few organizations in individual BBCs were actively involved with their HBLCs, overall BBCs and HBLCs were unaware of each other's purpose or progress.
 - The original HBI model of multi-level, integrated activities all focused on the same outcomes is fragmenting into its component parts. First 5 LA and LABBN may need to develop and implement some strategies to prevent further fragmentation.

C. BBC CASE MANAGERS

1. Since becoming part of a BBC, case managers reported that relations between organizations have become exaggerated: previously good relationships have become stronger and previously bad relationships have become more difficult now they must collaborate.
 - First 5 LA needs more detailed and nuanced data about existing relationships before funding collaborative activities.
 - If future Collaboratives are formed, past relationships should be taken into account.
2. All BBCs and most organizations providing case management within them had difficulties getting women into appropriate services. Case managers identified service barriers (e.g., transportation and provider communication

barriers) and service shortages (e.g., housing/shelters, food, and domestic violence services).

- LABBN may be able to address most service barriers and some service shortages by increasing information exchange within and between BBCs; for example, organizing regular forums for which case managers set the agenda.
 - First 5 LA may be able to address some service shortages through its other initiatives or policy projects.
3. Three BBCs reported that their high risk clients were receiving high risk medical care; at the fourth, case managers struggled to get these clients into appropriate care.
 - The lack of high risk medical care presents a systems level problem that is beyond the scope of HBI. This fourth Collaborative will not achieve its goals if this problem is not addressed.
 4. In general, case managers reported making referrals based on convenience. Those in larger organizations that offer a broad range of medical and psychosocial services refer in-house. Those in case management focused organizations refer to wherever is most convenient for the client, regardless of BBC affiliation.
 - First 5 LA needs to be aware that interagency referrals may not fully capture services women are receiving, especially if disproportionate numbers are being referred to non-member organizations.
 - First 5 LA could design future Collaboratives with this finding in mind. For example, smaller organizations could be coupled with larger organizations in close proximity to increase likelihood that smaller organizations will keep referrals within the BBC.
 5. Most case managers had high expectations for DCAR and appreciate JMPT's willingness to allow them to customize the system, but many had not yet begun to use it and some were concerned about the amount of time needed to collect and enter data.
 - To assure high quality data, First 5 LA and JMPT need to provide case managers with ongoing trainings.
 - First 5 LA might consider funding data entry positions.
 6. Across all BBCs, new case managers were not "up to speed" about BBC services and resources.
 - Especially in areas where there is high staff turnover, the LABBN, and BBC administrators need to work together to provide new case managers with appropriate resource trainings.
 7. Most case managers were unaware of the recommendations generated by the Perinatal Summit, the HBLCs and some were unaware of the LABBN.
 - Based on the assumption that HBI and the Action Plan will need ambassadors at every level of the perinatal health service system if it is to be successful, the LABBN and BBC administrators need to develop strategies for helping case managers understand these components and their roles in them, particularly in relation to the HBLCs.

D. BBC CLIENTS

1. An overwhelming majority of clients reported being dissatisfied with their medical care providers, some of which were not BBC members.
 - This issue appears to be beyond the scope of HBI, but might be relevant for First 5 LA's internal discussions.
2. Many case managers reported offering clients unconditional support by providing, for example, personal phone numbers, transportation, and in-home visits over several years.
 - Successful case management appears to be based on establishing close, personal relationships between the client and case manager. In order to avoid dependency, First 5 LA and/or LABBN could provide case managers with appropriate trainings.
3. Although many case managers reported informing them of their participation in the Initiative, most clients were unaware of their BBC and HBI.
 - First 5 LA must decide how much visibility HBI should have at the client and community levels, and if necessary, work with LABBN and BBC administrators to achieve it.

E. HEALTHY BIRTHS LEARNING COLLABORATIVES

1. The structure and functioning of HBLCs that started in 2003 ("established" HBLCs) and those started in 2005 ("new" HBLCs) are quite different. Consequently, their technical support needs are also quite different.
 - The staffing challenge to LABBN, to provide different training and technical assistance to "new" and "established" HBLCs, is considerable. "New" HBLCs need, for example, team building and leadership training and, perhaps, more direct intervention. "Established" HBLCs, on the other hand, need problem solving and marketing support. LABBN staff to be participants, not leaders.
2. As a result of First 5 LA funding two overlapping BBCs in one SPA, one "established" HBLC has been severely weakened; it may not recover.
 - First 5 LA's reputation was not enhanced as a result and several lessons could probably be learned from this experience for future funding strategies.
3. Most HBLCs did not understand how their activities fit into and support HBI achieving its goals and successful implementation of the Action Plan.
 - LABBN needs to develop and distribute a "one-pager" that simply describes HBI and its various components. Note: the Healthy Births Initiative Logic Model (Outcomes Schematic) could be adapted to meet this need.
4. Across all HBLCs, resource directories that are useful at the local level are much in demand, and there were many of them.
 - Can First 5 LA and LABBN develop a more rational approach to resource directories in Los Angeles County? Such an approach would be based on the "ideal" geographic/political area for a directory. What does

research or common wisdom say about this? It would also include local representatives responsible for updating the information.

Analyses of the interview and observational data have generated a range of comments and questions relating to peoples' perceptions of HBI's strengths and weaknesses and their expectations for the ultimate success of both it and the implementation of the Action Plan. Open and frank discussion about the comments and concerns reported and efforts to answer some of these questions could maximize the likelihood HBI will be successful.

III. FINDINGS

This section presents findings from the qualitative studies conducted as part of NHF's evaluation activities in the first year of HBI implementation. They are presented in five sub-sections with each starting on a new page to facilitate separation and distribution. The sub-sections are entitled: Health Leaders, BBC Administrators, BBC Case Managers, BBC Clients and HBLC Observations. The formats within each of these sub-sections have evolved from the data analyses and are not exactly parallel.

A. HEALTH LEADERS

The original list of health leaders to be interviewed included 18 individuals, 7 of whom were not interviewed. Five could not respond for personal or work reasons and two were unresponsive to multiple attempts to schedule an interview. Thus data from interviews with 11 Los Angeles County perinatal health leaders are included in this report.

Findings from these interviews are presented under two headings: 1) Views of HBI and 2) Perceptions of the Action Plan and its Recommendations. These are followed by a brief discussion of the implications of the findings.

1. Views of HBI

Health leaders' perceptions of and expectations for HBI can be categorized under two main themes: a) overall approval of HBI, and b) knowledge of HBI components.

a. Overall approval of HBI

All health leaders approved of HBI's multi-layered design and multi-strategy approach; some examples of how it was described include "It is a good, integrative approach," "There's no one simple fix in LA and complex problems need multi-layered solutions." However, some are disappointed with it and these disappointments centered on two omissions: the absence of pre-conception care and a public education campaign. Discussion of both arose under the Action Plan and recommendation #5, but the absence of the public education campaign is relevant to health leaders' overall views of HBI. Those raising this issue recognized that educating the public is challenging "because different ethnic groups have different perinatal issues," which some might suggest could have "racist overtones." Nevertheless several felt "disappointed" at its absence. Acknowledging that the disparity in birth outcomes for African Americans has not been fully addressed and that increasing numbers of Latinas are having poor birth outcomes, some health leaders explained their disappointment was centered on the fact that "no effort is being put into sorting out this issue."

Health leaders' views vary by how involved they currently are with implementing the recommendations. Those that are actively involved are optimistic about success and felt they were, at the very least, moving in the "right direction." Several of those less actively involved had uncertain expectations for the HBI's success. More than one indicated "there was lots of planning" but they "[hadn't]

seen anything yet.” They report having “no detailed knowledge of where all the parts currently are,” but they want to see effects as soon as possible. As some health leaders commented, “I don’t know what they are up to,” and “I don’t know if they have had any successes yet or what their outcomes are designed to be.” Most of the health leaders were interested in discovering the overall status of the Initiative in a summarized format, so they can better understand what is going on. They look to LABBN to provide this information.

b. Knowledge of HBI component parts

Many more health leaders reported knowing about the LABBN and what it is doing than knowing about the HBLCs and BBCs. Those few that understood the structure and purpose of the HBLCs and BBCs thought the structure is good because “operational objectives won’t be achieved unless they are internalized at the local provider level” and because “people in prenatal care work in isolation.” They acknowledged HBI has put “lots of energy into trying to be effective at the local level” and several underscored the importance of the HBLC and BBC collaboration.

However, most of these health leaders did not have a clear understanding of the different structures and purposes of the HBLCs and BBCs, and several felt they did not know enough to comment on the question. Those that were aware had knowledge of one component or the other, but not both. Several had the wrong information (e.g., number of geographic areas targeted) about the difference between the Healthy Births Learning Collaboratives and the Healthy Births Care Quality Collaborative. That is, few of these health leaders understood how the various components work together, as one commented, “I really don’t have the big picture.”

Knowledge and awareness of LABBN was far greater. Although some health leaders were not yet accustomed to thinking of “the Center” as “the Network,” most agreed that the “LABBN’s role in improving perinatal services in Los Angeles County is pivotal” and they had positive expectations for its future. Many commented that LABBN provides “the infrastructure for perinatal services in Los Angeles County” and several described LABBN as providing “the glue” for bringing everyone together. Other comments included that through this infrastructure “the content of services in the community can be improved,” that LABBN provides “a place where leaders and workers can discuss and define what the issues are,” and that “such a core is essential.” One health leader felt strongly that “LABBN brings a level of prestige to LA that the County didn’t have before. You only realize this when you go outside the County and tell people about the Best Babies Network, which others think is great.”

Health leaders’ expectations for the LABBN successfully achieving its goals were high. Everyone was positive about its leadership and staff, as one said “I’m impressed with the caliber of people the Center (sic) has hired.” Another feels “the Network ‘works’ because of the personalities involved.” It was clear that this health leader conceptualized the Network as including all the organizations working to improve perinatal services in LA County and not simply an organization that used to be called the Center for Healthy Births.

This inclusive aspect of LABBN's name change was implicitly recognized by many of the health leaders. This was shown in one health leader's response to the question about expectations for LABBN being able to achieve its goals: "I expect it to do well because it's done an excellent job of incorporating opinion leaders, key stakeholders, and community members into the Advisory Group and Committee structure and the process is extremely collaborative." This modeling of collaboration and inclusivity reinforces the positive views of, and expectations for LABBN and all its activities.

In general, health leaders' expectations were that LABBN will continue to grow and become more visible. Suggestions for increasing its visibility included "partnering with established providers that are seen as leaders so that LABBN is seen as a leader" and "building relationships with local politicians."

The health leaders actively involved in implementing the Action Plan suggested that LABBN must assure its technical assistance is not only timely but also accurate. These health leaders had either experienced or heard that initially LABBN had distributed outdated forms and inactive website addresses, which did not promote the relationship building necessary for success. However, health leaders commenting on LABBN's communication activities "very much" liked the layout and content of its electronic newsletter which they "frequently forward to staff." As one health leader summarized, "LABBN is a good source of centralized communication."

2. Perceptions of the Action Plan and its Recommendations

The information in this section is presented in six sub-sections. The first provides information relevant to the a) overall Action Plan. The following five sub-sections (b-f) each focus on an individual recommendation with discussion presented under up to four headings: current activities, implementation challenges, other issues, and a summary.

a. Overall Action Plan

Not surprisingly, the health leaders knew most about the recommendations on which they were working. If they were not working on any recommendations, their knowledge was far less and some had not read the Action Plan or recommendations within it. Several wanted information about the recommendations and their current activities and they wanted this information to be "simple" and "easy to digest."

In the general discussion about HBI, the LABBN was lauded and there were high expectations for its success. However, when the Action Plan and recommendations was discussed, doubts regarding its success were obvious. Everyone agreed that all the recommendations are important and that the Action Plan "is a good plan." However, this entirely positive view was qualified because "LABBN faces significant challenges in making the changes" and is "reaching for the stars."

If health leaders did not raise the "lack of public education" issue in relation to HBI, they mentioned it in this overall discussion of the Action Plan. Here they were concerned that the success of implementing the Action Plan

recommendations “depends on an important component that is missing...public education.” The details of these concerns varied, but there is the belief that without a public education campaign on the importance of prenatal and interconception care, LABBN and its various stakeholders will not have the “cheering section” they need to help implement any policy changes.

A subset of this concern was that none of the recommendations, while important, is “emotionally engaging.” Without emotionally engaging the public and policy makers, will they care enough to make the recommended changes? The implication being that the public and policy makers must be emotionally engaged in and empathetic with the problems associated with delivering a healthy child if LABBN and the perinatal service system are to be successful.

b. Recommendation #1: Building upon, strengthening comprehensive perinatal services for all women in LA County

This first recommendation actually includes two areas of activity. One focuses on the Comprehensive Perinatal Services Program (i.) and the other on promoting the use of best practices among prenatal care providers (ii.). Each is discussed in turn.

i. Recommendation #1: Comprehensive Perinatal Services Program (CPSP)

The Los Angeles County Department of Public Health, Maternal, Child and Adolescent Health Programs is leading the Committee to implement this recommendation. The long term goal is to be able to compare the quality of CPSP services across different provider types/payment systems and different providers.

Current CPSP-Related Activities

Those not involved in this Committee think this recommendation should be easy to implement; however, those who are working on it have found this is not the case. Rather than being able to achieve this recommendation in the 15 months remaining, they currently plan to set up a framework to look at this issue. To do this, they have to understand what each of the CPSP elements was designed to do, how they are being implemented across different providers and payment systems and how they are impacting outcomes. This requires input and outcome data. Some outcome data are available, but how best to inexpensively gather input data? How to compare the existing outcome data? Answers to these questions will shape and inform the framework.

Implementation Challenges

Challenges center on the lack of fiscal support for CPSP, the variation in implementation of CPSP across providers, and the difficulties of comparing service quality. Every informant mentioned that managed care financing systems (Medi-Cal and private sector) do not provide additional funding for CPSP. Whether and what educational services these patients receive depends entirely on the providers. As one informant said “the only ones getting the education are Medi-Cal FFS and the privately insured.” These patients may be getting the education but the quality of these services varies enormously. To illustrate the disparate treatment between patients,

one leader offered, “nutrition counseling can consist of being handed a flyer, to sitting down with a nutritionist.”

Other Issues

Most health leaders felt this recommendation is extremely important because it “addresses a major quality issue” and “the current CPSP guidelines are too loose.” A few suggested that findings from this work “could blend with the efforts in Medi-Cal managed care programs to provide quality incentives.”

However, one informant was extremely unhappy with this recommendation because “it’s coming at things all wrong.” That is, CPSP is a “tag on to this inefficient and inadequate prenatal care system...these services should be standard... don’t call it CPSP, its called prenatal care.” There was despair here about patients having no time to talk to physicians and assessments being incomplete because “it doesn’t pay.”

ii. Recommendation #1: Improving the quality of prenatal care

LABBN is taking the lead on implementing this recommendation through the Healthy Births Care Quality Collaborative, which, in turn, is collaborating with “the National Initiative for Children’s Healthcare Quality to develop and implement practice and system changes.” The intent is “to enhance the delivery of care through improved screening, provision of health promotion and evidence-based interventions, and linkages to community resources for pregnant women and their families.” (Healthy Births Care Quality Collaborative, Collaborative Charter, distributed by LABBN)

With the high rate of women in LA County receiving prenatal care in the first trimester (>90%), the major prenatal services’ problems are disparities in care quality. Despite a solid agreement about the importance of this work, some health leaders criticized this recommendation for “only working with community clinics,” and for having unachievable goals. Several health leaders felt that in the time remaining, LABBN “is not going to permeate the system with enough change to alter low birth weight and perinatal mortality,” and that there could be “more practical and important end points for such a time period.”

Health leaders understand that the process of implementing this recommendation is underway and are willing to watch its progress. However, many of them doubt that it will be successful and cite a wide range of reasons for their doubts (see Implementation challenges below).

Current Activities

The Breakthrough Series Collaborative approach¹ is being used to implement this project and one informant, having seen “it work with chronic disease,” praised it enormously. Other informants had different kinds of concerns (see the discussion below). However, all agreed that if providers were to fully engage in the process, the improvements could be tremendous.

Implementation Challenges

The health leaders had many concerns about implementing this recommendation and identified many different challenges. Although these challenges were differently framed, most rested on the cost, in time and money, of going through the Breakthrough Series Collaborative process and adopting the changes.

As health leaders explained, the Breakthrough Series Collaborative approach requires considerable time and “physicians don’t have the time and don’t get paid to do it.” Also, because it is resource intensive, “some key players cannot or do not participate, and it is usually those that need it most (i.e., solo and small practice private physicians). One health leader argued that because it is so resource intensive, a more efficient way to improve quality of care is needed to achieve measurable impact. Hence, although this work is important and worthwhile, “scalability” presents a major problem.

These health leaders also linked the “resource intensity” issue to organizational and provider problems. Organizational problems included getting the organizations fully committed—establishing a team, understanding what they are doing and changing their infrastructures. Internal systems problems can only be affected if the people on the team can influence top management to bring about changes. This requires that some of the top management be involved in the process, which requires a lot of time, etc., and the circle continues. This concern is compounded by the fact that many see the Breakthrough Series Collaborative approach as “very bottoms up and therefore challenging in heavily hierarchical organizations ... which medical entities tend to be.”

The health leaders discussing provider problems were concerned that if OB/GYNs are asked to “share payments” when they are already not being paid, or are asked to do more for no extra money, that they will “let those populations go ... and ... the first populations to go will be the managed care populations (HMOs) because there is way too much paper work.”

Other Issues.

Despite the many challenges to the Breakthrough Series Collaborative being successful, some informants saw positive possibilities. One felt that once the demonstration sites are up and running, and “we can show it doesn’t take extra time and money,” practitioners will adopt these services (e.g.,

¹ Institute for Healthcare Improvement. *The Breakthrough Series: IHI’s Collaborative Model for Achieving Breakthrough Improvement*. Institute for Healthcare Improvement, Boston, MA 2003.

making sure all women get screened, etc.). Another commented that LABBN and the group doing the Breakthrough Series Collaborative approach are setting up a “nice system for collecting data, it’s a credible and replicable project.” A third felt that just having a “menu” is tremendously helpful, it shows you what “additional ingredients” you need in your range of services.

c. Recommendation #2: Assuring every eligible newborn is enrolled in Medi-Cal before leaving the hospital

Maternal and Child Health Access (MCH Access) is taking the lead on the implementation of this recommendation, which is thought by many health leaders to be eminently achievable. Two or three of them described it as a “no brainer,” and one emphasized that it had been successfully implemented in four different hospitals simply by “adding one page to the birth clerks’ package of forms to be completed by the family.” Nevertheless, those most responsible for implementing this recommendation report that it is not as easy as they originally thought; some felt that success will come not through HBI but through State-level policy efforts. Others explained that it is only necessary to “take this band aid approach because the State won’t implement electronic enrollment (from hospitals)” and that ideally, enrollment should be integrated into birth registration but that this would take “an Act of Congress.”

While there was a great deal of discussion on how to accomplish newborn enrollment, some health leaders felt that this recommendation should have been stretched further to include enrolling mothers. One suggested that the recommendation should be changed to read “assuring every eligible high-risk newborn and its mother are enrolled in Medi-Cal.”

i. Current Activities

As the Task Force working on this recommendation agreed, MCH Access developed a toolkit for parents (NHF is currently researching whether this was also for hospitals) and set out to implement it. Implementation did not go as easily as expected and interviews with hospitals about possible reasons for this revealed a variety of responses. The responses ranged from “there’s no need to do this in the hospital because we send our clients to a clinic and they get enrolled there,” to “we’re so overwhelmed don’t ask us to do one more thing,” to “we want to do it but the Medi-Cal case workers tell parents not to” (the toolkit tells parents to talk to their case workers).

The Task Force has realized that the current problem (absent combining Medi-Cal enrollment with birth registration), might be different than they imagined. For example, if hospitals are referring babies to clinics where they are enrolled in Medi-Cal, is it necessary to implement recommendation #2 in all hospitals? Consequently, they have determined that to move the implementation of this recommendation forward, they must find ways to get hospitals to commit to it. To gain this commitment, they must be able to describe the size of the problem. To do this requires Medi-Cal data from the State, which is taking longer than anticipated to obtain.

ii. Implementation Challenges

Health leaders identified challenges that tended to be equally divided between those focusing on hospitals and on patients. Some health leaders anticipated no problems with the hospitals because “it is in the hospital’s self interest” to do this. Others felt that hospitals would not benefit from implementing this recommendation because most babies receive their care through solo or small group providers and clinics. Certainly, the hospital interviews mentioned earlier indicated a broad range in hospitals’ perceived abilities to implement it. Most health leaders agreed that the biggest hospital-based challenge is “almost certainly getting [hospital] administration commitment to putting in a system to do this remembering that even so, some families will be reluctant to participate”.

Many health leaders mentioned patient-based implementation challenges surrounding undocumented mothers and their willingness to sign documents. Other challenges emerged from a pilot enrollment project at a large private sector hospital which has a 50% refusal rate. This was attributed to fear of signing documents or unwillingness to sign without other family members present (especially the father) and misinformation from the Los Angeles Department of Public Social Services telling moms not to enroll (see earlier discussion).

Another patient based issue that arose during this discussion concerned the inappropriate use of Medi-Cal cards by patients. Currently, Medi-Cal cards include names only--no photo identification--and may be shared among several individuals. Consequently, hospitals might not have the correct chart with the correct patient. While this issue does not seem relevant to HBI pregnant clients all of whom are eligible for Emergency Medi-Cal, it dominated one informant’s discussion of this recommendation.

d. Recommendation #3: Integrating perinatal resources into the 2-1-1 system

The Los Angeles County Maternal, Child and Adolescent Health Program is taking the lead on this project to integrate perinatal resources and a “Mommy Line” into 2-1-1. The 2-1-1 system, formerly Info Line, provides information and referrals to over 28,000 programs from 4,000 health and human services organizations. Integrating perinatal resources into this system is relatively easy, requiring the BBCs and the HBLCs to provide up-to-date information about the programs with which they work. Health leaders seemed to think this work was underway. However, this recommendation includes integrating a “Mommy Line” into 2-1-1. This Mommy Line was envisioned as being modeled on the “Warm Line” that Info Line used to provide and which 2-1-1 is now contracted to provide.

The envisioned Mommy Line would employ trained operators and secure the availability of professional nurses, social workers, psychologists so that when families called they would have access to a professional who could help them decide what services they needed and where they should go to get them. Everyone agreed that this is, theoretically, possible and that it needed to be done well.

i. Current Activities

Currently, there hasn't been much success on moving the Mommy Line component of this recommendation forward and more than one of the health leaders complained about the lack of progress. As with other recommendations, the Mommy Line component has been more difficult to implement than originally envisioned.

ii. Implementation Challenges

Reasons for the actual and the anticipated problems surrounding the Mommy Line implementation and its ultimate use fell into two main areas. One centered on issues between 2-1-1 and First 5 LA and the other on its use by communities. Health leaders tended to speak more to the former than the latter.

At the organizational level, many health leaders reported that 2-1-1's Warm Line is not functioning as required by First 5 LA's contract and that First 5 LA is extremely frustrated. There was also discussion about 2-1-1's "union problems." While none of the health leaders interviewed had detailed knowledge of these issues, they posited that 2-1-1 staff did not want to take on the Warm Line (or presumably the Mommy Line) responsibilities because "appropriate staff have not been hired," there has been "no proper training," and "too much data collection is required."

Health leaders with any inside knowledge of the implementation of this recommendation appear to have accepted the fact that until the Warm Line problems have been resolved, Mommy Line implementation will not be addressed. Because the Warm Line problems rest between First 5 LA and 2-1-1, no other organization has any power in the situation. Although, individuals can try to discuss how to achieve the recommendation, what needs to be done, etc.

Health leaders identified a variety of community level challenges. The most mentioned included the fact that the public neither knows about nor understands 2-1-1 and that public awareness of it needs to be raised. One said "we probably need a public campaign just about 2-1-1." Some wondered about exactly how well communities, especially ethnic communities, will embrace such a phone system when they are more used to getting their information from family and friends. A few health leaders were also concerned about whether 2-1-1 calls would be free. If they are not, the health leaders felt, members of low income, ethnic communities would be even less likely to use the Mommy Line.

e. Recommendation #4: Promoting risk appropriate perinatal care

The Regional Perinatal Program of California is taking the lead on implementing this recommendation, which is outlined as follows:

"In LA County very premature babies and babies with pre-diagnosed conditions requiring higher levels of care or surgical interventions are delivered at hospitals unable to provide such services. It is recognized that neonatal transport systems are working well and the neonatal community manages risk appropriate care well. On the maternal side, there remain system barriers for the practitioner as well as the medical facilities to

being able to affect appropriate maternal transfers and transports.” (LA Best Babies Network, County of Los Angeles, Maternal, Child and Adolescent Health Programs, *Perinatal Summit Proposed Action Plan 2005-2007*).

The intent is to compile data necessary to describe the need, risks, outcomes, regulatory issues affecting maternal transport, referral and reimbursement practices and transport standards.

This recommendation is often referred to as “regionalization,” as one health leader said “It’s the basic age old regionalization concept, nothing new.” Several health leaders referred to Los Angeles having such a system in the past; however one felt that the result of the system was that communities “were left without the expertise to care for all their residents.” This view holds that high-risk women should not go to regional centers but to community programs that have the resources and access to expertise they need to care for both children and mothers.

Others believe that different levels of perinatal care functioned--and functioned well--in the past but that “with the HMOs and managed care trend this system started breaking down.” There is concern that this problem will not be much affected during the short time remaining to this project. While they expect to show the pilots make a difference, they hope that First 5 LA will continue to fund this work and that other funders can be brought in to support these efforts too.

i. Current Activities

The March of Dimes is looking at this issue statewide and “the vision of this work is broad enough that it will apply to LA as well as the entire State.” The intent is to begin this work by making sure a woman with a prenatal diagnosis showing she needs tertiary level care (e.g., she has a fetus with spina bifida) will be delivered at an appropriate level hospital. Over the next 15 months, participants in this project will come to consensus on defining what should occur in these circumstances and what needs to be done to make sure it does occur. The next phase will be to educate those in the perinatal field about these recommendations. Two other projects are already underway. One involves working with hospitals and moms known to need tertiary level care to make sure that beginning at 5 months into her pregnancy, the mom is prepared for her delivery at the right hospital—her records are there, she has consulted with the physicians taking care of her and these practitioners and the mom’s own physician are communicating. The other project involves working with tertiary level centers to help them work with level-1 hospitals in their service areas to develop easy systems “for transferring micro-premies to them.”

ii. Implementation Challenges

As one health leader commented:

“There is a continuum of challenges ranging from women being appropriately screened as soon as possible about whether they have special risks, to whether developing risks are picked up after they have enrolled in prenatal care, through to whether there is an appropriate commitment to referring them to a risk appropriate environment. Solving these challenges depends on many things too from who a patient first sees to whether there are real incentives about getting patients in to appropriate care.”

The complexities of implementing this recommendation are reflected in the many explanations of where the problems are. At least two of the interviewed health leaders commented on each of the four that follow:

“Business—I want to say perverse—incentives are involved.” Many factors drive delivery decisions; for example, “clinical affiliations, contract relations, and hospital networks, and hospitals and managed care contracting arrangements do sometimes drive deliveries to less than appropriate facilities.”

“There are conflicting state policies.” The Emergency Medical Treatment and Active Labor Act (EMTALA), which requires hospitals to take “all comers” is in conflict with Nursing Staff Ratio requirements because inappropriate level hospitals don’t have the correct Nursing Staff Ratio. However, EMTALA violations are fined while Nursing Staff ratio violations are not and therefore hospitals take the patients.

“NICU’s have done an excellent job, regardless of their level, of marketing themselves and telling people to trust us.” The OBs believe them and are delivering patients at inappropriate level hospitals saying babies will be transferred if necessary.

“The immediate problem is the lack of a centralized communication system that provides up-to-date information about where maternity beds of the required level are available.” As one health leader explained, this is “such a critical piece because there have been hospital closures because of hospitals getting women they can’t care for.” Such a centralized system could help with getting women to appropriate level hospitals, however, as another health leader commented, “while this might be a great tool, it assumes there is a willingness to transfer and business relationships often results in a reluctance to transfer (e.g., out of a hospital system).”

iii. Other Issues

This discussion centered on health leaders' proposing or responding to questions about two solutions—one solution involved fiscal issues and the other the development of level of care protocols. One health leader suggested that hospitals need to be penalized for conducting inappropriate deliveries, although the problems resulting from pitting perinatology, maternal/fetal medicine and OB/GYNs against one another were acknowledged. However, most other health leaders strongly disagreed with this suggestion, saying that doctors make these decisions, not hospitals, and that a better solution is to reward physicians. OBs are paid little for prenatal care, getting the primary payment upon delivering the baby. Therefore, if OBs are not going to do the delivery, "insurance plans need to look at and build in a financial incentive/remuneration system that recognizes the prenatal care that has been provided. "

Several health leaders discussed the need for clinics and hospitals to commit themselves to the kinds of care they can provide and hence which patients are appropriate for their facilities and which should be excluded. These commitments have to be in writing and the written protocols must be available and understood by everyone in Labor & Delivery, then "the front end people who are seeing patients, in ERs or OB admitting, would know immediately when a patient falls out of one of those categories and they would know to tell the referring physician right then." A slightly broader view held that separate protocols and procedures are needed for the highest risk group along with special alertness among all prenatal providers—hospitals, EMS and practitioners.

f. Recommendation #5: Supporting every woman to have a reproductive life plan particularly promoting pre- and inter-conception care

LABBN is taking the lead on implementing this recommendation, the goals of which are to identify funding mechanisms to cover pre- and inter-conception care and to increase awareness of the need for this care. It was described as "one of the more noble and difficult recommendations to fund and sustain, but if they could achieve this, it would be a major achievement."

During the health leader interviews there were several references to First 5 LA as being "skittish about preconception care" or as another said "Everyone acknowledges that for First 5 LA, preconception care is verboten." This leaves people frustrated with the politics because "all the science suggests preconception care is extremely important to lifetime health outcomes" and

"all the work that we've done around premature delivery points more and more strongly to the importance of preconception because once a mom is pregnant the damage is already done. If we don't address the high blood pressure, obesity, and smoking, then we're not going to change birth outcomes."

Given this and First 5 LA's stance as an organization dedicated to supporting "evidence-based" and "best" practices, people look to it for leadership in this area. The health leaders interviewed for this report recognized that for HBI, this recommendation is about inter-conception care whereas for those working on it, it is equally about pre-conception care. However, First 5 LA's reluctance to

address pre-conception care affects HBI more than simply requiring participants to carefully frame the recommendation and HBI related activities. It is affecting how HBI is being implemented and could jeopardize its success. As one health leader clearly articulated:

“if health care providers are to give reproductive life plans a priority in what they do, Planned Parenthood needs to be a partner in everything being done in this area, they are a major provider and an important source of policy input but Planned Parenthood hasn’t been included in meetings, it’s not mentioned in the literature. It may be a political or a religious thing and it concerns me deeply.”

i. Current Activities

Efforts to figure out how to get a mechanism for financing these services are occurring at the national, state and local levels. At the state and national levels, they are working on larger preconception care goals; and at the national level there are several groups including a Consumer Awareness Sub Group that is designing a national campaign for consumers about the importance of preconception care. At the State level, a Public Health Sub- Committee is discussing how the idea of every woman having a reproductive life plan can be implemented. That is, how women’s health can be promoted by the public health wherever women come into contact with it.

Locally, the Los Angeles Department of Public Health is focusing on how to disseminate information about the importance of preconception care and two examples of these educational activities were provided. First, the Maternal, Child and Adolescent Health Program just wrote an article for the *Southern California Physician* on pre-conception care, which outlines what each physician can do to promote pre- and inter-conception care, specifically, the three categories of questions that should be asked of any women of reproductive age. Second, they have worked with physician groups to get the American Medical Association to recommend that physicians talk about preconception care to their female patients.

Also locally, the March of Dimes held a Preconception Summit at the end of August. This brought together state and local leaders to discuss whether extending women’s Medi-Cal coverage should become a major public initiative for this organization next year. There is a definite sense that this issue is building momentum.

Finally, also in Los Angeles County, many health leaders are taking a policy approach to financing inter-conception care by looking at the cost savings from this care for the highest risk women. Although Los Angeles County is undertaking this work, it is clear that this issue requires a statewide solution. Apparently, it is felt nationally that if California with its republican Governor, along with the Governor of Florida who is also interested in the issue, pushed Medi-Cal for coverage they could be successful using the cost argument. Some of the health leaders definitely expect that this work will result in the beginnings of legislation to fund interconception care in the next 15 months.

As one health leader explained, this same case needs to be made to employers and indirectly to the private insurance sector because “not all private insurance covers all pregnancy related issues.”

ii. Implementation Challenges

“The biggest challenges are getting funding and educating providers and patients about what this care means and involves.” Most informants focused on the difficulties of getting this recommendation funded. “It is going to be an uphill battle like anything that costs money...women’s Medi-Cal should be extended to at least six months post delivery.” There is concern that it will be particularly difficult to get Emergency Medi-Cal funded with the Distribution Reconciliation Act (DRA) that became effective July 1st. DRA requires women to show proof of citizenship before they can be covered by federal funding. Pregnant women on Emergency Medi-Cal are (probably) exempt, but if they want to sign up for Medi-Cal after giving birth DRA applies to them.

One health leader felt that getting this recommendation funded was extremely unlikely because it would require covering women 18-34 during their reproductive years and that “this would be too much like National Health Insurance.” Another was more optimistic saying, “There are a lot of initiatives, such as Prop 86, where a lot of money is going to be allocated to health services and this could be something that could support the expansion. Those women will come back into the system, so why not do the right things off the bat?”

The political challenges involved in successfully achieving this recommendation were acknowledged by many health leaders and those interested in increasing public knowledge about the importance of pre- and inter-conception care emphasized this here. As one health leader commented “It’s a wonderful aspiration but people won’t buy into that dream unless they know the problem that they need to counteract, without communication and education campaigns they won’t know this.” According to the same health leader, LABBN and the BBCs need to identify women “who will speak to their experiences of not getting care who will carry the message.” It will also need “people in the business of health education meeting and talking about it and coming, collectively, to how this can be successfully promoted.” Another health leader stated that the biggest challenge to HBI achieving its goals and successful implementation of this recommendation is “creating this issue as a priority in the minds of political leaders given the complexities of modern life and the competition for resources, and elevating this to a higher priority level. It’s the age old problem of trying to bring women’s health care to the top of the pile, it’s extremely difficult.”

B. BBC ADMINISTRATORS

During the summer of 2006, NHF conducted 32 semi-structured interviews with administrators from 29 BBC partner organizations across the four HBI focus areas. All organizations participating in a BBC during the summer of 2006 were interviewed with the exception of one organization in which independent review board approval could not be obtained. Findings from these interviews are presented under four major headings: 1) Collaboration, 2) Services, 3) Data Collection and Reporting System (DCAR) and 4) Knowledge of HBI.

1. Collaboration

Collaboration as discussed by Mattessich et al.² is an elemental principle of the HBI. The BBCs, HBLCs and Healthy Births Care Quality Collaborative are all based on this principle. First 5 LA assumes that together these Collaboratives will result in HBI achieving its long-term outcomes.

Administrators' views on collaboration are presented under three main headings: a) how Collaboratives are working, b) Collaborative visibility, and c) how the LABBN can help administrators be better collaborators.

a. How the Collaboratives are working

Thoughts and perceptions of how well the BBCs are collaborating are presented under four headings: i. History of collaboration, ii. Leadership, iii. Accomplishment, and iv. Utility of collaborative analytic tools.

i. History of collaboration

BBCs vary greatly in their partnering experiences both among members and with non-member organizations. Two BBCs with several years of collaboration history among current members agreed that this history helped them more quickly decide how to share resources and responsibilities. However, they also viewed the work of the planning phase differently. One felt that the HBI planning time was wasted, saying that First 5 LA had "underestimated the value and experience of areas with a history of collaboration," and that "going back to basics" in this phase was unnecessary because of "already developed alliances." The other, however, felt that the planning phase was overwhelmingly successful because they used it to formalize existing relationships, resolve issues of territory among partners, and increase communications both within and beyond the BBC.

For another BBC, some members had considerable previous partnering/ collaboration experiences but reported having been over ambitious in planning for HBI and inviting too many new members to the table. Because there were insufficient funds to support them all, many have left the BBC. Administrators report this Collaborative has struggled to keep partners at the table and engaged in the process, and even those that agreed to participate do not attend the meetings. The result appears to be an unequal distribution of knowledge and responsibility within this BBC and the tendency to "dump more work on the more experienced partners without any incentive."

² Mattessich, P. W., Murray-Close, M., & Monsey, B. R. *Collaboration: What Makes It Work*. Amherst H. Wilder Foundation, St. Paul, MN 2004.

Finally, the fourth BBC had no track record of collaboration. It encountered multiple problems during the planning phase and continues to encounter them. Administrators in this BBC appear despondent about collaboration, as one said “this year one has been terrible.” Others reported that partners are “holding out on sharing resources,” and that they “were not sure if the idea of sharing resources or knowing who provides what has gotten through to partners yet.” Several administrators reported that this BBC needed to “go back to basics” and resolve “issues like lack of trust and battles about roles and responsibilities among members,” which are significant barriers to progressing forward as a Collaborative. Several administrators in this BBC wish First 5 LA and the LABBN had given more attention to its need for team building and conflict resolution.

ii. Leadership

The strength, and hence ease or difficulty, of BBC leadership also related to the presence or absence of BBCs’ histories of collaboration. Those with a history of collaboration have negotiated issues of trust, responsibility, and accountability. Those with no collaboration history were described as having leaders “without much experience in the area of perinatal health.” Administrators in these BBCs reported communication problems and lack of members’ understanding of their role in the Collaborative. Administrators in one BBC reported having leaders without sufficient experience to guide or help partners solve problems. As a result, non-lead, but more experienced partners, have stepped in repeatedly to make decisions rather than the BBC making them collectively. This weak leadership is reflected in partnering organizations’ decision makers not attending BBC meetings, further slowing a BBC’s ability to take collaborative action.

iii. Accomplishments

Regardless of collaborative history and leadership, all BBCs reported struggles transitioning from the planning to the implementation phase and needing a longer planning phase that took into account the availability of senior staffs. All BBCs were particularly concerned about the delays in beginning their case management programs, although the reasons for these delays differed. One BBC was delayed by its requirement to go through a review process for any client intervention which involved three separate review boards. Another BBC took longer than anticipated to recruit a central case manager partly because filling this position, located at a government organization, had to adhere to established hiring protocols. A third BBC took more time and effort than anticipated to develop shared screening, assessment, referral, and follow-up protocols; this delay was attributed to unequal partner experience with case management and perinatal health. The fourth BBC’s lack of accomplishments were explained by unwillingness to collaborate, and changes in leadership and BBC focus.

iv. Utility of collaborative analytics

All BBCs reported using the Wilder Collaborative Factors Inventory³ (Wilder) to gauge their progress and views of its usefulness were similar across all of them.

Except for the few administrators who did not remember using the scores, most thought this tool “is a good way of capturing group dynamics” and of identifying areas of disagreement so BBCs can focus problem solving and resources. Two BBCs used their Wilder scores to change communication strategies and build relationships. One BBC plans to administer it every 6 months and another requested that First 5 LA repeat the test and LABBN train its members on how to use the scores. One BBC also administered a partner satisfaction survey; it reported using both the Wilder and satisfaction survey scores to help the steering committee make continuous improvements to how the Collaborative operates

b. BBC visibility

The administrators interviewed distinguished between two levels of Collaborative visibility: i. Client and ii. Local government/business. They are discussed in turn below.

i. Client level visibility

Both across and within the BBCs, there are differing views about whether clients should or should not identify themselves as BBC clients. Two BBCs want their clients to recognize the Collaboratives’ involvement in service delivery. They promoted themselves by having a community “coming out” party, developing logos, holding community health fairs, and disseminating paper media and branded incentives (e.g. pens, tote bags, magnets, etc.). Some of the organizations in the other BBCs wanted their services to be “seamless.” These administrators thought “women don’t know they are part of a collaborative...it’s more of a technicality; a means to an end”. Most often BBCs debating this “seamless” approach cited concerns about differentiating between Collaborative and non-collaborative funded clients and established brand names of organizations.

ii. Local government/business level visibility

Except for the one that held a community coming out party, all the BBCs felt unknown by their local businesses and government organizations. They are seeking to remedy this situation and to improve their visibility through various marketing ideas including public service announcements on local networks, brochures, health fairs, local print media, and community outreach to providers and social service organizations. Two BBCs specifically asked for help from First 5 LA and LABBN with marketing their Collaboratives through media training and a cross-BBC newsletter.

c. How LABBN could help administrators be better collaborators

Administrators had many suggestions for how LABBN could help them be better collaborators. These suggestions can be grouped as follows: i. Facilitate cross-BBC communication, and ii. Provide support to BBCs still building Collaboratives.

i. Cross-BBC communication

BBCs envision the LABBN as a “go between” to help them communicate. In general, they know nothing or very little about other BBCs’ struggles and accomplishments and have requested LABBN to host periodic newsletters as forums for discussing and disseminating information and ideas. Also, BBCs

wanted LABBN to host more face-to-face meetings like the interconception care conference which they found extremely useful. One administrator hoped LABBN would arrange a round table discussion among the lead BBCs' organizations.

b. Provide support for BBCs still building the Collaborative

Two BBCs requested more collaborative development support ranging from assistance with administrative and recruitment issues to guidance and training on group dynamics, team building, and conflict resolution. Administrative support included more LABBN presence at steering committee meetings and at individual organizations to help project coordinators identify roles and delegate responsibilities. Recruitment support included either help with recruiting, for example, paraprofessional staff or with restructuring responsibilities when there is a shortage of such talent in their geographic area. Some of these Collaborative building concerns could, if not addressed, severely limit program success.

2. BBC Services

The administrator interviews were designed to ascertain the extent to which service capacity had increased at the individual organization, collaborative, and cross-Collaborative levels. Several administrators mentioned that being part of the Collaborative increased their awareness and understanding of services offered by partner organizations and this was seen as one of the most valuable benefits of BBC membership. It also allowed them to "get to know" partner organizations and coordinate services and activities with them. This has led to an "increase in access to each member's specialized service." As one stated, "the main thing [we] get from the BBC is a relationship to [the BBC hospital], so it's easier to talk to the OB clinic director to get patients back to our clinic after they give birth at [the hospital]." These new partnerships have created "a better view of prenatal care and services in the County" and have also made organizations more comfortable with referring clients to one another. More detailed descriptions about BBC services fall into three topic areas: a) services currently provided, b) future services, and c) client access to services.

a. Current services partners provide and knowledge about them

BBC administrators reported on services offered by their own organization as well as services offered by partner organizations (i.) and discussed their staffs' knowledge of the services provided by BBC partners (ii.).

i. BBCs' Services

While all BBCs but one include partner organizations that provide medical care, administrators were more likely to emphasize "other services" such as case management, social support, and health education. As one administrator stated, his organization viewed case management as "the most intensive and more targeted intervention." Despite this emphasis on more case management and related services, most administrators felt that there was a "balanced mix of services" available within their BBCs.

All administrators also reported working closely with and making referrals to their BBC partners, with some particularly commenting that they had developed strong relationships with organizations offering complimentary services to their

own. For example, several administrators reporting receiving a large number of WIC referrals; as one mentioned, WIC “focuses on referring their clients with diabetes...and other medical conditions” to the BBC. As would be expected within BBCs, organizations that offer a wide range of medical and case management services reported fewer referrals than those that offered a limited number of services.

ii. Staff member knowledge about services BBC provides

Staff member knowledge about available services within, across and beyond BBCs varied, as did BBCs’ responses to disseminating information about them. Three BBCs reported either having undertaken or currently planning actions to disseminate service knowledge laterally to BBC and non BBC staffs in their communities. Within the BBCs, this information is disseminated through staffs’ and managers’ meetings at individual organizations or through the BBCs’ meetings. However, the lead organizations of two BBCs have taken responsibility for enhancing the lateral spread of service knowledge beyond BBC membership and have created more formal trainings about their BBCs’ resources. One took a centralized approach, bringing staff from member and non-member organizations together for training. The other went out to organizations, regardless of BBC member or participation status, and trained all interested staffs.

b. Future Services

BBCs have thought about the new services they might provide in implementation years two and beyond from several different perspectives: i. Identifying and filling gaps in existing services, ii. Establishing a process for adding new services, and iii. Planning to build on existing services.

i. Identifying and filling gaps in existing services

All BBCs reported shortages, rather than excesses of services available within their Collaboratives; only one mentioned that it had “duplicate” programs offered by two different organizations. This comment was qualified by “however, they are spread out and target different areas of the city.” BBCs focused on describing the additional services needed and the difficulties, primarily staffing, relating to getting them. Thus, some administrators emphasized the lack of services, while others emphasized their inability to hire appropriate staffs.

In discussing service shortages, several BBCs mentioned a shortage of teen services, with one stating “teen populations desperately need services.” Another BBC with specialized teen case management services reported needing other teen programs such as education and support groups. But overall, other service needs identified across BBCs included mental health services, transportation, dental care, interconception care, and funding for outreach (and other “core approaches”).

The inability to hire appropriate staffs generated considerable discussion. Three BBCs reported needing additional case managers and two pointed out that they have had problems in finding them. Administrators in both South Los Angeles and Harbor Corridor BBCs agreed that it is difficult “finding qualified people that

you have the money to pay for.” This problem appears to apply to both “professional” and “para-professional” staff. As one administrator explained, “there are not service shortages, but there is a lack of BBC staff across the board, all clinics are facing this problem.”

ii. Establishing a process for adding new services

Methods and protocols for adding new services and partners differed across BBCs. None of them discussed conducting a formal needs assessment; most often, administrators thought services would be added by bringing in new partners rather than adding new services to existing partners. Also, some administrators reported wanting to bring into the Collaborative services at partner organizations not currently accessible to BBC clients.

While three BBCs reported discussing gaps in services at steering committee meetings or BBC meetings, only two had protocols for bringing in new partners. One described identifying and filling gaps as a “conscious process” and plans to use both First 5 LA mid-year and year-end reports as well as member surveys to do this. Another BBC explained that its community has known where there are services gaps for years but the main barrier to adding new ones is “an absence of a talent pool of health professionals and untapped health and community services organizations.”

iii. Planning to build on existing services

Although every BBC discussed plans for building on current services and building new ones, the examples of service enhancements and expansions they provided varied considerably. The only common examples were the plans to expand current health education services reported by three BBCs. Other examples are outlined in the table below.

Table 1. Reported activities and plans to enhance/expand BBC services

BBC	Selected Exemplars of Service Enhancement/Expansion
Antelope Valley	<ul style="list-style-type: none"> ▪ Create a health education matrix that will include a listing of health education services offered (names of courses, when, and where they are offered) ▪ Hire a Spanish-speaking community health outreach worker ▪ Offer additional education classes (e.g., legal advocacy) ▪ Offer social support to families ▪ Create and offer programs/classes that would focus on the father’s involvement, role, and responsibility
Harbor Corridor	<ul style="list-style-type: none"> ▪ Expand case management services ▪ Expand prenatal care services

BBC	Selected Exemplars of Service Enhancement/Expansion
Long Beach-Wilmington	<ul style="list-style-type: none"> ▪ Create a community asset map to help with outreach and identify new services and develop services where they are lacking ▪ Expand new case management programs (i.e., the centralized case management and nurse-family partnership programs) ▪ Increase focus on media; Talk to the local cable company to broadcast a program for free ▪ Increase the frequency of community partners' referrals to the BBC ▪ Collaborate with health plans to teach women how to navigate the system. ▪ Enhance dissemination of health education and social support class information to clients
South Los Angeles	<ul style="list-style-type: none"> ▪ Launch a community wide health education campaign. Ideas would be decided by a steering committee ▪ Search for funding to support the BBC case management services

c. Client Access to Services

Clients' ability to access and thereby utilize BBC services can be summarized under four headings: i. Defining who is eligible to receive BBC services, ii. Language and cultural barriers to services, iii. Targeting women for enrollment in services, and iv. Women coming in for services.

i. Defining who is eligible to receive BBC services

There was disagreement across the BBCs on the operational definition of high risk and on the experiences of the process for arriving at it. Some BBCs described the process as "easy," while others said it was "a heated and difficult debate between community, clinical, nutrition perspectives." There was also disagreement between the BBCs on the definition's scope. Some said it is "broad" while others described it as "narrow" or, more negatively, as "overly exclusive." Those describing it as broad commented that it was designed to be inclusive, while those that describing it as narrow had specific target populations in mind. For example, some BBCs focus on teens; their definitions state "teens 12-19" as opposed to other BBCs whose definition do not mention teens or simply state "teen."

The administrators in three BBCs tended to report a shared definition both within their organizations and within their BBCs. Administrators in one BBC reported disagreements about certain criteria; the most frequently mentioned being the focus on African American women. One administrator commented that "Initially, there were strong feelings (i.e., disagreements)...that the entire focus of the BBC should be on African American women. Then, the view shifted to all high risk pregnancies...regardless of ethnicity." It seems as if there is still

some disagreement or lack of understanding about where the BBC stands on this issue.

There was no single, simple list of eligibility criteria because both medical and psychosocial risks were included and different risks emphasized by different BBCs. Administrators also reported various tools being used to assess whether a woman is high risk; these tools included WIC’s ISIS tool, ACOG and CPSP. The following table presents the criteria most frequently mentioned.

Table 2. Medical and psychosocial risk factors

Medical Risks	Psychosocial risks
<ul style="list-style-type: none"> ▪ Previous poor birth outcome ▪ Being a teen ▪ Having gestational diabetes, diabetes, a heart condition, hypertension, chronic disease, or poor overall health ▪ No prenatal care and late in pregnancy ▪ Advanced maternal age ▪ Being pregnant and having a child <1 yr ▪ Lacking access to appropriate services ▪ Reporting substance abuse 	<ul style="list-style-type: none"> ▪ Living in designated target zip codes ▪ Low SES (<300% FPL) ▪ Low educational level ▪ Living or working in a high stress environment ▪ Being uninsured/unemployed ▪ Lacking social support ▪ Lacking transportation ▪ Needing translation services ▪ New to the area ▪ Being homeless

ii. Languages/Cultural barriers to services

BBCs vary on how severely they view the language and cultural barriers to services that their clients encounter. Three of them reported some concerns relating to the language barriers they perceive between staffs and clients, with one specifically being described as having a shortage of Spanish-speaking staff members. An administrator explained, “no one in-house in the BBC speaks Spanish” and that the “BBC doesn’t represent the ethnic profile of the community.” Administrators describing language barriers also described a lack of “cultural competency,” with one reporting that she had heard clients complaining that “they didn’t feel comfortable and didn’t feel like they were treated well by the hospital staff.” One Collaborative that agreed it faced cultural barriers reported steps to correct this problem by providing a cultural competency training and hiring culturally competent outreach workers.

BBCs that reported few language/cultural barriers described themselves as having “a lot of bilingual, bicultural staff” and “no exclusively monolingual clients.” As one administrator commented, “our BBC is fortunate to have cultural competency...[my organization] has 44 language speakers.” Another

BBC reported that they had a “fairly mixed group of collaborative partners” and that “the clinics are staffed well to meet cultural competencies.”

iii. Targeting women for enrollment in services

When asked how their organizations targeted high risk women, administrators generally gave one of three type of responses; that they conducted outreach, were already at capacity, or they did not have any plans or sufficient staff to do outreach.

Capacity issues: Across BBCs most organizations reported doing little to no outreach because they do not have the capacity to enroll new clients. BBCs were receiving many referrals from word of mouth and through other organizations. These BBCs stated that they enrolled enough women and as one explained, they “[don’t] have to advertise because [they had been] in the community for 25 years and [were] well known in community.” Another reported that “[her organization] sees so many people they don’t need to do outreach. [They have] 156 clients that qualify for the BBC.”

Outreach: At least one organization from each BBC reported conducting outreach activities. The range of these services is considerable with not all BBCs doing everything. These activities included sending BBC staff to community and cultural events, health fairs, and to target zip codes to screen women; informing women who come in for services about the program; conducting outreach at non-traditional sites (e.g., nail salons, laundromats, schools, churches, and malls); conducting traditional outreach (door-to-door; distributing flyers & pamphlets through off-site clinics, business, etc.); targeting WIC sites; and working with high schools for pregnant teens. Several BBCs reported a lot of work completed to date has been preparing to do collaborative outreach and they expect to do a great deal during the next implementation year.

Staff and planning issues: One BBC reported that it didn’t conduct outreach activities mostly because it didn’t have an outreach plan in place, with an administrator explaining that there were “no plans to do outreach.” This same administrator also mentioned that there is “an outreach committee, but [I don’t] know who’s in charge of it.” Another administrator in this BBC cited staffing shortages as the reason for not focusing on outreach (they had just lost one case manager).

iv. Women coming in for services

When asked the question if women contacted via the Collaborative’s outreach efforts were coming in for case management services, all BBCs prefaced their answers by stating that it was “too early in the process to properly address this issue.” Nevertheless, all BBCs offered that high risk women weren’t coming in for care from Collaborative outreach. One reason was that “the BBC doesn’t have an image the clients can trust...the community needs to become familiar with the BBC and the BBC needs to look legitimate.”

3. Data Collection and Reporting System (DCAR)

First 5 LA contracted JMPT, a technology consultant, to create a system to collect information about clients and group activities, electronically refer and collectively case manage clients, and report progress on the BBCs' activities and outcomes to First 5 LA. This system is called DCAR. BBC administrators were asked about DCAR in two areas: a) their familiarity with the system, and b) how BBCs planned to use the data collected via the system. The responses in each area are summarized below.

a. Familiarity with DCAR

Overall, BBC administrators are generally pleased with DCAR. It is seen as helpful when making referrals, following up clients, and sharing data in real time. As one administrator explained "partners don't share detailed information, this system will allow partners to share rich client information needed for interorganization referrals." Other positive features of the system included the security features behind sharing the data (while also recognizing that the "kinks have to be worked out"), and that the "Scope of Work, progress reports and sustainability are all in one system."

BBCs reporting negative experiences with this system stated that many organizations use multiple data collection systems that are hard to integrate because organizations that only see a few clients "can not afford to modify their own systems" and therefore have to duplicate the data entry, and First 5 LA "only wants the women whose case management services it funds entered into the system, even though this system could probably accommodate all the women they case manage." Other criticisms from several administrators involve the report format "not looking good" and being "too difficult to read," and an issue for organizations involved in the Healthy Births Care Quality Collaborative, that the amount of data required and the time needed to enter it are onerous.

Finally, some BBCs expressed concern that the system was not yet being fully utilized. They attribute this to there being "lots of bugs" in the system and "issues to be worked through," (some implicitly acknowledged that it was their own BBC's customization needs that were the source of these). But, everyone reported that JMPT was responsive and fixed problems quickly. It should be noted that at the time of the interview BBCs were mostly using the system for health education and outreach data and for reporting, but client/case management data were not yet being entered by all BBCs.

b. How BBCs will use the data they collect on DCAR

Administrators had a lot of ideas about how they could use these data, but because they do not yet have them, nothing is being done. Their ideas fell into three areas, using the data to: monitor their programs, raise funds, and to educate stakeholders.

Plans to use the data to monitor program effectiveness included identifying gaps in service while avoiding program duplication, and evaluating programs and identifying different organizations' strengths and having those that do well mentor other organizations. Administrators argue that having these data will allow them, along with other community needs assessments, to raise funds to sustain this program or to support new programs. Those who said they will use

these data for stakeholder education plan to use them as a marketing tool to increase BBC visibility by educating their communities, including the businesses, and as a way to exemplify the efficacy of a coordinated system of care for improving birth outcomes to funders and policy makers.

4. Knowledge about Other Areas of the Healthy Births Initiative

BBC administrators were asked about their knowledge of the HBLCs and LABBN and how they and the BBCs fit together. Findings from these discussions are grouped into the following headings: a. Impressions of the LABBN, b. Opinions on LABBN's technical assistance, c. Thoughts on LABBN's interconception care policy efforts and d. What administrators know about the HBLCs.

a. Impressions of LABBN

Most BBCs knew about LABBN, liked its Board and staff, and admired the commitment of its committees' members. LABBN's Board leadership was described as "exceptional," and the staff as "impressive." Many agreed the main role of LABBN is to be a "central coordinator," that is to link all the parts of HBI, including the BBCs. However, the details of how this works varied across BBCs. Some saw the LABBN as being a technical, training and information resource, others as an assistor to the BBCs as they strategically plan to meet community needs, and still others as the leader and coordinator of policy and advocacy activities relating to perinatal health services in Los Angeles County. BBCs whose staffs were involved in the Healthy Births Care Quality work saw LABBN's main role as being the central coordinator for promoting best clinical practices and standardized guidelines. Finally, most administrators commented that finding funding opportunities and obtaining funding to sustain these services for high-risk women is the most important LABBN role.

While most BBCs were able to articulate one of LABBN's roles, some of the BBCs did not have a solid understanding of who LABBN is and what it does. These BBCs acknowledged they had more contact with LABBN during HBI's planning phase but have felt distanced during the implementation phase. Some wanted more interaction now, although those that had asked for help had not always received it. At issue is a lack of BBCs' understanding on what the LABBN can do to help them. Several BBCs that wanted to start using LABBN needed to better understand its role. For example, one BBC asked for help in resolving issues between BBC members and another asked for help when a woman had to be asked to leave the program. Both reported LABBN could not provide the assistance they needed.

All BBCs reported wanting LABBN to further fulfill its central coordinator role by organizing additional meetings to disseminate information and promote cross-BBC communications. Several BBCs reported they were disappointed that LABBN had not brought all the BBCs together more often. They reported wanting to know more about what other BBCs are doing, the problems they are facing and what solutions they are trying. Others would value the ability to jointly discuss and generate solutions to shared problems. Still others wanted LABBN to facilitate partnerships between BBCs. Suggested activities LABBN could undertake to facilitate cross-collaboration included publishing a BBC newsletter

and changing the format of the web based forum so administrators can get automatic updates rather than needing to log on to follow threads.

Much of the substantive information about progress in non-BBC areas of the HBI had not reached BBCs. Many of these administrators were not familiar with the Action Plan and wanted to better understand them and how the BBCs and HBLCs actions fit into them. One administrator suggested that LABBN bring the original Town Hall participants together and present the Action Plan and recommendations, tying the BBC and HBLC activities into it. Another wanted LABBN to bring the Action Plan back to the BBCs and to explain how all the pieces fit together, particularly how what they do can support LABBN's policy and advocacy work.

b. Opinions on LABBN's technical assistance

BBCs comments about the LABBN's technical assistance fell into two areas: i. using its website and listserv and ii. what technical assistance they needed.

i. Use of LABBN's website and listserv

Many administrators in all BBCs reported not visiting the website, some it seemed almost as a point of pride and others because they do not have the time. Those BBCs who did use it reported that after a "shaky beginning" when it was "down a lot," and the "information was not up-to-date," it was now extremely useful, providing good resources and information about events, and was up-to-date.

LABBN's listserv was also highly valued and appreciated by BBCs. The few administrators that did not even scan or read it commented that they do not scan or read any listserv information from any organization whatsoever. Listserv compliments included "very useful," "it's nicely written, concise," "it keeps me up-to-date with events, what other organizations are doing, inter-conception care knowledge," and "it provides lots of good information that I'd not gotten in the past." Several BBCs reported passing it along to staff, particularly for the training announcements, and using it in staff meetings. LABBN's listserv seems to have found the right mix of style, topics and length. As one administrator said "I read the bulletins, they are very helpful and informative and I don't want any more [than what is already included in them]."

ii. Technical assistance needs

Areas where administrators said they wanted more assistance from the LABBN included: team building, media coverage, and cross collaborative communication. One BBC reported it was aware that First 5 LA was concerned about its ability to complete its tasks said, "this is not for lack of trying," and voiced its need for guidance from First 5 LA and the LABBN to help steer it in areas such as team building and group dynamics. Specifically, it wanted more training in perinatal health topic areas and conflict mediation. This request was echoed by another BBC saying "the[ir] BBC needs much more attention and guidance from LABBN." Again speaking to increased cross collaboration, one BBC reported it would "love to learn from other BBCs to see how they are doing it...how they are communicating and building relationships". These respondents

also wanted the LABBN to help them work with other BBCs in areas of interest that overlap.

c. Thoughts on the LABBN's interconception care policy efforts

Most BBCs commented that they are pleased LABBN is taking this on, although some qualified this by saying pre-conception care should also be included. While a few think that LABBN “could be successful,” more BBCs discussed the various challenges—lack of public awareness, timing, political and fiscal—that this work faces.

Several BBCs were concerned that interconception care is “not a hot topic;” funders do not want to support it and the public does not understand its importance. From the timing point of view, there can be no short-term success because providers must show that inter-conception care “improves next births.” When positive outcomes are achieved will the “the time and environment for interconception care be right?” From the lobbying point of view, many BBCs commented on how this work will “involve lots of politicking,” which they suggest should be conducted by LABBN at the State and County levels and by the BBCs at the local level. Finally from the fiscal point of view administrators in most BBCs feared that they will integrate interconception care into existing services and when HBI funding ends in 3 to 5 years no other funding will be available because this issue is “not the flavor of the month.” In relation to this fiscal challenge, LABBN was urged to “lead the charge on funding sustainability.” This means they will have to challenge policy makers to invest in healthy births in poor communities.

Administrators in almost all BBCs had ideas about what needs to be done for LABBN to be successful in its interconception care policy efforts. These ideas ran the gamut from documenting why it is needed to developing a communications package about its importance. Several BBCs emphasized the need to “make the case” for interconception care. This involves defining what interconception care is, describing how it affects pregnancy outcomes, showing its cost savings, and having programmatic evidence of how it impacts birth outcomes. This was expanded by other BBCs who recommended also showing how many women are lost to care because they lose their health insurance between pregnancies and putting these data into clear “talking points” so that everyone--LABBN staff, BBC and HBLC members--is “on the same page.”

d. What administrators know about HBLCs

Most administrators knew about the HBLCs but only a few participated in them. Their knowledge of them can be presented under two headings: i) HBLC awareness and participation, and ii) the roles of HBLCs in HBI. It is summarized below.

i. HBLC awareness and participation

The degree of awareness of the HBLCs in their SPAs appeared to be the same across the BBCs, however, administrators’ and member organizations’ participation in them varied greatly. Reasons for non-participation often included reports that the HBLCs had lost momentum and administrators in one BBC particularly associated loss of HBLC membership with the BBCs being

funded. As one administrator explained, “the LABBN didn’t bail out the HBLCs when they were struggling” during this period. The idea that funding the BBCs negatively impacted the HBLCs was shared by those who thought HBLCs have “been an enormous flop” despite the fact they are an “interesting concept”. Certainly administrators thought First 5 LA should “look at why no one is going” to the HBLCs.

An administrator from one organization in each of three BBCs reported participating in the local HBLC. However, although participation was limited, it appears to have been quite committed and active. Those participating attended both BBC and HBLC meetings and all of them had filled the roles of HBLC co-chair during the first year of implementation.

ii. HBLC’s role in HBI and in its community

Only those organizations that actively participated in the HBLCs, were able to articulate how their HBLCs fit into HBI and what the HBLCs were doing this year. One of these administrators summarized the role of the HBLCs as follows, the “BBC’s role is to provide services while [the] HBLC’s role is about community action and network building; especially for organizations interested in healthy births, but without the time or resources to give to BBCs”. All attending administrators saw HBLCs as a “grass roots” effort. All administrators, those who attended the HBLCs and those who did not, reported the need to figure out what their HBLCs do and how the BBCs and HBLCs can collaborate.

C. CASE MANAGERS

This section presents the results from interviews with individuals offering case management services, regardless of their titles. For example, although most were “case managers,” other titles ranged from “community health worker” to “registered nurse.” All respondents for this component of the qualitative evaluation are referred to as “case managers.”

The original list of case managers to be interviewed included 38 individuals, 23 of whom were interviewed. NHF began with the intention of interviewing the entire list of case managers, but the scheduling process proved to be particularly onerous and the interviewing objectives were changed to one case manager per organization that offered case management services. All such organizations, with the exception of one that could not secure independent review board approval prior to the end of data collection, are included in this analysis.

Most interviews were conducted during the beginning of the implementation phase, when case managers were just beginning to see women under HBI. As such, many felt that they did not have enough information or experience to comment on progress towards outcomes. Findings from these interviews are reported under five headings: 1. Collaboration, 2. BBC Clients and Services, 3. High Risk Care, 4. DCAR and 5. Knowledge of HBI.

1. Collaboration

The BBCs are designed to facilitate collaboration among organizations to provide comprehensive, integrated, continuous care to high risk women in selected geographic locations. The outcomes of HBI depend heavily on the ability of these organizations to work together to provide women with appropriate services. This section discusses a. History of collaboration and its impact on case management, b. BBC visibility and indirect measures of the Collaboratives’ identities and c. New relationships and knowledge as indicators of collaboration successes and challenges.

a. History of collaboration

Across the BBCs, it was clear that the history of collaboration affected case manager’s views of their partnerships with other organizations. Organizations with no or a “poor” history of collaboration frustrate others with their lack of involvement. In one of the more extreme circumstances, case management organizations described the uninvolved organization as “egotistical” and a “wild child.” This weakens the Collaborative and perpetuates the cycle of failed partnerships. As one case manager stated, it places a “grey cloud” over the BBC.

The opposite occurred where there was a successful history of collaboration. Where “organizations were already working together,” partnerships were “stronger” and relationships had changed “for the better.” These organizations’ activities were bolstered by HBI funding. For example, regular BBC or case management meetings provided them with a forum to share information and discuss areas needing improvement.

Such organizations felt that the BBC had created mutually beneficial relationships as they “work together to promote each others services.” However, organizations with nonexistent or weak histories of collaboration viewed Collaborative membership as a “burden.” According to case managers, HBI funding has intensified poor relationships among organizations with poor histories of collaboration has improved relationships among those successful with histories.

b. BBC visibility

A Collaborative’s sense of unity and identity may be indirectly assessed by the extent to which it conducts activities to enhance visibility. This was captured by responses to questions regarding client knowledge of the BBC and HBI. Essentially, the case managers in all BBCs felt obligated to inform women that they were participating in BBC services. This was most commonly done as a component of the consent process. None of the organizations reported informing women as a point of pride or as a means to strengthen BBC visibility. Their responses to the question were short and, typically, they stated nothing more than “the women know.” It is unclear whether the women understand or remember the explanation.

The BBC administrator and case managers in one organization and an administrator in another BBC were very straightforward in explaining that clients were not told about the BBC or HBI. As one case manager stated, “The clients don’t know. We haven’t told them...they think they are case managed by our program, not by [the BBC].” Another case manager reported that her organization does “not differentiate between BBC and non-BBC clients,” suggesting that these organizations viewed their BBC as competition and choose to promote BBC funded services as their own.

c. New relationships and knowledge

Concrete indicators of successful collaboration include new relationships or resources gained as a result of BBC participation. Views of the benefits of BBC involvement varied both across and within BBCs. Because some organizations had previously worked with BBC partners, they felt that they had not gained any new relationships or knowledge. Other organizations reported that network and relationship building through BBC or case management meetings lead to increased referrals.

Organizations that had been working with each other prior to the BBC reported that they “pretty much knew about the resources before,” although the intensity of this attitude varies across organizations. Consequently, these organizations had not increased referrals to BBC partners. One of the more extreme organizations expressed resentment stating, “We’ve given more than we’ve received.” It is unclear whether or not these organizations had received increased referrals from other BBC members.

Other organizations felt that BBC or case management meetings had provided them with a forum to create new relationships and learn about each other’s services. Unlike case management organizations that had partnered with BBC members in the past, these organizations reported that they were unaware of

the services available within their BBCs. One case manager stated that meetings have opened up a communications channel that “[her] organization didn’t have before.” Case managers and their organizations felt “empowered” by their new relationships and knowledge and have increased referrals to partnering organizations as a result.

2. BBC Clients & Services

Case managers’ views on the clients they are serving and the availability of services are reported under a. Clients and b. Services.

a. Clients

HBI focuses on serving women living within targeted zip codes, below 300% of the federal poverty level, and who are at increased risk for having a poor birth outcome. Case managers were asked how they i. define and ii. target high risk women and if they felt their outreach efforts were effective in accessing them. Across and within the BBCs, case managers’ feedback reveals that they had a clear definition of the target population and although they conducted a wide variety of outreach and inreach activities, some felt that the women were not being reached.

i. Defining high risk women

There was remarkable similarity across BBCs and organizations in defining high risk women. Most case managers categorized the risks as being either medical or psychosocial, although there was some overlap between the two. When asked if case managers within and outside the organization agreed on this definition, most case managers stated that the definition they provided was “generally understood” by most in the medical field. Very few case managers stated that BBC criteria required women to reside in targeted zip codes. It is unclear how much, if any, distinction is made between the overall BBCs’ definition of high risk and the “generally understood” definition of high risk.

ii. Targeting High Risk Women

All BBCs conducted a wide variety of outreach and inreach (i.e., activities to target the organizations’ clients) activities. However, their views on the effectiveness of these activities vary by organization. Some felt that their outreach efforts had been successful in targeting high risk women from the HBI targeted zip codes. Others felt that the women who were most in need of services were not being reached. One case manager commented, “I have a feeling there are a lot of people are out there who aren’t getting the services they need, but I can’t prove that.” Case managers felt that additional and strengthened community outreach activities were needed to reach the target population.

b. Services

The BBCs are responsible for coordinating services as well as increasing service quality and capacity. Of the organizations involved in this analysis, some offer case management exclusively, while others offer a wide range of medical and psychosocial services. Yet, regardless of the range of services available within the organization, all BBCs and most organizations reported service barriers and

shortages. Both the severity and types of barriers and shortages experienced varied by organization and are reported in sub-sections i. and ii., respectively.

i. Service barriers

Service barriers are factors that make it difficult for the BBCs to provide necessary services to at risk women. This information was provided by case managers from their clients' perspectives. Case managers from all four BBCs reported that their clients experience transportation and language barriers, while those within three BBCs reported provider related communication barriers. The severity of each problem varied by organization and was generally related to location.

Transportation

Transportation was a serious problem for organizations in areas without adequate public transportation. The problem exists, but is less severe, for organizations serving clients with access to public transportation systems. Transportation continued to be an obstacle in getting clients to appropriate services despite the fact that organizations tried to alleviate the problem through vouchers and van or bus services. For the most part, case managers attempted to personally remedy the situation by providing home visits and transporting clients and their clients' children to appointments.

Language barriers

Case managers in all BBCs reported language barriers that interfered with service delivery and client satisfaction. However, the problem was most salient for one BBC with a shortage of Spanish speaking staff and another BBC that had a high percentage of clients that spoke other South American languages. This not only made communication with the clients difficult, but, in one case, lead to "complaints from the Hispanic community."

Provider related Communication Barriers

Case managers in three of the four BBCs experienced major problems with provider-client communication. They reported that clients did not feel "listened to by providers" and that they received "several complaints" because clients "leave [the doctor] feeling like they don't understand what's going on." Many case managers interpreted this as either a lack of communication or a miscommunication between doctor and patient and spent a good amount of time "filling in the gaps of communication" between them.

ii. Shortages

All BBCs have trouble accessing certain services for clients. Unlike service barriers, shortages were not unique to location. Instead, these deficiencies seem to result from a high demand and low supply of needed services. Most case managers in all BBCs mentioned the following shortages: housing/shelters, food programs, and domestic violence services.

Housing/Shelters

All BBCs mentioned that housing is a major problem for clients. Many case managers felt that there was little they could do to help clients with housing difficulties. As one stated, "Some of the ladies feel like there is not enough housing for them. A lot are pregnant and homeless and [we] cannot do anything for them." When asked to elaborate on the problem, case managers commented that it is hard to find shelters for women who are underage and pregnant. Unfortunately, the sentiment expressed by one case manager that "there is no resolution to this problem" was echoed by case managers from other areas who stated that "housing is impossible these days."

Food Programs

Another issue reported by at least one organization from each BBC was food. Although some BBC women qualify for WIC services, "women born outside of this country do not." As one case manager said, "The biggest problem is probably with food vouchers...the women can't afford food."

Domestic Violence Services

Case managers in three BBCs reported that domestic violence is a problem for some of their clients. Teenagers living at home are sometimes abused by parents or relatives as well as significant others. These organizations reported that one of their biggest challenges was "working with issues of domestic violence."

3. High risk care

Most of the women that qualify for BBC services need high risk care to assure a healthy birth. However, those involved with HBI have expressed concern and uncertainty about whether these women are receiving appropriate medical care. In response to this issue, NHF asked case managers if high risk women were receiving high risk care and, if so, how the case managers followed-up with such care. The case managers in one BBC reported inadequate access to high risk medical care. Other BBCs had access to high risk care, but methods for following-up with it varied by organizations within each BBC. This section details the a. difficulties surrounding high risk care at one BBC as well as b. high risk care follow-up methods used by organizations within the other three BBCs. It ends with a brief discussion about client referrals (c.).

a. High risk care difficulties

Case managers in one BBC expressed concern and frustration with the availability of high risk care. When asked if her clients were receiving high risk care, one case manager responded by stating that "they are supposed to." According to case managers, there is a shortage of doctors that will see high risk patients. Even doctors that see high risk women "will only take so many patients." Women unable to access high risk care in this BBC's service area must "travel nearly 40 miles to get high risk care."

b. Follow-up with high risk care

According to the case managers from the other three BBCs, methods for following-up with high risk care usually depended on range of the services their organizations provided. Case managers at larger organizations (where medical care is provided on site) felt that it was easy to keep track of their client's medical status and follow-up with appointments. One case manager stated that she simply "request[s] the chart. Because everything's in-house, it's easy to get." A case manager from a smaller organization stated that the case managers have to contact the provider in order to get information about the appointment/high risk care while another stated that "the doctor sends [them] the information." Others acknowledged that contacting the provider for that information was difficult and instead, asked clients for high risk care information.

c. Referral Patterns

Case managers' responses to referral questions were consistent across BBCs, with the same variations showing within all of them. These variations revealed a referral pattern among larger organizations and explanation for non-BBC referrals.

Case managers in larger organizations reported less inter-organization referrals than smaller organizations. The larger organizations "haven't had to refer out to BBC members" because they have access to "everything [their] clients need" in-house. In these cases, the absence of referrals to BBC organizations does not result from a lack of knowledge or willingness to collaborate, but from a desire for convenience and motivation to promote in-house services.

Similarly, other case managers reported that they refer to organizations that are most convenient for their clients. Given that clients often have trouble with transportation, case managers reported that they would rather refer to non-BBC organizations if it will increase the likelihood that clients will show up for their appointments. While this may or may not be convenient for the case manager or her organization, its aim is to make access to medical care and other services as easy as possible for clients.

4. DCAR

Case managers are largely responsible for improving data collection, sharing, and use. The BBCs hope to achieve this through the use of DCAR, which allows organizations to create, view, share, and modify information on case managed women so as to provide integrated, continuous care to them. The system is a forward thinking model for monitoring and evaluating the activities, successes, and challenges of community collaboration at multiple levels and is designed to improve data sharing and use between partner organizations through features such as electronic referrals, client screenings, and client records. At the time interviews were conducted, most case managers at all BBCs had not begun using DCAR. Their views are presented under: a. Trainings, b. Concerns regarding time, and c. First impressions.

a. Trainings

Case managers in all four BBCs enjoyed the trainings and stated that they were “well done” and “user friendly.” However, most felt that they were done too early in HBI and that by the time they were ready to use the system, “lots of things [had] changed” or they had forgotten what they learned during the training. Case managers felt that a more interactive format (e.g., trainings in a computer lab so that all could log in and follow along) would be helpful and appreciated. Refresher trainings were offered at the end of interview data collection and it is not known if these trainings remedied the problem.

b. Concerns Regarding Time

Case managers from all BBCs reported concerns regarding the amount of time needed to collect and input data into DCAR, although attitudes about it varied slightly by organization. As one case manager stated, “there is not enough time in the day” to enter all of the information into the system. Those that were responsible for programming risk assessments into the system were especially frustrated by the amount of time it took to enter each question. One case manager stated, “It takes 8 minutes to save each question!” Concerns about the amount of time required by such a comprehensive system may make case managers reluctant to use it.

c. First Impressions

Case managers from all BBCs reported that they had positive expectations for DCAR’s capabilities. One case manager stated, “It has a huge capacity, can do assessments, goals, and can see whether the referral was accepted or denied right away.” Case managers also stated that the system would help them make sure that “high risk patients...don’t fall through the cracks.”

5. Knowledge of the HBI

This section details case managers’ knowledge of various components of the HBI. It begins with a review of BBC resource knowledge (a.), then provides information on case managers’ impressions of the LABBN (b.) and ends with a discussion of the HBLCs (c.).

a. Knowledge and use of BBC resources

To assess the BBCs ability to link services between organizations, case managers were asked about their knowledge of BBC resources. Their knowledge of the BBC and its resources varied across and within BBCs. The largest concern in this area is that new case managers felt they did not have adequate knowledge of BBC resources. Although these case managers reported that they were “learning as [they are] going” and that this situation will “change with time,” they also stressed that additional information and meetings were needed to help increase awareness of BBC resources.

b. LABBN

This sub-section presents case managers’ general impressions of the LABBN (i), its listserv and website (ii.) and their requests for assistance from LABBN (iii.).

i. General Impressions of the LABBN

Approximately half of the case managers across all BBCs reported little to no knowledge of the LABBN. Some case managers stated that they “[didn’t] know anything about the Network” while others mentioned that “the name sound[ed] familiar” but couldn’t recall any information about it. Those that did not know about it thought their supervisors would. Most case managers do very little administrative/management activities and have less contact with the LABBN than BBC administrators. This was evident in that only two of the 23 case managers interviewed had participated in the Perinatal Summit and so almost all knew nothing about this work. None of them had seen or received the recommendations generated by the Perinatal Summit.

Case managers who knew of the LABBN stated that its purpose was to “keep moms healthy so they can have a healthy birth,” and that they “oversee, disseminate information into the community, and provide services for high risk women.” These case managers spoke of LABBN and its staff in very positive terms. LABBN was described as a “great resource” and as being “very supportive.” Case managers also reported that the LABBN provided a wide variety of non-technical assistance (e.g., workshops, advice) to them.

ii. Listserv & Website

Most case managers at all BBCs and various organizations within them are not part of the LABBN’s listserv and also, have not been to its website. Most stated that they had e-mail access, but they did not receive e-mail updates from the LABBN. It is unclear whether or not case managers viewed themselves as responsible parties for seeking out this information, as many reported that they didn’t receive the updates because their supervisor provided them at meetings.

iii. Case Manager Assistance

Various case managers across the BBCs felt that the LABBN could and should provide them with additional information on BBC resources and issues related to HBI such as trainings on policy and advocacy. Most of all, the case managers would like LABBN to provide them with a forum in which they could meet case managers from other BBCs. The LABBN is aware of this need and has organized a “Healthy Births Through Healthy Communities: Partners Symposium.”

c. HBLCs

A large majority of the case managers across and within all BBCs have no knowledge of the HBLCs. The few that knew their SPA had an HBLC stated that they were “not sure how it fits in to HBI or the BBC.” A case manager that attended an HBLC meeting commented that after the meeting she “was unclear about what [the HBLC] was and what it was supposed to do and some attendees shared with [her] that they don’t know what they got out of it.”

D. CLIENTS

This section presents the results from interviews conducted in English and Spanish with 26 clients of BBC case managers. The findings are reported under two headings: 1. Services and 2. BBC Knowledge and Data Collection.

1. Services

The greater part of client interviews focused on service related questions regarding case management and medical care. Clients comments are presented under three headings: a. Case management, b. Medical care and c. Housing shortages.

a. Case management

Comprehensive case management is a central component of HBI and should lead to coordinated and comprehensive interconception care programs that support high risk women in preparing for their next healthy birth, comprehensive screenings and appropriate referrals for all target population women, and early initiation of prenatal care among high risk women. The findings presented in this section suggest that across all BBCs, women i. receive a wide variety of services from the case managers' organizations, ii. are referred to the appropriate services when necessary, and iii. are extremely satisfied with their case management.

i. Services received from case management organizations

Clients of all BBCs reported that they received a wide variety of services and resources from their case manager's organization. Services provided ranged from medical services (e.g., prenatal care, surgery preparation, birth control) to psychosocial services (e.g., health education classes, job preparation and assistance, assistance scheduling appointments). Resources received included items such as transportation vouchers, baby clothes, and diapers.

ii. Referrals

Nearly 8 out of 10 women from all BBCs reported that their case managers had referred them to services and that they felt their case managers were "connected" and aware of community resources. As a result of referrals, women reported that they had access to "whatever [they] need[ed]." However, some women did not know if the services they were "referred" to were sponsored by the case manager's organization (and therefore, would not qualify as a referral). In addition, many of the women did not know the name of the referral organization or provider, which made it impossible for the interviewer to determine if it was a BBC or non-BBC referral.

iii. Satisfaction

All but one of the women interviewed reported that they were "very satisfied" with their case management services. Most spoke extremely positively of their case managers and gave concrete examples of instances in which their case managers assisted them. These examples generally fell into three categories: social support, resources, and knowledge. In addition, women felt that the ease with which they were able to communicate with their case manager and their her availability both contributed to their overall positive experience.

Social support

Women who felt that the most worthwhile aspect of case management was social support often stated that their case managers were “like family.” One woman reported, “I can’t put into words how I feel about [my case manager]. She is always there for me.” Often the women felt that it helped “just to have someone to talk to” and many reported that both they and their families noticed a difference in their overall mood and happiness as a result of case management services.

Resources

Case managers provide clients with resources either directly (e.g., books, food vouchers, baby clothes, etc.) or indirectly through referrals. One woman stated that on one particular occasion when she wasn’t able to afford diapers, her case manager bought them for her. “Even though she might not have had any money either, she bought me diapers that day.”

Knowledge

Women reported that their case managers provided them with one-on-one health education, and many said they had taught them about “pregnancy, the baby’s development, and nutrition.” Women who received case management during their first pregnancy were pleased with case managers’ willingness to answer questions and educate them about important issues.

Communication

Clients were comfortable communicating with and confiding in their case managers because they felt respected and “never judged.” Spanish speaking clients also reported that “everyone speaks Spanish” and that makes everything “very easy.” Some of the women interviewed had been seeing their case managers for over five years and stated that they “talk about everything” because they “have been seeing each other for so long.” Clients reported that this relationship with case managers made it easy for them to ask for help in times of need.

Availability

All of the women interviewed reported that it was easy to make case management appointments and that they were pleased with their case managers’ general availability. Some reported that their case manager came to their house for appointments, while others reported that they were “always available” in person or by phone.

b. Medical care

An overwhelming majority of women from all BBCs had medical care complaints. Four out every five stated they were dissatisfied with their care and provided concrete examples of the poor services they received. All of the clients interviewed in one BBC expressed dissatisfaction with the area’s hospital. The majority of the complaints fell under the following five categories: i. Lack of respect, ii. Inappropriate care, iii. Test result follow-ups, iv. Poor communication and v. Wait time.

i. Lack of respect

Many women felt that they were treated in a “rude” and “disrespectful” manner by both nurses and doctors. Some reported that they were treated “like dirt” when they questioned the provider. A younger woman mentioned that it was her first pregnancy and “the doctors acted like [she] should have known the things [she] was asking them about.” Another stated, “I don’t know if the doctors treat me differently because I’m young or if that’s just how they are. My friends who go [here] don’t like the doctors, they treat them badly.” Others simply felt that the providers had “bad attitudes” and “no patience.” When asked for examples, many women were able to provide accounts of situations in which they received improper care (see below).

ii. Inappropriate care

Examples of inappropriate care ranged from the hospital losing clients’ paperwork to their children being prescribed the wrong medication. One client reported, “I didn’t like the service because they gave [my daughter] the wrong medication. I went back to my regular doctor and he told me never to take my child to [that hospital] again.” The clients were frustrated with this care, but as one woman stated, there is “no other hospital to go to.” Some reported driving to other cities for trusted medical care.

iii. Test result follow-ups

Women from three different BBCs stated that their hospital or clinic did not give them test results in a timely manner. One mentioned that she had been fainting because she was anemic and stated, “I didn’t like [the clinic]... I was anemic and they didn’t tell me about it until I asked them. They told me they thought they had given me my results, but they hadn’t.” Another called the interviewer the next day to report a complaint with her clinic. She stated that she had been tested for HIV and gonorrhea three months prior to the interview. After the interview, she went to her appointment and was told that she tested positive for gonorrhea. She was extremely upset and stated that the clinic had put her and other people’s health in danger by taking so long to give her this information.

iv. Poor Communication

Women from various BBCs reported frustration in trying to communicate with their providers. All women felt that the difficulties with communication were the provider’s fault. They stated that the doctors were “bad at explaining things” and that “it’s hard to communicate with them.” One woman felt that her poor medical care stemmed from the fact that “the doctor was sort of cold and not good at explaining things.” Others weren’t explicit in describing communication as a problem, but expressed confusion about their services. One woman commented, “I don’t really know why they are giving me insulin. I don’t think I have diabetes. I don’t think I ever had it before.”

v. Wait Time

Approximately half of the clients interviewed believed that their wait times for medical appointments were longer than normal. Most felt that they were able to get appointments within a reasonable time but reported that the clinic or hospital was often “crowded” and that they waited up to four hours. One woman reported that she was going to start driving from Long Beach to Los

Angeles because of the poor medical care and long wait times she had to endure.

Women that did not have to wait very long for services reported wait times of approximately 30 minutes. They felt that this was “just the normal wait that you have at a doctor’s office.” Two women reported that walk-in appointments had a longer waiting period, but that they preferred being able to walk in without an appointment to making an appointment and waiting less time. Women that have frequent visits to the hospital or clinic are often aware of busy times and report that they try to avoid certain days when they might have to wait longer.

c. Housing shortages

Clients were asked if there were any services they needed that they were not able to get through their case managers. Respondents from various BBCs stated that they had trouble with housing but acknowledged that their case managers could not do much to help with the situation. One woman reported “I have no where to go because the rent is too expensive. I’ve applied everywhere, but Section 8 is closed.” Case managers from all BBCs also expressed difficulty in finding housing or housing services for clients.

2. HBI knowledge and data collection

Case manager interviews showed that some organizations inform clients about HBI and their participation in it, while others do not in order to provide seamless services between partner organizations. However, most of the clients interviewed stated that they had never heard of the HBI. Others stated that the name sounded familiar but they weren’t quite sure what the HBI was. For example, one woman stated, “I don’t know... Maybe it’s like the Healthy Families Program with prenatal care. That’s what [my case manager] works on.”

More women knew about the BBC than HBI. Those that said they might have heard of it (one out of every three) stated that it “sounds familiar” and “I think my case manager gave me information about it when I started.” However, most reported only vague knowledge hinting that they didn’t know the details and may not have known they were part of the Collaborative. For example, one women reported that she “heard it was a good program” but didn’t mention that she was part of that program.

Clients were asked if information was collected from them when they started working with their case managers. Those that had been seeing their case managers for a long time (approximately 5 years), but had no knowledge of HBI or the BBC, were asked if they remembered filling out any forms in the recent past. Women reported that they “had to fill out a lot of paperwork,” but that it was a “normal” amount of paperwork. Some even reported that they appreciated the questions because “it shows they are paying attention to what’s important.” Women that had been seeing their case managers prior to the start of the BBC reported that their case managers were able to fill out much of the information for them. Also, clients mentioned that the questionnaires were personal but they felt comfortable answering them because of the trusting relationship they have with their case managers.

E. HEALTHY BIRTHS LEARNING COLLABORATIVES

This section presents the results from observations of HBLCs at two time points. It includes findings under four headings and begins by 1. describing and comparing the structure and activities across two categories of HBLC, “new” and “established.”

1. Structure & Actions of New vs. Established HBLCs

“New” HBLCs are defined as those that began in 2005 while “established” HBLCs are those that began in 2003. Compared to the most recent HBLCs, the older HBLCs would be expected to have negotiated issues of mission and vision and to be functioning more collaboratively with stronger leadership and established rules and roles for member participation. However, this is not necessarily the case. Findings are presented on the structure and activities first of the “new” HBLCs and then “established” HBLCs.

a. “New” HBLCs

The original HBI plans included the establishment of four “new” HBLCs in 2005, however, only three have begun to meet regularly.

i. Structure

The membership and administrative structures of these three HBLCs are extremely fluid. Although membership numbers appear to be slightly increasing, the proportion of returning participants (i.e., those observed in round 1 who were also observed in round 2) ranged from 25 to 50%. The co-chairs tended to be equally unstable. Only one of these three HBLCs had the same co-chairs at both observations. Of the other two HBLCs, one had retained one of its first round co-chairs and the other had as its co-chair someone who had presented a program during the first round (i.e., was not at that time formally a member).

Such changes in membership and structure combined with uneven participation make group movement extremely challenging. This is seen in the difficulties of recruiting co-chairs and other volunteers. Participants being encouraged to become co-chairs explained they were unwilling to take on this position because they felt they could not justify the 24 hrs/year (4 hr/meeting; 6 meetings/year) it would take to their supervisors. This was because they could not see how it helped them achieve their work-related responsibilities.

At this point, it is unclear whether these HBLCs will survive and become established. The work of keeping them going falls primarily on LABBN staff. This support must be provided very carefully—too much and local HBLC leadership will not allow it to develop, too little and the HBLC will fade away.

ii. Actions

While HBLC actions during the first round of observations focused on developing ground rules for how each would conduct its business, along with developing mission and vision statements, by the second round there was some discussion about their Action Plans. Two HBLCs wanted to develop Resource Directories, though they were having difficulties getting the contact information they needed to do this. Other items on the actions plans included developing work-place

breastfeeding policies and developing a resource card for teens. However, no action has been taken on the teen resource card and it remains as a discussion item. Members volunteered to draft the work-place breastfeeding policies and agreed that their HBLC should award certificates to employers that adopt them.

At each of the second round observations, LABBN reported on the Action Plan and their November 15th Healthy Births Symposium. It appeared that none of these HBLCs' members had participated in the original meetings, the discussion from which had informed the Perinatal Summit. They knew very little about it or the recommendations. However, during these presentations, HBLC members appeared to agree with the recommendations and the Action Plan but they commented that they did not know how their HBLC, the organizations they worked for, or themselves as individuals fit into it.

b. "Established" HBLCs

These HBLCs all began in 2003 and have been functioning since. Their structures and actions vary considerably.⁴

i. Structure

One HBLC that began in 2003 had been well established. It had mission and vision statements, three issue/action-focused sub-committees, and committed co-chairs. Thus it had a structure including rules, recognized responsibilities, expectations, etc. that could maintain it. However, once the BBCs were formed, membership in this HBLC dropped (two BBCs overlap with it). Apparently, its members said that they did not have time to go to both meetings and money was associated with being in a BBC.

This formerly established HBLC now appears to be attempting to re-establish itself. At the first observed meeting one of the co-chairs was stepping down, but was being replaced. By the second, none of the original co-chairs remained, and although the numbers of members had increased slightly from the first observation, none from the first were seen at the second. The meeting discussion had also changed focus. In the second observation, rather than being focused on actions (albeit to recruit new members), as it was in the first round, it was more informational and included presentations of local programs.

The other three HBLCs appeared more structurally stable, although they each function differently. The stability comes from shared agreements about how they operate, the processes they follow and how they view themselves.

All of these HBLCs had apparently experienced co-chairs and broad membership but they differ considerably in how they function. One appears to be run by a small "executive group" that includes the co-chairs and one other member. It was fairly obvious that this leadership group gets together between HBLC meetings to determine what needs to be done because it was observed essentially using the meetings to 'convince' the other members to endorse what

⁴ In the interest of full disclosure, NHF must report that its staff attends one of these HBLC meetings as a member.

it had decided. The other two HBLCs function in a more 'grass roots' and egalitarian manner.

Two of the three established HBLCs have participant requirements and one has a participant reward system. The participant requirements for one include attending a certain number of meetings and completing an "application" form, probably more correctly described as a "getting to know you" form. For the other, each new member must register and create an account on the HBLC forum before the next meeting. The participant reward system involves distributing "Perfect Attendance" certificates.

Only one of these three HBLCs reviews and approves meeting minutes and had its 2006 meetings scheduled. This HBLC appears to be the most sophisticated. It is the only one that has renamed itself. That is, it has reframed and shaped the HBLC to meet its community needs, to incorporate it into its existing community structure and has thereby imposed a local definition of how it relates to other entities. In other words, this community has made this HBLC its own.

While this HBLC has been almost completely absorbed into the community, because it was co-opted by an existing group, its range of members is smaller than those of other HBLCs. It is interesting to note that the BBC associated with this HBLC is the least established and collaborative of the BBCs. At the second observed meeting of this HBLC, there was a presentation about how its "sister" BBC is to be restructured, both internally and externally through its MOUs. HBLC members appeared to be very pleased that this was happening.

ii. Actions

The "established" HBLC negatively affected by the creation of the BBCs changed completely between the two observations. During the first, one member was present from each of three sub-committees, but the issues of only one of these committees was discussed. During the second observation, after several program presentations, discussion centered on a postcard they are developing for teens. The LABBN is providing considerable support to this effort.

The three other HBLCs have either fully implemented or are close to fully implementing their action plans. The fully implemented action plan involved increasing perinatal health education through a health fair. The cost of which is covered by a combination of fund raising activities ranging from sponsorship to donations thereby making it possible to continue the fair each year. This HBLC is now identifying its next action plan item. Two other action plans are close to being implemented, one involves increasing health education for families and the other educating CPSP providers about women's needs for social services. The family level nutrition and physical activity health education is being conducted through libraries and has an unpaid student intern conducting the physical activity workshops. The CPSP provider education is envisioned as the first step in a larger effort which includes talking to CAAs, surveying providers (MDs and NPs), and talking to medical office managers and clients. This latter project is being conducted by the HBLC that has the "executive" group described earlier.

iii. Summary

In sum, the HBLC observations suggest that three of the four HBLCs that began in 2003 are taking action and moving forward as envisioned. The three newer HBLCs, those that began in 2005, are working through structural and operational issues and we must wait to see whether and how well they survive. Even so, this analysis of cross-HBLC observational data has generated some questions, answers to which could maximize the likelihood all these HBLCs will be successful.

III. METHODS

Qualitative data were collected via interviews and observation. Interviews were conducted with informants having four distinct perspectives on HBI and the HBLCs were observed. The four informant perspectives included those of 1) Los Angeles county health leaders, 2) BBC administrators, 3) BBC case managers, and 4) BBC clients. Brief descriptions of data collection activities and data analyses frameworks follow.

A. DATA COLLECTION

Data were gathered through semi-structured interview instruments designed to cover different aspects of HBI and through observations of the community-level component of this initiative. This information is presented under 1) Interviews and 2) Observations.

1. Interviews

Similar or parallel approaches were taken across all four informant groups in recruiting informants, developing the interview instruments, and collecting the data. These activities are summarized in Table 3 below.

Table 3. Interview informants, instruments, and data collection

	Health leaders	BBC Administrators	Case Managers	Clients
Informant identification/recruitment	All who had participated in the 2 nd day of the Perinatal Summit in 10/2005. LABBN provided contact info. NHF recruited a convenience sample	Administrators of member organizations of all BBCs. First 5 LA provided membership lists. NHF recruited a convenience sample	Those providing case management in each BBC. Lead organizations of the BBCs provided contact information and administrators advised on whom to interview. NHF recruited at least one case manager from all but one organization offering case management services ⁵	Case manager & administrators identified and recruited English and Spanish speaking client informants. Each informant was given \$40 cash or a grocery card worth \$40.
Instrument domains (All developed using First 5 LA Commission "success" criteria,	1. Knowledge of & expectations for HBI 2. Knowledge of & expectations for the Action	1. BBC services 2. Definition & targeting of high risk women 3. Collaboration	1. BBC services 2. Definition & targeting of high risk women 3. Collaboration	1. HBI awareness 2. Services received/wanted 3. Data collection

⁵ The one organization not involved in this interview was unable to obtain independent review board approval before interviewing ended.

	Health leaders	BBC Administrators	Case Managers	Clients
LABBN and BBC outcomes)	Plan 3. Personal HBI involvement	successes & challenges 4. DCAR 5. Knowledge of HBI	successes & challenges 4. DCAR 5. Knowledge of HBI	
Data collection	Informant chose between face-to-face and telephone interviews 7/19/06-9/6/06	Telephone interviews; 5/12/06-8/9/06	Telephone interviews; 5/2/06-7/28/06	In person interviews in English or Spanish 8/9/06-9/1/06
Interview length	30-90 minutes	30-60 minutes	30-60 minutes	20-30 minutes

2. Observations

HBI includes encouraging and supporting HBLCs in each of Los Angeles County's eight SPAs. HBLC observations were conducted twice in 2006, during the first and third quarters. The first round was conducted between January 12 and March 14, 2006, and the second between August 2 and September 14, 2006. During these time frames, seven of the eight HBLCs held meetings. The SPA 5 HBLC could not be observed because it did not meet.

Data collection involved taking notes of observations during meetings, collecting handouts, tracking the number of meeting participants, handouts distributed, LABBN representatives present, meeting locations, and meetings per year. Where applicable, it also included a review of past meeting minutes and the LABBN's meeting summaries.

B. DATA ANALYSIS

The questions in all four interviews and observational domains were developed to allow data analysis within a framework consisting of the "success" criteria the First 5 LA Commission is using across all its investments and of specific short term and long term HBI outcomes. However, because only one round of interviews and one set of observations have been conducted, the findings from these data should be considered baseline. Future qualitative data collection could both build on the information presented here and focus more on outcomes.

All interview data were transcribed into Word and uploaded into NVivo 7.0, a qualitative data analysis and management software program. This program allows large amounts of textual data to be managed and analyzed by simplifying and automating tasks traditionally associated with manual analysis.

The overall framework for future data analyses will be comprised of the First 5 LA Commission's areas of evaluation interest and BBC and LABBN outcomes. The First 5 LA Commission's areas of evaluation interest will be applied to all interview and observational data, whereas success in achieving LABBN and BBC outcomes will be applied to the relevant strategies, interview domains and

discussion issues. A summarized framework is shown in Table 4 below. A detailed version of this table, titled “guiding Evaluation Questions and Data Sources,” was submitted to First 5 LA on February 28, 2006.

Table 4. Summarized interview framework

Level of data analysis	Criteria/Outcomes	Source
All interview & observational data	<ul style="list-style-type: none"> i. Increased capacity to provide appropriate, accessible services ii. Improved systems of services and service delivery iii. Programs, services and changes that are sustainable iv. Advocacy that results in the policy changes required to support the increased and improved services and systems, and v. Improved data collection, sharing and use 	First 5 LA Commission's areas of evaluation interest
Health Leader data	<ul style="list-style-type: none"> i. Have adopted and begun implementation of the Action Plan ii. Healthy Births Care Quality outcomes (Action Plan recommendation #1): <ul style="list-style-type: none"> a. More clinical sites implementing best practices guidelines during prenatal care b. Breakthrough Collaborative Series sites using more community resources iii. Supporting women to have reproductive life plans (recommendation #5)/extending Medi-Cal coverage beyond 2 months post-partum: <ul style="list-style-type: none"> c. Have policy language for state legislation and a champion to advocate for the legislation d. Los Angeles County Department of Health Services moving toward encouraging interconception care and care quality amongst its providers iv. Medical providers better informed about the importance of interconception care v. More employers with family and pregnancy friendly policies and understanding the importance of preparing for the next pregnancy 	LABBN Outcomes
BBC Administrator data	<ul style="list-style-type: none"> i. <u>Technical Assistance</u>: Listserv for sharing TA resources; Website to support BBCs/HBLCs; BBCs/HBLCs handle more of their own TA needs; LABBN is the go to organization for First 5 LA ii. <u>HBLC Building and Sustainability</u>: HBLCs have taken concrete steps toward improving birth outcomes iii. <u>Policy and Advocacy</u>: Have policy language for state legislation and a champion; More employers will have family and pregnancy friendly policies & more employers will understand the importance of preparing 	LABBN Outcomes

Level of data analysis	Criteria/Outcomes	Source
	<p>for the next pregnancy; Have adopted and begun implementation of the Action Plan to improve birth outcomes developed with health leaders; LAC-DHS moving toward encouraging interconception care and care quality amongst its providers</p>	
	<ul style="list-style-type: none"> i. <u>Collaboration</u>: Form a vibrant learning collaborative with shared goals and objectives; Strengthen partners knowledge of collaborative resources ii. <u>Case management</u>: Increase case management capacity; Identify, share, and encourage BBC members to adopt best practices iii. <u>Outreach</u>: Increase early initiation of prenatal care among high risk women iv. <u>Health education and messaging</u>: Promote community and individual knowledge about how to have healthy births and access to appropriate services and resources. v. <u>Interconception care</u>: Increased access to coordinated and comprehensive programs that support high risk women in preparing for their next healthy birth vi. <u>Social Support</u>: Conduct comprehensive screening on all target population women and refer appropriately 	BBC Outcomes
BBC Case Manager data	<ul style="list-style-type: none"> i. <u>Technical Assistance</u>: Listserv for sharing TA resources; Website to support BBCs/HBLCs; BBCs/HBLCs handle more of their own TA needs; LABBN is the go to organization for First 5 LA ii. <u>HBLC Building and Sustainability</u>: HBLCs have taken concrete steps toward improving birth outcomes 	LABBN Outcomes
	<ul style="list-style-type: none"> i. <u>Collaboration</u>: Form a vibrant learning collaborative with shared goals and objectives; Strengthen partners knowledge of collaborative resources ii. <u>Case management</u>: Increase case management capacity; Identify, share, and encourage BBC members to adopt best practices iii. <u>Outreach</u>: Increase early initiation of prenatal care among high risk women iv. <u>Health education and messaging</u>: Promote community and individual knowledge about how to have healthy births and access to appropriate 	BBC Outcomes

Level of data analysis	Criteria/Outcomes	Source
	<p>services and resources.</p> <p>v. <u>Interconception care</u>: Increased access to coordinated and comprehensive programs that support high risk women in preparing for their next healthy birth</p> <p>vi. <u>Social Support</u>: Conduct comprehensive screening on all target population women and refer appropriately</p>	
BBC Client data	<p>i. <u>Case management</u>: Identify, share, and encourage BBC members to adopt best practices</p> <p>ii. <u>Outreach</u>: Increase early initiation of prenatal care among high risk women</p> <p>iii. <u>Interconception care</u>: Increased access to coordinated and comprehensive programs that support high risk women in preparing for their next healthy birth</p> <p>iv. <u>Social Support</u>: Conduct comprehensive screening on all target population women and refer appropriately</p>	BBC Outcomes
HBLC Observational data	<p>i. The HBLCs become vibrant, learning collaboratives,</p> <p>ii. HBLC members learn and are satisfied with their involvement in the Collaborative,</p> <p>iii. The HBLCs take action to improve birth outcomes, and</p> <p>iv. Each HBLC develops an information sharing system</p>	LABBN Outcomes