

AMCHP 2007 ANNUAL CONFERENCE

HEALTHY COMMUNITIES

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Preconception Care:

Achieving Healthy Communities

CAROLINA REYES: Thank you, Nan. It's a real honor to be working with Arlene and Chico and Shavir Amad, and Dr. Langstrom in California. And with CDC's efforts, it's wonderful to see this collaborative effort in trying to align forces as we realize that this is going to require multiple strategies. What I'm going to be given is the opportunity to talk about what we're doing in Los Angeles County, around preconception, inter-conception care. This work is funded by First Five Los Angeles Commission, which is a commission set up by tobacco tax funding. Their mission is to improve the health and well-being of children. We are the prenatal component of their mission in terms of helping ensure that kids are nurtured, prepared for school, and promoting optimal health. Just to give you a little bit of context, I know Arlene actually did this, but within Los Angeles County, it's a population of 10 million. It is a population with births of 152,000, which is comparable to let's say the state of Illinois, Ohio, or Michigan. We have, one out of two of the pregnancies are paid for by Medical, which means that they are either at 300% of poverty or below. Two hundred two out of the five deliveries actually though, are 200% of poverty and below. We have about one infant out of 15 born low birth weight, one infant out of 185 that died in their first year of life, one out of seven begin prenatal care late. We are now as of 2003, met the health

people 20/10 goal of 90% of women who are pregnant or receiving care in the very first trimester, and our 2004 data demonstrate 93% on average, but clearly there are disparities within certain regions. One birth out of 16 is a teen, and 20% of those teens have a repeat pregnancy in their teen years.

Our definition of inter-conception care and the primary focus of this Healthy Birth Initiative is identifying women in pregnancy who have risk factors, who have had an adversary, were identifying to be at risk, or have an adverse birth outcome, either in a prior pregnancy or in this pregnancy, or an increased risk of having a subsequent pregnancy with an adverse outcome. Since we know that 15 to 30% of pre-term deliveries, those moms with pre-term delivery have a 15 to 30% chance of having a repeat pre-term delivery, as I mentioned, for teen pregnancies, it's about 20%. We know among low birth weight babies, it's up to 12-fold. And we have a very high prevalence of uncontrolled chronic illness, and especially gestational diabetes, or preconception, excuse me, pre-gestational diabetes. The issues are that many women do not receive appropriate follow-up, and one of the primary reasons is that they are uninsured between pregnancies. We do not have a financial axis barrier for prenatal care in California, but clearly, that funding is no longer available after two months postpartum for a very high percentage that have deliveries that are publicly funded.

The goal of this healthy birth initiative is a \$28 million effort, by First Five over hoping it'll be five years. It was initially funded for three years. I think we're

extending it to five. I will know this year. The goal of this initiative is to improve outcomes for pregnant women and their families with a focus on these adverse birth outcomes. The vision, as I mentioned, is to optimize the health and well-being of each mother, child, and family, and optimize the potential for early childhood development with a focus on improving birth outcomes as our role. Our aims for this healthy birth initiative is to focus on these adverse outcomes. And I believe you know well.

The outcome measures are based on to what extent are we effectively changing systems, so that we're able to help support existing organizations, so that they're able to provide these programs. Enhancing services, and primarily around case management and home visitation, for those women we're identifying at high risk, and following them for a period of up to two years. We are focused on working with care providers who provide prenatal care and follow women, actually in between pregnancies. And I must say that almost two thirds of deliveries in LA County are born to moms who've already had one child. So, the focus on inter-conception care pregnancy really does capture a wide cohort of those that are pregnant.

Enhancing the capacity of existing organizations that provide services in between these pregnancies, as well as family and community support, and I would love, I don't have the opportunity right now to talk to you about some of the examples of a faith-based organizations working with our medical providers and other

community support networks in our effort to reach out to them, and as well as improving access to prenatal care.

Some fundamental guiding principles that underlie this healthy birth initiative, that it's not a single issue, not a single strategy, but that it has to be comprehensive, multi-level, collaborative. The beauty and the success of this initiative has been that it has a participatory component. We have learned tremendously from other examples throughout the country, on collaborative models, and have adopted many of those, that it be community driven, that we incorporate to the extent possible evidence-based practices, and that we understand how to optimize our ability to communicate with families. These are the core strategies. There are many. Our focus with policy and advocacy, as well as our community building effort, the planning of this initiative involved 225 organizations, about 525 individuals over a two-year period. We have developed networks throughout L.A. County that meet actually regularly, and I'll talk a little bit about that. But those are the components. These are the target populations.

The initiative itself is broken into these categories. We have best baby collaboratives, which are comprised of about seven to eight organizations working regionally in areas of high need. And I'll, we'll actually go through these. Those best baby collaboratives are very focused on core approaches, meaning the primary source of funding, excuse me, the primary amount of funding is on inter-conception care and case management. It is, as you know, very costly. We

pattern this based on other case management home visitation programs, and understand that it takes about \$10,000 per client. There is a social support component that varies among regions, and outreach health education messaging. And we've developed a case registry for case management. This was developed with the organizations that are participating, along with what we have been able to develop from other case management programs, and we now have a case registry that helps us follow women over this two-year period. These are the organizations that are involved. The areas in red are these areas of high need, up in the top 10 percentile for many of these conditions that I just spoke about. We have a perinatal index we use, combining teen pregnancy, low birth weight, those that are 200% of poverty and below, infant mortality as a perinatal index.

With these multiple organizations working together, the beauty of that collaborative is that what we did in the process is, we had a three-month planning process where collectively all 34 organizations came together. We brought together external resources that they typically do not have, so that they're not left alone in the planning. We've had external evaluators to help in the facilitation of the logic modeling, we brought organization development consultants to work with all 34 organizations together so that they develop their government's decision structure, as well as their budgets and scope of work collectively, and it's a participatory process and not simply a project lead organization that

determines all of it, and then their MOU's signed by various organizations, but this was a collective process, and as well as in the development of the measures.

We gave flexibility among those best baby collaboratives to develop their own measures and success, but there are common elements for each of these, and they are provided monthly reports. At this point, we have over 600 cases that are in that registry system. We have a healthy births perinatal care quality component, again, where we're working with 10 perinatal regions within Los Angeles County, in those areas of high need, to introduce evidence-based practices. We spoke extensively about this at a workshop, just prior to this, in terms of how we're incorporating the tools that have been adopted by other chronic care models, such as the Bureau Primary Cares Asthma Project and Diabetes Project and the Infant Mortality Project around again incorporating the chronic care model, the learning collaborative model, bringing it to scale for perinatal health, and now working with 12--