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II. SPECIAL REPORT

Responding to California’s Perinatal Access Crisis

by Thomas G. David, Ruth Lyn Riedel, and Barbara M. Aved

California’s birth rate continues to increase, in contrast to trends elsewhere in the nation. One out of eight births in the United States now take place in California, one-third of that number in Los Angeles County. A large and growing number of those births are to low-income women. This situation is severely taxing the capacity of county medical centers and other traditional “safety net” providers. Waits of as long as twelve weeks for initial prenatal appointments at county clinics in Los Angeles were reported during the past year.

The results are a rate of low-birthweight deliveries that is above the national average and increased infant mortality in some areas of the state, particularly among African-Americans. Back to Basics, a 1986 report by the Children’s Research Institute of California, sounded the initial alarm. It also pointed out the cost-effectiveness of ensuring that all low-income women get prenatal care rather than risking “no care” emergency room deliveries and expensive neonatal intensive care services for premature babies.

The report helped to stimulate a series of incremental state legislative reforms that increased Medi-Cal (California Medicaid) reimbursements for obstetricians and expanded eligibility for Medi-Cal obstetric services to women with incomes below 200 percent of federal poverty guidelines and to undocumented immigrants. The Comprehensive Perinatal Services Program (CPSP) also was created to provide a broader range of support services to low-income women.

Over the past five years three foundations (Alliance Healthcare Foundation, The James Irvine Foundation, and Sierra Health Foundation) have developed grant-making programs to complement and build on these policy developments. The recent joint publication, Models that Work: Solving the Perinatal Care Crisis for Pregnant Women and for California Communities, describes in more detail the context for that work and focuses on fifteen projects that each exemplify a different community approach to the problem of access to perinatal care.

Each foundation independently established access to perinatal care as a funding priority. Most of the grant making in this area has been initiated by an individual foundation, but different pairs of foundations have collaborated on a number of projects. Geographic restrictions have so far prevented three-way collaboration. Since 1988 combined grants for perinatal access have exceeded $10 million, with Irvine’s grants totaling $5.4 million, Sierra’s Prenatal Care Access Initiative and other grants topping $3.4 million, and Alliance contributing $1.4 million.

To maximize funding impact, we focused on four strategies to increase access to care: (1) incentives to encourage private provider participation; (2) multiinstitutional partnerships to create coordinated local systems of care; (3) new models of care to respond to the needs of low-income women; and (4) planning, policy analysis, and advocacy to stimulate policy changes at the local and state levels. We have learned much about the elements of success of each of these strategies, which are most effective when they are used in combination. Some of those lessons are summarized below.

Incentives. While the California legislature provided a potentially strong package of incentives by increasing reimbursements and creating new funding streams such as the CPSP, it did not provide funding for planning or start-up expenses for new programs. As a result, providers’ initial response was mixed at best. One role for foundations has been to provide grants for technical assistance and initial capital and personnel costs for new CPSP clinics to hospitals, community health centers, and Planned Parent-
hood groups. Those grants have been highly successful.

To encourage private physicians to accept Medi-Cal, however, a different set of incentives is necessary. Physicians are wary of public-sector reimbursement problems and concerned about the level of financial and legal risk Medi-Cal patients might bring. To answer these quite legitimate questions, grantees have designed systems to prescreen patients, simplify the Medi-Cal eligibility process, and provide physicians with a managed flow of referrals. In some cases, physicians’ malpractice insurance premiums have been paid by local government.

Physician leadership has been critical to the success of these efforts. Only physicians can convince their peers to participate; indeed, several potentially promising ideas did not reach the proposal stage because physician leadership was missing. A major success story is San Diego, where more than a hundred obstetricians who did not accept Medi-Cal patients now participate in a countywide prenatal care and delivery program supported by Alliance and Irvine.

**Partnerships.** Experience has taught us that the perinatal access problem cannot be solved by any one sector of the community. Clinics, hospitals, physicians, and local government all must do their part to provide access to care. Bringing disparate individuals and institutions together is a complicated task, even when all parties agree on the need for a solution. It requires local leadership, good timing, and a willingness to set aside preconceptions and turf issues. The attention and funding of a private foundation can also serve a catalytic role, convening various interests and keeping them focused on patient needs and program goals. For example, Sierra’s Prenatal Care Access Initiative has had a galvanizing effect across its twenty-six-county funding region.

The funding has brought in skilled facilitators to assist in forming and maintaining community partnerships. It has helped to empower emerging local leadership to craft creative solutions. In addition, grants have served as the “carrots” for implementation once the hard work of planning and compromise is accomplished.

Outcomes range from a large public/private partnership in Los Angeles supported by both Irvine and Alliance (and several other funding partners) to the development of new working relationships among a clinic, hospital, and obstetrical practice in rural Yolo County accomplished with Sierra and Irvine funding. Patients are the ultimate beneficiaries; they no longer have to fend for themselves but are connected (as early in their pregnancies as possible) to coordinated perinatal care.

**New models.** Simply opening a new prenatal care program in a community is not enough to create access to care for low-income women. Sometimes formidable cultural and language barriers discourage their participation. For a low-income family struggling to make ends meet, keeping a routine prenatal appointment may not be a priority compared with other problems they face.

Recognizing these realities, grantees have developed a variety of outreach strategies specific to their communities to identify pregnant women and encourage them to seek and continue care. Grantees provide personalized, one-to-one support to help women with a variety of life challenges as well as negotiating the health care system. Support groups on issues faced in pregnancy or parenting have been established.

A variety of patient incentive programs have been established to encourage women to keep all of their prenatal appointments. Women can earn “points” that can be exchanged for baby clothes, car seats, and other tangible goods. One community clinic in San Diego County established a special loan fund for uninsured women to cover the cost of prenatal care and delivery; the fund initially was underwritten by Alliance.

Different approaches to medical care have been piloted, including deliveries by certified nurse midwives in both hospitals and a freestanding birthing center. Mobile prenatal clinics were started with grant funds to take services directly to women who have no transportation. Both outpatient and residential programs also have been developed for pregnant, substance-abusing women.

The key element in all of these programs is respect for patients. Speaking their languages and understanding their cultures are
important first steps. Also, program staff should reflect the races and ethnicities of the client community whenever possible.

**Analysis and advocacy.** Even when the right policies are in place, bureaucratic systems are slow to respond to the needs of low-income women. Constant monitoring and targeted advocacy are needed to ensure that appropriate services are provided. Grant funds have supported local data collection, planning, and the preparation of reports to quantify local needs and stimulate action. Policy analyses to test the effect of proposed changes on the current system at the state level have been underwritten. For example, Sierra has commissioned extensive data collection and analysis on perinatal health indicators and the availability of providers in its grant-making region. Other ongoing projects seek to link disparate provider groups to enable them to monitor state and local decision making and achieve consensus on goals for improving existing services.

**New developments.** Several major policy developments are pending in California that will have a significant impact on the three foundations’ work in this domain. First is the transformation of Medi-Cal from a fee-for-service to a managed care system. This has been driven to date by the desire of political leaders to curb the exponential growth of Medi-Cal costs. It is seen as a way to lower spending, even though experience (in California and elsewhere) has shown that managed care results in only modest savings when applied to low-income populations. It is uncertain how the grantees’ newly developed programs will fare under managed care. It would be ironic indeed if all of the current incentives for private provider participation in perinatal care for low-income women were reversed by state government in the name of cost containment.

A second related change is a proposed consolidation of maternal and child health programs at the state level. While this could streamline eligibility procedures and simplify management, the scope of services for a program such as the CPSP might be diminished, if not eliminated entirely. If other state categorical funds (for example, cigarette tax dollars, which have supported expanded access to primary care) are redirected, some of the effective outreach programs that grantees have developed also could be jeopardized.

Finally, ongoing state and local budget shortfalls have dire implications for the existing public health care system. As those services are eroded, there will be even more need for the private sector to assume more of the funding for the Medi-Cal population.

The message of *Models that Work* is that there is no single “best” solution to the problem of perinatal access. Instead, grantees have demonstrated the effectiveness of a variety of approaches that evolved out of local needs and maximized local ingenuity and resources. What these approaches share is good outcomes. They are reaching women early in their pregnancies, enrolling and retaining them in comprehensive prenatal programs, and delivering healthy babies.

With existing government funding streams, huge sums (grants or other private financing) are not required to start up similar programs. What is essential is leadership. It is required to break through denial and inertia to confront the dimensions of the problem. What is also required is a commitment to action.

**NOTES**

1. Actually, California’s overall birth rate declined slightly in 1991, the most recent year for which data are available. But births to low-income women have not declined, and the state’s fertility rate of 2.4 births per woman is the highest in the United States (and among Western industrial nations).