First 5 LA Welcome Baby Expansion:
Early Implementation Experiences

Prepared for:

Prepared by:
Ian Hill, Margaret Wilkinson, and Sarah Benatar
Urban Institute

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EXECUTIVE SUMMARY

STUDY BACKGROUND AND PURPOSE

In 2009, First 5 LA adopted a strategic plan titled *Strengthening Families and Communities in L.A. County*, which described how the organization planned to improve the lives of families with young children—and the communities they live in—through various investments, including a place-based approach called Best Start. At the foundation of this plan was a home visiting program called Welcome Baby, which was designed to support women and their infants and enhance parental understanding of child development by providing education on topics related to pregnancy and caring for an infant through a strength-based approach. Welcome Baby was piloted in one downtown community called *Metro LA* beginning in 2009 and was refined over the subsequent four years.

In 2013, Welcome Baby expanded to an additional 13 Best Start communities. This expansion required significant effort in contracting with new providers, hiring and training new staff, integrating Welcome Baby into existing organizational structures and encouraging fidelity to the model. Other preparatory steps involved the development of a universal risk screening instrument for Welcome Baby enrollees, and the creation of a data system to collect and track client information and report on service provision and outcomes.

To document and learn from this critical phase, First 5 LA invested in an Early Implementation Study that was conducted in spring 2014. The goal was to assess the early implementation of Welcome Baby as it expanded to the 13 Best Start communities during the first year. Findings from the study will guide program improvement and mid-course corrections for First 5 LA, the Oversight Entity, and Welcome Baby providers.

RESEARCH QUESTIONS

The research questions explored by the study relate to factors that typically affect the quality of early implementation, based on the scientific literature. Research questions included:

1) To what extent have organizational factors\(^1\) affected implementation of Welcome Baby?
2) To what extent have training and technical assistance providers (LABBN, MCHA, PAC/LAC) effectively prepared staff to implement Welcome Baby?
3) To what extent do staff feel knowledgeable, skilled and positive towards Welcome Baby?
4) What are the early experiences of staff in implementing Welcome Baby?\(^2\)

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\(^1\) Organizational factors examined by this study included the hospital work climate and culture, communication, leadership and integration of programming into existing routines.

\(^2\) Elements of the model that were explored in this study included outreach and enrollment, implementing the curriculum, identifying community resources and making referrals, the family-centered approach and reflective supervision.
STUDY METHODS

The Early Implementation Study used qualitative methods to capture the rich experiences of the various providers and stakeholders involved in Welcome Baby. In March 2014, the Urban Institute conducted a 10-day site visit to Los Angeles and held individual and small group semi-structured interviews with 94 key informants, including First 5 LA staff, training and technical assistance providers, and Welcome Baby providers. Study participation was limited to providers who had completed training and begun to implement the program on the ground.

MAIN FINDINGS AND FUTURE IMPLICATIONS

_Welcome Baby providers were excited to be implementing the program and encouraged by their potential to positively impact the lives of families with young children._ Providers were almost universally excited to be on the job, serving pregnant women and new mothers, and working to strengthen parents’ ability to foster the healthy growth and development of their children.

**Implications:** First 5 LA can feel satisfied by the promising launch of Welcome Baby and should build upon this positive foundation by focusing on continuous program improvement and fidelity monitoring to ensure that providers’ early enthusiasm translates into ongoing delivery of high quality care.

_Piloting Welcome Baby in the Metro LA community was a wise investment that laid the critical foundation for the expansion._ Important lessons from Metro LA about the timing and content of home visits, staff qualifications, prenatal outreach and assessing client risk were incorporated into the expansion and are reflected in the fidelity framework, Modified Bridges for Newborns Assessment, and service protocols.

**Implications:** First 5 LA and its technical assistance providers should not presume that Welcome Baby is a static model; rather, new providers working in new settings and new communities will learn their own lessons and the process of refining and improving Welcome Baby based on this process should be allowed to continue.

_A smoother expansion of Welcome Baby was undermined because several key building blocks for implementation were not ready._ The expansion began without some key tools and processes in place, including the fidelity framework, data collection tools and protocols, and the Stronger Families Database. This likely resulted in more variation and, potentially, a lack of fidelity across sites.

**Implications:** Moving forward, it will be incumbent on First 5 LA and its Oversight Entity partners to work closely with providers to promote fidelity to the Welcome Baby model, but in a manner

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3 Welcome Baby providers included Program Directors, Clinical Supervisors, Outreach Specialists, Parent Coaches, Nurses, and Hospital Liaisons from 10 out of the 14 Welcome Baby hospitals.
that recognizes that sites may have developed their own interesting and innovative ways to implement the program in their communities.

Providers praised the intensive training they received, but many also felt under-prepared to go to the field and fulfill their roles, expressing a need for more practical, ‘hands-on’ training. Overall, providers thought the training they received was extensive and covered important clinical and psychosocial topics in the Welcome Baby protocol, however, they did express frustration that the training did not demonstrate how the subject matter applied in the field. Despite this, providers reported positive experiences and were learning “on the job.”

Implications: There will be an ongoing need for training new staff, and thus opportunities to improve the Welcome Baby training curriculum, protocol, and process. More hands-on training through role-playing, shadowing and peer-to-peer workshops could help staff become more prepared to perform their jobs.

While the program model and curriculum were universally praised, common suggestions for improvement were cited by providers. Providers cited the challenges of restricting information related to birth control and family planning at some religiously-affiliated organizations. In addition, providers felt that the curriculum for the abridged version of Welcome Baby4 did not adequately meet the needs of high risk mothers living outside of Best Start communities. Moreover, providers believed that the gap between the 3-4 month and 9-month visit was too long and could be detrimental to the provision of quality care.

Implications: First 5 LA would be wise to remain open to suggestions for improving the Welcome Baby model based on the experiences and feedback of providers.

Welcome Baby providers struggled with challenges related to Best Start community boundaries—especially with regard to marketing and outreach—and First 5 LA’s messaging that suggests the program is “universal.” At the beginning of the expansion, women were recruited based on the promise of home visiting assistance, only to be told that they were not eligible because they did not live in a Best Start community. Support from physicians waned after many patients were not eligible because they did not live in a Best Start community. Providers repeatedly identified program brochures and other marketing materials as part of the problem because they refer to Welcome Baby as a universal home visiting program.

Implications: Clearer and more nuanced messaging—especially given the recent launch of Select Home Visiting—will be needed to describe the range of services that are available to pregnant and parenting women depending on where they live and their levels of risk.

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4 This is also referred to as "Welcome Baby Lite."
Professional discretion as related to the Modified Bridges for Newborns Assessment was variable. Providers shared differing opinions on how strictly or flexibly the assessment could be used to assess risk and the amount of professional discretion hospital liaisons could exercise in assigning scores to clients.

**Implications:** In the year ahead, more training on how to administer the Modified Bridges for Newborns Assessment will be needed to improve consistency and inter-rater reliability.

Welcome Baby has the potential to work well across a range of provider settings. The expansion was implemented across a range of provider settings (hospitals and community based-organizations) serving as fiscal agents and implementers. In hospital settings, high levels of support from hospital leadership and a history of community work appeared to be important factors in the success of Welcome Baby in those settings.

**Implications:** As hard data become available, First 5 LA should analyze service use and outcomes to more precisely measure how model-type influences quality of care and impacts; such findings would help inform potential future expansions of Welcome Baby.

**CONCLUSIONS**

First 5 LA is in the midst of an ambitious expansion of home visiting services for mothers and families with young children in Los Angeles County, and can be commended for its hard work and perseverance. The expansion has been implemented unevenly at times, however, and at the approximate conclusion of “year one,” Welcome Baby in the 13 additional communities is a work in progress and in need of refinement. It is hoped that this study of early implementation has identified the successes and challenges thus far, and provides useful ideas for how First 5 LA can move forward with ongoing implementation.
I. Introduction

In 2009, First 5 LA adopted a strategic plan “Strengthening Families and Communities in LA County,” specifying how the organization planned to improve the lives of families with young children—as well as the communities they live in—through a variety of methods, including a place-based approach called “Best Start.” At the foundation of this plan were a series of strategies, designed to both strengthen families and maximize child development, including a home visiting program called “Welcome Baby.” Welcome Baby was piloted in one downtown community (“Metro LA”) beginning in 2009 and refined over the subsequent four years. In 2013, the home visiting program was expanded to 13 additional Best Start communities throughout Los Angeles County, marking a pivotal point in First 5 LA’s Family Strengthening efforts and an exciting opportunity to touch the lives of more than 34,000 families per year. The work presented here summarizes findings from a study of early implementation of First 5 LA’s Welcome Baby expansion.

The stated purpose and goal of this study is to capture early information on the expansion of Welcome Baby, assess how early implementation is proceeding, and inform any mid-course corrections that might be required. To that end, this report presents an early look at the expansion of Welcome Baby to 13 additional Best Start communities, describing the evolution of Welcome Baby and the activities involved with expansion. This includes a description of the hospital selection process, training and technical assistance provided to Welcome Baby providers, and detailed descriptions of the activities new Welcome Baby contractors and TA providers have engaged in over the past year and their implementation progress. The report concludes with a discussion of the cross-cutting lessons that have emerged at this early point in Welcome Baby implementation, lessons that should inform First 5 LA, its stakeholders, and others interested in the replication and expansion of locally designed home visiting programs.

A. Background on Welcome Baby

Welcome Baby is a voluntary, locally designed home visiting program that was developed to support women and their infants and enhance parental understanding of child development by providing education on topics related to pregnancy and caring for an infant through an empathetic and strength-based approach. The program was first launched in 2009 in a pilot community designated as Metro LA—one of 14 Best Start communities identified by First 5 LA for their high levels of need, limited resources, and existing infrastructure for young children and their families. For the subsequent five years, Welcome Baby evolved to better accommodate the needs of its clients, but always maintained its original intention to increase breastfeeding and provide families with knowledge and skills to support the positive health and development of their infants. Welcome Baby’s current goals are articulated as:

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Based on estimates from the 2010 birth data for Los Angeles County; California Department of Public Health, Center for Health Statistics, OHIR Vital Statistics Section 2012
1) Parents provide enriching, structured, and nurturing environments;
2) Parents have self-efficacy and resiliency;
3) Children and mothers are healthy; and
4) Families’ essential needs are addressed.

The following section describes the Welcome Baby program design and the changes that occurred to the program during the pilot phase in Metro LA.

**Welcome Baby Program Design.** Women can enroll in Welcome Baby prenatally or at the hospital when they give birth and, depending on the timing of enrollment, can receive up to nine contacts (or “engagement points”), with up to three engagement points occurring prenatally, one at the hospital, and five offered once the baby is born. The content of each Welcome Baby visit or phone call is designed to focus on developmentally appropriate topics, though the approach is flexible and family centered, therefore depending on each family’s situation some topics may receive more attention than others. A visual presentation of all the Welcome Baby engagement points, and resources provided to the mother at each visit, is presented in Figure I.

The Welcome Baby provider staff is composed of outreach specialists, parent coaches, hospital liaisons, and nurses. Outreach specialists mostly work in the community—with obstetrical provider offices, community-based organizations, and community events—to recruit women into Welcome Baby prenatally, while hospital liaisons work only in hospitals to recruit women soon after the births of their infant. Hospital liaisons are also responsible for conducting the universal risk assessment during the Welcome baby hospital visit and providing early breastfeeding support. The first postpartum home visit—at 72 hours post-discharge—is conducted by the nurse, while the remaining engagement points are conducted by parent coaches. All parent coaches, hospital liaisons and nurses are certified lactation educators (CLEs), as breastfeeding education and support is a central focus of this home visiting model. Parent coaches and hospital liaisons have varying degrees of expertise, ranging from college graduates to Master’s level supervisors with social work training and other relevant backgrounds. Nurses hired for Welcome Baby are expected to be public health nurses or have experience in a public health setting. Where applicable, Welcome Baby programs have sought to hire bilingual staff (English/Spanish, or other languages represented in the communities served) to best serve clients from the communities they target.

Women living in a Best Start community are eligible for prenatal Welcome Baby visits that are conducted by parent coaches, beginning in the first or second trimester of pregnancy. Generally, prenatal visits focus on strategies for promoting a healthy pregnancy, including receipt of adequate prenatal care, the importance of healthy eating and appropriate weight gain, preparation for childbirth, breastfeeding intentions, and warning signs of pre-term labor. Clients also receive program materials (see Figure I, Welcome Baby Client Flow Chart for list of materials) that support the key messages of the corresponding engagement points.

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Only women residing in a Best Start community can enroll and receive Welcome Baby prenatally. However, those living outside of a Best Start community are often informed about the program prenatally.
As mentioned above, breastfeeding instruction and support begins at the hospital with the assistance of the hospital liaison. During this contact, mother and infant bonding is also emphasized. Additionally, hospital liaisons administer a medical and psychosocial risk screen called the “Modified Bridges for Newborns Assessment” to determine a potential client’s eligibility for Welcome Baby, or another more appropriate, higher intensity home visiting program (described in Section II.A).

The 72-hour nurse home visit focuses on the health of the mother and infant, and presents an additional opportunity to support women who are breastfeeding. At this visit, the nurse assesses the infant’s height and weight, checks on the mother’s post-delivery healing, ensures that mother and baby have a source of health care and follow-up appointments scheduled, and provides breastfeeding assistance as needed. Nurses also discuss family planning strategies and screen the mother for depression using the Patient Health Questionnaire (PHQ-9) screening tool.

During postpartum visits, parent coaches continue to provide education, guidance, and support on a broad range of issues, including the client’s healthcare and baby’s well-baby check-ups, breastfeeding,
parent-child bonding, child health and development, home safety, safe sleep positions, maternal depression, and referrals to community resources and concrete services where appropriate and available. Additionally, parent coaches administer the Ages and Stages Questionnaire (ASQ) to screen infants for developmental delay at the 3-4 month and 9 month visits, the Patient Health Questionnaire (PHQ) to screen for depression, and the Life Skills Progression tool (LSP) to identify women’s strengths and needs.

**Welcome Baby in the Metro LA Pilot Community.** As mentioned above, Welcome Baby was first introduced as a pilot program in Metro LA to test its efficacy and address any issues in the program’s design before it was expanded to additional communities across the county. Since 2009, Welcome Baby in Metro LA has been offered to women giving birth at California Hospital Medical Center (CHMC) who live within a five mile radius of the hospital. CHMC partners with Maternal Child Health Access (MCH Access), a local community based organization, to provide Welcome Baby home visiting services.

The Welcome Baby program has been fine-tuned over the past five years, and several adjustments were made to the intervention’s engagement points to better meet the needs of women and foster a trusting rapport between home visiting staff and clients. For instance, after recognizing early on that the first few weeks after birth are particularly challenging and an important window for establishing breastfeeding, MCH Access and First 5 LA decided in 2012 to change the 1-2 week phone call to an in-person visit. (Hill and Benatar 2011, Benatar et al. 2012, Hill and Wilkinson 2013). The timing of prenatal engagement points was also expanded over time and modifications were made to allow parent coaches to enroll participants earlier in pregnancy. Recognizing an association between prenatal enrollment and retention, MCH Access managers and First 5 LA increased their focus on outreach and retention efforts by hiring additional “outreach specialists,” building relationships with obstetrical providers in the community, and throwing “baby showers” at local clinics, to reach women earlier.

Another critical lesson learned during the pilot phase was that Welcome Baby is not always intensive enough to meet the needs of high risk women, particularly in areas where community resources are limited. During the Metro LA pilot, there was no risk assessment administered to clients, and all women living within a 5-mile radius of the hospital were offered Welcome Baby, including women residing outside of the Metro LA boundaries. As a result, MCH Access staff observed that women giving birth in Metro LA were often at very high risk. Indeed, many women were adolescents or first-time mothers, living in poverty and substandard housing, and experiencing mental and behavioral health problems. As a result, the Welcome Baby providers believed that these women could have benefited from more intensive support than the model permitted (Hill and Wilkinson 2013, Benatar et al., 2012, Hill and Benatar 2011).

**B. Study Methods**

This study of early implementation builds on prior work conducted by the Urban Institute and its partner the University of California, Los Angeles for First 5 LA under a six-year contract to evaluate the implementation and impacts of Welcome Baby and the Best Start investment in the pilot community of Metro LA. This mixed-methods evaluation has included:
• Annual case studies of implementation;
• Focus groups with Welcome Baby clients and home visitors, and with community members involved with the Best Start investment;
• A longitudinal (3-wave) in-home survey of women who received Welcome Baby and a comparison group of women; and
• A cost analysis of the Welcome Baby program as implemented in Metro LA.

**Research Questions.** This year, augmenting the original study design, the evaluators were asked to also conduct an early implementation study of the expansion of Welcome Baby in the additional Best Start communities. Specifically, evaluators were asked to focus on answering the following research questions:

1) To what extent have organizational factors at sites (work climate, culture, communication, integration of programming into existing routines, hiring practices, internal support) affected implementation of Welcome Baby?
2) To what extent have TA providers effectively prepared staff to implement Welcome Baby through training and technical assistance?
3) To what extent do staff feel knowledgeable, skilled and positive towards the Welcome Baby model?
4) What are the early experiences of staff in implementing the Welcome Baby model (including outreach and enrollment, the Modified Bridges for Newborns Assessment tool, the Welcome Baby curriculum and engagement points, the family-centered approach, reflective supervision, and community resources and referrals)?

In addition, and time permitting, the evaluators were asked to explore several other research questions of interest, including:

• What are the characteristics of the families served by Welcome Baby?
• To what extent are family characteristics consistent with provider expectations?
• How do First 5 LA and TA providers perceive the role of Welcome Baby in the context of Best Start?
• How do First 5 LA and TA providers view their role in promoting Best Start Community Partnership work?
• How are sites, TA providers and F5LA learning from each other and developing networks for sharing lessons learned?

**Data Collection.** To prepare for this implementation study, evaluators from the Urban Institute began by conducting a review of various relevant documents, including Welcome Baby staffing models, hospital quarterly progress reports, the Modified Bridges for Newborns Assessment, minutes from quarterly Welcome Baby hospital leads meetings, the draft Welcome Baby Fidelity Framework, and the Welcome Baby logic model.

Next, Urban Institute staff worked with First 5 LA to identify the range of stakeholder groups that should be interviewed, and specific key informants within these groups. Together, we decided to focus interviews on three groups—Welcome Baby providers, the technical assistance organizations, and First 5 LA staff. Using the key research questions, the evaluators worked with First 5 LA to develop a series of
semi-structured protocols to guide each interview (see Appendix A). Though the protocols were tailored to each of the three key informant categories, they followed a similar structure and often included identical questions to allow different informants to express their views of a given research question of interest.

Among Welcome Baby providers, we were instructed by First 5 LA to concentrate on the 10 hospitals that had completed staff training and had begun Welcome Baby implementation as of the spring of 2014. We interviewed key staff at all three organizations providing training and technical assistance, including Los Angeles Best Babies Network (LABBN), MCH Access, and PAC/LAC. At First 5 LA, we focused on senior staff from Program Development responsible for overseeing the Welcome Baby expansion and implementation. Given this large number of interview targets and time limitations, we decided jointly, with First 5 LA staff, to conduct two interviews at each of the 10 Welcome Baby provider sites; one with the program manager and clinical supervisor, and the second with clinical staff including the hospital liaison, outreach specialist, nurse, and parent coaches. All such staff were invited to participate by the evaluators, but attendance at the interviews depended on staff availability and the discretion of each Welcome Baby program manager. Thus, the number of informants per interview varied—depending on the size of the Welcome Baby team, availability of staff members and preference of the program manager.

In March 2014, the Urban Institute conducted a ten-day site visit to Los Angeles. While on site, evaluators held one- to two-hour individual and small group interviews with the 94 key informants described above (shown in more detail in Appendix B). Evaluators also attended a Welcome Baby Peer-to-Peer Workshop led by LABBN. All interviews with key informants were conducted by two or three evaluators from the Urban Institute. In most cases, interviews were conducted by one senior evaluator, with a junior researcher taking notes. Where possible, all three evaluators attended each interview. However, in cases where scheduling conflicts arose, one senior staff member conducted interviews independently with the use of a recorder to verify the notes. Before starting all interviews, key informants were informed that their participation was voluntary, that they did not have to answer any questions they were not comfortable answering and that they would not be identified and quoted without their permission. All informants consented to these ground rules before interviews began. Each interview was recorded with the permission of the informants.

Given the relatively small number of interviews that were conducted by a single team, the use of qualitative analytical software (such as NVivo) was not required. Instead, interview notes were reviewed independently by the three evaluators to identify and compare common themes, discrepant

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7 PAC/LAC previously stood for the Perinatal Advisory Council: Advocacy, Leadership, and Consultation, but is now officially called PAC/LAC (i.e. PAC/LAC is no longer used as an acronym by the organization).
8 The Welcome Baby Peer-to-Peer Workshop is held quarterly with all Welcome Baby providers. The timing of the workshop during the site visit was coincidental and opportunistic. The Urban Institute, jointly with First 5 LA, decided that attending the workshop as observers would help provide valuable context to our study of implementation, and specifically to the training and technical assistance provided to Welcome Baby providers.
information, and findings. Following commonly accepted qualitative research methods, the team then developed its cross-cutting analysis of findings, supporting data, and themes, which are presented in this report.

**Limitations.** Key informant interviews represent a qualitative research method that can provide valuable and nuanced insights, based on input from those implementing or overseeing the program. By their nature, however, case studies based on key informant interviews are limited by their reliance on information gathered from a relatively small number of individuals. For example, we did not speak with every provider participating in Welcome Baby, including the four hospitals that had yet to begin Welcome Baby enrollment services at the time of our site visit.
II. Welcome Baby Expansion

According to the Strategic Plan, the “Countywide Approach Roll-Out Plans” were to be finalized during the first half of 2010 to allow for the implementation of Welcome Baby shortly thereafter. However, there were implementation delays due to questions among First 5 LA Commissioners regarding the continued investment of resources in place-based strategies, as well as changes in top leadership and staffing constraints at First 5 LA. As a result, First 5 LA did not begin the process of rolling out Welcome Baby in the 13 additional Best Start communities until 2012, nearly two years after the effort was originally scheduled to begin and in a more hurried manner than ideal. Many of the early implementation activities, including the procurement of provider sites and an Oversight Entity charged with standardizing the Welcome Baby program and establishing a fidelity framework, did not begin until 2013.

The remainder of this section summarizes the timing and steps involved in launching the expansion of Welcome Baby across the 13 communities, addressing the development of the Modified Bridges for Newborns Assessment, the hospital selection and application process, the selection of the Family Strengthening Oversight Entity, training and technical assistance, and development of the Stronger Families database.

A. Universal Risk Assessment

Building on lessons from the pilot community, First 5 LA worked to refine and expand the Welcome Baby program across all of the Best Start communities as part of its Strategic Plan and Family Strengthening strategy. In addition to the changes to the engagement points that occurred over time with input from MCH Access, a decision was made to implement a universal screening tool—the Modified Bridges for Newborns Assessment—as part of the Welcome Baby expansion, and to launch a new program of intensive Select Home Visiting programs. Implementing universal screening represented an important change to Welcome Baby, as it allowed high risk mothers to be identified and placed into the home visiting program that best fits their level of need. In 2012 First 5 LA selected a validated tool—called the Bridges for Newborns Assessment—that had been used successfully in an early outreach and referral program for pregnant women and new mothers in Orange County for over eleven years. To test the applicability of the tool for implementation in Los Angeles County, MCH Access piloted the tool for several months in early 2012 with women delivering at CHMC. The hospital liaisons and program managers at MCH Access found the tool tended to be biased towards identifying and prioritizing medical risks, rather than psychosocial risks. In particular, the tool included double-barreled questions that grouped together multiple psychosocial risks—like child abuse and history of domestic violence, and several behavioral issues—which resulted in fewer points being scored for psychosocial risks relative to medical risks. Additionally, MCH Access noted that homelessness, a problem for some mothers in Los Angeles County, was not well accounted for in Orange County’s tool. To address these issues, First 5 LA

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9 The Bridges for Newborns Assessment was adapted from the Bridges Maternal Child Health Network, which is funded by Proposition 10 Tobacco Tax revenues and managed by Children and Families Commission of Orange County.
modified the tool by separating out the double-barreled questions and identifying sub-score categories for medical, psychosocial, and demographic/basic needs.

During this time, each Best Start community was permitted to select at least one of four Select Home Visiting (SHV) models to offer to high risk women living in the Best Start community as part of the greater Family Strengthening efforts. They chose from the following options: Healthy Families America, Parents as Teachers, Safe Care, or Positive Parenting Practices. Several communities selected Healthy Families America while the remaining communities selected either Parents as Teachers; one community selected Positive Parenting Practices and none selected Safe Care. These programs would be offered to women residing in Best Start communities who are screened as “high risk” during the hospital visit, using the Modified Bridges for Newborns Assessment.

MCH Access also helped First 5 LA determine an appropriate “cut-off” score on the Modified Bridges for Newborns Assessment that would serve to classify women as either high or medium/low risk, enabling placement into the appropriate home visiting program. To do so, hospital liaisons at MCH Access noted the Bridges score for women who they believed were high risk and thus could benefit from a higher intensity program. These data helped First 5 LA set a cut-off score of 60. Women who score above a 60 and live within a Best Start community are offered a more intensive SHV program. Women who score below the cutoff and live in a Best Start community are offered Welcome Baby. Meanwhile, women who score above the cutoff (and are thus considered high risk), but reside outside of the boundaries of a Best Start community are offered an abridged version of Welcome Baby. Women who score below the cutoff and live outside of a Best Start community only receive the hospital visit and are offered referrals to needed services based on risk assessment results, but no postpartum home visiting services. Figure II demonstrates how the Modified Bridges for Newborns Assessment score is used to place women into home visiting programs.

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10 This evaluation does not assess the Select Home Visiting programs selected by Best Start communities.
13 [http://safeare.publichealth.gsu.edu/](http://safeare.publichealth.gsu.edu/)
15 Women eligible for the abridged version of Welcome Baby (also referred to by some as Welcome Baby “Lite”) can receive up to three engagement points, including: the hospital visit, 72-hour nurse visit, and 2-4 week parent coach visit.
Figure II. Universal Assessment and Home Visiting Flow

B. Hospital Selection and Application Process

During the development of the Modified Bridges for Newborns Assessment, First 5 LA began contacting hospitals eligible to participate in Welcome Baby. To determine hospitals’ eligibility to participate, First 5 LA conducted an internal review and analysis of available birth data in early 2012 and identified the County’s birthing hospitals serving the highest number of women living in a Best Start community. Based on this analysis, First 5 LA established that hospitals must have a minimum of eight percent of their deliveries from women living in a Best Start community to participate in Welcome Baby. Of the 64 birthing hospitals across Los Angeles County, 24 (25 including California Hospital Medical Center) met this threshold. First 5 LA invited representatives from these 24 hospitals to attend an informational luncheon, during which physicians, administrators, and other labor and delivery staff from CHMC spoke about their positive experiences with the Welcome Baby program in Metro LA. Although some hospitals were already aware of the opportunity—either through their previous involvement with other First 5 LA initiatives like the Best Babies Collaborative, or through the Best Start Community Partnerships—this was reportedly the first time that many had heard about the program.

Providing Welcome Baby through hospitals represented a crucial component of the Welcome Baby model to First 5 LA staff; as the site of the hospital visit was seen as the only venue in which a universal risk screening could be conducted to all new mothers. As such, First 5 LA approved all 24 hospitals as “strategic partners” which allowed them to participate in a non-competitive, Letter of Intent (LOI) process. In June 2012, First 5 LA released the LOI, which detailed the Welcome Baby home visiting

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10 2010 birth data for Los Angeles County was taken from the California Department of Public Health, Center for Health Statistics, OHIR Vital Statistics Section 2012.
model—including the specific engagement points, training, technical assistance requirements and the philosophy of Welcome Baby, which emphasizes the family-centered approach.

Hospitals began submitting LOIs on a rolling basis beginning in August 2012, and ending in May 2013. Interest in Welcome Baby exceeded First 5 LA’s expectations; within the first three months, it had contracted with six hospitals. Currently, First 5 LA has contracts with 13 of the 14 hospitals that initially completed the LOI, in addition to CHMC; as of the writing of this report contract negotiations are still underway with the last hospital. According to First 5 LA staff, eligible hospitals that did not apply for Welcome Baby were generally smaller birthing hospitals that did not have the resources to provide home visiting. In some instances, however, larger birthing hospitals that were eligible and had the capacity to offer Welcome Baby, either did not have an internal champion for the program, or had recently undergone a major transition.

Although most of the 13 additional Welcome Baby providers are not situated within a Best Start community boundary, each Best Start community is well-represented by one or more participating hospitals, as many hospitals serve multiple communities and each provider serves at least one community. Indeed, of the almost 43,000 births annually among the 13 participating hospitals, First 5 LA expects to reach 13,000 Best Start families and an additional 21,300 non-Best Start families through the universal screening.\(^{17}\)

C. Selection of the Family Strengthening Oversight Entity

Throughout the planning process, First 5 LA understood the need to provide training and oversight to the new Welcome Baby programs to enable the implementation of a standardized program across all the Welcome Baby providers. As a result, First 5 LA issued a Request for Qualifications (RFQ) in November 2012 to identify an Oversight Entity that would ensure program fidelity by providing training and technical assistance (TA) to Welcome Baby clinical and program staff.

Several months later, in April of 2013, First 5 LA contracted with the LABBN—a community organization with a mission to help medical providers improve their capacity to serve pregnant and parenting patients through technical assistance and consulting—as the lead Oversight Entity. Notably, by this date, First 5 LA had already contracted with six hospitals to provide Welcome Baby. LABBN was particularly well suited for this role, as they had a long relationship with F5LA; for example, they helped design the original Welcome Baby model implemented in Metro LA, the training curriculum for the pilot community, and the data system that was used there.\(^{18}\)

LABBN partnered with two other organizations as subcontractors—MCH Access and PAC/LAC—that also played key roles in the Welcome Baby pilot. As described above, MCH Access is the community-based organization providing Welcome Baby in Metro LA, and was instrumental in helping First 5 LA design and test tools for the expansion of Welcome Baby to the additional hospitals, including the

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\(^{17}\) First 5 LA presentation to the Research Advisory Committee 2014.

\(^{18}\) LABBN was also involved in First 5 LA’s Healthy Babies Initiative and the Best Babies Collaborative (described in more detail in Section III) in a similar technical assistance and training role.
Modified Bridges for Newborns Assessment and the Stronger Families Database (described in more detail below). PAC/LAC also was one of the initial “systems-level” partners involved with the Best Start Pilot in Metro LA. In this capacity they worked with CHMC and other area hospitals to support hospitals in becoming Baby Friendly—a designation that recognizes hospitals’ commitment to breastfeeding. Many of these same hospitals also applied to provide Welcome Baby.

Although the three organizations (LABBN, MCH Access and PAC/LAC) work in conjunction with one another, each organization lends its particular expertise to different components of the training and technical assistance:

- LABBN, as the lead Oversight Entity, is responsible for facilitating the curriculum and database trainings for Welcome Baby providers, as well as additional trainings for the organizations that provide Select Home Visiting (SHV). In addition, LABBN is the “face” of the technical assistance, and is the first group Welcome Baby sites contact with any technical assistance needs.
- MCH Access is tasked with assisting LABBN with the development and facilitation of the training and the provision of technical assistance to the sites. In particular, MCH Access focuses its training on the Welcome Baby model, including the protocols, family-centered approach, and reflective supervision practices.
- PAC/LAC is responsible for working directly with Welcome Baby providers after formal training is complete to conduct organizational assessments of each provider to gauge their infrastructure and preparedness to provide Welcome Baby, help them manage change within their organizations, and create individual technical assistance plans for each Welcome Baby site. These plans are designed to enable sites to smoothly adopt a new program and role in their community by providing home visiting services.

In addition, one of the major tasks of the Oversight Entity and their partners was to assist First 5 LA in the development of a fidelity framework for Welcome Baby sites that would help to ensure program fidelity on a variety of topics, including:

- Staff qualifications;
- Completion of Welcome Baby training;
- Supervisory requirements and the provision of reflective supervision;
- Home visitor workloads and enrollment targets;
- Service dosage and adherence to engagement point time periods;
- Family-centered approach; and
- The content of home visits.

The fidelity framework—based on best practices from the pilot site and variables most associated with quality in home visiting—was not finalized by First 5 LA and had not yet been released to Welcome Baby providers at the time of the site visit for this evaluation.

**D. Training and Technical Assistance**

After contracting with First 5 LA in April 2013, LABBN, MCH Access, and PAC/LAC quickly began working to develop the training curriculum and technical assistance plan for the new Welcome Baby providers.
1. Training.

The trainings were designed to provide Welcome Baby staff with the necessary background on the Welcome Baby model and philosophy, as well as common prenatal, postpartum, and psychosocial topics relevant to pregnancy and child rearing. Though much of the curriculum had already been developed for the training in the pilot community in 2009, LABBN modified the curriculum based on recommendations from MCH Access. Many of the modifications that were made attempted to directly connect the training materials with the Welcome Baby program and home visiting experiences.

The first two cohorts of hospitals began training in June 2013, just two months after LABBN’s contract was signed. The training—which involves 150 hours of education for all Welcome Baby providers—occurs over 12 weeks, with eight-hour sessions three to four days a week. Every provider’s staff is required to complete the trainings before they begin enrolling women into the program. In addition to the trainings, all staff providing engagement visits are required to complete an additional 45 hours of certified lactation educator training. Though some sessions of the training are optional for certain staff positions, the majority of the trainings are mandatory for every staff member from each site. The purpose of this is to provide every staff member a full understanding of the Welcome Baby model and philosophy.

Throughout the course of the training, 27 individual topics are addressed, beginning with an overview and orientation to the program and philosophy, and continuing with topics that cover:

- Prenatal care and pregnancy;
- Childbirth preparation;
- Bonding and attachment;
- Breastfeeding;
- Child development;
- Perinatal mood disorders;
- Depression;
- Domestic violence;
- Family planning;
- Postpartum and infant care;
- Modified Bridges for Newborns Assessment;
- Home visitor safety;
- Screening tools, including the ASQ and Life Skills Progression;
- Cultural sensitivity;
- Reflective supervision;
- Enhancing Parental Understanding of Child Development; and
- Child abuse mandatory reporting.

Following primarily a lecture format, these topics are presented by a variety of trainers—including doctors, nurses, midwives, social workers, and other health professionals—invited by LABBN to participate in the trainings based on their expertise. Additionally, MCH Access staff lead (or co-lead) sessions on reflective supervision practices and perinatal mental health training.
In addition to the training, LABBN also conducts quarterly workshops for continuing education and peer-to-peer learning. At the time of our visit, two peer-to-peer workshops had occurred. The first peer-to-peer workshop—held in December 2013—allowed staff from all of the Welcome Baby sites to meet with their counterparts and discuss their specific roles, responsibilities, and challenges. In March 2014, LABBN held its second quarterly workshop to provide information on the Select Home Visiting programs, as well as strategies to improve communication among team members. Quickly after the launch of the Stronger Families Database (described in more detail in section II.E.), LABBN and MCH Access also provided database trainings to each of the 10 Welcome Baby sites that had begun enrolling clients. During these trainings, staff were taught how to use the system, and given the opportunity to practice with the database and become familiar with it.

2. Technical Assistance

To complement the training efforts, provide ongoing support for Welcome Baby providers during implementation, and to ensure fidelity to the Welcome Baby model, LABBN and its partners also provide technical assistance to providers through a multi-pronged effort. Shortly after sites complete the training—but before enrolling women into Welcome Baby—PAC/LAC conducts an assessment at each site to gauge how early implementation is progressing; identify problems or concerns between staff members, and/or the implementing organizations; and identify problems that could hamper successful implementation. Information from this assessment feeds into a specific TA plan that PAC/LAC develops for each site. Based on identified needs, PAC/LAC then provides in-person coaching—either to individuals or teams—at their Welcome Baby sites. Alternatively, sites are invited to reach out directly to PAC/LAC for any additional in-person TA they might require throughout implementation to promote team cohesion and smooth implementation.

Several months after a TA plan is developed and providers begin to enroll clients, PAC/LAC returns to each Welcome Baby site to conduct an all-day “change leadership management” workshop. This workshop is designed to encourage changes to the hospital environment that will support the smooth implementation of a family centered home visiting program in a medical setting, improve leadership skills, and promote individual responsibility. Additionally, PAC/LAC teaches the providers self-care skills, and sends weekly motivational emails to combat what they refer to as “compassion fatigue.”

In addition to PAC/LAC’s in-person work with the sites, LABBN also holds monthly calls with the Welcome Baby program managers to discuss implementation challenges and share ideas for improvement. In the future, LABBN hopes to use data from the Stronger Families Database to identify specific quality improvement areas that can be discussed on the calls. Similarly, LABBN’s communication specialist speaks to sites once a month over the phone to share best practices for recruiting women and discussing marketing materials.

LABBN and MCH Access also respond to individual questions from sites on an as-needed basis. These questions are typically communicated via phone, email, or through the Welcome Baby listserv. To further support sites on common issues and frequently asked questions, MCH Access develops materials to share with all Welcome Baby providers. For example, after receiving several questions about the
patient progress notes (required after each visit), MCH Access developed an outline detailing what information needs to be within each section of these notes. These documents were posted on a shared Welcome Baby website for providers to access.

**E. Stronger Families Database Development**

Another key component of the expansion process was the selection and development of a database that could be used across Welcome Baby and the SHV programs. During the pilot, MCH Access invested significant effort into adapting a database system called Data Collection and Reporting (DCAR) that was developed to track Welcome Baby clients. Though the database was not originally designed to assist Welcome Baby providers with program management tasks, MCH Access worked with First 5 LA during the pilot to develop “work-arounds” that enabled parent coaches to utilize DCAR for program management purposes. Based on this experience, First 5 LA began looking for a new database system in 2012. In particular, First 5 LA wanted to find a system that would allow it and providers to:

1) Collect and track information and short-term outcomes for Welcome Baby and SHV clients;
2) Identify who is being served and what services are being provided;
3) Compare data from single sites and across sites;
4) Promote quality assurance and monitoring; and
5) Ensure adherence to program fidelity.

Ultimately, First 5 LA selected NetChemistry, a database provider that was also being used in Orange County for hospital referrals and case management to develop the database. First 5 LA, MCH Access, LABBN, and a program consultant provided direction, input and requests to NetChemistry, who began modifying and building what would become the Stronger Families Database in 2012. Although the database structure used in Orange County met many of the needs of the Welcome Baby program, significant changes and additions were still required to account for the higher number of engagement points in Welcome Baby. For example, a prenatal section had to be added to the system to capture women reached prenatally. Additionally, there were delays due to the finalization of data fields and HIPPA compliance required across hospitals and CBO partners. Given the changes required, release of the database was delayed. It was introduced to Welcome Baby providers in January 2014 for use in the database training, but was not fully developed at the time of our visit.

As currently designed, the Stronger Families Database houses information on each Welcome Baby home visit; client and household demographics and characteristics; prenatal and pregnancy outcomes; home safety; breastfeeding; depression; parent and infant interaction; and infant care. To accommodate the wide range of user needs, the database displays a different screen with content individualized to the position and role of each user. For instance, a parent coach has access to information on their clients only, while a clinical supervisor has direct access to each staff member’s client information and can thus manage workloads and track progress. Since the launch of the database, LABBN, MCH Access, and Welcome Baby providers have identified several additional items that will be addressed in later versions, which were added to a “parking lot,” representing the “wish list” of changes to be made. Additionally, at the time of our visit, First 5 LA was planning to migrate MCH Access’s previous and active Welcome Baby clients from DCAR into the Stronger Families Database.
III. Findings from the Early Implementation of Welcome Baby

This section summarizes key findings from our study of the early implementation of Welcome Baby’s expansion to 13 additional Best Start communities in Los Angeles County. As mentioned in Section I.B., the findings are based on information gathered through face-to-face interviews with over 94 individuals during a 10-day span in March 2014. Interview subjects included Welcome Baby provider staff, staff of the organizations providing training and technical assistance to Welcome Baby providers, as well as First 5 LA staff responsible for overseeing the expansion of Welcome Baby across Los Angeles County. The discussion is organized to address the study’s key research questions, including:

- The extent to which organizational factors at Welcome Baby provider sites have affected implementation of the program (including work climate, culture, communication, integration of programming into existing routines, hiring practices, and internal support);
- Whether or not TA providers have effectively trained and prepared Welcome Baby staff to implement the program;
- The extent to which Welcome Baby staff report feeling knowledgeable, skilled, and positive toward the program model;
- The early experiences of staff in implementing Welcome Baby, including those related to outreach and enrollment, the program curriculum and engagement points, the family-centered approach, the Modified Bridges for Newborns Assessment referrals to community resources, reflective supervision, and the Stronger Families Database; and
- Whether or not relationships are being formed between Welcome Baby providers and Best Start Community Partnerships.

A. How Do Organizational Factors Affect Welcome Baby Implementation?

One of the key research questions guiding this study of early implementation focused on how organizational factors at Welcome Baby provider sites—such as work climate, culture, communication, integration into existing routines, hiring practices, and internal support—were affecting early implementation of the program. Generally speaking, our evaluation found that while a wide variety of implementation models have emerged, mostly positive and supportive work environments exist in the hospital and community-based organizations that implemented Welcome Baby, and that these factors facilitated implementation.

1. Early Implementation of Welcome Baby Sees a Variety of Organizational Models Emerge

When the expansion of Welcome Baby across Los Angeles County was first announced, some individuals interviewed for this study reported that they had assumed the program would be implemented in a manner consistent with Metro LA’s model. That is, funding would be funneled through major birthing hospitals, and hospitals would (in turn) subcontract with community-based organizations (CBOs) to deliver Welcome Baby. Others, however, recognized that circumstances might vary, community to community, and that some hospitals might prefer to deliver all Welcome Baby services “in house.” Thus First 5 LA staff reported that they intentionally included flexibility into the Letter of Intent process to accommodate hospitals interested in different approaches to structuring their Welcome Baby programs.
Interestingly, the Welcome Baby expansion has seen a majority of hospitals deciding to implement the home visiting program completely themselves. As illustrated in Table II, this is the case in six of the 10 hospitals interviewed for this study (and seven of the 13 currently contracted Welcome Baby providers in total). The financial support provided by First 5 LA was cited as a direct motivator for implementing Welcome Baby in-house and staff in these hospitals described their desire to control these funds, maximize the marketing opportunity, enhance their capacity to support perinatal providers and their patients and limit any liability that might come from contracting with a community organization, as important factors playing into their decision-making. Meanwhile, two of the ten Welcome Baby providers interviewed for this study followed California Hospital Medical Center and the original Metro LA model by forming a partnership between the hospital and a CBO, and in one site a CBO is the lead agency and works with its local hospital as an unpaid partner (See Table II).

Table II. Welcome Baby Provider Model Types

<table>
<thead>
<tr>
<th>Welcome Baby Provider</th>
<th>Implementation Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antelope Valley Partners for Health</td>
<td>CBO subcontracting with two other CBOs</td>
</tr>
<tr>
<td>California Hospital Medical Center</td>
<td>Hospital and CBO</td>
</tr>
<tr>
<td>St. Francis Medical Center</td>
<td>Hospital and CBO*</td>
</tr>
<tr>
<td>White Memorial Medical Center</td>
<td>Hospital</td>
</tr>
<tr>
<td>Citrus Valley Health Partners</td>
<td>Hospital</td>
</tr>
<tr>
<td>Providence Holy Cross Medical Center</td>
<td>Hospital</td>
</tr>
<tr>
<td>Northridge Hospital Medical Center</td>
<td>Hospital</td>
</tr>
<tr>
<td>Providence Little Company of Mary San Pedro</td>
<td>Hospital</td>
</tr>
<tr>
<td>St. Mary’s Medical Center</td>
<td>Hospital and CBO</td>
</tr>
<tr>
<td>Miller Children’s Hospital</td>
<td>Hospital</td>
</tr>
</tbody>
</table>

*St. Francis originally subcontracted with a private, for-profit home health agency, but was transitioning to a new contract with a CBO at the time of our site visit.

At this early stage of implementation, there were mixed opinions regarding this variation among those interviewed for this study: while some viewed it as a positive development that allows First 5 LA to assess implementation under a variety of circumstances, others feared that hospitals might not be able to implement Welcome Baby in accordance with the program’s fidelity framework. It is too early to know definitively which may be the case, but the discussion below illustrates that Welcome Baby appears to fit and work well within a broad range of organizational models. Important factors observed include: the degree to which Welcome Baby providers had prior experience working in their communities; whether or not providers had experience providing home visiting; how well the hiring process had gone; whether or not Welcome Baby staff felt support from administrative leadership, physicians, and nurses; and whether Welcome Baby staff were provided adequate and functional space in which to work. These factors are discussed in more detail below.
2. **A history of working in the community is an important factor to facilitate implementation.**

It is noteworthy, especially among the many hospital-centric programs,¹⁹ that most providers were implementing Welcome Baby upon a strong foundation of in-depth work in their communities. Nearly all of the providers interviewed for this study are public and/or not-for-profit organizations, therefore performing community work with needy populations was described as “core” to their missions. For example, Providence Little Company of Mary (in San Pedro) had for decades run its own Department of Community Health which provided free care to uninsured children through a mobile medical unit and application assistance to uninsured families in the community. Similarly, White Memorial has served the East Los Angeles and Boyle Heights neighborhoods since the 1930s, conducting health fairs, diabetes prevention, and providing services to the homeless (among other efforts). Miller Children’s Hospital in Long Beach has run a variety of community outreach programs (e.g., to improve child nutrition and to prevent asthma), and works closely with the City of Long Beach’s health department to coordinate its services for high risk pregnant women. Lastly, St. Mary’s Hospital implements Welcome Baby through its “Families in Good Health” foundation, an organization with a nearly 30-year history of serving the needs of Southeast Asian populations in and around Long Beach.

Groups like MCH Access and Antelope Valley Partners for Health (AVPH) are community-based organizations founded upon the mission of providing education, support, and a wide variety of direct social and health services. For these groups, Welcome Baby represents a natural extension of that capacity. Indeed, the strong history of community work in both hospital-centric models and CBOs facilitated the implementation of Welcome Baby at a large number of sites.

3. **Experience providing home visiting services and/or becoming “Baby Friendly” provides a helpful foundation upon which to implement Welcome Baby.**

Beyond more general work in their communities, many Welcome Baby providers reported having a history of providing home visiting services, often to pregnant and/or parenting women. Most often, we heard of providers’ involvement with First 5 LA’s Healthy Births program, which included the recently concluded Best Babies Collaborative (BBC).²⁰ Of the 47 partner organizations in the BBC, six are now involved in the Welcome Baby program, including AVPH, MCH Access, White Memorial, Providence Holy Cross, St. Mary’s, and Citrus Valley. In addition to the BBC, sites like Citrus Valley pointed to numerous other past (and current) maternal and child health-related community projects, including the GEM (Get

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¹⁹ The term “hospital-centric” is used throughout this report to refer to those Welcome Baby programs that are operated out of a hospital-based setting, and to distinguish these Welcome Baby providers from those that are operated by a community-based organization or some other arrangement.

²⁰ The Healthy Births Initiative sought to improve outcomes for pregnant women and their families and reduce poor birth outcomes through sustainable networks across Los Angeles County ([http://www.first5la.org/Programs/Healthy-Births](http://www.first5la.org/Programs/Healthy-Births)). The Best Babies Collaborative supports the overarching goals of the Healthy Births Initiatives—to improve outcomes for pregnant women and their families and reduce poor birth outcomes in vulnerable populations—by providing comprehensive, integrated continuous care via case management to high-risk women through seven BBCs providing care throughout Los Angeles County.
Enrollment Moving\textsuperscript{21} initiative, running a Healthy Mothers/Healthy Babies Coalition,\textsuperscript{22} and serving as a Comprehensive Perinatal Service Programs (CPSP)\textsuperscript{23} provider under Medi-Cal.

Beyond the Best Babies Collaborative, organizations such as AVPH reported being active providers of Healthy Families America home visiting (called Healthy Homes by AVPH), and one of its subcontractors—the Children’s Bureau—had provided a “micro” version of Welcome Baby to residents in the Antelope Valley in recent years. St. Mary’s other previous home visiting experience was through a program called Families and Children Together, a prenatal care-focused effort targeting African American, Cambodian, and Latino women.

Furthermore, at the time of our visit, many of the hospitals interviewed had recently completed their certification as, or were in the midst of becoming, Baby Friendly.\textsuperscript{24} Experiencing the Baby Friendly Hospital process—at Providence Little Company of Mary, White Memorial, Citrus Valley, Northridge, California Hospital Medical Center, and Providence Holy Cross—was described as creating a supportive organizational environment for adopting Welcome Baby, since it succeeded in getting hospital administrators oriented toward supporting better outcomes for infants.

4. Providers largely succeeded in hiring staff, but encountered a variety of challenges along the way.

When First 5 LA began contracting with Welcome Baby providers in the spring of 2013, providers were charged with hiring staff as quickly as possible. Responding to this charge, providers largely succeeded in assembling their teams—though some positions were harder to fill than others. According to key informants interviewed for this study, Welcome Baby providers mostly hired new staff to form their teams, rather than “hiring from within.” In most cases, these staff did not have previous experience with home visiting. Some providers, however, described how they were able to transition staff who were prior employees of the BBC to Welcome Baby, and one site even hired a former Welcome Baby employee of MCH Access, from the Metro LA pilot community. In such cases, providers felt they had a “leg up” that allowed their teams to implement Welcome Baby somewhat more smoothly. These more experienced staff felt more prepared to provide home visiting and were also described as able to provide more leadership and mentoring to less experienced staff.

For many providers, several factors made hiring Welcome Baby staff challenging. First, several program managers noted that the salary ranges permitted by First 5 LA were low by market standards,  

\textsuperscript{21} Get Enrollment Moving is a nonprofit community-based project to help individuals and families enroll in health coverage.
\textsuperscript{22} Healthy Mothers, Healthy Babies is a national coalition, with state and local chapters, that helps creates partnerships among stakeholders to improve the health and safety of mothers, infants, and families.
\textsuperscript{23} The Comprehensive Perinatal Services Program provides culturally competent services to Medi-Cal pregnant women designed to complement medical care through nutritional, education, psychosocial and care coordination services.
\textsuperscript{24} Baby Friendly Hospitals is an initiative that encourages hospital providers to embrace policies and practices that promote breast feeding by implementing a series of policies and procedures that lead to “Baby Friendly” certification. https://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative
which made it difficult to lure some qualified candidates. Second, First 5 LA made the hiring criteria for each Welcome Baby labor category more restrictive several months after the launch of Welcome Baby. Over time, as the program’s fidelity framework took shape, more specification was added to various aspects of the program, including minimum hiring qualifications (for example, nurses must have prior community health experience and should preferably be bilingual.) As a consequence, several providers mentioned how the new, stricter rules made it that much more challenging to complete their teams. Interviewees from the TA providers generally felt that this was a positive development for Welcome Baby, that higher and more uniform standards would increase the quality of the program, saying, “The specification of the basic qualifications has increased the quality of the individuals doing the work...they understand it better.” On the front lines, however, some Welcome Baby providers felt the opposite, and expressed the opinion that the more rigid rules were hurting them. One project director shared, “Some of my best staff are ones I hired early, and they wouldn’t even qualify now, given the new standards. Since the rule changes, I’ve had to turn away perfectly good candidates that I’m certain could have worked out well.”

The challenge of filling various staff positions slowed Welcome Baby implementation, in many cases, especially with regard to enrollment. Program directors repeatedly reported that hiring nurses that meet the Welcome Baby criteria of being bi-lingual English/Spanish speakers and of having prior community health experience posed the greatest challenge. The second most challenging position to fill was consistently reported to be the Clinical Supervisor, who is required to be a Licensed Clinical Social Worker (LCSW), RN, or Licensed Developmental Psychologist with experience in MCH home visiting and reflective supervision. In contrast, Welcome Baby project directors generally felt that qualified parent coaches, hospital liaisons, and outreach specialists were more easily hired. “There is a great supply of skilled college graduates out there,” said one provider.

Staff retention has generally been strong across providers. Nearly every provider, however, experienced some turnover, and some experienced more significant turnover than others. Providers shared that it was particularly disruptive when they lost nursing staff, since a vacant nursing position creates a bottleneck for the rest of the Welcome Baby team and decreases the teams’ ability to schedule home visits with infants. One provider’s response to having an extended nurse vacancy was to allow parent coaches to conduct the 72-hour nurse visit, completing the full protocol except for the mother and infant health assessments.

Another challenge described by Welcome Baby staff was the problematic dynamics between hiring and training; specifically, the timing of these two processes did not always align. There were many cases where staff were hired, but a new training cohort was not scheduled to begin for a month or more, meaning the new staff were left somewhat idle—unable to provide services, and unable to begin training, as well. Both Welcome Baby providers and TA staff described how they always felt like they were “playing catch-up,” trying to get new staff trained and ready to perform. One provider faced a situation where they made an offer to a prospective employee, and that person accepted the offer, but paperwork at the hospital was moving slowly. Meanwhile, a training cohort was about to begin. Therefore, rather than have this new hire miss the training, they arranged to pay the prospective employee a stipend so that they could attend training before being officially hired.
5. **Hospital administrators were often very supportive of Welcome Baby, but gaining support from doctors and nurses was sometimes more challenging.**

Another factor that appears to have fostered more successful early implementation of Welcome Baby is the support of hospital administration and leadership. In several hospitals, we heard staff describe hospital administrators and CEOs as “very supportive” of Welcome Baby and its mission. At one hospital, the program was described as the CEO’s “pet project.” Others described somewhat less supportive environments—where leadership “had lots of questions” about the nonmedical model of Welcome Baby—but where support steadily grew as administrators became more familiar with the program and its benefits for families.

For PAC/LAC, one of the driving assumptions behind their role was that there would be considerable tension between Welcome Baby staff and hospital administration, and that they would be working with providers to smooth and integrate those relationships. This tension, however, largely did not materialize; in fact, PAC/LAC staff described hospital administrations as quite “welcoming” of Welcome Baby. Problems only surfaced to a significant degree in two hospitals, so PAC/LAC instead focused its assistance on helping Welcome Baby providers adjust to their roles and implement the program.

In most instances, Welcome Baby staff also described largely positive and supportive relationships with hospital doctors and nurses. There were cases, however, where staff said it took time to “work out the puzzle pieces” and build trust with doctors and nurses. Nurses were sometimes described as “territorial” and “protective of their patients,” and hospital liaisons talked of sometimes having to work hard to “get on their good side” and make it clear that they were there to support nurses and obstetrical team. In almost all cases, hospital liaisons reported feeling like they eventually were able to become mainstays on the ward, welcomed and valued by nurse supervisors. Indeed, some believed they were now seen as a strong complement to the routine hospital services and often reported that nurses directly inform them of potential new Welcome Baby clients.

In hospitals with less community experience, however, this acceptance did not come as readily, making it harder for staff to carry out their responsibilities. Staff at one hospital described how labor and delivery providers were not initially trusting of Welcome Baby staff, that it was a struggle to become accepted, but that it has improved over time. At another hospital, leadership was not described as a barrier, but not as a facilitator, either. For example, in the time since the program launched, the outreach specialist only had one or two opportunities to make presentations to other hospital staff and providers, and did not feel like the program was “well known,” thus hindering referrals by obstetrical providers affiliated with the hospital, which has proven to be a rich resource for other Welcome Baby programs.

6. **Organizations signal support by providing Welcome Baby providers with dedicated space.**

One reflection of administrative support for Welcome Baby is the extent to which program staff enjoy attractive, or at least adequate, space, a factor that was described as raising staff morale. At one hospital, Welcome Baby staff did not have much of a space to call their own, until a bungalow that formerly served as part of the institution’s physical plant was completely refurbished for Welcome Baby...
staff. At a second hospital, Welcome Baby occupies space that was a former physician suite and that was completely remodeled with new furniture, paint, and carpeting. The Welcome Baby program at another hospital occupies space described as “beautiful” by staff, but in so doing, they actually engendered the resentment of other departmental staff whose space is less new and modern. Of course, not every hospital—even those with strong support from leadership—has adequate space. Indeed, we heard from two Welcome Baby programs that they had quickly outgrown their office space and were looking for a newer, larger space.

B. Have TA Providers Effectively Prepared Staff to Implement Welcome Baby Through Training and Technical Assistance?

When First 5 LA began contracting with Welcome Baby and TA providers in the spring of 2013, hospitals and community-based organizations were charged with hiring staff as quickly as possible, and the TA providers were left with only two months to design and launch the training curriculum for new Welcome Baby staff. Under these rushed circumstances, providers largely succeeded in assembling their teams, and LABBN and its partners were able to formulate and implement a thorough training regimen that was both universally praised for its comprehensive subject matter, but also criticized for its lack of focus on practical application to job-specific roles. These dynamics are described in more detail below.

1. Praise for the training’s comprehensive content.

As described in Section II.D, LABBN and its partners quickly developed a broad and in-depth training curriculum for Welcome Baby staff during the early spring of 2013, covering 27 different topic areas of importance to the provision of the Welcome Baby program’s services. Without exception, providers praised the comprehensiveness of the training and, in most instances, the caliber of the trainers that participated. Welcome Baby provider staff felt that they were treated well and with respect, and that they were “taken care of” well during the training, in terms of appealing facilities, meals, and refreshments. Another aspect of the training that was praised was the fact that all provider staff, regardless of position, were trained together as a group. This allowed for important team building, according to interviewees, as well as having all team members exposed to the same Welcome Baby training material.

Staff at the organizations providing TA also expressed a fair amount of satisfaction with the training they developed. Given the rushed timeframe, it was a clear advantage that LABBN had developed the original training curriculum for Welcome Baby in Metro LA, and could build off of and refine that approach. MCH Access, too, had a wealth of experience to draw on that also lent itself to the rapid development of new training materials.

2. Criticism for the training’s lack of practical, job-specific focus.

Unfortunately, as uniform as the praise was for the comprehensive curriculum content, so was criticism for the lack of more practical, job-specific training for the various members of the Welcome Baby teams. Consistently and repeatedly, Welcome Baby project directors, supervisors, and staff reported that while they appreciated all of the subject matter content that they learned, they were equally frustrated by the
lack of focus on how to apply that knowledge to the job itself. The training approach was described as mostly lecture style, with only limited “role playing.” No break-out sessions were provided for the various Welcome Baby provider positions—outreach specialists, hospital liaison, nurses, or parent coaches—that could have been devoted to training these staff on how to effectively play their particular roles. Critical tools—like home visit protocols, the Welcome Baby fidelity framework, and the Stronger Families Database—were not yet ready or available during the training; therefore participants could not learn the specific scope and content of what was expected of them on the job. Overall, these gaps resulted in a large majority of staff reporting that they felt unprepared to do their job at the conclusion of their training.

One problem that exacerbated this frustration was that Welcome Baby providers said they were told they would have opportunities to “shadow” MCH Access home visitors so that they could observe and learn how to conduct home visits. However, this “promise” (as many called it) was scaled back so that only each provider’s clinical supervisor could participate in one shadowing visit, and some providers reported that they never participated in even this one shadowing experience. Some staff were surprised and disappointed by this omission because MCH Access had made “shadowing” a critical and routine aspect of its staff training in Metro LA.

Another problem cited was the lack of sufficient peer-to-peer learning opportunities. After four cohorts were trained, LABBN’s first quarterly peer-to-peer session convened in December 2013 (as described in Section II.D). Without exception, provider staff reported that the session was valuable, describing it as “wonderful,” “eye opening,” “so instructive, to see that others were doing the same things we were doing, and experiencing the same problems we were experiencing.” Even that session, however, was described as frustratingly short—lasting only half a day. Providers were very excited to participate in the second quarterly peer-to-peer session in March 2014 (attended by the evaluators), but that event “turned out not to be peer-to-peer at all,” as one staff described it. Rather, it was composed of several presentations related to the upcoming expansion of the Select Home Visiting component of the Family Strengthening initiative, as well as a facilitated full-group session on alternative and effective communication styles. In contrast to the first peer-to-peer training, a full day was devoted to this second session, but numerous staff interviewed for this study were disappointed that they had not been extended the opportunity to learn from one another.

Other feedback offered by key informants regarding the training included:

- The lecture format was too long, too intense, and very difficult to sit through for 8 hours a day;
- In contrast to early training cohorts that were spread out across three months, more recent cohorts were completed in 7 weeks, with full day session, 4 or 5 days a week, for 7 weeks straight. This intensity was described as making it difficult to absorb the full content of the training.
- As much value as providers saw in learning together, as a team, some also questioned the efficiency of requiring administrative staff, and even nurses, to participate in the full training curriculum, given their more limited scopes of responsibility.
The TA providers acknowledged some of these shortcomings of their training. They reported being surprised that they would have to work so hard at connecting training to practice, and suggested that this outcome might be linked to the large number of hospitals that decided to provide Welcome Baby directly (rather than through a CBO), and inexperienced or under qualified staff hires. TA providers said they reached a point where “there wasn’t enough of us to go around” to provide the practical and shadowing aspects of the training that were needed. They were frustrated, as well, that so many of the critical tools for Welcome Baby implementation—protocols, the fidelity framework, and the database—were not ready in time for the training. TA providers did describe how they were constantly working to improve and refine their training approach, and this improvement was observed by Welcome Baby providers whose teams had attended multiple cohort trainings over the course of the year.

Notably, Welcome Baby providers reported that PAC/LAC was consistently available to help them through these challenges. In its role providing hands-on technical assistance to Welcome Baby providers after training is complete, the group was universally praised for its diligence and insightful assistance. Providers consistently praised the constructive help they provided—in setting a vision for their work, and in managing the change and stress that comes with their jobs. One provider that experienced a particularly rocky launch to their program said it was “a unique privilege to work with PAC/LAC through our tough transition.”

C. To What Extent Do Provider Staff Feel Knowledgeable, Skilled, and Positive Toward Welcome Baby?

Welcome Baby provider staff expressed very positive and upbeat feelings about the program and services they are providing. Almost uniformly, they were excited to be involved in the home visiting intervention and proud to deliver services that they believed could help the families in their communities. However, as described in the previous section, this positivity was often tempered by feelings of anxiety surrounding their knowledge and skills in carrying out their specific jobs. Once again, an overall lack of job-specific training, coupled with insufficient opportunities to shadow experienced home visitors and to learn from their peers, left Welcome Baby provider staff too often feeling unprepared for their jobs.

Importantly, provider staff described several strategies that they engaged in—independent from the trainings and technical assistance—to compensate for this reported lack of practical training. These strategies included: additional in-service and professional development training at the provider sites; extensive role-playing exercises to simulate home visit and outreach interactions; developing flow charts to get a better handle on how various Welcome Baby engagement points fit together; producing checklists for items and topics to cover during home visits; and creating their own tracking systems for clients, since the Stronger Families Database was not yet ready. At one organization, where numerous extant home visiting programs are in operation, Welcome Baby staff were permitted to shadow home visitors and gain a sense of what to expect when they went into the field. Taken together, these activities went a long way, in the opinion of the providers, to better prepare them for their eventual case work. In many cases, staff were grateful that “enrollment got off to a slow start, since we would not have been ready to handle a full caseload.”
D. What Are the Early Experiences of Staff in Implementing the Welcome Baby Model?

At the time of our site visit, most Welcome Baby providers had six months or less of implementation experience. Still, in most instances, this was sufficient time for providers to begin making important observations about how several core activities surrounding Welcome Baby operations were going. One of the key research questions of this study was to explore the early experiences of staff in implementing Welcome Baby. This section describes providers’ early experiences implementing the program model, examining a number of key program features: outreach and enrollment; use of the Modified Bridges for Newborns Assessment; implementing the Welcome Baby curriculum during engagement points with families; the family-centered approach to working with clients; reflective supervision; identifying community resources and making referrals; and early experiences with the Stronger Families Database. Each of these features is discussed, in turn, below.

1. Providers had mixed experiences with outreach and enrollment.

Each Welcome Baby team includes an outreach specialist who is responsible for engaging pregnant women who reside within a Best Start community and encouraging them to enroll in the program. Reaching and enrolling women prenatally—rather than at the hospital post-delivery—has been a growing priority for First 5 LA since the early years of the Metro LA pilot program. Thus far, however, it has proven to be quite challenging; outreach specialists often reported that when they introduce Welcome Baby, pregnant women (and their partners) are not always open to the idea of having someone visit them in their homes, and do not always acutely feel the need for such help before their babies arrive, as compared to women right after their deliveries. In Metro LA, MCH Access experienced much higher acceptance rates among women in the hospital, recruited by hospital liaisons, than they did with pregnant women. They also worked hard over time to develop prenatal outreach strategies and reach a point where approximately 40 percent of their enrollees were pregnant women (Hill and Wilkinson 2013).

With the expansion of Welcome Baby to 13 additional communities, prenatal outreach successes were observed during early implementation, but serious challenges also existed. Combined, these factors resulted in overall enrollment numbers that were mixed, with some providers surpassing their initial prenatal enrollment goals, and other struggling to reach prenatal enrollment goals. Findings are summarized below.

- **Hospital-centric providers appear to enjoy distinct outreach advantages.** Interviews with Welcome Baby managers and staff, and TA providers, suggested that hospital-centric providers likely benefit from certain “built in” advantages when it comes to prenatal outreach. Namely, outreach staff, as employees of the hospital, can take advantage of various aspects of the hospital’s infrastructure—like affiliated obstetrical clinics and doctors, hospital tours and baby showers for expecting mothers, and hospital marketing or provider relations departments. This allows Welcome Baby outreach specialists to focus their outreach efforts and gain direct access to women served by the hospital. Very consistently, we heard outreach staff of hospital-centric Welcome Baby providers describe how their outreach was directly focused on obstetrical
providers. Obstetrical providers involved with Medi-Cal’s Comprehensive Perinatal Services Program (CPSP) were often singled out as particularly open to Welcome Baby’s outreach efforts, since the pregnant women they serve are so often experience high psychosocial risks and could benefit from home visiting assistance.

Beyond this, all Welcome Baby providers more generally described how they conducted community-based outreach as well, at such sites as WIC programs, Head Start and child care agencies, libraries, community social services agencies, and at local health fairs. CBO-based Welcome Baby providers also described successful efforts targeting obstetrical providers—one organization spoke of its close relations with Kaiser Permanente prenatal clinics and how they represented one of their key sources of referrals, for example. Such providers tended to describe community-focused outreach strategies more prominently compared with hospital-centric programs.

• **Marketing Welcome Baby effectively was seriously challenged by Best Start Community Boundary issues.** Unlike Metro LA, where all women living within a five-mile radius of California Hospital Medical Center are eligible for Welcome Baby, most of the other 12 new Welcome Baby sites are not located within the boundaries of the Best Start communities they serve, but serve families living both within and outside of a Best Start Community, which impacts the program dosage families are eligible to receive (See Figure III). This circumstance led to serious challenges surrounding how the program was marketed to both women and obstetrical providers, while creating somewhat unexpected problems between these programs and the communities they serve. Time and again, interviews revealed that outreach specialists began marketing Welcome Baby as the “universal home visiting program” it was described as being (in program brochures and other materials), only to find that large proportions of the women they met did not live within the Best Start community boundaries, and were thus not eligible for the prenatal portion of the intervention. Early efforts to gain the cooperation of obstetrical providers in referring women to Welcome Baby often backfired when women who were referred to the program did not qualify because of where they lived. Program staff discussed how they often encountered very angry and frustrated women and obstetrical providers. In fact, we heard that many obstetrical providers have simply stopped referring women to Welcome Baby because doing so too often puts them in the position of appearing to mislead their patients about the program.

This problem was experienced more acutely in some communities than others—both AVPH and St. Mary’s Hospital, for example, are located within the boundaries of their Best Start communities, thus simplifying their marketing efforts. Other Welcome Baby providers, however, are situated many miles away from their Best Start communities, and thus marketing and outreach had to be adapted and refined. Staff were more careful to travel to their target communities to engage women and concentrate their efforts within the correct boundaries. Messaging, as well, had to be softened and made more nuanced—outreach specialists no longer
said that Welcome Baby is a “universal” program, but rather one that women might be eligible for, depending on where they live. Some hospitals developed different marketing scripts for different audiences—including mothers and providers within, or outside of, the community boundaries. Attempting to explain the differences between Welcome Baby and the abridged version of Welcome Baby in this context was not easy, and further muddied what was hoped to be a simpler and straightforward outreach campaign.

Importantly, Welcome Baby provider staff consistently reported that Best Start community boundaries felt arbitrary—that women outside of the specific community boundary seemed just as high risk, and equally in need, as those living within the boundaries. Indeed, Welcome Baby staff reported hearing from both obstetrical providers and women in the community who struggled to understand why they were being denied a service that their neighbor was receiving, simply because they “lived on the wrong side of the street.” In several instances, interviewees—especially those in leadership positions—acknowledged that First 5 LA and Welcome Baby needed to figure out a way to be more “transparent” and “open” about the program, and to stop portraying it as “universal.”

- **Various other challenges disrupted outreach efforts.** Key informants in leadership positions often described Welcome Baby outreach specialists in very positive terms, calling them some of the programs’ most “enthusiastic and energetic” staff. Yet this enthusiasm was tamped down from time to time by some (but not all) providers. Specifically, when providers had staff turnover or delays in hiring members of the Welcome Baby team—nurses, in particular—then
programs had to “put the brakes on outreach” and stop recruiting new enrollees, or target women who were very early in their pregnancies to buy time for the programs to secure additional hires. Other marketing challenges identified by some Welcome Baby providers included:

- Concern that the marketing brochures provided by First 5 LA and the Oversight Entity were too generic and thus inappropriate for the communities they service (if, for example, the ethnic diversity in a given community did not seem well reflected in the brochure);

- Related concern that brochures were particularly inappropriate for use in non-Best Start communities because they portrayed Welcome Baby as a universal program and did not highlight the importance of Best Start community boundaries and how that affects eligibility;

- The fact that outreach specialists are the lowest paid members of the Welcome Baby team, a status that risked making them feel undervalued and that potentially undermined their status; and

- The general sense that budgets and materials to support effective outreach were insufficient.

• **Enrollment appeared to be proceeding well, though experiences varied considerably across Welcome Baby sites.** Encouragingly, and despite the challenges described above, early enrollment into Welcome Baby was relatively strong, and “much better and faster than expected,” according TA providers. That said, there was also considerable variation across the providers with level of enrollment directly influenced by how early (or late) programs were established, fully staffed and trained.

Providers that enrolled the largest numbers of women (e.g., 300 or more women), as of March 2014, included Antelope Valley Partners for Health, St. Mary’s Hospitals, St. Francis Hospital, and Providence Holy Cross. Providers with some of the lowest enrollment included Miller Children’s Hospital, who did not launch until February 2014, and Citrus Valley Medical Center, who experienced high rates of staff turnover.

In several cases, as mentioned above, Welcome Baby providers were forced to halt outreach efforts when staff turnover meant that there were insufficient nursing resources to handle more enrollees. This was the case with one hospital provider, for example, which succeeded in enrolling a reported 250 women in December 2013 alone, only to be forced to almost completely stop enrollment in 2014 when two nurses left the program. A second provider slowed down its outreach efforts after a quick start (roughly 150 enrollees in December 2013)

25 Since the Stronger Family Database was not in place at the time of this study, Welcome Baby providers could only self-report their enrollment data. Therefore, “round numbers” are presented to account for the potential for imprecise and/or variable data across the Welcome Baby providers.
put pressure on the rest of the team—and nurses, in particular—to keep up with the volume of cases. The TA providers and First 5 LA staff were explicitly supportive of such adjustments; numerous key informants reported that they were told that First 5 LA preferred to see high quality care being provided to a smaller number of women, rather than lower quality care provided to larger numbers. This reflects First 5 LA’s strong focus on promoting quality and maintaining fidelity to the Welcome Baby model.

Given the program’s focus on prenatal recruitment, it is encouraging to note that Welcome Baby providers in the additional Best Start communities appeared to be successful in enrolling pregnant women at similar, if not higher rates than occurred in the Metro LA pilot community. White Memorial and St. Mary’s both reported that nearly 50 percent of their enrollees were recruited prenatally; AVPH and St. Francis thought this number is closer to 40 percent for their hospitals.

Somewhat less clear was the proportion of all enrolled women that were coming from the Best Start versus non-Best Start communities. For providers located inside the boundaries of their Best Start communities, like St. Mary’s Hospital, upwards of 90 percent of enrollees were thought to reside in the target community. For hospitals like Northridge situated roughly 10 to 15 miles away from the Best Start communities of Panorama City and Pacoima; providers believed nearly three-quarters of enrollees were from non-Best Start neighborhoods more closely adjacent to the hospital. For Providence Little Company of Mary, Welcome Baby staff noted that the proportion of non-Best Start enrollees was even larger—close to 90 percent—since their facility was in San Pedro and the Best Start community they serve (Wilmington) is already served by two other birthing hospitals participating in Welcome Baby (St. Mary’s and Torrance Memorial).

- Early experience with retention was quite positive and seemed to very closely reflect the experiences of MCH Access in Metro LA. Specifically, every Welcome Baby provider reported that the only women who drop out of Welcome Baby with any consistency are those that enroll in the hospital, after the delivery of their babies. When these women do drop out, it tends to be before the first nurse visit can take place. This phenomenon was often attributed to the fact that little or no opportunity to develop rapport with women had occurred (since recruitment did not occur prenatally) and/or partners had pushed back on the idea of having home visitors come into their homes. Otherwise, retention of women recruited prenatally was very strong.

2. Mixed reactions to the Modified Bridges for Newborns Assessment.

As described in Section II, one of the critical steps preceding the expansion of Welcome Baby was the testing and adaptation of a standardized risk assessment instrument—the Modified Bridges for Newborns Assessment—that could be used to identify the level of risk faced by women. Since implementation numerous issues have cropped up surrounding the use of the Modified Bridges tool. First, Welcome Baby staff received just one half-day of training on how to administer the risk assessment, and the expectation set by trainers and First 5 LA staff was that doing so would add
approximately 15 to 20 minutes to the typical 30-to-60 minute hospital liaison visit. In reality, provider staff reported that it often takes closer to 30 minutes, and sometimes as much as 90 minutes to complete the risk assessment, depending on the woman and her needs.

Second, providers struggled with how rigidly they should administer the tool. On one hand, training emphasized the importance of fidelity to the Welcome Baby model, and thus many providers believed they should be using the Modified Bridges for Newborns Assessment in a very strict manner, asking questions verbatim, and recording mothers’ answers similarly. On the other hand, some providers believed that several of the instrument’s questions that deal with sensitive subject matter—like domestic violence or depression—required a more nuanced approach, given that this is the first interaction between the hospital liaison and the new mother with no prior opportunity to build trust or rapport. These providers concluded it is more appropriate to use their professional discretion in interpreting mothers’ answers to questions, and indicating that risks may be present even when mothers did not explicitly admit them. Furthermore, providers expressed varying interpretations of the guidance they received from the TA providers on how they should administer the Modified Bridges for Newborns Assessment; some believed the teaching clearly indicated that no subjectivity should enter the exercise, while others said they were told it was “okay” for them to exercise their judgment. Still others reported that, in tough situations, hospital liaisons should consult with their clinical supervisors and that supervisors would make the ultimate decision on how to score a potential risk.

This variation and uncertainty was attributed by many to what they believed was insufficient training on how to administer the Modified Bridges for Newborns Assessment. TA providers reported that they were well aware of the problem and that they anticipated needing to provide more technical assistance to providers in the future to improve inter-rater reliability. While this issue remained unresolved, a small number of providers were found to be “up-scoring” their Modified Bridges for Newborns Assessments, especially for non-Best Start community members, so that they could be eligible to receive services. First 5 LA and the TA providers, however, have worked with these providers and generally believe that the identification of “high risk” clients is no longer being manipulated.

These challenges aside, many respondents did feel like the Modified Bridges for Newborns Assessment was a fundamentally sound one that did a reasonably good job of identifying women with a range of medical and psychosocial risks. Still, many providers remarked at just how few mothers were scoring above 60 points, as a proportion of all mothers who were administered the Modified Bridges for Newborns Assessment. Only two providers reported that 30 percent of their clients were scoring 60 points or above—the initial target estimate of First 5 LA—while the remainder reported much lower rates. One hospital reported that its average score was just 20 points; theirs was a heavily Latino community where mothers reportedly experienced strong family support, and the feeling was that the Modified Bridges for Newborns Assessment was more appropriate for communities with higher rates of serious problems like gang violence or substance abuse. Interestingly, several providers reported that women from non-Best Start communities were more likely to score “high risk” than those within the Best Start community boundaries. These dynamics have led First 5 LA to reconsider its 60 point “cut off”—a level they admitted was somewhat arbitrary—and program staff said that they were considering lowering the high risk cut-off score to 50 points.
One final issue related to the Modified Bridges for Newborns Assessment that arose frequently during key informant interviews was providers’ frustration that they could only administer the risk assessment at bedside in the hospital shortly after delivery. As mentioned above, hospital liaisons are typically meeting mothers for the first time during this visit, and have established no trust or rapport with them. Furthermore, this can often be a very hectic time—with partners or family members visiting new mothers in the hospital, infants crying, mothers exhausted and recovering from their deliveries—and as such, is not an ideal time to administer a complex and sensitive risk assessment instrument. Providers repeatedly wondered why they were not permitted to use the Modified Bridges for Newborns Assessment during calmer prenatal visits, as parent coaches and mothers were getting to know one another. Additionally, providers felt that conducting the assessment tool prenatally would allow high risk women living inside a Best Start community the opportunity to be flagged for the higher intensity Select Home Visiting program earlier. This would also avoid challenges Welcome Baby providers anticipate regarding shifting women to another program once they have developed a rapport with a Welcome Baby parent coaches. Other staff suggested that the Modified Bridges for Newborns Assessment should not be a “one shot” deal. Rather, they felt that nurses should be able to revisit the assessment during their home visits, to see whether the ability to more accurately identify risks changes when mothers are at home and, as a result, improve the focus and quality of the care they are providing. At the time of this report, however, First 5 LA was adhering to their decision that the Modified Bridges for Newborns Assessment should be applied universally to all women in the hospital after the birth of their infants.

3. Nurse and Parent Coach home visits were going extremely well.

Nearly all Welcome Baby providers were still in the early stages of serving their first waves of clients. Most had worked with mothers through the 3-4 month visit in the Welcome Baby protocol, but none had yet completed 9-month visits with their clients. Almost universally, staff and program managers expressed excitement and satisfaction with how the visits were proceeding. Mothers responded very positively to home visitors, and expressed appreciation for the help they were extended. “Young mothers are eager to learn everything about raising their child, while older mothers are interested in seeing if child-raising has changed since they had their previous children,” said one provider. Even mothers who were perceived as initially reluctant to allow a “stranger” to enter their homes were described as “coming around” and feeling good about the service once it was provided.

Providers singled out the Welcome Baby Book as one particularly effective and beneficial tool for their visits. Nurses and parent coaches praised the rich and accessible information contained in the book, and mothers reportedly “love” not only the useful reference information, but also the ability to use it as a journal for keeping track of their infants’ development.

With regard to timing of the Welcome Baby engagement points, providers consistently reported that nurses were often not able to visit mothers within the 72-hour target that was indicated in their training. Rather, nurses were more likely to conduct their visit within the first 7 days or so after discharge from the hospital, primarily due to workload demands. No one felt this delay was causing problems. On the contrary, most felt it was a better time to visit because later nurse visits would not
compete with mother’s first post-partum pediatric visit. Just as was the case with MCH Access in Metro LA, parent coaches from the 12 new Welcome Baby providers expressed considerable alarm at the gap between the 3-4 month, and the 9-month home visit (Hill and Benatar 2011, Benatar et al. 2012, Hill and Wilkinson 2013). Coaches felt the gap was too long, and occurred during a period of critical child development when infants were transitioning to solid foods, beginning to crawl, and the like. Some expressed fear that they may lose women during the long gap. Similar to what was expressed in the pilot, the new providers wished that the protocol allowed for a 6-month visit (Hill and Benatar 2011, Benatar et al. 2012, Hill and Wilkinson 2013).

Also like the pilot, providers reported that retention problems virtually disappear once the nurse visit is successfully completed. As one program manager described it, “Moms are locked in, from that point on, and committed to staying involved.”

Less positive views of the abridged version of Welcome Baby were shared by providers that serve predominantly non-Best Start community residents. These providers felt that the smaller number of home visits permitted under the abridged version was wholly inadequate to meet these mothers’ high levels of need. Some parent coaches also thought that the small number of visits was concentrated in too narrow a time span, and would be more effective if the visits were spread out.

Though many of the Welcome Baby providers experienced slower enrollment than they originally anticipated and were not yet at full capacity, a majority expressed concern regarding the requirements for nurse and parent coach workloads. In particular, program managers and clinical supervisors did not think one nurse—permitted to see 8-10 clients each week—was sufficient to support the work of three parent coaches, who were also expected to visit 8-10 clients each week. Indeed, several of the program managers requested funds from First 5 LA to hire an additional nurse, but were denied because it would not follow the program model.

One significant issue that arose with each of the Catholic-affiliated hospitals—of which there are five among the 10 Welcome Baby providers we interviewed—was that staff were not permitted to directly discuss family planning and/or birth control with their clients. To varying degrees, this subject was described as “off limits” for nurses and parent coaches, and most staff were instructed to say that mothers “…should talk to their primary care provider” about needs related to family planning. One hospital even said that it used a “Catholic version” of the Welcome Baby book that omitted the pages addressing birth control methods. Others said that they used the Welcome Baby book as is, but suggested that mothers talk with their physicians about the sections dealing with birth control. This was a controversial and uncomfortable topic for some Welcome Baby nurses and parent coaches; some said they had a bit more freedom to share information in the home setting than at the hospital. Some we spoke with felt that not directly addressing birth control issues with mothers was a large and direct breech of fidelity to the Welcome Baby model, and not in keeping with the model’s “family centered approach” (discussed below).
4. The “family-centered approach” embodied by Welcome Baby was fully embraced by all provider types.

According to the fidelity framework, Welcome Baby providers are required to “...promote a family-centered and strength-based model of care,” which is non-directive and values the client as the authority regarding her own experiences and capable of fulfilling her own potential for growth. The TA providers’ training focused considerable attention on this concept, and it appears that it was well received and was well followed by Welcome Baby providers in the 13 additional Best Start communities. Despite concerns among some that hospitals would try to medicalize Welcome Baby, no providers interviewed for this study expressed any concern or discomfort with this underlying philosophy or as an approach to the service. Most said it was completely consistent with the way they were used to rendering services. One hospital provider noted that LABBN was very effective in teaching that Welcome Baby was much more than a medical model of care.

Once again, however, the only exception to this finding was the concern that resistance by some hospitals to teaching birth control methods was not in keeping with fidelity to the family centered approach, especially to the extent that mothers might directly request help in this area but providers cannot address their expressed needs.

5. Reflective supervision was new to most providers but seen as a valuable staff support.

The fidelity framework includes a requirement that Welcome Baby providers engage in a practice called “reflective supervision,” whereby Welcome Baby staff are “...supervised to model empathy, reflective communication and positive regard so that parents can model that same behavior with their children.” In practice, this means that all home visiting and hospital liaison staff are to receive one hour of individual reflective supervision per week, and four hours of group reflective supervision per month. Furthermore, all home visitors are to be observed by their supervisor during a visit at least four times per year.

In contrast to the “family-centered approach,” reflective supervision was new for the vast majority of Welcome Baby staff and project managers interviewed for this study. According to the TA providers, only one of 10 hospital clinical supervisors had any experience with it, and the rest were requiring more ongoing consultation to bolster what was taught during the Oversight Entity’s training. Despite its newness, Welcome Baby providers generally had positive views of reflective supervision. Welcome Baby program managers, clinical supervisors, and staff each saw value in the technique’s ability to promote a supportive work environment for home visitors and relieve the stress that can build when providing direct services to families with multiple needs. Supervisors, in particular, appreciated that routine reflective supervision could help keep members of their team from “burning out,” and help them identify individual staff at risk of being overwhelmed by the volume and scope of their work.

Still, implementation of reflective supervision was not seamless. Some providers were conducting the required group supervision but had not dedicated sufficient time to provide as much individual supervision; for other providers, it was the other way around. One clinical supervisor expressed concern that the individual reflective supervision she was providing was turning into “psychotherapy” for one of
her staff. Another program director thought it was fine, but also added “...as long as the work gets done!” Finally, one director acknowledged the value of reflective supervision and also said she was glad it was a requirement, “...or else our hospital administrator would be all over me, worried that this wasn’t a productive use of staff time.” In general, the majority of Welcome Baby provider staff felt they needed more training and assistance so that they could better implement reflective supervision.

6. Families’ needs are many and community resources are not always sufficient.

Despite the size and diversity of Los Angeles County, Welcome Baby providers were quite consistent in describing the needs of their clients, beyond those that could be directly addressed by the program’s home visitors. Needs for affordable housing, nutritious food, health and dental care, mental health services, transportation, education, and employment assistance were repeatedly identified. Welcome Baby providers drew on a wealth of resources when attempting to meet these needs. Many, as mentioned above, have longstanding ties to their communities and thus strong connections with a wide range of community service agencies, food banks, WIC programs, Head Start and child care agencies, legal assistance and advocacy, and community colleges. Several hospitals pointed to their departments of community services as rich resources for their clients. AVPH, a community organization itself, could refer Welcome Baby clients to many of the other social support services that the agency offers families. Still, many gaps in community services were noted, especially in the area of mental health and housing. And new families often lacked many of the essentials for child raising—diapers, strollers, and car seats—and those resources, too, were described as wanting.

7. Stronger Families Database shows strong potential, yet its delayed launch impeded Welcome Baby implementation.

The Stronger Families Database was designed to allow Welcome Baby (and Select Home Visiting) grantees to track and report on program and case management as well as allow First 5 LA and the Oversight Entity to track client information for Welcome Baby and SHV clients and to help ensure fidelity to the Welcome Baby model. At this early point in implementation, the emerging system received some praise for its design, but its delayed launch was also described as impeding Welcome Baby’s expansion.

- The delayed launch of the database impeded implementation across the Welcome Baby providers. As described above in Section II, the development of the database was a collective effort between First 5 LA, MCH Access, the Oversight Entity and NetChemistry (the contracted database developer) that took place between 2012 and 2013. With the specific system design phase beginning in January 2013, the process of building the database required more time than was available and, as a result, the database was not ready when providers began training in June of 2013, nor when the first sites began enrolling women in August 2013. Numerous interviewees described this as a major impediment to implementation, noting that while “it will be difficult for any startup program to get going, things like the database should be there from the beginning.”

Indeed, providers that began implementation early reported having to “scramble putting together systems or paperwork” to track women enrolling in Welcome Baby, without knowing
what data elements would eventually be in the database. In general, these sites relied on Excel spreadsheets that were similar to those developed by MCH Access during the Metro LA pilot. One site—St. Francis—even created its own PDF documents that could be used on tablets provided to clinical staff.

Several months after enrollment began, LABBN released a list of the data elements that would be included in the database, and documents to help sites track women until its launch. Though these helped track women enrolling in the program, clinical supervisors across the sites had no mechanism for forecasting the size of their workloads or tracking upcoming visits. As a result, many sites struggled to manage the workloads of their clinical staff, particularly when issues arose with staff turnover or short-staffing. While larger sites, and those with experience providing home visiting, were able to accommodate these challenges, TA provider staff noted that smaller sites and community-based organizations struggled more because they did not have as many resources to support their efforts.

Once the database is officially launched, Welcome Baby sites are expected to enter data into the database that was collected through their various original tracking methods. Many sites, particularly those that began enrolling women early, expressed concern about the amount of time and work that would be required to back-enter data for these women.

- **Welcome Baby program and clinical staff were guardedly positive toward the Stronger Families database and its capabilities.** In January 2014, the Stronger Families database was released solely for use in the database training. The training—led by LABBN and MCH Access—consisted of 38 training sessions across the 10 hospitals that were already enrolling women into Welcome Baby. Several providers reported that they were able to explore the system during the training with the assistance of the TA providers. Overall, these staff were pleased by the training and appreciated the opportunity to “demo” the system before it went live. Others, however, recalled completing the training before the database was functional. Consequently, many of these staff felt that the database could have been more helpful if they were able to use the database during the training, and were concerned that once the system launched, they would not be prepared to use it.

Overall, the providers who were able to explore the database expressed excitement about its potential. In particular, staff at Welcome Baby provider sites and the TA providers thought that the database was user-friendly, and appreciated that the features varied by staff position. Other features that staff were excited about include:

- The system automatically tells users if a woman lives in a Best Start community based on her address and zip code, making it easier for outreach specialists to determine if a woman recruited prenatally or approached in the hospital is eligible for Welcome Baby;

- Supervisors have direct access to the clients’ information, and can easily monitor nurse and parent coach workloads;
- Users can send messages across the system to one another; and

- The system allows users to upload consent forms and is HIPAA compliant.

- **Still, many felt the database was insufficient and did not fully meet the needs of Welcome Baby staff.** Throughout the database training, staff from the TA providers and Welcome Baby sites identified items missing from the database; by the end, more than 100 items were placed in the “parking lot” of issues and concerns to be addressed in future versions of the database. A majority of the items identified were features that would assist program staff at Welcome Baby sites with case management. In particular, clinical supervisors and program managers across the sites noted that there were no workload forecasting capabilities to help assign new clients to parent coaches and manage workload size. Additionally, many expressed the need for a scheduling tool with “ticklers” that would alert staff when a client was coming close to another engagement point. Most Welcome Baby staff were hopeful that revisions to the database—expected over the coming year—will create a system that will help support the needs of First 5 LA, the TA providers, and the Welcome Baby providers.

**E. How Do Providers View the Relationship Between Welcome Baby and Best Start Community Partnerships?**

Each Welcome Baby provider is required, as specified in their contract, to regularly attend meetings of the Best Start Community Partnerships in the target communities they serve. These Partnerships, represent the “community-capacity building” portion of the organization’s Best Start investment and are intended to facilitate community organization and mobilization among stakeholders and residents in the 14 Best Start communities. Evaluations of the Metro LA pilot community found that Welcome Baby’s engagement with the Partnership was not always as easy as one might suspect—it took years before meaningful connections and productive working relationships were formed between MCH Access and the Community Guidance Body26 in Metro LA, as each group was busy working within their silos and natural, productive connections were hard to identify.

Across the 13 Best Start communities that are newly implementing Welcome Baby, partnerships had often gotten off to a quicker and more positive start. All Welcome Baby providers reported that they had attended several meetings convened by their Best Start Community Partnerships, and most had been invited to make presentations to the Partnerships on Welcome Baby. In a few cases, program directors expressed frustration that the Partnerships did not “get” Welcome Baby and that no explicit linkage was occurring. More often, we heard that partnership members were very excited about Welcome Baby and enthusiastic in their support of the program’s goals. Furthermore, they recognized that Welcome Baby represented the most tangible service, or benefit, they could extend to their residents. In these cases, there was a sense that Partnerships could play an active role in performing

26 The Community Guidance Body was a group composed of representatives of a variety of public and private agencies, present in the Metro LA community, who volunteered to meet and discuss strategies for community mobilization and improvement (Hill and Benatar 2011, Benatar et al. 2012, Hill and Wilkinson 2013).
outreach and serving as an important referral source for their local Welcome Baby programs. In turn, Welcome Baby program managers saw the Partnerships as a new way that they could keep abreast of changes occurring in the communities they served.
IV. Early Lessons Learned and Implications for the Future

This study of the early implementation of Welcome Baby expansion set out to collect the insights and document the experiences of Welcome Baby providers, TA providers, and First 5 LA staff at a critical point in time—roughly one year after the program’s expansion to 13 additional Best Start communities. As such, it provides an important baseline against which future implementation and progress can be gauged, and sheds light on the facets of the program that are working well, and not so well, at this early stage. Most importantly, it identifies the lessons that have been learned to date, and the implications of those lessons that can guide mid-course course corrections and program improvements moving forward. Some of the most notable, cross-cutting “take-aways” from this study are shared below.

- **Welcome Baby providers are excited to be implementing the program and are encouraged by its potential to positively impact the lives of families with young children.** In-depth, face-to-face interviews with 94 Welcome Baby program directors, clinical supervisors, nurses, parent coaches, hospital liaisons and outreach specialists revealed that provider staff were almost universally excited to be on the job, serving pregnant women and new mothers, and working to strengthen parents’ ability to foster the healthy growth and development of their children. Despite a sometimes slow and uneven start-up process, these providers had begun recruiting clients, assessing their needs, and providing hands-on assistance in their homes, and were already receiving positive feedback from the families they were helping.

  **Implications:** First 5 LA leadership can feel satisfied by the successful launch of this fundamentally important first step, and encouraged that Welcome Baby provider staff are enthusiastically implementing the model. First 5 LA should build on this positive foundation by focusing on continuous program improvement and fidelity monitoring to ensure that providers’ early enthusiasm translates into ongoing strong performance and delivery of high quality care.

- **Piloting Welcome Baby in the Metro LA community was a wise investment that laid the critical foundation for the program, and “best practices” learned during the pilot are apparent throughout the expansion of Welcome Baby.** Since its launch in the downtown Metro LA pilot community in 2009, the Welcome Baby model was steadily refined and improved by First 5 LA, managers and staff at MCH Access and CHMC. Over a careful four year process, important lessons were learned about the timing and content of home visits, the qualifications and configurations of provider staff and teams, strategies for reaching women prenatally, and approaches to assessing the risks pregnant and parenting women face. These lessons, by design, formed the foundation of the training curriculum extended to new Welcome Baby providers and fueled the development of a new fidelity framework intended to guide consistent implementation across the now-much-larger network of providers.

  **Implications:** As described in this study, new providers are already observing and sharing many of the same experiences that MCH Access did in Metro LA, especially with regard to recruitment, retention, and families’ responses to receiving care. As positive and reinforcing as this is, it will
be important for First 5 LA and TA provider staff to not presume that Welcome Baby is a completely static model, perfect in its present form. Already, there are multiple models emerging for implementing Welcome Baby—hospital-centric, hospital-CBO partnerships, and CBO-based—that appear to be providing home visiting services effectively. Thus, these new providers working in new settings and serving new communities will learn their own lessons, and the process of refining and improving Welcome Baby based on this process should be allowed to continue, when and where appropriate.

- **A smoother and more systematic expansion of Welcome Baby was undermined because several key building blocks for implementation—including the fidelity framework, data collection tools and protocols, and the Stronger Families Database—were not ready.** First 5 LA staff acknowledged that circumstances did not permit a smooth and systematic expansion of Welcome Baby to the 13 additional Best Start communities. Rather, in 2013 staff were anxious to expand the program—already several years behind schedule—as quickly as possible. Yet, they also knew that important tools to support implementation would not be ready. In addition, the involved processes of establishing contracts with 13 new providers, and for soliciting bids and awarding the contract for the Oversight Entity, meant that the expansion felt very “hurried” according to key informants, and everyone felt like they were constantly “playing catch up.” Without tools like the fidelity framework in place for providers, this hurried expansion likely resulted in more variation—and, potentially, a lack of fidelity—across sites. That said, programs are now up and running and delivering valuable services.

**Implications:** Moving forward, it will be incumbent on First 5 LA and its Oversight Entity partners to work closely with providers to promote fidelity to the Welcome Baby model, but in a manner that recognizes that sites may have developed their own interesting and innovative ways to implement the program in their communities. Welcome Baby providers have already demonstrated such initiative in the areas of outreach, provider recruitment, and working with Best Start Community Partnerships, for example.

- **Welcome Baby staff praised the intensive training they received, but many also felt underprepared to go out in the field and fulfill their roles, expressing a need for more practical, ‘hands-on’ training.** Overall, Welcome Baby providers thought the training they received was extensive and covered important clinical and psychosocial topics applicable to the Welcome Baby protocol. At the same time, staff across the Welcome Baby sites consistently expressed frustration that the training did not demonstrate how to apply the subject matter knowledge to the job itself. As a result, many providers felt unprepared to do their jobs at the conclusion of the training.

**Implications:** Though a majority of the 13 new Welcome Baby providers have completed their training, staff turnover even during the first year of implementation means that, moving forward, the pressures of hiring and training new staff will continue. Therefore, there exists the need and opportunity to continuously improve the Welcome Baby training curriculum, protocol
and process. Specifically, more hands-on training through role-play, shadowing, and break-out sessions for specific Welcome Baby positions could be provided to help staff feel more prepared to perform in their jobs. Additionally, content experts hired to conduct trainings could be coached to better connect the subject matter they teach with the Welcome Baby model and roles. Finally, convening more peer-to-peer workshops would provide invaluable continuing education and training opportunities and would allow provider staff to share, discuss, and compare their experiences, thereby fostering collective improvement and adoption of best practices.

- **Still, Welcome Baby providers are quickly learning “on the job” and encouraged by their accomplishments.** Despite the weaknesses identified in the training, Welcome Baby staff reported positive experiences in the field. Indeed, almost every provider reported feeling comfortable conducting home visits under the Welcome Baby model. Many attributed their confidence to the preparation activities they engaged in after training, and to simply getting out in the field and refining their skill set by conducting home visits, outreach presentations, and risk assessments. Continued support from the TA providers was also cited as an important tool that helped providers feel comfortable as they prepared for and assumed their positions.

**Implications:** To allow this positive momentum to continue and grow, First 5 LA would be wise to maintain a focus on ongoing technical assistance to ensure that Welcome Baby provider staff continue to provide high quality care and implement program to fidelity. For example, continuing to support LABBN, MCH Access, and PAC/LAC during the early years of implementation so that they can continue to convene quarterly peer-to-peer learning sessions will be important.

- **While Welcome Baby staff universally praised the program model and curriculum, common suggestions for improvement were cited by many providers.** Overall, Welcome Baby clinical staff believe that the model, curriculum, and family-centered approach are strong and give them the flexibility to provide pertinent and important assistance and information to meet the needs of their clients. However, restrictions surrounding the sharing of information related to birth control and family planning at some religiously-affiliated organizations prevented several Welcome Baby programs from providing women with the information they request, according to staff at these provider sites. Other challenges identified were related to the timing and intensity of the home visits. In particular, providers felt that the curriculum for the abridged version of Welcome Baby did not adequately meet the needs of high risk mothers living outside of Best Start communities. Moreover, as was the case during the Metro LA pilot program, many new Welcome Baby providers expressed the belief that the gap between the 3-4 month and 9-month visits is too long and could be detrimental to the provision of quality care. Finally, many Welcome Baby providers noted that they were unable to complete the nurse visit within a 72-hour timeframe due to the nurse’s workload, though they also did not think that this was causing any negative consequences.
Implications: Over time, First 5 LA would be wise to remain open to improving the Welcome Baby model based on the experiences and feedback of providers. For instance, if providers continue to report that the abridged version of Welcome Baby is insufficient to meet high-risk women’s needs, First 5 LA might consider eliminating that intervention, and instead direct those resources to improving the current model. For example, Welcome Baby provider staff have often suggested that adding a 6-month home visit would improve the continuity of the intervention, and that supporting additional nursing positions within each team could smooth Welcome Baby service provision and alleviate pressure on nursing staff. Finally, First 5 LA should monitor the family planning issue moving forward to see if the more limited information being shared at some sites is proving consequential for clients at hospitals where restrictions are in place.

In most communities, Welcome Baby providers were struggling with challenges related to Best Start community boundaries—especially with regard to marketing and outreach—and First 5 LA’s messaging that suggests the program is “universal” needs adjustment. Unlike Metro LA, most designated Best Start communities do not contain within their boundaries the birth hospitals and providers that are operating Welcome Baby programs. As described in this report, this caused challenges for staff as they conducted outreach and attempted to target resources to the communities they serve. Early on, women were recruited into the program based on the promise of being extended home visiting assistance, only to be told that they were not eligible because they did not live in the right neighborhood. Obstetrical providers, as well, were recruited to refer their patients who needed home visiting. Yet initial enthusiastic support from these doctors and clinics rapidly waned after many of the women they referred to Welcome Baby were told they were not eligible because they did not live in a Best Start community. Welcome Baby managers and staff repeatedly identified program brochures and other marketing materials as part of the problem because they refer to Welcome Baby as a universal home visiting program.

Implications: Moving forward, this represents a complex issue that will need the attention of First 5 LA leadership and TA provider staff. Clearer and more nuanced messaging—especially given the recent launch of Select Home Visiting—will be needed to describe the range of services that are available to women, depending on where they live and their levels of risk. Some providers are already developing and using alternative marketing scripts for mothers and providers located within, or outside of, the community boundaries, and First 5 LA should facilitate the sharing of such materials among Welcome Baby providers. Still, further consultation and assistance will likely also be needed to help Welcome Baby providers consistently describe the program and present the available options in ways that do not risk alienating either community residents or providers.

Implementation of the Modified Bridges for Newborns Assessment by Welcome Baby providers was variable and further work will be needed to improve both how the instrument is administered and how risk scores are used to triage women into different levels of care.
described in Section III, Welcome Baby providers shared differing opinions on how strictly or flexibly the tool could be used to assess women’s risks, and we heard differing opinions on how much professional discretion hospital liaisons could exercise in assigning scores based on women’s answers to the risk screener’s questions.

**Implications:** In the year ahead, more training on how to administer the Modified Bridges for Newborns Assessment will likely be needed to improve consistency and inter-rater reliability. As consistency improves, First 5 LA staff will also need to reevaluate what an appropriate cutoff score should be to identify which women should be eligible for Select Home Visiting (in the Best Start communities) and the abridged version of Welcome Baby (in the non-Best Start communities). Finally, there was a widespread call for revisiting the rule that the assessment can only be administered in the hospital, immediately after delivery. For numerous reasons, providers believe that the quality and accuracy of the instrument would be improved if it could be administered prenatally.

- **Welcome Baby appears to have the potential to work well across a range of provider settings, but this issue should be examined over time.** Many people involved with Welcome Baby’s implementation in the pilot community expected that the program’s expansion to additional communities would follow a similar course—that is, hospitals would serve as fiscal agents and subcontract with community-based organizations to provide home visiting. Some even felt that this approach was critical to the program’s success and that such arrangements should be required as part of the model’s fidelity framework. As it turned out, however, Welcome Baby has been implemented in a variety of ways, with hospitals (more often than not) taking the lead in providing Welcome Baby, and in one case a community organization serving as both fiscal agent and provider. In hospital-centric models, there appears to have been high levels of support provided by hospital administration and leadership. To date, it appears that such support, coupled with a relevant history of work in the community, is more important to the success of Welcome Baby than whether or not the service is delivered by a certain category of organization.

**Implications:** No data are yet available to support this observation, and First 5 LA and its evaluators should carefully analyze service use, outcomes, and impact measures over time to more precisely determine how model-type influences quality of care. Findings from such analyses would inform potential future expansions of Welcome Baby.

First 5 LA is in the midst of an ambitious expansion of home visiting services for mothers and families with young children in Los Angeles County, and can be commended for its hard work and perseverance. The expansion has been implemented unevenly at times, however, and a variety of factors have led to a situation where, at the approximate conclusion of “Year 1”, Welcome Baby in the 13 additional communities is a work in progress and in need of refinement. It is hoped that this study of the early implementation of Welcome Baby expansion has identified the successes and shortcomings thus far, and provides useful ideas for how First 5 LA can move forward with ongoing implementation.
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Appendix A: Early Implementation Study Key Informant Interview Protocols
Welcome Baby Program Officer Interview Protocol
Evaluation of the Early Implementation of Welcome Baby

Thank you very much for agreeing to meet with us. We are from the Urban Institute, and have been funded by First 5 LA to conduct an evaluation of the early implementation of Welcome Baby in the Best Start communities.

Over the past four years we have been conducting a mixed methods evaluation of Best Start in the Metro LA Pilot Community. A major part of that effort has focused on our assessment of Welcome Baby so that we could better understand how well the home visiting investment has met the needs of children and families in Metro LA. For the full evaluation, we have conducted annual case studies of implementation; hosted multiple focus groups with recipients of Welcome Baby, parent coaches from MCH Access, and other community members; and conducted a longitudinal survey of mothers receiving Welcome Baby to measure the impacts of the home visiting program in Metro LA.

This year, our case study is expanded in scope and is designed to assess the set up and early implementation of Welcome Baby across all 14 Best Start communities. We will conduct interviews with a broad range of “key informants”—including clinical and administrative staff implementing Welcome Baby services in the communities, and First 5 LA contractors that are providing training and technical assistance to Welcome Baby providers. We also like to interview First 5 LA officials like you so that we can get the funding agency’s perspective on how early implementation is going. Based on the findings from this site visit, we will write and publish an early implementation study report.

We have a series of questions that we would like to ask you over the next hour or so. Before we get started, please know that this interview is voluntary and that you can choose to not participate without penalty or judgment. None of the information you share with us today will be attributed to you nor quoted without your permission and you are not required to answer any question you do not feel comfortable answering. There are no direct benefits for you that accrue from participating in this interview, nor are their risks given the safeguards I’ve already described. Finally, we will be taking extensive notes during our interview with you, but we would also like to record our discussion just so that we have a “back up” in case we need to go back and clarify our notes. No one would have access to this recording except for the research team.

Do you agree to participate in the Urban Institute Early Implementation Study of Welcome Baby? (Yes/No)

May we record the interview? (Yes/No)

Do you have any other questions about our project? (Yes/No)

May we proceed with our questions? (Yes/No)
I. Background

We would like to begin with a few background questions.

1. What is your position at First 5 LA, and how are you involved with the agency’s work related to Welcome Baby?
   a. How long have you been in this position?
   b. What are your specific responsibilities?

II. Welcome Baby Roll-Out to 14 Communities

To set a context for our work, during the first year of our evaluation, we learned a lot about how the Best Start initiative took shape and the impetus for First 5 LA’s movement toward place-based investments. Over subsequent years, we learned about the various changes made to the Best Start model, including a growing emphasis on the Welcome Baby component of the initiative. And now we are looking at how Welcome Baby is being rolled out in 14 communities across Los Angeles County. Against this backdrop:

2. Can you summarize for us the factors that most influenced the design and development of Welcome Baby in the 14 communities? In what ways did the Best Start experience in Metro LA shape and influence the subsequent roll-out in 13 other communities?

3. How were the hospitals selected for Welcome Baby?
   a. How did you narrow down the initial list of qualified hospitals?
   b. What were some of the strengths of this process? (i.e., what worked?)
   c. What were some of the challenges you encountered?

4. Tell us more about F5LA’s process for deciding what other kinds of help and contractual support the Welcome Baby initiative would need. How were contractors (like LABBN, PAC-LAC and MCHA) selected?
   a. What were some of the strengths of this process? (i.e. what worked?)
   b. What were some of the challenges you encountered?

5. I’d like to hear more about the specific roles and responsibilities of each of these contractors. Can you summarize the contractual scopes of work for:
   a. LABBN
   b. MCH Access
   c. PAC-LAC
III. Organizational Factors Affecting Start-up and Implementation

Our next questions are designed to explore the extent to which organizational factors at sites (work climate, culture, communication, integration of programming into existing routines, hiring practices, and internal support) have affected implementation of Welcome Baby.

6. First, to get us caught up on any new developments, can you summarize for us the latest implementation status of Welcome Baby in the 14 Best Start communities?

7. Can you say whether Welcome Baby seems to “fit” well with traditional missions of the hospitals and other providers you’ve funded?
   a. Does this “fit” differ between hospitals that have decided to directly implement Welcome Baby, compared to community based organizations that are providing Welcome Baby (either directly or under contract with a hospital)?
   b. For hospitals that are subcontracting with CBOs, do you know whether these organizations have had prior working relationships? Or are these new partnerships? If new, how do you think that has affected Welcome Baby implementation?

8. Can you summarize for us how Welcome Baby is typically integrated into routine operations at the providers/CBOs? Were existing staff given new/additional responsibilities when providers picked up Welcome Baby? Or did Welcome Baby represent an entirely new program, with new and dedicated staff? Or a mix?

9. In cases where hiring new staff was required, how is that going?
   a. How many programs are fully staffed vs. still hiring?
   b. Have there been any challenges finding qualified individuals with the right mix of skills?

10. In cases where existing staff are being utilized, have they been receptive to Welcome Baby?
    a. Are other hospital staff, including providers and administrative staff, supportive of the program? Or has the new home visiting program caused disruptions of any sort?

IV. Training and Technical Assistance

We understand that First 5 LA has contracted with several organizations (LABBN, MCH Access, PAC-LAC) to provide training and technical assistance to Welcome Baby providers. Let’s talk about each of these efforts for a few minutes.

11. How are the training and technical assistance efforts going?
a. Summarize for us your training curriculum and its component parts.

   - What seems to be going well?
   - What challenges have emerged?
   - What feedback have you received from staff?

b. Summarize for us your technical assistance plan and its component parts.

   - What seems to be going well?
   - What challenges have emerged?
   - What feedback have you received from staff?

12. Have there been any efforts at FSLA to bring the different TA contractors together to meet,
talk, network, and share lessons with one another?

13. Do you think First 5 LA is providing Welcome Baby providers with the right amount of
support/resources? If yes, can you describe what efforts are being made to support home visiting? If not, can you describe the shortcomings?

V. Staff Readiness

14. Do you feel that the assistance and training that has been provided has adequately
prepared Welcome Baby providers? In other words, do you perceive that Welcome Baby
providers and staff feel:

   a. Knowledgeable?
   b. Skilled?
   c. Positive toward Welcome Baby?

15. Do they feel confident and well prepared to go out in the field and support mothers,
newborns, and families?

16. Or do you hear any anxiety from staff about feeling unprepared?

VI. Early Experiences Implementing Welcome Baby

Let’s turn to providers’ experiences with the initial rollout and early implementation of
Welcome Baby. In this set of questions, we want to explore how providers are doing with
outreach and enrollment, use of the Bridges screening tool, implementation of the Welcome Baby curriculum and protocol, and experiences identifying community resources that support families with young children.
17. What activities are providers undertaking to reach out to potentially eligible pregnant women in the community?
   a. What are some common prenatal outreach strategies targeting pregnant women?
   b. How successful have programs been at reaching women while they're pregnant?
   c. What barriers have gotten in the way of prenatal recruitment?

18. How is enrollment going, overall? To the extent data are available, can you tell us:
   a. Have there been particular challenges?
   b. Have there been any particular successes?
   c. What proportion of women do you think have been recruited prenatally, versus at the hospital after birth?
   d. Have any women completed the Welcome Baby curriculum yet?
   e. What is retention in the program like? Do you think you have lost a lot of women to follow up after they've enrolled? If so, why do you think these women dropped out of the program?

19. How is the universal assessment tool (Bridges for Newborns) working? What feedback are you receiving from Welcome Baby providers?
   a. On average, how long does it take to administer the tool? Does this seem too long, too short?
   b. Do you think that the tool accurately assess women’s various risks, both medical and psychosocial? Or is it more focused on certain types of risks, and not others?
   c. Does the Bridges tool seem to triage women into the appropriate level of home visiting support?
   d. Are providers struggling with implementing the Bridges screen according to the protocol that you were taught? Or do they seem to be adjusting risk scores based on a perception that they are not accurately assessing risks?
   e. How do you think that the tool can be improved?

20. What feedback have you heard about providers’ experiences implementing the Welcome Baby protocol (or curriculum), and its various “engagement points”?
   a. Are hospital liaisons, nurses and parent coaches responding positively to the Welcome Baby curriculum, thus far?
   b. Are you hearing about any challenges being confronted by providers as they implement the curriculum, such as trouble scheduling home visits, or women deciding to drop out of Welcome Baby after they get home from the hospital?
   c. What are the key issues parent coaches and nurses are helping new mothers with? Are they reporting that they feel well equipped to address women’s needs? Do you hear that providers feel like women need more visits than Welcome Baby can provide?
21. Are nurses and/or parent coaches having difficulty identifying resources in the community that are able to address the needs of Welcome Baby mothers, children, and families? What kinds of resources seem to be readily available? What kinds of resources are typically more difficult to find?

22. Overall, how are Welcome Baby providers adjusting to the “family-centered approach” embodied in the curriculum?

23. What are you hearing about providers and how they’re supervising the various members of the Welcome Baby team? How are they implementing “reflective supervision?”

VII. Lessons Learned

We would like to conclude by asking you a series of overarching “lessons learned” questions.

24. Overall, how would you describe the early implementation of Welcome Baby across the communities?
   a. Has it been going well, or have there been some problems?
   b. Is implementation on schedule?
   c. What factors have facilitated implementation?
   d. What factors are inhibiting implementation?

25. What would you say have been the greatest successes of the expanded Welcome Baby, thus far?

26. What would you say have been the key shortcomings of the expanded Welcome Baby, thus far?

27. Do you feel like the services you are developing/implementing are the “right” ones for families and the community?
   a. If not, why not?
   b. What is missing?

28. Looking back, would you do anything differently? What?

29. Looking forward, what would you like to see happen to support the rollout of Welcome Baby?

Thanks so much for your time!
Questions to Ask Only if Time Permits

Client Characteristics

Now we would like to ask you some questions about the clients that are being served through Welcome Baby.

1. What are the demographic characteristics of the clients who are receiving Welcome Baby? (e.g., age, race/ethnicity, income level, etc.)

2. Are these the clients that you expected to see enrolled? Or are they somehow different from what you expected (e.g., higher or lower risk, different demographic mix, etc.)? How so?

3. Are there systematic differences between Welcome Baby clients who live within the Best Start boundaries and those who do not live within those boundaries? If so, what are those differences?

Stronger Families Database

1. Can you describe the rollout of the database?
   a. What were some of the successes and challenges in implementing the database across the communities?
   b. Does the database capture everything you need to collect?
   c. Do you have any thoughts on how the database might be improved?

Learning from One Another

1. To what extent were there any “lessons learned” from the Metro LA Pilot Community that informed or facilitated implementation of Welcome Baby in the 13 other communities?

2. Have any efforts been made to bring the different Welcome Baby providers together so that they could share experiences and lessons learned, or develop supportive networks?
   a. If so, who was the convener of those sessions?
   b. What was discussed?
   c. How helpful and informative was it?

3. Do you have any thoughts on how coordination among the sites can be improved? Are there opportunities for peer-to-peer learning that can be implemented?
4. Who is responsible for disseminating findings and best practices amongst the communities? Is that a F5LA role, or is it the role of one of your TA Providers?

Welcome Baby and Community Partnerships

1. How do you view the role of Welcome Baby in the broader context of Best Start?

2. Is F5LA assisting Welcome Baby providers in connecting to the Best Start Community Partnerships? How so? How would you characterize the connections being made?

3. What feedback have you received from Welcome Baby providers about Best Start and their role in the Community Partnership efforts? Do providers view these as part of their role, or does it seem separate from what they are doing?
Welcome Baby TA Provider Interview Protocol
Evaluation of the Early Implementation of Welcome Baby

Thank you very much for agreeing to meet with us. We are from the Urban Institute, and have been funded by First 5 LA to conduct an evaluation of the early implementation of Welcome Baby in the Best Start communities.

Over the past four years we have been conducting a mixed methods evaluation of Best Start in the Metro LA Pilot Community. A major part of that effort has focused on our assessment of Welcome Baby so that we could better understand how well the home visiting investment has met the needs of children and families in Metro LA. For the full evaluation, we have conducted annual case studies of implementation; hosted multiple focus groups with recipients of Welcome Baby, parent coaches from MCH Access, and other community members; and conducted a longitudinal survey of mothers receiving Welcome Baby to measure the impacts of the home visiting program in Metro LA.

This year, our case study is expanded in scope and is designed to assess the set up and early implementation of Welcome Baby across all 14 Best Start communities. We will conduct interviews with a broad range of “key informants”—including First 5 LA program development staff and clinical and administrative staff implementing Welcome Baby services in the communities. We are also interviewing First 5 LA contractors like you so that we can better understand the various types of training and technical assistance that Welcome Baby providers are receiving, and to get your insights regarding how early implementation is going as you work with providers across Los Angeles County. Based on the findings from this site visit, we will write and publish an early implementation study report.

We have a series of questions that we would like to ask you over the next hour or so. Before we get started, please know that this interview is voluntary and that you can choose to not participate without penalty or judgment. None of the information you share with us today will be attributed to you nor quoted without your permission and you are not required to answer any question you do not feel comfortable answering. There are no direct benefits for you that accrue from participating in this interview, nor are their risks given the safeguards I’ve already described. Finally, we will be taking extensive notes during our interview with you, but we would also like to record our discussion just so that we have a “back up” in case we need to go back and clarify our notes. No one will have access to this recording except for the evaluators.

Do you agree to participate in the Urban Institute Early Implementation Study of Welcome Baby? (Yes/No)

May we record the interview? (Yes/No)

Do you have any other questions about our project? (Yes/No)

May we proceed with our questions? (Yes/No)
I. Background

We would like to begin with a few background questions.

1. What is your position at this organization?
   a. How long have you been in this position or with this organization?
   b. What are your specific responsibilities?

2. Tell us more about your organization. What is your organization’s traditional mission?

3. How do the goals of Welcome Baby “fit” with your organization’s traditional mission?

4. Are the TA and Training services you are now providing under contract with F5LA similar to services that your group has provided in the past? If so, can you describe those past efforts?

II. Organizational Factors Affecting Start-up and Implementation

Our first questions explore your impressions of the Welcome Baby providers you’ve been working with, and the extent to which organizational factors (such as work climate, culture, communication, integration of programming into existing routines, hiring practices, and internal support) present in those providers are affecting Welcome Baby start-up and implementation.

5. Can you say whether Welcome Baby seems to “fit” well with these providers’ traditional missions?
   a. Does this “fit” differ between hospitals that have decided to directly implement Welcome Baby, compared to community based organizations that are providing Welcome Baby (either directly or under contract with a hospital)?
   b. For hospitals that are subcontracting with CBOs, do you know whether these organizations have had prior working relationships? Or are these new partnerships? If new, how do you think that has affected Welcome Baby implementation?

6. Can you summarize for us how Welcome Baby is being integrated into the routine operations of providers? Were existing staff given new/additional responsibilities when providers picked up Welcome Baby? Or did Welcome Baby represent an entirely new program, with new and dedicated staff? Or a mix?

7. In cases where hiring new staff was required, how did that process go?
a. How many programs are fully staffed vs. still hiring? Have there been any challenges finding qualified individuals with the right mix of skills?

8. In cases where existing staff are being utilized, have they been receptive to Welcome Baby?
   a. Are other hospital staff, including providers and administrative staff, supportive of the program? Or has the new home visiting program caused disruptions of any sort?

III. Training and Technical Assistance, and Welcome Baby Staff Readiness

9. Can you tell us about your role in providing training and technical assistance to Welcome Baby providers?

10. How are the training and technical assistance efforts going?
   a. Summarize for us your training curriculum and its component parts.
      - What seems to be going well?
      - What challenges have emerged?
      - What feedback have you received from staff?
   b. Summarize for us your technical assistance plan and its component parts.
      - What seems to be going well?
      - What challenges have emerged?
      - What feedback have you received from staff?

11. Do you feel that the assistance and training you have provided has adequately prepared Welcome Baby providers?
   a. Are there parts of the assistance that you feel are stronger or more effective?
   b. Are there parts of the assistance that you feel are working less well in preparing providers? How so?
   c. What kind of feedback have you received from Welcome Baby providers in terms of their preparation for the field? Has it been largely positive, or negative, or a blend? Please describe.
   d. Based on this feedback, do you think the training has been sufficiently intensive, or could more training be necessary?
   e. Are there any ways that you’re planning to tweak your curriculum in the future, based on these observations?

12. At this early point, do you perceive that Welcome Baby providers and staff feel:
a. Knowledgeable?
b. Skilled?
c. Positive toward Welcome Baby?

13. Do they feel confident and well prepared to go out in the field and support mothers, newborns, and families? Or do you hear any anxiety from staff about feeling unprepared?

14. Have there been any efforts at First 5 LA to bring the different TA contractors together to meet, talk, network, and share lessons with one another?

15. Are you receiving the desired amount of support/resources from First 5 LA? If yes, can you describe how they are supporting your efforts? If not, can you describe the shortcomings?

IV. Early Experiences Implementing Welcome Baby

Let’s turn to your observations of the initial rollout and early implementation of Welcome Baby. In this set of questions, we want to explore how providers are doing with outreach and enrollment, use of the Bridges screening tool, implementation of the Welcome Baby curriculum and protocol, and identifying community resources that support families with young children.

16. What activities are providers engaging in to reach out to potentially eligible pregnant women in the community?

   a. Do you have a sense of how successful programs have been at reaching women prenatally?

17. More generally, what do providers tell you about how receptive a) pregnant women and b) new mothers have been to the home visiting services being offered?

18. Do community members, organizations, clinical providers or other stakeholders targeted for outreach seem to understand what Welcome Baby is trying to accomplish? Do they also seem receptive to the suggestion of recruiting or referring clients to Welcome Baby?

   a. How receptive are clinical providers to referring clients to Welcome Baby?

19. How is enrollment going, overall?

   a. Have there been any particular challenges?
   b. Have there been any particular successes?

20. How is the universal assessment tool (Bridges for Newborns) working? What feedback are you receiving from Welcome Baby providers?
a. On average, how long does it take them to administer the tool? Does this seem too long, too short?
b. Do providers they think that the tool accurately assess women’s various risks, both medical and psychosocial? Or is it more focused on certain types of risks, and not others?
c. Do providers tell you that the Bridges tool seems to triage women into the appropriate level of home visiting support?
d. Are providers struggling with implementing the Bridges screen according to the protocol that you were taught? Or do they seem to be adjusting risk scores based on a perception that they are not accurately assessing risks?
e. How do you think that the tool can be improved?

21. What feedback have you heard about communities’ experiences implementing the Welcome Baby protocol (or curriculum), and its various “engagement points”?
   a. Are hospital liaisons, nurses and parent coaches responding positively to the Welcome Baby curriculum, thus far?
   b. Are you hearing about any challenges being confronted by providers as they implement the curriculum, such as trouble scheduling home visits, or women deciding to drop out of Welcome Baby after they get home from the hospital?
   c. What are the key issues parent coaches and nurses are helping new mothers with? Are they reporting that they feel well equipped to address women’s needs? Do you hear that providers feel like women need more visits than Welcome Baby can provide?

22. Are nurses and/or parent coaches having difficulty identifying resources in the community that are able to address the needs of Welcome Baby mothers, children, and families? What kinds of resources seem to be readily available? What kinds of resources are typically more difficult to find?

23. In cases where community resources are available, do nurses and parent coaches ever have trouble referring women to these services? Are there waiting lists, for example, to get help?

24. What about follow-through on the part of Welcome Baby moms? Do nurses and parent coaches report any challenges getting moms to follow through with their referrals to community services?

25. Overall, how are Welcome Baby providers adjusting to the “family-centered approach” embodied in the curriculum?

26. What are you hearing about how providers are supervising various members of the Welcome Baby team? How are they implementing “reflective supervision”?
IX. Lessons Learned

We would like to conclude by asking you a series of overarching “lessons learned” questions.

27. Overall, how would you describe the early implementation of Welcome Baby?
   a. Has it been going well, or have there been some problems?
   b. Is implementation on schedule?
   c. What factors have facilitated implementation?
   d. What factors are inhibiting implementation?

28. What would you say have been the greatest successes of Welcome Baby expansion, thus far?

29. What would you say have been the key shortcomings of the Welcome Baby expansion thus far?

30. Do you feel like the services you are developing/implementing are the “right” ones for families and the community?
   a. If not, why not?
   b. What is missing?

31. Looking back, would you do anything differently? What?

32. Looking forward, what would you like to see happen to support the rollout of Welcome Baby? What do you need to further support your work?

Thanks so much for your time!
Questions to Ask Only if Time Permits

Client Characteristics

We would like to ask you some questions about the clients that are being served through Welcome Baby.

1. What are the demographic characteristics of the clients who are receiving Welcome Baby? (e.g., age, race/ethnicity, income level, etc.)
2. Are these the clients that you expected to see enrolled? Or are they somehow different from what you expected (e.g., higher or lower risk, different demographic mix, etc.)? How so?
3. Are there systematic differences between Welcome Baby clients who live within the Best Start boundaries and those who do not live within those boundaries? If so, what are those differences?

Stronger Families Database

1. Can you describe the rollout of the database?
   a. What were some of the successes and challenges in implementing the database across the communities?
   b. What kind of feedback have you received from Welcome Baby providers about the database? Do they find it easy or difficult to use?
   c. Do you have any thoughts on how the database might be improved?

Learning from One Another

1. To what extent were there any “lessons learned” from the Metro LA Pilot Community that informed or facilitated implementation of Welcome Baby in the 13 other communities?
2. Have any efforts been made to bring the different Welcome Baby providers together so that they could share experiences and lessons learned, or develop supportive networks?
   a. If so, who was the convener of those sessions?
   b. What was discussed?
   c. How helpful and informative was it?
3. Do you have any thoughts on how coordination among the sites can be improved? Are there opportunities for peer-to-peer learning that can be implemented?
Welcome Baby and Community Partnerships

1. How do you view the role of Welcome Baby in the broader context of Best Start?

2. Does your training include discussion of Welcome Baby in the context of Best Start and its Community Partnerships?

3. Are you working directly with the Community Partnerships? If so, please describe.

4. Have you helped Welcome Baby providers to participate in Best Start’s Community Partnership activities? Please describe.
   a. Are Welcome Baby providers receptive to these activities?
Welcome Baby Provider Interview Protocol
Evaluation of the Early Implementation of Welcome Baby

Thank you very much for agreeing to meet with us. We are from the Urban Institute, and have been funded by First 5 LA to conduct an evaluation of the early implementation of Welcome Baby in the Best Start communities.

Over the past four years we have been conducting a mixed methods evaluation of Best Start in the Metro LA Pilot Community. A major part of that effort has focused on our assessment of Welcome Baby so that we could better understand how well the home visiting investment had met the needs of children and families in Metro LA. For the full evaluation, we have conducted annual case studies of implementation; hosted multiple focus groups with recipients of Welcome Baby, parent coaches from MCH Access, and other community members; and conducted a longitudinal survey of mothers receiving Welcome Baby to measure the impacts of the home visiting program in Metro LA.

This year, our case study is expanded in scope and is designed to assess the set up and early implementation of Welcome Baby across all 14 Best Start communities. We will conduct interviews with a broad range of “key informants”—including First 5 LA program development staff and other First 5 LA training and technical assistance contractors involved with the Welcome Baby expansion. But the largest focus of our interview effort is with Welcome Baby providers, like you, and our questions are designed to explore a broad range of issues related to your early implementation experiences with the program. Based on the findings from this site visit, we will write and publish an early implementation study report.

We have a series of questions that we would like to ask you over the next hour or so. Before we get started, please know that this interview is voluntary and that you can choose to not participate without penalty or judgment. None of the information you share with us today will be attributed to you nor quoted without your permission and you are not required to answer any question you do not feel comfortable answering. There are no direct benefits for you that accrue from participating in this interview, nor are their risks given the safeguards I’ve already described. Finally, we will be taking extensive notes during our interview with you, but we would also like to record our discussion just so that we have a “back up” in case we need to go back and clarify our notes. No one will have access to this recording except for the evaluators.

Do you agree to participate in the Urban Institute Early Implementation Study of Welcome Baby? (Yes/No)

May we record the interview? (Yes/No)

Do you have any other questions about our project? (Yes/No)

May we proceed with our questions? (Yes/No)
I. Background

We would like to begin with a few background questions.

1. What is your position at this organization/hospital?
   a. How long have you been in this position or with this organization/hospital?
   b. What are your specific responsibilities?

2. How did you first hear about Welcome Baby? What were some of the primary factors that motivated you/your organization to get involved?

II. Organizational Factors Affecting Start-up and Implementation

Our next questions are designed to explore the extent to which organizational factors at the provider sites (work climate, culture, communication, integration of programming into existing routines, hiring practices, and internal support) have affected implementation of Welcome Baby.

3. Tell us more about your organization. What is this provider’s traditional mission in serving this community?

4. Were you already providing any type of home visiting services to families in your community, or was Welcome Baby an entirely new service?

5. How do the goals of the Welcome Baby program “fit” with your organization’s traditional mission?

6. We understand that each hospital made different choices about how they would implement Welcome Baby.

[If talking with a Hospital]:

   a. Do you provide Welcome Baby services directly, or do you subcontract with another organization to implement the home visiting services?
   b. Why did you choose this approach?
   c. (If you subcontract) How did you choose this organization to work with? Was there a formal bidding process? Did you have a preexisting relationship with the organization that is providing the direct services?
   d. How is the relationship structured?
[If talking with a CBO provider]:

e. Do you directly receive funding for Welcome Baby home visiting or are you a subcontractor to a hospital?
f. If a subcontractor – how is this relationship structured? Are hospital staff involved with the implementation of Welcome Baby, and in what manner?

7. Tell us a little more detail about how Welcome Baby is integrated into your routine operations. Were existing staff given new/additional responsibilities when you picked up Welcome Baby? Or did Welcome Baby represent an entirely new program, with new and dedicated staff?

8. If you hired new staff, how did that go? Were you able to find qualified individuals with the mix of skills you were seeking?

9. In cases where existing staff are being utilized, have they been receptive to Welcome Baby?
   a. Are other hospital staff, including providers and administrative staff, supportive of the program? Or has the new home visiting program caused disruptions of any sort?

10. Is there any care coordination built in between medical providers and the home visiting staff? Have medical providers been receptive to Welcome Baby?

11. More broadly, how well has Welcome Baby been integrated with other (hospital/provider) services?

12. Has Welcome Baby required the organization to transforming space or purchase new equipment? How has that gone?

III. Training and Technical Assistance

13. We understand that First 5 LA has contracted with several organizations to provide training and technical assistance to Welcome Baby providers. Can you tell us about your participation in such efforts?

14. What assistance/training have you received from LABBN?

15. What assistance/training have you received from MCH Access?

16. What assistance/training have you received from PAC-LAC?

17. To what extent does it feel like this assistance and training has prepared you to provide Welcome Baby services to families in your community?
a. Are there parts of the assistance that you feel are particularly strong and effective?
b. Are there parts of the assistance that you feel are insufficient in preparing and your staff? How so?
c. Is there any feedback you have for First 5 LA on how it might improve its training and technical assistance resources and approach?

18. Are you receiving the desired amount of support/resources from First 5 LA? If yes, can you describe how they are supporting home visiting? If not, can you describe the shortcomings?

IV. Staff Readiness

19. Do you feel that the assistance and training that has been provided has adequately prepared you, as a Welcome Baby providers? In other words, do Welcome Baby providers and staff feel:

   a. Knowledgeable?
   b. Skilled?
   c. Positive toward Welcome Baby?

20. Do they feel confident and well prepared to go out in the field and support mothers, newborns, and families?

21. Or do you hear any anxiety from staff about feeling unprepared?

V. Early Experiences Implementing Welcome Baby

Let’s turn to your experiences with the initial rollout and early implementation of Welcome Baby at your site. In this set of questions, we want to explore your experiences with outreach and enrollment, use of the Bridges screening tool, implementation of the Welcome Baby curriculum and protocol, and your experiences trying to identify community resources that support families with young children and your process of referring clients to these resources.

22. What activities are you engaging in to reach out to potentially eligible pregnant women in the community?

   a. What are some common prenatal outreach strategies targeting pregnant women?
   b. How successful have programs been at reaching women while they’re pregnant?
   c. What barriers have gotten in the way of prenatal recruitment?

23. Overall, how receptive have pregnant women, and new mothers, been to the home visiting services you are offering?
24. Do community members, organizations, clinical providers or other stakeholders targeted for outreach seem to understand what Welcome Baby is trying to accomplish? Do they seem receptive to the suggestion of recruiting or referring clients to Welcome Baby?

25. How is enrollment going, overall? To the extent data are available, can you tell us:
   
a. How many women have been enrolled in Welcome Baby?
   b. How many of those were prenatal recruitments, versus hospital (after birth) recruitments?
   c. How many women have begun receiving home visiting, by nurses? By parent coaches?
   d. Have any women completed the Welcome Baby curriculum yet?
   e. Have you lost any women to follow up, after they’ve enrolled? Tell us about when these women dropped out of the program.
   f. What are your estimates for enrollment and service delivery over the next six months?
   g. Overall, what have been the major challenges related to enrollment? What about successes?

26. Tell us about your experience with the universal assessment tool (Bridges for Newborns)?
   
a. On average, how long does it take to administer the tool? Does this seem too long, too short?
   b. Do you feel like the tool accurately assesses women’s various risks, both medical and psychosocial? Or do you think it’s more focused on certain types of risks, and not others?
   c. Does the Bridges tool seem to triage women into the appropriate level of home visiting support?
   d. Do you ever feel like you struggle with implementing the Bridges screen according to the protocol that you were taught? (In other words, do you ever adjust your screening outcomes based on your professional judgment that the tool is not adequately identifying high risk women...or improperly identifying women as “high risk” that shouldn’t be?)
   e. What feedback would you give First 5 LA on the tool and how it could be improved?

27. Tell us about your experiences implementing the Welcome Baby protocol (or curriculum), and its various “engagement points”.
   
a. What do hospital liaisons do, after they’ve administered the Bridges screening tool? How are “hand offs” made to Welcome Baby nurses?
   b. What are nurses doing during their visits? Are nurses encountering problems scheduling their 72-hour visits? What’s the routine practice of the nurse in the home? Have you encountered any challenges in implementing the Welcome Baby curriculum?
   c. How are parent coaches doing with their visits? Are they having any trouble connecting with mothers and scheduling visits? What are the key issues they are helping new
mothers with? Are they feeling like they’re meeting moms’ needs, or are there issues that are particularly difficult to address? Does the timing of visits feel right? Do they ever feel like mothers need more visits/engagement than what the Welcome Baby protocol provides?

28. Are nurses and/or parent coaches having any difficulty identifying resources in the community that are able to address the needs of Welcome Baby mothers, children, and families? What kinds of resources seem to be readily available? What kinds of resources are typically more difficult to find?

29. In cases where community resources are available, do nurses and parent coaches ever have trouble referring women to these services? Are there waiting lists, for example, to get help?

30. What about follow-through on the part of Welcome Baby moms? Do nurses and parent coaches report any challenges getting moms to follow through with their referrals to community services?

31. Overall, how are you adjusting to the “family-centered approach” embodied in the curriculum?

32. Tell us about how your organization provides supervision to the various members of the Welcome Baby team. How does “reflective supervision” work? How does “reflective supervision” feel?

VI. Lessons Learned

We would like to conclude by asking you a series of overarching “lessons learned” questions.

33. Overall, how would you describe the early implementation of Welcome Baby at your site?

   a. Has it been going well, or have there been some problems?
   b. Is implementation on schedule?
   c. What factors have facilitated implementation?
   d. What factors are inhibiting implementation?

34. What would you say have been the greatest successes of Welcome Baby, thus far?

35. What would you say have been the key shortcomings of the Welcome Baby implementation, thus far?

36. Do you feel like the services you are developing/implementing are the “right” ones for families and the community?
a. If not, why not?
b. What is missing?

37. Looking back, would you do anything differently? What?

38. Looking forward, what would you like to see happen to support the rollout of Welcome Baby? What do you need to further support your work?

Thanks so much for your time!
Questions to Ask Only if Time Permits

Client Characteristics

We would like to ask you some questions about the clients that you’re serving through Welcome Baby.

1. What are the demographic characteristics of the clients who are receiving Welcome Baby? (e.g., age, race/ethnicity, income level, etc.)

2. Are you seeing the clients in Welcome Baby that you expected to see? Or are they somehow different from what you expected (e.g., higher or lower risk, different demographic mix, etc.)? How so?

3. In your community, is there a difference between Welcome Baby clients who live within the Best Start boundaries and those who do not live within those boundaries? If so, what are those differences?

Stronger Families Database

1. Can you describe the rollout of the database?
   a. Were you trained on how to use the database?
   b. What data you are expected to collect?
   c. Does the database capture everything you are collecting?
   d. Do you have any thoughts on how the database might be improved?
   e. Have you been successful in integrating the Welcome Baby database with your electronic medical record system?

Learning from One Another

1. To what extent were there any “lessons learned” from the Metro LA Pilot Community that informed or facilitated implementation of Welcome Baby in your community?

2. Have any efforts been made to bring the different Welcome Baby providers together so that they could share experiences and lessons learned, or develop supportive networks?
   a. If so, who was the convener of those sessions?
   b. What was discussed?
   c. How helpful and informative was it?

3. Do you have any thoughts on how coordination among the sites can be improved? Are there opportunities for peer-to-peer learning that can be implemented?
4. Were there specific lessons from the Pilot Community that you were made aware of that facilitated implementation of Welcome Baby in your community or organization?

Welcome Baby and Community Partnerships

1. How do you view the role of Welcome Baby in the broader context of Best Start?

2. Have you participated in any of Best Start’s “Community Partnership” activities, to date? Please describe.

3. Do you believe that part of your role, as a Welcome Baby provider, is to promote Best Start and its Community Partnership efforts? Or does that feel separate from what you are doing?
Appendix B: Number of Key Informants by Category and Organization
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<th>Organization Name</th>
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