

## **AMCHP 2007 ANNUAL CONFERENCE**

### **HEALTHY COMMUNITIES**

March 3rd to 7th, 2007

#### **Community Engagement and Participation in Perinatal Health and Policy Initiatives**

CHERYL CLERK: Thank you Betsy. Betsy is also my boss's boss so thanks for the kind words. My name is Cheryl Clerk as Betsy introduced me and then my partner in crime is Judi Vitucci. She is the Executive Director of Healthy Start Coalition in Pinellas County. We got started with this initiative in 2004 when we participated in an action learning lab that AMCHIP sponsored specifically regarding perinatal disparities in communities in our country. And what we found out when we went there as you all know what the result of this conference has been all about is that community involved and engagement is key to addressing to create interventions and strategies are successful to address perinatal disparities. So we have a network of coalitions and we wanted to further the institutionalized community involved specifically within the Florida Healthy Start program.

So what is community? I don't think I have to really go over this for you guys because I'm preaching to the choir but we know communities are persons with diverse characteristics therein linked by their ties, their common perspectives and they're usually in the same geographic location and participate in joint actions

within that community, in that area. And we're using community involvement interchangeably with community engagement which is the process of working with and thru groups of people who are affiliated by geographic location or share that special interest. But we want to specifically address the well being of persons in that population.

The objectives of community involvement should always be that we are trying to address inequalities and work towards a healthier population. But we're also assisting communities in releasing their own self confidence and try to reveal what's already there so they can promote and advocate for themselves. We want to be able to plan services that are responsive to the issues that the communities identify as important. And we want to emphasis the roles of communities always as interacting with our heath care and services in the planning, implementation and assessment. We need to work with community existing networks and organizations to create the support and direct capacity that they already have within. And we want to be able to assure that communities or individuals who represent these communities are supported and linked but also held accountable to a wider community network.

Of course resource allocation is very important to support the initiatives and sustain the relationships and the activities the communities do have and we also need to be able to demonstrate that there are benefits from community involvement and I'll talk more about that later.

In the first healthy start model I think Marie, I'm going to point her out because she's a historical reference for me. We try to integrate thru orientations. First is the empowerment where we focus on process and a shared power of participation of communities within the activities regarding—addressing health disparities. We also focus on outcomes and we try to have evidence based strategies and interventions to identify risk behaviors and also to promote healthy behaviors. And we like to provide an organizational structure so there's accountability and there's a process for service integration along with management of information that is important for people to do self assessments and different things.

Some of the people may have been in the Federal Healthy Start Evaluation session earlier today and you know that community involvement has always been a foundation for the federal projects. Healthy Start started around—the State Healthy Start model for Florida started around the same time and we have those specifically in our state statute along with who should be incorporated from the community such as community based organizations and also consumers. But we didn't really have a primary directive about how to go about doing this and specifically how to document that this is being done.

So let me tell you a little bit about the Florida Healthy Start Initiative. It's a state wide collection of 32 coalitions that are assigned to the oversight of identifying

pregnant women and infants at risk and also assuring care coordination for these pregnant women and infants through individually assessed needs and risk appropriate care. And some of these things include prenatal infant care services, psychosocial services, childbirth education, etc. Within as a primary reference for healthy start we have a document called Healthy Start Standards and Guidelines and we thought that this would be the logical place to start our community involvement platform since this is the primary reference for programs and their day to day activities regarding Healthy Start. So we created a new chapter specifically to address community involvement in our program. And our chapter deals with cultural competency, communications and training and technical assistance, involving and service planning. Delivery and assessment and also feedback mechanisms to receive input from community regarding our services as well as our subcontracted providers.

Our logical model I placed up here just as a graphic depiction of the process we took to develop this chapter. We use internal and external partners such as Healthy Start, Federal Healthy Start coalition directions as well as our state directors. And we also had some cultural competency experts that were external to the Department of Health that helped us with the consumer and in the beginning we did have a family physician that also initiated the idea for us. My role as well as my counterparts at the state health office was basically to facilitate the work group process and to make sure that there was an environment for us to do an interactive community involvement chapter that practiced basically what

we wanted to preach to develop a document with input from all of our stakeholders.

We also went thru an internal review process and we're now in the middle of an external review process but I'll talk about that later. Our whole idea was to create a permanent foundation for Healthy Start and also to hopefully lead to some strategic and technical mechanisms that address disparities that the community respected and bought into from the very beginning.

When we completed this chapter we did a review and we also did a revision which I'll speak about a little bit later. We wanted to pilot it to three coalitions that were diverse in population and region. Florida has 67 counties and we choose three of these coalitions that represented a portion of these counties because they were so diverse in nature. And this is just a graph of where these coalitions existed. We have Northeast Florida Coalition which is a collection of five counties in the northeast part of Florida. We have Bay, Franklin, and Gulf Coalitions which represent three rural to a mid population size county and the Gulf Coast of Florida panhandle. And now we also have the Healthy Start Coalition of Pinellas County which is an essential side of Florida on Florida's Gulf Coast. Judi Vitucci is here with me and I'm going to introduce her to get up and talk to you a little bit about the pilot process and what she found in conducting the pilot in her own area. Judy.

JUDY VITUCCI: As Cheryl told you, the Healthy Start Coalitions in the state of Florida are really perfect examples of community involvement. The legislation is there that says we must be, we must have community involvement and we already work with many, many community partners to address the needs of pregnant women and young children. So when Cheryl put out the call and said we're developing new standards and guidelines, new rules for you and we need some pilot sites every one of them went Hey, me, I want to be it! Oh please, pick me! Well, maybe not. Maybe not but I was really excited to be selected as a pilot site and to be able to give input to the new standards and guidelines. One because I'm cultural anthropologist and it really fit the bill and because I really believed that the new standards were really quite good and would move us forward.

So the guidelines really told us what we needed to do but they didn't tell us how to do it. So I want to in this little bit of time that I have, I want to give you some concrete examples of how the chapter was implemented in one county. It's an urban county with a lot of surfaces. We say we're resource rich and sometimes duplicative in our resources. The first component of the standards and guidelines is on cultural competency and it required cultural competency training for all coalition staff, our board and our community. This freaked a lot of people out. Because if you think about it back in your community how in the world are you going to train your whole community on cultural competency. And this really was I believe the hardest component of all to implement. The first thing that we did

was we disseminated the cultural competency self assessment tool. There was a similar—we used Georgetown's, the Center for Cultural Competency puts out a very nice self assessment tool for practitioners and for providers and I see that they've modified it to be for even a more diverse group. So I encourage you to look at the Center of Cultural Competency. So we first disseminated that to get the juices flowing of the people in our community and help them see that gee they really did need to do some work in Cultural Competency. Then we disseminated a CD. It's actually a CD/DVD. It's put out by the United States Office of Health and Human Services Office of Minority Health. It's a free CD. It's nine hours. Providers get CME's to do it.

What we found out is life is short and the DVD is very long. And people had a difficult time doing it and completing it. So one of the things that we're currently doing is we're developing a shorter web base training for providers and we actually got some funding from AUCA in our state to do that two hour training so that should be out relatively soon. We also brought in nationally recognized speakers and we did grand rounds presentations for our physicians. A two day conference on communication issues with a diverse population. So we brought in Dr. Like, Dr. Denise Corabramble—that's not here first name, yes it is and Dr. Fletamath Jackson to do these very well attended conferences. We also brought in Paul Wise and did something on disparities at the same time that was just very well attended.

The second component that we were addressing is communications training and technical assistance. This allowed us to do a whole lot of different kind of diverse things. Some of my counterparts did newspaper inserts that were directed towards the disparities that are in our community. We wrote letters to the editor. We published articles about the importance of early prenatal care in the Spanish magazines that are distributed in our area. So it was very targeted messages for the specific populations in our community.

We also sent out informational postcards to our churches. Those are pretty dramatic. They said 24 out of 1,000 African American infants die in our community each year. Will the next be from your congregation? We sent it to the pastors and then we made follow up phone calls to those pastors to say we really need your help. This is really an issue in some segments of our community—in your segment of the community and our pastors really responded back. I bury one child a month. Yes I'm on board. They want to do something too. So one of the—I don't know how innovative it is but I'm really excited about is called United Churches for Health and each of the large churches in our area, we started in the African American community because that's where our infant mortality is have appointed a health minister. So provide the messages for them, the minister preaches about it from the pulpit on Sunday and then the health ministers, they're doing all kinds of things. They're going out and visiting the new moms and providing them the SIDS information and the information, you know, the safe sleep message, etc.

We also talk to service clubs whenever we get a chance. We joined the Chamber of Commerce and talked to them about what the needs are. Mother's clubs, we participate in health fairs and community baby showers and other community events, where ever we can get our messages out about what the issues are in our community. We also meet with legislators about perinatal issues and legislative needs. And one of the things that we found to be most successful is that we take a consumer with us who tells the Healthy Start story and says how much it's impacted their lives. And sometimes they cry and the legislators are like—but it really has impact for the legislators and they may not remember me the next time they see me but they remember the mother who was there telling her story.

The next component in the implementation is service, planning, delivery and assessment. And the guidelines really require that we involve the community in collecting data, conducting community assessments and factors that influence outcomes. We did that by using a world café kind of a format that's been used by City Match a couple of times. It's really a wonderful way to get input from the community. We joined, well we were already involved in a lot of different organizations but organizations like the Hispanic Leadership Council, again the Chambers, Head Start board, the Early Learning Coalitions, the Safe Kids Coalitions we really got, we got down and we got involved in all these community coalitions so that we're at the table and they're hearing our issues as well as us

working on theirs. And it's those community partnerships that have been very rich and very fertile ground for grabbing people to get them involved in what we're doing as well.

We also were required to ensure representation of our community. And we found that our Healthy Start Coalitions are made up of community folk. And we were legislated to have you know, a member of the homeless, who's working on homeless issues, a member of this agency and that agency but it didn't talk so much about the diversity of the community. So we were required to look at the composition of our Board and of our coalition in relation to the community at large. So if we're 17% African American we need to look to make sure our coalition and our Board reflects that composition so we all did that.

The next component is the feed back mechanism and we did a lot of things to get that kind of feedback. Focus groups, we've done focus groups with our African American community, with our Latino community, with our teen parents. We've even done focus groups with our providers to get feedback about what they think about the service and that's our care coordination providers. We do customer satisfactions surveys and utilize the results of those in our ongoing improvement efforts. We also use staff satisfaction surveys. We evaluate all our trainings and our events and we get feedback from our community forums. For a long time we've been required to have a complaint process, a complaint log. We didn't really do anything different with that but we made sure that we have a process for

follow up. The issues go in the log and they get followed up and you make sure that they're resolved.

We did note benefits along the way from this pilot project. You better believe that when guidelines, new standards, new rules are being implemented there's a lot of—I mean that's what you're being evaluated on so there's a lot of fear out there in the 32 coalitions about oh no, what next? More unfunded mandates, that seems to be the hark and cry. Gees, we have to do something else. But what we really found is that it improved our efforts. As one who was there doing it we were able to involve the community based and grassroots organizations in assessment planning and even in our funding allocation activities. So they helped decide where the money should be spent.

We provide information, education assistance to the community on a regular basis. The other thing that it really helped us with is standardization of reporting practices. So it required you, you knew that you were going to have to report on the diversity of your coalition and your board every year. So you better have a method to figure that out. So it required that we change our application process for board membership and for coalition membership to put ethnicity on there. It also improved provision of cultural competency training and I believe that this is the area that had the biggest impact. Where in the past we might have had a speaker on postpartum depression or sudden infant death or safe sleep. We

focused our training on cultural competency and we had a lot of really wonderful sessions and conferences.

We found that that's been no significant increase in the workload but this new focus was required.

There were a few challenges. Again we needed to develop some new data collection tools. One of them was a tool to figure out how we were involved in the community so we had to develop what I call the community outreach tool that every Healthy Start Coalition staff member has to fill out every month. But it helps us do our quarterly report to the state on what we're doing too. So each month each staff member fills it out and says you know, I was at Safe Kids coalition on this day and I went here and I went there and it helps you keep track of all the wonderful, marvelous things that you do so it wasn't the bad thing.

There are multi-factorial reasons for health disparities and as we've been in these sessions about health disparities you know it's easy to see that nobody has all the answers. And that makes it difficult to implement strategies and see short term results in the timeframes that we have.

The politics of unfunded care is also very dicey as it is in my community as it is in the state and it is in the nation. We're probably all working on the unfunded prenatal care issue. We know from our PPOR that women's health before

pregnancy is a key factor to outcomes. And this year the state of Florida was able to snag us, go team, some funding for interconceptual care that we really hadn't been able to fund before. And so we're getting some marvelous, really innovative projects out there that hopefully we'll see some results from. So those new dollars were very, very helpful. And sometimes it's difficult to keep our community involved due to competing interests. Lately in my community the homeless issue has been pretty intense with the homeless developing a tent city and then the police coming and ripping the tops of the tents off with box cutters and just you know this whole political yucky stuff. So now people are focused on the homeless issue rather than infant mortality or the things that I'd like them to be focused on.

I love this pictorial because I really think it sums it up in a very nice way. This slide talks about—the slide talks about how to build health leadership and ultimately get sustainable programs, sustainable and successful programs over here. And you do that by setting your inclusion standards which I love this because it's so perfect about this project. It tells you what those inclusion standards should be and what you need to have in your standards in order to get diverse perspectives and inclusive responsiveness and a support of the community that participates in your issues.

And when the diverse community leaders have and also change agents are provided with the opportunity, knowledge, capacity and support to do things then

you get true partnerships that really make a difference and helps you able to make change. And those partners are academic and health care and public health and that's what we've been able to do. I give that in large part to these new standards that helps scoot us along to that affect. Now Cheryl will come back and tell you about how this program is being evaluated because in every session I've been to, one of the questions is how are you evaluating this program. Cheryl is going to tell you.

CHERYL CLERK: Thanks Judi. I want to just say Judi was very, very involved in this and also she came at a time that we were having some difficulties with this process. We had a round one and Betsy can attest to this and we put it out for public review and pretty much got shot up about it. Because the coalitions gave us some really strong feedback and very positive feedback of how we needed to modify this document so that it could be successful and it would have buy in from them. So Judi was very much involved in that and we thank her.

As I was stating earlier, a little earlier that we do want—it's good to have communities involved because it's a good thing to do. We feel in our hearts that that's what we need to do. But we also need to be able to show what impact this is having. And like Judi was saying thru out this whole conference that's what I've been hearing over and over in each session that we need to kind of prove that and be able to assess what our interventions are doing and what the responses are. So the center that I'm employed by is conducting an evaluation not only of

the chapter's outcome but the process that we took to create the chapter. We have baseline surveys going on right now. There's going to be post implementation surveys next year.

I want to talk a little bit about some challenges that we've had that are well defined in the literature and I'm sure you all have been thru. Between the leaders in the community, sometimes public leaders that we know—the community may see these leaders not able to share power, to listen or respect the community views or just use them when it's monetarily necessary to have them included. And participants may see that we're seen as not being able to find common ground or consensus or build comprise. And both parties sometimes think that inappropriate people are involved in the process. Not that the people are bad inherently but they may have different agendas that may bog down this process.

And as always we also know that we can't always represent all the key prospectives. We can't either politically or financially to adequately address the issues that we need to address to affect perinatal disparities. There's always a question of resources. It took a lot of time to do this one chapter. It took us a year and like I said, we thought we were done. We had to go back and revisit and revise and look thru every word, I mean every word we had to review and we had to have some additional partners come up and assist us with that. And the money it takes to do that kind of thing just in our little chapter. You can imagine as you all know what it takes to do that actually in the community. And there's

also the problem with logistical support. What we did for our meetings, we did have some people who were not part of the Department of Health. We had our meetings over Live Meeting, Microsoft Live Meeting and that allowed us to have a completely interactive, editing and creation of this chapter which I think everybody that participated said that was the best of it. And it got rough sometimes. People got feelings hurt and were mad you know and came back and were kind of sulking about things including me because compromise is not always a easy thing. But that really helped us. And we put the audio portion of our live meeting through a teleconference and we had to at the end get a toll free number which Betsy approved because we wanted everybody to be able to hang on the phone with us for an hour and a half and not worry about running up their long distance bill. We did have a consumer very, very much active in this chapter's development. We wanted all of our voices to be present.

The document policy, the policy link produced this document that recommend some policy and strategy that were necessary for community involvement. And this is what we think we've accomplished. Some of this is historical because of Healthy Start's inception and state statute but we have invested in coalition building and community organization and advocacy. We have used a community building approach to develop place based health programs. We have used community driven health assessments to determine the priorities as set by the community and the coalitions as Judi has stated heavily relies on local residents for cultural abridgment and also for community outreach. And so therefore we

have improved the linkages between the community for region health development and also health outcomes and policies.

What we need to work on and this is a reiteration of Judy as well is we need to work on and I think some people can attest to this, improved data collection and assessment and community indicators. Bill is laughing at me. Stop it Phil, because he knows this is primary. And we also need to enhance our knowledge and research. We need to really assess what's the impact of community involvement and at the same time continuously try to understand the very, very complex reaction between environment, social economic conditions and health outcomes. And we also have to continually educate our own professionals and staff on the benefits of having their community included even though it is very difficult to keep them engaged and we need to provide this thru legislative and policy support.

So it's not enough to start once we clean up our own backyard, our state Healthy Start but we have a vision to expand this to all of our MCH programs and DOH initiatives. We currently are over, our unit encompasses prenatal, infant and more recently interconceptual care. Women's health issues always is a part of our auspices as well as well as family planning. But we really do need to reach out to our county health departments for they are located in the counties to incorporate some of this involvement of communities and also within our subcontracted providers of people who provide services on our behalf.

There is one coalition that actually has a provision in her subcontractor language that requires the subcontractors to participate in cultural competency and a lot of people are really hesitant to go there with providers sometimes. Her coalition has. In doing this and trying to reach the department wide and state wide perspective we have a person who sits on the strategic planning board of our department, our Office of Minority Health within our department because we want our voice at the table as we go off into other areas and as we interlink with programs in our own agency. So we're not going to stop here. We're going to keep going and this is just the start. Thank you.

TONYA GORHAM: Good afternoon. Again I'm Tonya Gorman, sorry. I'm Tonya Gorman, Policy Coordinator with the L.A. Best Babies Network and I will just be providing you an overview of how we use a community engagement process to develop and implement a policy agenda for L.A. County.

Just first as an overview of Los Angeles County, it's made up of 88 cities and covers 44,000 square miles and we have nearly ten million people. So we're bigger than a few states. We have approximately 152,000 births a year. That's about one in 27 births in the United States is in Los Angeles and two in seven in California are born in Los Angeles. In terms of perinatal health in Los Angeles we know that 90% of women receive prenatal care in the first trimester. However we also know that about 50% of the births are under Medi-Cal or Medicaid so that's 300% that are poverty. And we know that two out of five women are below 200%

poverty. We also know that one infant in 15 is born low birth weight and one infant out of 185 in Los Angeles County dies before his or her first birthday.

We also have an issue in terms of teen pregnancy. It's improving but we also know that one in 16 births occur to teens.

To address some of the perinatal health issues in L.A. County the First Five L.A. Commission recognize a need to fund programs to improve birth outcomes in the county. The Healthy Birth Initiative was developed and we the L.A. Best Babies Network was developed as the coordinating arm of the initiative. Our mission as a network is dedicated to improving—to achieving healthy pregnancy in births in Los Angeles and providing the infrastructure programs, advocacy and support to increase the capacity of our community partners to succeed in these efforts.

This slide kind of illustrates how the Healthy Birth Initiative is laid out and I've also provided brochures that kind of explain the different components of the Healthy Births Initiative. Again it was funded by First Five L.A. which is itself in California there is a state tax on tobacco passed back in 1998 thru a proposition and that tax went directly to programs for children zero to five, birth thru five. So First Five L.A. decided to develop their Healthy Birth Initiative to address birth outcomes. As part of the initiative they fund directly for Best Baby collaboratives throughout the county and it just kind of lists some of the geographic areas where the Best Baby collaboratives are located. One in Long Beach, two that are along

what we call the harbor corridor which is south L.A. or south central L.A. and one in Antelope Valley which is far east, well northwest of Los Angeles where there is a high black infant mortality rate. So those organizations are funded directly and we as a network, we provide technical assistance to them to implement their part of their contract with First Five L.A. which is to provide interconception care for high risk women and to follow the women two years postpartum.

As a network we also coordinate what's called Healthy Birth Learning Collaboratives which I'll talk about a little more later. My component is the Policy and Advocacy component which this process addresses as well and we also have a hair quality component in which we work with 11 clinics throughout the county to implement a best practice model in their particular clinic.

The Healthy Birth Learning Collaboratives, we have seven geographically based HBLC's. Los Angeles is broken down by what we call service planning areas or SPAS and so out of the eight service planning areas we have seven active HBLC's. And they basically are free, interactive meetings where groups, stakeholders can come together and develop action plans, share knowledge and build capacity in order to address the issues in their particular areas. Each HBLC develops an action plan like I said for their area and just to give you an idea of kind of what their focus has been, some of the issues they've been working on, one particular HBLC has identified breastfeeding as their area of focus. So they felt it was important to develop an employer breastfeeding policy and they are in

the process of developing that policy and they're going to implement it and pilot in there individual organizations.

Another organization, another HBLC felt it was important to get an understanding of the implementation of what's called the Comprehensive Perinatal Services Program California or CPSP program. It's a statewide program that providers can enroll in and provide services to women. And so they wanted to understand what the needs were of those providers implementing that program. And so they host breakfast, provider breakfasts to bring them together and talk to them about what their needs are so that they can develop a strategy to be able to address some of those needs.

Another HBLC felt that nutrition and physical activity was their key need and key area of focus. And so what they have developed and this was actually a really unique activity that they developed. They hired an intern thru I forget which—I believe Title X funding, Title IX funding? They hired an intern to develop a physical activity curriculum that was implemented in waiting rooms throughout their area and she just kind of worked with some of the mothers in the waiting room, some of the people in the waiting room and taught them easy physical activity things that they can do while in the waiting room, while at home and things that they can do with their toddlers and I think there's actually some toddler aerobics involved as well in that project.

We decided in September, 2005 well before then we brought together all of the HBLCs for what we call the Healthy Births Townhall. It was a townhall called Healthy Births through Healthy Communities Townhall. I called it Action. We brought together all the HBLC's, one to help increase their membership, two to allow them to start developing their action plans but also for them to begin to identify policy priorities for their particular areas. We had about 164 participants and 113 organizations. Each geographic area identified priority actions and laid the foundation for their actions plans and each was kind of at a different stage in developing their action plan so each had an opportunity to have that discussion and began to develop their policies priorities which we later took kind of as a cohesive list. We took those policy priorities to health care leaders at our next event which was the perinatal summit in October of 2005.

The perinatal summit which was titled Healthy Births through Healthy Communities, Connecting Leadership to Achieve a Unified Commitment to Action was hosted by a tri partnership between the L.A. Best Babies network, our L.A. County Maternal Child and Adolescent Health programs and the March of Dimes. And the goals of this event were to engage communities, connect leadership, build sustainable policies and achieve unified commitment to action. So on day one we brought together about 170 participants and we had a gallery wall presentation in which all of the participants who were members of the HBLC and the Best Baby collaboratives as well as the partners were able to demonstrate what their priorities were and demonstrate what their actions plans were on

posters so that we can start the discussion on what the priorities were for L.A. County as a whole.

We had Mag Depeck from City MAJ as our keynote speaker and also she facilitated most of the discussion. The priorities from the townhall, the event in September were put together as kind of a menu of recommendations and they were used kind of as you know to set the table for the discussion or to set the foundation for our afternoon discussions to really begin to break apart what the priorities were and what those people at the table on that day and like I said, there were about 170 participants, what we wanted to tell health care leaders about the priorities in terms of policy in Los Angeles County. And so at the end of that day we ended up with a list of recommendations from that group and they were categorized into the different areas and we took those recommendations forward to day two.

Day two was a much smaller group. We had about 30 invited guests on day two and they were the people who were termed the health leaders in Los Angeles County. So we had representatives from key organizations like health plans such Kaizer, L.A. Care Health Plan which is our Medical one of our Medical plans. We had key representatives from county programs. So like our director of public health was represented. First Five L.A. was represented. We had key foundations like the California Endowment which funds health care issues throughout the state.

These participants and we also—I'm sorry, we also had key representatives from advocacy groups and we also had people who represented the people from day one. So we had about four people who were at day one who felt the full breath of that conversation and were able to bring that to day two and represent those people very well actually. It ended up being a very good discussion.

On day two the leaders, again it was facilitated by Mag Depeck and the leaders were able to take the recommendations from day one and really look at them and sit down and work in groups and talk about them and decide what it was that they felt that they would be able to commit their organizations to and commit their time to. And at the end of the day we literally asked the health leaders to stand and deliver. We asked them to stand up, sign their name on the paper next to a recommendation and let us know what they were going to commit themselves to for the next two years. So by the end of the day we had six—five recommendations and I'm just going to briefly review the recommendations.

The first one was to build upon and strengthen comprehensive perinatal services for all women. As I mentioned before we have the comprehensive perinatal services program in the state of California so part of this recommendation was to look at that program and look and see how it's being implemented. But the other part of this particular recommendation is to develop a quality framework for

prenatal care in Los Angeles County and to be able to implement that throughout L.A. to serve all women.

The second recommendation was to assure eligible newborns are enrolled in Medical or Medicaid before leaving the hospital. And part of this recommendation also included advocacy behind electronic enrollment because there's some state issue with being able to get that implemented throughout the state.

The third recommendation was to integrate perinatal resources into the county information line. We have what's called a 211 line where people can get referrals to services. And so it was understood through the townhall and through the Perinatal Summit that not all of our resources were in there. If women were calling to get referrals they weren't getting appropriate referrals. So that was a big issue with a lot of community members was making sure that the information was there in the system and so we've set this as a recommendation to be able to work with that county line and work with the community and make sure the referrals were—the resources were in there.

The fourth recommendation is promote risk appropriate perinatal care. And then the fifth recommendation is support every woman to have a reproductive life plan and that really encompasses our interconception care and preconception care recommendation.

After the Perinatal Summit in October, it was a two day summit, October 24 and 25. That ended kind of phase one. The summit itself was about a year and a half, two year planning process to actually hold the event. So that ended phase one with the recommendations in hand. We ended phase two in November, December to develop a strategic action plan around each recommendation and it was really important during phase two to make sure that we kept the community involved and to also make sure that we kept the leaders at the table involved. And so we met in small working groups, one group for each recommendation and we also went out and kind of interviewed some of the key leaders to say okay, you signed your name on the paper on October 25 but what did you mean? What did you mean by your commitment? What do you really want to do?

And so based on those discussions in the work group meetings we were able to really develop an action plan, a strategic action plan around each recommendation. And then in June of 2006 we received a full endorsement of all partners involved for the overall action plan and phase three, the implementation phase begin in July of 2006. We're currently in the 18 month implementation phase so we don't really have necessarily outcomes in terms of the recommendations and how things are going but you know it is a process. It ends December, 2007 in terms of the outlined 18 months and it's actually been quite an exciting process to actually see things getting done and to see the work continue.

What I should mention here that's very important is that you know in terms of the endorsement of the action plan, we received the endorsement but what was important to me personally was to go back out to all the HBLC individually, the community groups and meet with them and make sure that there was a full understanding of the action plan and to help them to understand how their information that they gave us at the townhall and the Perinatal Summit really went into the development of action plans. So that's been, that was a really good activity to be able to go out to them and make sure also that their action plans that I mentioned earlier, because each of them have action plans, make sure their action plans were aligned with this action plan and vice versa. So just to say the action plan we believe is ambitious but we do believe is realistic and achievable as long as we keep all the partners involved and plan an active role.

Some of the implications in terms of the process is that you can use a community participatory process to develop policy and to implement a policy agenda. And that this I think strongly represented how we feel about policy which is our feeling is that policy should be grounded in the community, supported by knowledge and focused on results. And I truly believe that our policy agenda that we developed was truly grounded in the community and I'll be open to any questions. Thank you.

I'd like to thank all three of our presenters and if we have any questions now I'm sure they'd be more than happy to answer them. Any comments or questions?

Yes.

TERI: My name is Teri and I'm from Palm Beach County. I'm a Healthy Start field nurse and I now work for the Public Service Council. (Inaudible) as I moved up thru the last couple jumps that I took, I found myself very intimidated by the new surroundings and people I was with and decisions that were being made and the whole structure of things being somewhat unsophisticated to that. And I wonder how do you address the challenge of finding members, people in the community who are completely unfamiliar with this sort of workings with boards and community (inaudible). Do you support them thru that process so that they can be effective in their role?

BETSY: Could everybody hear that question? Yes. Okay.

CHERYL CLERK: I may defer to my historical reference Marie Melton who's very heavily involved in training and things like that but I'll try to field it myself Marie so she won't get mad at me. But we do—the coalitions themselves and Judi can probably speak to this since she's got personal experience with this, have a role to train their members you know so when they bring people in there is the process that they do go through to get acquainted with how the coalition—what the coalitions roles are and that's even specified in our community involvement document that there are perimeters that we do operate within and there's certain responsibilities that the board members have, the members have and staff have

in their duties. So that definitely is a training process. So when we recruit people from the field we do want to have that be an educational process so they know about the subject that they're going to be addressing and how they fit in with our whole healthy start process. Judi do you want to add anything?

JUDI VITUCCI: I do. We're always trying to recruit new board members and new coalition members and it a little different in a coalition versus—coalition you know we may have 142 members of the coalition but maybe 16 of those serve on the Board. The board members get a very specific, a very defined orientation process. So they're brought aboard, they get something on the roles and responsibilities. We talk about the service delivery plan and what we're trying to do in this community. There are fiduciary responsibility. We do a Power Point on whose Robert and what are all those rules he's talking about. It gets people on board and feel like they can participate.

For the coalition, the 142 members that we have and some people have bigger coalitions than that, we don't do as much. They get some information on what is a coalition. They get all the information about the service delivery plan but we use them in a little bit different way. They only have to know their perspective. I mean we're really inviting their perspective. So we do things like maybe focus groups and invite folks to come in or we do the community café or using the world café format has been a wonderful thing for us where you bring people in and do table top discussions of key questions. You know, what can we do in this

community to reduce African American infant mortality. What can we do to support dads in their fatherhood role? So you have these big hairy meaty questions. Then you just have table top discussions and you give your perspective from whence you came. And that's really valuable. You're a community person. You're the eyes and ears of what's going on in our community and you have valuable information for the coalition that we need to use in our planning and in our service delivery, you know, planning what's needed. So if you tell me that mental health is really an issue that you struggle with everyday with the moms that you're dealing with, say you were a care coordinator then we would put some funding and some actions devoted to that because you're telling us it's important. Did that answer your question?

TERI: Oh yes.

JUDI VITUCCI: Okay. Thanks.

UNKNOWN SPEAKER: Just a comment on our HBLC, our Healthy Birth Learning Collaboratives, they are designed to eventually become kind of self supporting organizations and we provide the staffing for them so we help coordinate the meetings, that type of thing but it really is an internal leadership. They have co-chairs. They decide the agendas. They really move their action plans forward. We do thru our technical assistance provide technical assistance to our HBLC members as well as our Best Baby Collaborative members to help

them thru that process. To help them work thru the collaborative process and to learn all those things that people need to learn to be on boards and coalitions. So it really has been an interesting process. We just recently held a symposium back in November that talked to them about kind of the group process and really was a training ground for them to learn about being HBLC members so.

BETSY: Other questions?

MOLLY: Well the first one—I'm Molly from Oregon Healthy Start. I'm assuming that community involvement was based on specific funding and guidelines to do that all that community involvement.

FEMALE SPEAKER: Correct.

MOLLY: And my question is as I see at the end of this you say these (inaudible) needs to go to all NCH programs in the United States. I just wondered if you had any ideas as to how that might be (inaudible) when you don't have that kind of funding. You have sort of this Title V funding.

CHERYL CLERK: I think in my rush to kind of introduce Healthy Start we do have universal—the gateway to Healthy Start is universal screening offer of risk based assessment. So the gateway comes really when the woman shows up for her first prenatal visit. Our Florida physicians are required by state statute to offer the

Healthy Start prenatal risk assessment screen. And if these women score at our risk assessment cut off criteria is four. If they score four or more it's an automatic referral into our program. So that's how we kind of introduce ourselves in there for the most part. Some of it is by word of mouth. As far as funding, in our state statute there is defined to have a coalition in every county that assures a system of care. So that is the primary foundation of Florida's Healthy Start Coalition. So our funding is definitely set to do that.

So as far expensive for CHD we're talking about right now there are MCH components or prenatal care components within our county health departments and we feel that there is a need and a lot of those people do too to have community more interaction. They may not be doing the same activities as Healthy Start like outreach and things like that but when they come in or they're assessed by the communities that they're involving them more in the process. So there are two types of entities, like I said the County Health Department is more of a service you know, maybe provision of services but there are ways to introduce community into that assessment of those services and the quality of those services because we all know that a lot of what's going on now is qualitative about not that their not getting the services but how are they getting them. How are they being treated when they come into our county health departments and do we feel like they have an equal say in what goes on. So we're talking more of that realm than actual Healthy Start activities. Did I answer your question?

FEMALE SPEAKER: Yeah, it was real good. We don't have any statutes that (inaudible) and we also don't have any state funding to do these things.

CHERYL CLERK: Right. But like Judi was saying there's a lot of—any time we ask for something now there's this thing about unfunded mandate so we have to you know but since this was the foundation it wasn't as hard of a sell as people thought it was originally because this is what they were created to do. And if there's not a coalition in place it defaults to the county health department and that's also in state statute right? Yeah. Bill?

BILL: In the Healthy Start evaluation they did their survey of all the federal Healthy Start Coalitions and clearly community involvement was one of the areas where they had significant deficits and that too is a program that theoretically is granted based off of community ability to show that they have community collaboration. How do you think Florida compares to the response received by the federal Healthy Start? Do you think we're better or worse, different? Is that really a struggle? I mean it's true on paper but is it a really struggle for practice?

CHERYL CLERK: I think it is and this is—I'm going to give my perspective and then I'm going to ask Judi to give her perspective. In doing this process we really heard a lot from people who were part of our development team was that it's hard to keep communities engaged you know. And then you have what we call the

hard to reach populations. It's hard to bring the people sometimes that are most at risk into the process because as Judi stated there's a lot of competing interest and if you're worried about other things that are going on in your life it's hard, it's probably not your priority to show up at a meeting and participate in some kind of organizational function. So that was expressed to us a lot and also what was a difficulty for a lot of coalitions was the standard about the racial and ethnic composition. Some of our communities are very, very, heavily Hispanic but we know that Hispanics generally have good outcomes as far as infant mortality goes and so a lot of people thought that we were telling them that we to and I'm quoting "fire all the African American staff and get Hispanics to adequately represent their population (inaudible)". So we're saying we have to go back to the table and say no, we want it to be based on who's at most risk so there's going to have to be a walk between population and the population that's most at risk. Do you know what I'm saying?

So yeah, that was a concern that was expressed by a lot of people and it's very hard to do and it was just hard for us to do just to do this chapter to get everybody to come in and get a diverse development team. So I don't know, I think they're probably about the same Bill to answer your question directly. I don't think that they're any worse or any better. I think that they have that as a very, very strong—it's hard to accomplish. But we should always have that as an optimal and do all we can to achieve it. And my thing is to and I think a lot of

people is we need to document that we're doing that so we show that this is the process we're undertaking to do that.

One particular coalition said that her county health department doesn't ever support her in recruitment of African American nurses. What does she do, does she get "dinged" for that because you know we say if you document the process that you may have written a letter to them saying maybe you should advertise here or go and do this we'll have to accept that as you're trying to do all you can but there may be other forces that are not allowing that to be accomplished for one way or the other.

JUDI VITUCCI: From my perspective it's not hard to keep the stakeholders, the professional stakeholders involved because their involved in it. If they think that there might be a project that their institution could take on and get some funding for they're at the table. We want them at the table and if it's a good project and the board is saying yeah, it's a good project and it moves us along in their service delivery plan we want them there. It's much harder to keep consumers involved. And what we have to do is you have to provide transportation and child care dollars or we encourage them to bring their babies with them. And our Board meetings aren't so scary that they're not running away that they're very vicious and scary. So we make a little play area for the kids. You know a quilt and the baby on this quilt or the baby in the stroller and then hear all those little baby sounds coming there and it helps keep you grounded in why are we here. So

that's how we keep people involved and we nurture them and we tell them how much we value them.

BETSY: Tonya do you have anything?

TONYA GORHAM: Actually I wanted to go back to the kind of funding question. Our—the Best Babies Collaborative like I said are funded directly through First Five but the HBLC aren't funded as you know kind of a voluntary program where people come. And I will say that our community I think is a little different in the sense that we don't have yet involved in the process a lot of consumers. Mostly our HBLC are made up of (inaudible) stakeholders whether they were (inaudible) community based organizations or clinics or hospitals and they're the people coming to the table to develop the action plans. They have a contact with the consumers but in terms of our actual activities there aren't a lot of consumers at the table. And in terms of the funding we like I said our goal is to make them to become kind of self sufficient groups to run beyond our funding. The overall initiative is a 28 million dollar investment by First Five L.A. but it's funded for three years. Hopefully it will be funded for five years because we expanded. But beyond this initiative kind of what can we do to sustain this effort and so we've taken steps. At the townhall, part of the townhall we brought in foundations to talk about applying for funding and talk about grants. So that was really helpful for participants to be able to kind of think more long term and how they can continue to sustain their organizations and sustain the funding.

BETSY: Any other questions? All right. We are a few minutes early and I want to thank the speakers one more time.