FIRST 5 LA

Champions For Our Children

Memo

29640

750 N. Alameda Street
Suite 300
Los Angeles, CA 90012
ph: 213.482.5902
fax: 213.482.5903
www.first5la.org
contact@first5la.org

To: Patrick H. West, City Manager
City of Long Beach, Dept. of Health & Human Services

From: Evelyn V. Martinez, Executive Director

Date: May 1, 2009

Subject: AMENDMENT TO HEALTHY BIRTHS GRANT AGREEMENT # 00667 - LONG BEACH BEST BABIES COLLABORATIVE

This document is official notification that Grant Agreement #00667, dated February 17, 2009, has been revised to reflect the rollover modification of FY 2007-08 unspent funds that has been negotiated between the City of Long Beach (Grantee) and the Los Angeles County Children and Families First – Proposition 10 Commission (Commission). This memorandum, when executed by the authorized signatories below, will constitute a duly-approved written amendment, incorporating the changes set forth below into said Grant Agreement.

Page 1. GRANT AMOUNT

The grant amount has been modified from $430,000 to **$474,918**, a difference of $44,918.

SCOPE OF WORK/STATEMENT OF WORK

The revised Scope of Work and Statement of Work will be attached as Exhibit A and will form an integral part of this Grant Agreement.

BUDGET

The revised Budget will be attached as Exhibit B and will form an integral part of this Grant Agreement.

The remaining provisions of the Grant Agreement are in full force and effect.

By acknowledging this memorandum where indicated below, you represent that you have reviewed and agree to the above-described amendment to the Healthy Births Initiative Expansion Grant #00667 with the Los Angeles County Children and Families First – Proposition 10 Commission and that you are legally authorized to sign and bind an agreement on behalf of the City of Long Beach.

GRANTEE

Agreed and Accepted:

Name of Grantee: City of Long Beach

Grant Number: 00667

Print Name and Title of Authorized Signatory: Patrick H. West, City Manager

Signature: Assistant City Manager **Date** 5-28-09

EXECUTED PURSUANT TO SECTION 301 OF THE CITY CHARTER.

COMMISSION

Approved:

Print Name and Title of Authorized Signatory: Evelyn V. Martinez, Executive Director

Signature: **Date** 06/10/09

EVM:agp

APPROVED AS TO FORM
May 20, 2009
ROBERT E. SHANNON, City Attorney
By
LINDA TRANG
DEPUTY CITY ATTORNEY

Los Angeles County Children & Families First
Proposition 10 Commission (aka First 5 LA)

Grant Agreement Number: 00667
Grant Agreement Period: October 1, 2008 – June 30, 2009

Healthy Births Initiative
EXHIBIT A - STATEMENT OF WORK

PROJECT SUMMARY PAGE

Agency Name	Long Beach Department of Health and Human Services						
Project Name	**Long Beach – Wilmington Best Babies Collaborative**						
Mailing Address	Long Beach Department of Health and Human Services, 2525 Grand Avenue			City	Long Beach	Zip	90815
Project Director	Yolanda Salomon-Lopez	Phone	562-570-4291	Fax	562-570-4099	Email	Yolanda_Salomon@longbeach.gov
Contact Person	Pamela Shaw	Phone	562-570-4208	Fax	562-570-4099	Email	Pamela_Shaw@longbeach.gov
Executive Director	Ronald R. Arias, Director	Phone	562-570-4016	Fax	562-570-4049	Email	Ronald_Arias@longbeach.gov

TOTAL GRANT AMOUNT:	**$430,000**		
Total UNDUPLICATED Persons Receiving Direct Services through the **Case Management** Core Approach	**Children 0-5**	**Families of Children 0-5**	**Pregnant and Parenting Women**
			140
Total Persons Receiving Services through the following Core Approaches*: **Outreach**			**650**
Health Education & Messaging			**600**
Social Support			**140**
Interconception Care			**140**
**Persons may be counted more than once across these core approaches*			

PROGRAM, BUDGET AND EVALUATION APPROVALS: The following representatives have reviewed and approved the Statement of Work, Scope of Work: Program Implementation Plan, Evaluation Plan, Budget Exhibits and any additional pages attached for use in carrying out this Grant Agreement.

Grantee/Agency Executive Director Signature _____ Date _____

First 5 LA Program Officer Signature _____ Date _____

First 5 LA Research Analyst Signature _____ Date _____

Healthy Births Initiative
EXHIBIT A - STATEMENT OF WORK

I. Project Site: For each collaborative partner (including the lead agency), provide the contact name, phone number, and address for each collaborative site (i.e. where services are being provided).
Lead Agency – Long Beach Department of Health and Human Services sites include main site at 2525 Grand Ave., Long Beach, 90815, and Miller Family Health Education Center site, 3820 Cherry Ave., Long Beach, 90807. Contact person – Yolanda Salomon-Lopez, Project Coordinator, 562-570-4291.
Long Beach Memorial Medical Center – 2801 Atlantic Ave., Long Beach, 90806. Contact person – Cathy Fagen, Coordinator Perinatal Outreach Education Programs (RPPC, CDAPP, Sweet Success), 562-933-8019.
St. Mary Medical Center, Families in Good Health – 411 E. 10th St., Ste. 207, Long Beach, 90813. Contact person – Lillian Lew, Director, 562-491-9100.
Wilmington Community Clinic – 1009 N. Avalon Blvd., Wilmington, 90744. Contact person – Vanilla Brooks, 310-549-1551.
The Children's Clinic, Serving Children and Their Families – 2801 Atlantic Ave., Long Beach, 90806. Contact person – Elisa Nicholas, MD, 562-933-0430.
St. Mary Medical Center, Mary Hilton Family Clinic – 1050 Linden Ave., Long Beach, 90813. Contact person – Eleanor Cochran, OB Clinic Manager, 562-491-9047.
Latino Diabetes Prevention and Management Program – 3820 Cherry Ave., Long Beach, 90807. Contact person – Laurie Gruschka, Family Health Education Center Coordinator, 562-.570-7900

II. Hours of Operation of Project Site: (i.e. Monday – Friday 8 a.m. to 6 p.m.)
Primary hours will be Monday through Friday, 8 am to 5 pm, for all sites, with additional evening and Saturday hours as needed.

II. Brief Project Description: (In your description state the collaborative mission, vision, and values. For each collaborative partner (including the lead agency), include the services provided, target population, and service area, i.e. zip codes to be served).
The mission of the LB-W BBC is to improve birth outcomes for perinatal families in the target zip codes of 90802, 90805, 90806, 90813, and 90744 by identifying gaps, coordinating services, and eliminating barriers and enhancing the capacity of the community to work together. Our vision is that all pregnancies will lead to a healthy birth outcome through improved community awareness and utilization of perinatal support resources. The community encompasses consumers, agencies, providers, educators, case manager, and paraprofessionals. Collaborative values include creativity, communication, inspiring others to become involved, commitment to continuity of services, and commitment to the collaborative process/consistency of involvement.
Project efforts continue to focus on improving coordinated services delivery – although many services exist for women in the LB-Wilmington area, there is often a lack of coordination between agencies, which can result in the underutilization of duplication of services. There are also gaps in available services. The Collaborative will address the disconnect, as well as the gaps, by providing a system for coordination. Improved continuity of care for high-risk women during prenatal and interconception periods will be a direct result of LB-W BBC activities. The specific services to be provided will include case management of high risk women (teens, women with prior poor birth outcomes, and women with conditions that may contribute to poor birth outcomes – such as chronic disease, substance use, psychosocial risk factors) to ensure that they are connected with the services they need to improve future pregnancy outcomes, improving the community's awareness of what services exist for the target population, as well as addressing gaps in available services by accessing funding opportunities and affecting policy issues. The LB-W BBC project will focus on the core approaches of case management, outreach, health education, interconception care, and social support.

Use additional sheets as necessary

Healthy Births Initiative
EXHIBIT A - STATEMENT OF WORK

PROJECT DESCRIPTION (Continued)

Agency Name:	**Long Beach Department of Health and Human Services**
Project Name:	**Long Beach-Wilmington Best Babies Collaborative**

Project Description:

Case management will be the primary core approach utilized by the LB-W BBC. The project will utilize a centralized case management component, to provide an overall administrative type of case management "clearinghouse" approach. The lead agency has a Public Health Nurse to fulfill this role as the Centralized Case Manager (CCM). The CCM will work closely with the Project Coordinator (PC) and the Core Collaborative to continue implementing the centralized case management system. The CCM will provide a "one-stop-shopping" approach that will help ensure that the existing community resources that are available for the target population (women who are at risk for poor pregnancy outcomes, either with a current pregnancy or a future subsequent pregnancy, and reside in the target zip codes of 90802, 90805, 90806, 90813, and 90744). The PC, along with the CCM, will work to ensure that the health and social service provider community is aware of the LB-W BBC and utilizing the centralized case management system. The CCM will be continually expanding her awareness of the array of services available throughout the community, and will become expert in assisting CCM clients in accessing needed services. The CCM system will enable efficient use of available resources by avoiding duplication, and will also serve to identify additional areas where gaps in services exist. The CCM will work with the PC and the Core Collaborative to address these gaps through identification of possible sources of funding for needed services. CCM will be provided in all 5 zip codes in the LB-W BBC. A LBDHHS public health nurse will provide specialized case management to 25 women and/or teens (first time pregnancies only) enrolled in the Nurse Family Partnership Program (David Olds Model).

Specialized **case management** will also be provided by other LB-W BBC partners, including the Latino Diabetes Prevention and Management Program, who will be funded to provide case management to 25 women residing in the 4 Long Beach zip codes (90802, 90805, 90806, and 90813) who were gestational diabetics or are Type II Diabetics who have had a previous pregnancy, in order to ensure receipt of adequate interconception care. Families in Good Health will provide case management to 15 Southeast Asian/Pacific Islander women and/or teens residing in the 4-targeted Long Beach zip codes. SMMC Mary Hilton Family Clinic (SMMC OB Clinic) will be funded to provide case management to 25 high-risk OB clients residing in all 5-target zip codes to ensure receipt of prenatal care and support services, as well as follow-up during the interconception period. The LBDHHS BIH Program will serve as a referral resource for the CCM, and provide case management to ensure that high-risk pregnant African-American women residing in the 4-targeted Long Beach zip codes receive the model interventions of the BIH program (including Social Support and Empowerment, and Role of Men services). The LBDHHS MCH program will also serve as a referral resource for the CCM, by providing short-term case management for women in all 5 target zip codes to ensure enrollment in health insurance to cover prenatal care and connection with a prenatal care provider, and by providing a resource for more long-term field PHN case management for very high risk clients who live in the 4 targeted Long Beach zip codes. The Wilmington Community Clinic will be funded through the project to provide on-site case management for 25 high-risk clients residing in the 90744 zip code.

Outreach is another core approach utilized by the LB-W BBC. In order to provide case management, it will be necessary to perform outreach to both the client and the provider community in order to increase the awareness of the availability of CCM services. The PC, CCM, and Core Collaborative members will **outreach** to the provider community to encourage utilization of the CCM system. **LB-W BBC partners will conduct outreach to the clients in the community**. The LBDHHS BIH Program provides outreach to high-risk African-American women and will inform contacts in the 4 target Long Beach zip codes of LB-W BBC services. The Latino Diabetes Prevention and Management Program will conduct outreach activities at community events targeting childbearing age women at risk for diabetes.

Health education sessions will be funded by the project and conducted by LB-W BBC partners, including health education sessions on diabetes management, preconception planning,

depression, and interconception health care, and referrals will also be made to established existing community health education resources (breastfeeding, parenting, nutrition, etc.) as appropriate. Increase of outreach activities will occur during April, May and June to assist in reaching benchmark numbers for case management program. Staff will participate in community events; outreach to providers and at MCH related classes/support groups.

The fourth year of the LB-W BBC project will focus on recruitment and retention as well as case management and social support services. The collaborative will work with health care and social service providers to identify the number of available social support services for their clients residing in the 5 LB-W BBC target zip codes, and increasing utilization of available **social support** services – such as BIH, the Latino Diabetes Prevention and Management program, parenting classes, mental health services – and identification of gaps in **social support** services. The PC will work with the community and collaborative to identify and address service gaps.

The collaborative will purchase four hospital grade electric breast pumps and supplies to be used by clients that are experiencing difficulties with breastfeeding. Staff will attend a lactation consultant certification program to work with breastfeeding clients and help increase breastfeeding rates. The program will also plan and host a provider workshop focusing on Postpartum depression. One staff will attend and complete a forty-hour certification program on Car Seat Safety. Trained staff will be able to provide hands-on assistance and education to clients because studies have shown that about eighty-five percent of child safety seats are not being used correctly. Program coordinator will attend the City MatCH conference focusing on the Life Course Health Development Model.
The LB-W BBC will also focus on **interconception care** in order to improve utilization of existing resources in the target zip codes, such as Family PACT, substance abuse services, Public Private Partnership providers for primary care for uninsured women with chronic medical conditions, and community education and support services for nutrition, breastfeeding, smoking cessation, and physical activity. Ongoing identification of **interconception care** service gaps will also be a function of the LB-W BBC, as well as identifying strategies to address these gaps. One gap that has been identified is the lack of resources for ongoing clinical care of childbearing age women with Type II Diabetes. The LB-W BBC project will provide funds for **interconception care** through The Children's Clinic for 10 women who have had a previous pregnancy who are type II diabetics, have no health insurance resources, and reside in the 4 Long Beach target zip codes 9f 90802, 90805, 90806, and 90813.

In addition to the core approaches outlined above, a major focus of the LB-W BBC will be the continuation of a functional, vibrant collaborative, containing members from all agencies providing services that improve pregnancy outcomes and support the families residing in the target zip codes. The LB-W BBC will effectively link the agencies together, in order to increase utilization of available services, maximize the effectiveness of services delivery, and identify and address gaps in needed services. Additional unpaid partners will be added on an ongoing basis.

Grant #00667: Long Beach-Wilmington Best Babies Collaborative
Scope of Work: Fiscal Year 08-09

I. Short-Term Outcomes *What results and/or changes does your collaborative aim to achieve during the **three (3) year project?***	**II. Strategies & Activities** *How will you get there? For each strategy, provide a list of sequential activities for the **current (08-09) grant period**. Include start-up activities.*	**III. Timeline** *Indicate the start and end date for each activity and strategy for the **current (08-09) grant period**.*	**IV. Collaborative Staff Responsible for Activity** *Per activity - List the collaborative organization and staff person(s) responsible for the **current (08-09) grant period**.*	**Performance Measures**	
				V. Output Measures *How will you track the amount of people, products, services, and/or organizations associated with each strategy during the **three (3) year project?** (Where appropriate, how will you measure the quality of the outputs?)* ***Benchmarks below are for the 08-09 contract period.***	**VI. Outcome Measures** *How will you know that the changes your collaborative aims to achieve during the **three (3) year project** in Column one have occurred?* ***Benchmarks below are for the 08-09 contract period.***
CASE MANAGEMENT					
COLLABORATION					
1) To have a functioning, vibrant collaboration, linked with existing Collaboratives, with appropriate and documented shared goals and objectives.	1. Develop a Continuous Quality Improvement Plan for the Collaboratives and incorporate activities based on these findings into MOUs.			) BBC meeting agendas and minutes) Collaborative membership matrix.) Continuous Quality Improvement Plan) PDSAs	) Improve Wilder Inventory score from baseline to an average of 4 for each category and maintain that average throughout the Healthy Births grant period.) Number of referrals from 211/First 5 LA Parent Help Line (888) to BBC agencies
	A. The Collaborative will review and revise the Continuous Quality Improvement Plan with the collaborative to improve output and outcomes.				
	a. Develop processes and timeline for: i.Timely completion of paper forms. ii. Timely completion of data entry of initial assessments,information forms and on-going client encounter documentation. iii.Monitoring accuracy of information as it is entered. iv. Reviewing and completing of 100% of the data error forms distributed by LA Best Babies Network within 10 days of receiving the form.				
	b. Develop output and/or outcome measures for CQI plan.				
	c. Identify and make necessary adjustments to processes and MOUs as necessary.				
	B. Enter a New Activity				
	a. Review monthly performance reports provided by LA Best Babies Network with Collaborative.				
	1.3. Invite new partner(s) to participate in collaborative meetings.	Quarterly basis 12/31/08, 03/31/09 & 06/30/09	Core Collaborative		
	2. Collaborate with Los Angeles Best Babies Network on all components of the Healthy Birth Initiative				
	A. Participate in Healthy Births Learning Collaboratives in the appropriate Service Planning Area (SPA).				
	I. To assure appropriate membership:	10/01/08 to 06/30/08	Core Collaborative		
	1.1. Review of SOW to identify membership (collaborative) needs.	Quarterly 10/31/08,	Core Collaborative (refers to the following		

	01/31/08, 03/31/09 & 6/30/09	program/agencies: LBMMC, CDAPP Coordinator, SMMC OB Staff, WCC Liaison FiGH) MCH PHN & LBDHHS NSO
1.2. Identify new potential partners and categorize (paid, non-paid, referral) and vote on partners to invite.	11/30/08 & 02/27/08	Core Collaborative, LBDHHS Nursing Services Officer (NSO)
i. Update and review each organizations strengths.	10/31/08 & 02/28/09	Core collaborative
ii. Update collaborative membership matrix.	12/31/08, 03/31/09 & 06/30/09	Core Collaborative
1.3. Invite new partner(s) to participte in collaborative meetings	Quarterly basis 12/31/08, 03/31/09 & 06/30/09	Core Collaborative
i. Make invitation	Quarterly basis 12/31/08, 03/31/09 & 06/30/09	Core collaborative
ii. Update process criteria for funding potential collaborative partner based on any new additional funding.	Quarterly basis 12/31/08, 03/31/09 & 06/30/09	Core collaborative
1.4. Identify partner responsibility.	Quarterly basis 12/31/08, 03/31/09 & 06/30/09	Core collaborative
i. Update document that outlines responsibilities	Quarterly basis 12/31/08, 03/31/09 & 06/30/09	Core collaborative
1.5. Update MOU's as necessary	Quarterly basis 12/31/08, 03/31/09 & 06/30/09	Core collaborative
i. Utilize MOU template	Quarterly basis 12/31/08, 03/31/09 & 06/30/09	Core collaborative
ii. Identify and make necessary adjustments to process and MOU's as needed	Quarterly basis 12/31/08, 03/31/09 & 06/30/09	Core collaborative
1.6. Revise/update matrix and distribute	Semi-annual 12/30/08 & 5/31/09	Core Collaborative & Project Coordinator
II. Design Collaborative Governance (meet, review, vote, document).		
2.1. Update criteria for membership	10/31/08, 1/31/09 & 4/30/09	Core Collaborative
i. Review/update & adapt existing HBLC resources	Quarterly basis 10/31/08, 01/31/09, 05/31/09	Core collaborative & Project Coordinator

ii. Review & update program information/data	Quarterly basis 10/31/08, 01/31/09, 05/31/09	Core Collaborative & Project Coordinator
2.2. Update invitation & exiting process	10/31/08 & 4/30/09	Core Collaborative
i. Review/update & monitor existing tools	Quarterly basis 12/31/08, 03/31/09 & 06/30/09	Core Collaborative
2.3. Update and monitor collaborative process on regular basis	Quarterly basis 12/31/08, 03/31/09 & 06/30/09	Core Collaborative
i. Review and update meeting frequency	Quarterly basis 12/31/08, 03/31/09 & 06/30/09	Core Collaborative
ii. Update & monitor collaborative progress toward Scope of Work	Quarterly basis 12/31/08, 03/31/09 & 06/30/09	Core Collaborative
iii. Implement use of LABBN monthly progress reports to monitor collaborative work	Quarterly basis 12/31/08, 03/31/09 & 06/30/09	Core Collaborative
2.4. Update Collaborative decision-making process	Quarterly basis 12/31/08, 03/31/09 & 06/30/09	Core Collaborative
i. Review and update voting strategies/protocols	Quarterly basis 12/31/08, 03/31/09 & 06/30/09 and as needed	Core Collaborative
III. Administer Wilder Collaboration Inventory each year and incorporate activities based on these findings into MOU's		
3.1. Collect and update contact information of new/old members (identify key contacts)	12/30/08, 3/30/09 & 6/30/09	Project Coordinator
3.2. Administer Wilder through AJWI/First 5 LA	semi-annual basis 11/30/08 & 5/30/08 and as needed for new members	AJWI, Project Coordinator & Administrative Assistant
i. Follow-up on completion of Wilder	Based on date received from AJWI/First 5 LA	Project Coordinator
ii. Update & share results with collaborative members (email)	12/30/08 & 5/30/08 based on dates received from AJWI/First 5 LA	Project Coordinator
3.3. Update, evaluate and compile results	12/30/08 & 5/30/09	Admin Assistant
i. Enter information onto spreadsheets	12/30/08 &	Admin Assistant

	5/30/09	
ii. Address issues that arise based on Wilder results at a collaborative meeting	1/30/09 & 6/30/09	Project Coordinator, NSO & Core Collaborative
iii. Share results with Healthy Births Center staff	1/30/09 & 6/30/09	Project Coordinator
IV. Implement the Continuous Quality Improvement plan for the Collaborative and incorporate activities based on the 2007-2008 findings into MOU's		
4.1. Continue to monitor progress toward scope of work/objectives	Quarterly basis 12/30/08, 3/30/09 & 6/30/09	Core Collaborative, Project Coordinator & MCH PHN
i. The collaborative will continue to review and revise the Continuous Quality Improvement Plan to continue improvement of output and outcomes	Quarterly basis 12/30/08, 3/30/09 & 6/30/09	Core Collaborative
ii. Continue reassessment of scope of work and objectives based on SOW timeline graph	Quarterly basis 12/30/08, 3/30/09 & 6/30/09	Core Collaborative, PC & AA
iii. Continue to identify areas that are under-met and formulate improvement action plans for 2008-2009	11/30/08, 2/28/09,5/30/09	Core Collaborative, PC & AA
4.2. Setting standards for Collaborative Partners	Quarterly basis 10/30/08, 1/30/09, 4/30/09	Core collaborative & PC
i. Introduction of new staff members to collaborative definition of "quality"	Quarterly basis and as needed 10/30/08, 1/30/09, 4/30/09	Project Coordinator & Admin Assistant
ii. Establish clear expectations for attendance and participation of collaborative meetings/events/trainings	Quarterly basis 10/30/08, 1/30/09 & 4/30/09	Core Collaborative & PC
iii. Establish set guidelines and requirements for program timeliness and compliance with reports	Quarterly basis 10/30/08, 2/28/09 & 6/30/09	Project Coordinator & Core Collaborative
iv. Establish and review set lines of communication/feedback for collaborative members	Quaterly basis 11/30/09, 3/30/09 & 6/30/09	Project Coordinator, Admin Assistant & Core Collaborative
4.3. Improve capacity of collaborative through the addition and orientation of new members	12/30/08, 3/30/09 & 6/30/09 and as needed	Core Collaborative, PC & AA
i. Establish mechanisms for sharing information and lessons learned with collaborative partners	10/30/08 & 1/30/09	Core Collaborative & Project coordinator
ii. Identify method(s)to share best practices at collaborative meetings (from within & outside collaborative)	10/30/08, 1/30/09 & 4/30/09	Core Collaborative, PC & AA
4.4. The collaborative will review and revise the CQI plan to improve output & outcome measures	10/30/08, 3/30/09 & 6/30/09	Core Collaborative, PC & AA
i. Set guidelines and implement process/timeline for completion of paper forms, data entry, information forms and on-going client encounter documentation	10/30/08, 2/28/09 & 4/30/09	Project coordinator & Admin Assistant
ii. Develop and implement guideline for 100% completion of data entry error forms distributed by LABBN within 10 days of receiving report	Monthly basis	Project Coordinator & Admin Assistant
iii. Update and review monitoring system to assess accuracy of client information entered	10/30/08 monitor on monthly basis	PC, AA & Centralized Case Manager

	iv. Review and complete 100% of the data error forms distributed by LABBN within 10 days of receiving error information	Monthly basis during program year	AA, CCM, SMMC Health Educator, Latino Diabetes health Educator, WCC CM & FiGH CM		
	4.5. The Collaborative will implement the CQI plan by monitoring the quality and quantity of data entered into the online Healthy Births Database by incorporating the use of the monthly progress report provided by LABBN	10/30/08 monthly basis to monitor	Core Collaborative		
	i. Review monthly performance reports provided by LABBN with collaborative	On a monthly basis during program year 10/30/08 to 6/30/09	Core Collaborative & LABBN staff		
2) Strengthen collaborative member organizations' knowledge of resources provided by Collaborative members.	V. Use a collaborative asset map to determine current resources and identify gaps	10/30/08, 1/30/09 & 4/30/09	Core Collaborative	) BBC member resource directory) Documentation of BBC staff training on collaborative resources	) Clients with at least one interagency referral Goal: None
	5.1. Review & update use of collaborative membership matrix with collaborative partners	10/30/08, 01/30/09, 4/30/09 & 6/30/09	Core Collaborative		
	i. Establish & review system-level training for new staff and collaborative members of resources & services	10/30/08, 2/28/09 & 5/30/09	Core Collaborative, PC & AA		
3) To have a functioning, sustainable and up to date web-based resource directory of LB-W BBC member agency services	VI. To have a functioning, sustainable and up to date web-based resource directory of collaborative agency services	10/30/08 to 6/30/09	Project Coordinator & Admin Assistant	) Signed MOU's on File of programs/agencies that wish to participate in web-based resource directory	) Total # of people accessing website
	6.1 . Update and maintain web-based resource directory	10/30/08 to 6/30/09	Project Coordinator & Admin Assistant		
	i. Identify LBDHHS staff to assist in updating resource directory	10/30/08 to 11/30/08	Project Coordinator & LBDHHS NSO		
	ii. Update and designate programs and agencies to be included in resource directory	10/30/08, 1/30/09, 4/30/09	Project Coordinator & Admin Assistant		
	iii. Update and add designated programs and agencies on resource directory with 211 program	10/30/08, 12/30/08, 2/28/09 & 4/30/09	Project Coordinator & Admin Assistant		
4) Promote the sustainability of the Collaborative through both social and financial resources.	VII. Present on the importance of program sustainability to the collaborative and community partners	10/30/08, 3/30/09 & 6/30/09	Project Coordinator & Admin Assistant	) Contact list of sustainaibility steering committee) Meeting agenda indicating topic of sustainability) Number of submitted articles promoting visibility of the collaborative	) Number of clients who state at initial screening that they got the information from collaborative efforts
	7.1. Designate steering committee to research and oversee possible funding sources	10/30/08	Core Collaborative, PC & AA		
	i. Steering committee to research funding sources and report to core collaborative	12/30/08, 3/30/09 & 6/30/09	PC, AA & Steering committee		
	ii. Submit at least one article promoting the collaborative efforts	10/30/08 to 6/30/09	Core Collaborative		
5) Promote referrals from 211/First 5 LA Parent Help Line (888) to Network Organizations.					) Number of referrals from 211/First 5 LA Parent Help Line (888) to BBC agencies
6) Participate at HBLC meetings	7.2. Attend and actively participate at HBLC meetings	10/30/08 to 6/30/09		) Number of HBLC meetings attended) Number of updates given to HBLC's	
	i. Identify key staff to attend HBLC meetings and report relevant information to core collaborative	10/30/08	Core Collaborative, PC & AA		
CASE MANAGEMENT					
1) Increase case management capacity within	I. Review and update case management program	10/01/08 to 10/30/08	Collaborative Staff	) Documentation of all case management services	) Case managed clients who meet enrollment criteria

the Collaborative (including retain CMs).	1.1. Review & update case management program including curriculum for FiGH, Centralized Case Management, SMMC, WCC, NFP and Diabetes program	12/30/08, 03/30/09 & 06/30/09	Core Collaborative, NFP Staff & CCM	provided in the collaborative and their similarities and differences) Documentation of sharing of screening, referral, assessment and follow-up tools and protocols across BBC members and coordination of case management activities) Number of eligible referrals) Number of referrals received) Recruitment & retention plan(s)) Referral protocols	Goal: 95%) Number of clients with adequate prenatal care) Prenatal case management clients lost to follow-up Goal: 95%
	i. Review & update case management protocols, implement program changes when applicable based on best practices	11/30/08, 4/30/09	All collaborative partners		
	ii. Conduct 3 trainings with case managers/health educators to discuss appropriate tracking of clients receiving services, use of DCAR system, referral services and performance measures based on LABBN progress reports	12/30/08, 3/30/09, 6/30/09	PC, AA & CCM PHN		
	iii. CCM PHN to provide case management to 20 high-risk women/teens referred from community and BBC partners including SMMC, LBMMC, BIH, LBUSD Parent Program & School Nurses, CDC Parent Program, LA County & LBDHHS Public Health Nurses	10/01/08 to 06/30/09 on-going basis	Centralized Case Manager PHN		
	iv. Nurse Family Partnership PHN to provide case management to 20 high-risk women/teens, first time pregnancy prior to seventh month of pregnancy referred from community and BBC partners (including non-comprehensive high-schools, LBUSD, SMMC, LBMMC, OB Providers, etc) to receive full-scope case management including lactation education, individual parenting & social support education & family planning (based on David Olds model)	10/01/08 to 06/30/09	NFP PHN		
	v. Families in Good Health health educator to provide case management to 15 high-risk women/teens (Southeast Asian/Pacific Islanders) using the PACT curriculum (includes individual health education sessions focusing on breastfeeding, parenting, self-esteem and social support education)	10/01/08 to 06/30/09	FiGH Case Manager		
	vi. Conduct training for new BBC staff members on referral system to BBC program/resources using DCAR system and for community services	As needed basis during program year	CCM, PC & AA		
	1.2. Implement the case management program	10/01/08 to 06/30/09	Core Collaborative		
	i. Facilitate two trainings to providers, staff and case managers/health educators on the BBC case management program, services and resources available including individual health education & social support education	12/30/08 & 6/30/09	PC, CCM & AA		
	ii. Provide case management review for case managers at WCC, SMMC & Diabetes Program including monthly case reviews to discuss special assistance with non-compliant clients, clients with unusual or special concerns/issues, programmatic issues including assistance with DCAR system from LABBN & BBC staff	Monthly basis during program year	CCM, PC, AA, LABBN staff		
	II. Review referral program for high-risk women/teens with Type II Diabetes and/or Gestational Diabetes	11/30/08, 3/30/09 & 6/30/09	Collaborative Staff		
	1.1. Review and continue referral program with LB Memorial & St. Mary Medial Center Sweet Success Programs (provides diabetes education & management during pregnancy period only) to the LBDHHS Latino Diabetes Program for women/teens with Type II Diabetes in need of continued diabetes education and management during postpartum & interconception period	10/01/08 to 06/30/09	SMMC OB Director, LBMMC & SMMC Sweet Success Health Educators, Latino Diabetes Health Educator		

	i. Train new LBMMC & SMMC staff on referral program to Latino Diabetes Program for women/teens with Type II Diabetes during postpartum period (Type I Diabetes requires intensive medical management-those clients will be referred to The Children's Clinic)	10/01/08 to 06/30/09 on going as needed	PC & Latino Diabetes Program Health Educator		
	1.2. Specialized case management for 20 referred women/teens with Type II Diabetes through Latino Diabetes Health Educator providing services such as, individual diabetes management education, proper use of medical equipment, importance of nutrition and exercise program, plus social support services for individual and family members of newly diagnosed diabetes patients	10/01/08 to 06/30/09	Latino Diabetes Program		
2) Identify best practices of individual case management programs, share them among the Collaborative, and encourage all case managers to adopt them.	III. Update and maintain a best practice and monitoring system (multi-level case management system) by implementing changes/updates at roundtable meetings for case managers	11/30/08, 1/30/09, 3/30/09, 5/30/09	CCM, PC, AA & collaborative case managers/health educators	) Documented case management quality review system) Documented shared list of case management best practices	) Clients with interagency referrals for whom at least one referral was completed Goal: 90%) Clients with the following poor birth outcomes: LBW, VLBW, Preterm birth, fetal death, neonatal death Goal: 90%) Pregnant clients 19 and over with at least one case management encounter per month Goal: 95%) Pregnant clients under 19 with at least two case management encounter per month Goal: 50%) Prenatal clients with at least partial achievement on 100% of care plan goals by the time of the birth Goal: 95%
	1.1. Train new case managers/health educators on best practices/monitoring system	As needed during program year	PC, AA & CCM PHN		
	1.2 . Review and continue referral system to Centralized Case Management Program focusing on high-risk women/teens that would benefit from services provided by a Public Health Nurse	10/30/08 and as needed basis during program year	CCM, AA, all collaborative case managers/health educators		
	i. Conduct a training session for all case managers/health educators using referral system, DCAR case management program & screening tools	12/30/08	PC, AA & CCM PHN		
	1.3. Review and update follow-up protocol for clients who withdraw from case management program at case managers roundtable meetings	11/30/08, 1/30/09, 3/30/09, 5/30/09	CCM, PC, AA & collaborative case managers/health educators		
	i. Identify and contact (via phone or letter) clients that have withdrawn from case management program to offer services if still needed or refer to appropriate services in community	12/30/08, 03/30/09, 06/30/09	Collaborative Case Managers/Health Educators		
OUTREACH					
1) High risk clients meeting program criteria will be enrolled in Case Management.	I. Present on the importance of early prenatal and interconception care around the community	10/30/08 & 4/30/09	Project Coordinator	) Documentation of BBC staff training in cultural competency) Number of community events and outreach activities) Number of outreach contacts	
	1.2. Update and review culturally appropriate materials to disseminate to high-risk clients in the community	11/30/08 to 12/30/08 and ongoing basis	All collaboratie members, PC & AA		
	1.3. Update and present collaborative information and materials to 2 or more community agency staff meetings to increase awareness of collaborative program and resources	10/30/08 to 6/30/09	Project Coordinator & Admin Assistant		
	1.4. Update & review protocol to identify and work with community based agencies and programs for outreach to new high-risk clients in targeted zip code areas	10/30/08 to 6/30/09	Core Collaborative, PC & AA		
	1.5. Continue to provide outreach to high-risk African American women through the LBDHHS African-American Infant Health Program	10/30/08 to 6/30/09	AAIH Staff & CCM		
	1.6. Review and continue outreach activities to new clients with a history of gestational diabetes or Type II Diabetes	On going basis during program year 10/30/08 to 6/30/09	Latino Diabetes Program & Sweet Success staff		
	1.7. Conduct outreach at five (5) community events	On going basis	FiGH, WCC, SMMC, Latino		

	targeting high-risk women/teens	during program year 10/30/08 to 6/30/09	Diabetes Program, PC & AA		
	1.8. Conduct outreach to OB Providers to inform them of BBC services available for women with history of Gestational Diabetes or Type II Diabetes	On going basis during program year 10/30/08 to 6/30/09	Latino Diabetes Program		
2) Develop and implement outreach/recruitment and internal and external referral processes.	1.1. Develop outreach and recruitment process for collaborative program	10/30/08 to 12/30/08	Core Collaborative, PC & AA	) Documentation of completed referral process	) Number of case managed clients that meet enrollment criteria
	i. Train and implement staff on established outreach/recruitment process	12/30/08 to 1/30/09	Project Coordinator & Admin Assistant		
	1.2. Develop established internal and external referral process for collaborative program	10/30/08 to 12/30/08	Core Collaborative, PC & AA		
	i. Implement referral process for the collaborative program	01/30/09 to 06/30/09	Core collaborative		
3) High-risk clients meeting program criteria will be enrolled in Case Management program	1.3. Identify clients meeting program criteria and enroll based on targeted zip-code areas	10/30/08 to 6/30/09	Collaborative Staff	) Number of eligible referrals) Number of referrals received) Recruitment and retention plans) Referral protocols	) Total number of clients enrolled in case management program
4) Staff will participate in outreach activities to increase number of individuals enrolled into case management program.	1.4. Provide outreach at various community events including health fairs, car seat check-up events and other community events in targeted zip code areas.	04/01 to 06/30/09	BBC collaborative		
HEALTH EDUCATION					
1) Increase and/or promote case managed knowledge about how to have healthy births and access appropriate services and resources.	I. Develop and adopt a client education curriculum and processes to complete the curriculum (i.e., CM directed &/or referrals to classes)	10/01/08 to 12/30/08	Core Collaborative, PC & AA	) All BBC members included in 211 directories) All health education materials include information about 211) Number and types of venues attended) Number of health education services) Number of participants in health education services	
	1.1. Train all case managers on using the developed client education curriculum	01/01/09 to 02/01/09	Project Coordinator, Admin Assistant, SMMC Health Educator, FiGH Case Manager, CCM, Latino Diabetes Health Educator, WCC Case Manager & NFP PHN		
	i. Implement client education curriculum	01/01/09 to 02/01/09	SMMC Health Educator, FiGH Case Manager, CCM, Latino Diabetes Health Educator, WCC Case Manager, NFP PHN PC & AA		
	II. Update, identify and assess culturally sensitive health education materials that focus on the importance of early prenatal care and interconception care	11/30/08, 3/30/09, 5/30/09	Core Collaborative, Project Coordinator & Admin Assistant		
	2.1. Review and disseminate health information materials focusing on health resources available within targeted zip codes and importance of early and continuous prenatal care	10/01/08 to 06/30/09	Core Collaborative, Case Managers and Health Educators		
	i. Collaborative staff will continue to provide health education information using identified brochures and First 5 LA materials to high-risk women/teens	10/01/08 to 06/30/09	Core Collaborative, Case Managers, Health Educators, PC & AA		
	2.2. Educate 3 community staff agencies/programs that provide health services to high-risk women on the utilization and importance of health education materials	12/30/08, 3/30/09, 06/30/09	Project coordinator, Admin Assistant		

	2.3. Continue to work with 211 to assure all LB-W BBC resources and services are included and updated in the database, plus provide 211 with collaborative program brochures, flyers and other applicable materials to increase understanding of services available through BBC program	12/30/08, 5/30/09 and as needed	Project coordinator & Admin Assistant		
	2.4. Conduct health promotion campaign to distribute materials and/or information at various community events, including Cinco de Mayo, Diabetes Convention and Juneteenth African American Celebration	10/01/08 to 06/30/09 based on event dates	LBDHHS Staff, WCC, SMMC, FiGH, BH, Latino Diabetes Program Staff		
	i. Identify and participate in community health fairs, church based events and city-wide events to disseminate health education information to increase awareness of services and resources for high-risk women/teens	10/01/08 to 06/30/09	Core Collaborative, PC & AA		
	III. Increase community recognition of LB-W Best Babies Collaborative				
	3.1. Include logo on all materials	10/01/08 to 06/30/09	Project Coordinator, AA and core collaborative		
	i. LB-W BBC logo to be included on all outreach, health education and miscellaneous materials	10/01/08 to 06/30/09	Core Collaborative, PC & AA		
2) All clients will receive health education relevant to pregnancy, postpartum and interconception care	II. Develop and implement process(es) to evaluate increased knowledge related to resources and health as part of CM activities	10/01/08 to 06/30/09	Core Collaborative, Project Coordinator & Admin Assistant	) List of resources/links for health education topics) Number of health education services provided	) Clients with >= 3 health education topics/referrals made & classes attended Goal: None) Measure on increased knowledge) Number of participants receiving any health education services
	2.1. Administer health education evaluation form for all case managed clients	01/01/09 to 06/30/09	SMMC Health Educator, FiGH Case Manager, WCC Case Manager, CCM PHN, NFP PHN, Latino Diabetes Health Educator		
	ii. Collect and track health education data from case managers	01/01/09 to 06/30/09	Project Coordinator & Admin Assistant		
	2.2. Refer women/teens to established no-cost health Education Classes held at LBDHHS, BIH, 5 WIC LB Sites, WCC, SMMC & LBMMC (focus on breastfeeding, parenting, nutrition, social support and empowerment classes, etc.)	10/01/08 to 06/30/09	Diabetes HE, FiGH CM, SMMC HE, WCC CM, NFP PHN, CCM PHN, core collaborative		
	2.3. Provide individual health education to high-risk prenatal & post-partum women receiving services at SMMC OB Clinic and/or delivering at SMMC	On going basis during program year 10/01/08 to 06/30/09	SMMC Health Educator		
	i. Review and update health education curriculum for high-risk women/teens attending SMMC OB Clinic	10/01/08, 02/28/09 & 04/30/09	SMMC Health Educator & Clinic Director		
	ii. Present five (5) group health education classes held at the Mary Hilton OB Clinic focusing on car-seat safety, parenting, infant safety and breastfeeding for high-risk women/teens attending SMMC OB Clinic	10/01/08 to 06/30/09	SMMC Health Educator		
3) Collaborative member(s) will participate in Car Seat Safety training and Lactation Consultant program to provide clients with added health education services.	3.1. Identify lactation consultant program and car seat safety training to attend and provide services to enrolled cients.	04/01/09 to 04/01/10	PC & PHN"s		
SOCIAL SUPPORT					
1) All Collaborative partners	I. Compile and review social support screening tools and	10/30/08 & on	Collaborative Staff	) All relevant staff trained on	) Clients referred for social

to conduct comprehensive social support screening on target population women and to refer to Collaborative organizations as indicated.	administer the tools	going during program year		use of screening tool) Documentation of agreed upon social support screening tool available to all collaborative members	support services with at least one social support referral completed Goal: 90%) Clients with at least one social support referral Goal: None) Documented increase in social support and self efficacy using validated tools
	1.1. Review and update screening tool to identify high-risk clients that would benefit from CCMP, referrals & added resources that all clinics, programs & agency staff can utilize	12/30/08, 3/30/09 & 6/30/09	Collaborative Staff		
	1.2. Provide referrals and linkage to social support programs available in the community (AAIH, parenting classes, breastfeeding workshops held at LBDHHS, SMMC, LBMMC, Community Hospital, LBUSD, etc.)	On going basis during program year 10/01/08 to 06/30/09	Collaborative Members		
	1.3. Identify gaps in social support services utilizing updated collaborative membership matrix at roundtable reviews	12/30/08, 3/30/09 & 6/30/09	Collaborative members, PC & AA		
	i. Utilize identified lack of social support services in the community to increase referrals to BBC case management program and other CM programs in the community	12/30/08, 3/30/09 & 6/30/09	Collaborative members, PC & AA		
	1.4. AAIH program to provide 2 social empowerment session of 6 classes each to high-risk African American women referred through the LB-W BBC focusing on parenting, child development, social empowerment, etc.	10/30/08 to 06/30/09	AAIH Staff, CCM PHN, LBDHHS Social Worker		
	1.5. Provide 2 group social support sessions of 8 classes each to high-risk women with Gestational and/or Type II Diabetes referred through the LB-W BBC focusing on diabetes management, related diabetes health concerns (foot care, family support, increase physical activity, use of medical equipment, maintain blood sugar levels, etc.)	10/30/08 to 06/30/09 based on scheduled classes	Latino Diabetes Staff		
	1.6. Provide social support assessment for each women receiving case management through LB-W BBC and refer to appropriate services/programs in the community including AAIH, SMMC, LBDHHS, LBUSD, WCC and LBDHHS Public Health Nurses for individual social support services	10/30/08 to 06/30/09	Latino Diabetes Program, WCC, SMMC, Core Collaborative		
INTERCONCEPTION CARE					
1) Increased access to coordinated and comprehensive interconception care programs that support high risk women in preparing for their next healthy birth.	I. Identify the existing programs and their capacity to provide interconception care for high-risk women using the collaborative membership matrix	10/30/08, 01/30/09, 3/30/09 & 6/30/09	PC, AA & Core Collaborative	) Documented review of existing inter-conception care services/programs within the collaborative	) Clients receiving post partum check-ups Goal: 75%) Clients who breastfeed for 12 months Goal: 25%) Clients who exclusively breastfeed for 6 months Goal: 25%) Clients who initiate breast feeding post partum Goal: 75%) Clients with chronic medical conditions who receive chronic care up to 12-months post partum Goal: 50%) Clients with chronic medical conditions who receive chronic care up to 24-months post partum Goal: 50%) Clients with chronic medical conditions who receive chronic care up to 3-months post partum
	1.1. Review and identify for gaps in interconception care services for high-risk women/teens, undocumented clients, clients with no access to health care due to lack of insurance or finances, etc.	10/30/08, 01/30/09, 3/30/09 & 6/30/09	PC, AA & Core Collaborative		
	1.2. Use indicators of service gaps to seek funding opportunities beyond First 5 LA included but not limited to matching government and private funds to provide interconception care and use LABBN newsletters to research available funding programs & services in community	10/30/08, 01/30/09, 3/30/09 & 6/30/09	PC, AA & Core Collaborative		
	1.3. Identify interconception care programs through use of local resource guides, Healthy Cities website, LBMCC & SMMC publications of services, HBLC SPA 8 meetings (agency representatives discuss & share program information, client eligibility, sessions, etc.) plus various local agencies and work to expand available services for high-risk clients by using information collected at various venues/meetings and integrating with existing programs	11/30/08, 2/38/09, 4/30/09, 6/30/09	Core collaborative, CDAPP MSW & SMMC OB MSW		

	to accommodate BBC clients and expanding program scope if applicable and presenting information at collaborative meetings				Goal: 18%) Clients with chronic medical conditions who receive chronic care up to 6-months post partum Goal: 31%) Interconception care clients 19 and over with chronic conditions with at least one case management encounter per month Goal: 95%) Interconception care clients 19 and over with no chronic conditions with at least one case management encounter per quarter Goal: 95%) Interconception care clients under 19 with chronic conditions with at least two case management encounter per month Goal: 50%) Interconception care clients under 19 with no chronic conditions with at least one case management encounter per month Goal: 95%
	1.4. Provide interconception care services for high-risk women/teens focusing on family planning, breastfeeding, health education, referrals to health care, etc.	10/01/08 to 06/30/09	FiGH, SMMC, WCC, Diabetes Health Educators, CCM PHN, NFP PHN,		
	i. Purchase up to four hospital grade breastpumps/supplies to be used by case managed clients continuing breastfeeding.	04/01 to 06/30/09	PC		
	II. Provide specialized interconception care for uninsured women with Type II Diabetes	10/30/08 to 06/30/09	LBMMC The Children's Clinic staff, Sweet Success Program & Diabetes Health Educator		
	1.1. Continue medical management program for Type II Diabetic uninsured women/teens to receive services focusing on health education, nutrition, importance of continuous health care, etc.	10/01/08 to 06/30/09	LBMMC The Children's Clinic staff, Sweet Success Program & Diabetes Health Educator		
	1.2. The Children's Clinic to provide medical visits (monitor blood sugar, health physicals, blood screenings and provide glucometer/strips) for 5 uninsured women/teens referred from the LB-W BBC program (Diabetes and/or Sweet Success) diagnosed with Type II Diabetes	10/01/08 to 06/30/09	The Children's Clinic		

EXHIBIT B

FIRST 5 LA
Champions For Our Children

First 5 LA Use Only
Grant # OO667

Projected Budget Form (All Years Combined)

Applicant Name: City of Long Beach
Project Name: Best Babies Collaborative YEAR 4 BUDGET (9 months)

Cost Category	First 5 LA Requested Funds Use only the columns applicable to your approved Grant							TOTALS (all years combined)		
	Actual FY 2003 - 2004	Actual FY 2004 - 2005	Actual FY 2005 - 2006	Actual FY 2006 - 2007	Actual FY 2007 - 2008	Budget FY 2008 - 2009	Budget FY 2009 - 2010	Total First 5 LA Requested Funds	Total Matching Funds	Total Projected Budget
(1) Personnel	n/a	24,321	73,615	310,112	452,895	362,824		1,223,767		1,223,767
(2) Contracted Svcs (ex. Eval)	n/a	12,183	53,460	132,721	128,540	53,219		380,123		380,123
(3) Equipment	n/a	n/a	4,800	-	-	-		4,800		4,800
(4) Printing/Copying	n/a	516	318	980	1,420	1,101		4,335		4,335
(5) Space	n/a	n/a	1,360	8,049	6,420	6,732		22,561		22,561
(6) Telephone	n/a	n/a	180	2,428	3,391	1,980		7,979		7,979
(7) Postage	n/a	255	5	5	184	76		525		525
(8) Supplies	n/a	225	3,474	1,379	2,985	2,700		10,763		10,763
(9) Employee Mileage/Travel	n/a	777	-	985	3,909	5,832		11,503		11,503
(10) Training Expenses	n/a	600	226	156	6,423	5,354		12,759		12,759
(11) Evaluation	n/a	n/a	-	-	-	-		-		
(12) Other Expenses (ex. eval)	n/a	n/a	1,075	-	796	12,222		14,093		14,093
(13) *Indirect Costs	n/a	417	4,693	20,047	29,250	22,878		77,285		77,285
GRAND TOTAL:	-	39,294.00	143,206.00	476,862.00	636,213.00	474,918.47	-	1,770,493.47	-	1,770,493.47

EXHIBIT B

FIRST 5 LA
Champions For Our Children

Formal Budget Modification Summary

Agreement # OO667
Page : 1 of 10

First 5 LA Use Only
Modification #:
Effective Date:

Agency: City of Long Beach

Project Name: Best Babies Collaborative YEAR 4 BUDGET (9 months)

Agreement Period: 10/1/08 to 6/30/09

	Cost Category	Most Current "Approved" First 5 LA Funds	Amendment Amount	Total Modified Amount
1	Personnel	331,344	23,552	354,896
2	Contracted Svcs *(Excluding Evaluation)*	61,647	0	61,647
3	Equipment	0	0	0
4	Printing/Copying	850	1,275	2,125
5	Space	6,732	0	6,732
6	Telephone	1,980	0	1,980
7	Postage	326	221	547
8	Supplies	1,700	1,020	2,720
9	Employee Mileage and Travel	3,633	2,230	5,863
10	Training Expenses	270	5,135	5,405
11	Evaluation	0	0	0
12	Other Expenses *(Excluding Evaluation)*	625	10,000	10,625
13	*Indirect Costs	20,893	1,485	22,378
	TOTAL:	$430,000	$44,918	$474,918

Nani Blyleven
Fiscal Contact Person — Date

Agency Authorized Signature — Date

Phone # 562-570-4231

First 5 LA Authorized Staff Only

Program Officer

Finance

*Indirect Costs ***MAY NOT*** exceed 10% of Personnel cost, excluding Fringe Benefits.

Additional supporting documents may be requested

FIRST 5 LA

Champions For Our Children

Section 1

Agreement # OO667

Personnel

Agency: City of Long Beach

Project Name: Best Babies Collaborative YEAR 4 BUDGET (9 months)

Agreement Period: 10/1/08 to 6/30/09

Title/Name	FT/PT	Gross Monthly Salary	% of Time on First 5 LA Project	Months to be Employed	Most Current "Approved" First 5 LA Funds	Amendment Amount	Total Modified Amount
BBC Coordinator - Y. Salomon-Lopez (plus skill pay	FT	5,314	100%	9	47,826	756	48,582
BBC Support - PHA 2 - D. Campos	FT	3,046	100%	9	27,414	0	27,414
Public Health Nurse II - M. Robinson	PT	6,027	60%	6	32,546	(10,849)	21,697
Public Health Nurse II - M. Robinson	PT	6,027	86%	3		15,550	15,550
Administrative Analyst III - N. Blyleven	FT	6,721	5%	6	3,024	(1,008)	2,016
Administrative Analyst III - N. Blyleven	FT	6,721	10%	3	0	2,016	2,016
Health Educator II -L. Parra	FT	4,239	70%	6	26,706	(8,902)	17,804
Health Educator II -L. Parra	FT	4,239	100%	3	0	12,717	12,717
Nursing Services Officer - P. Shaw	FT	7,700	5%	9	3,465	0	3,465
Nurse Family Partnership PHN II - B. Swartz	FT	6,027	100%	9	54,243	0	54,243
Public Health Associate II - A. Barajas	FT	3,046	50%	6	13,707	(4,569)	9,138
Public Health Associate II - A. Barajas	FT	3,046	100%	3	0	9,138	9,138
					0	0	0
					0	0	0
0					0	0	0
				TOTAL DIRECT SALARIES	208,931	14,851	223,782
				*Fringe Benefits: Percentage			
				FICA 6.20%	12,954	921	13,874
				SUI 0.15%	313	22	336
				Health 17.78%	37,148	2,641	39,788
				WC 5.89%	12,306	875	13,181
				Other 28.57%	59,692	4,243	63,935
				58.59%	122,412.67	8,701.18	131,113.85
				TOTAL OF ALL PERSONNEL:	$331,344	$23,552	$354,896

Indirect Costs may not exceed 10% of Personnel cost, excluding Fringe

USE ADDITIONAL SHEETS IF NECESSARY

***Fringe Benefits must be broken down by categories.**

FIRST 5 LA
Champions For Our Children

Section 2

Contracted Services

Agreement # OO667
Page: 3 of 10

Agency: City of Long Beach

Project Name: Best Babies Collaborative YEAR 4 BUDGET (9 months)

Agreement Period: 10/1/08 to 6/30/09

Contracted/Consultant Services	RATE OF PAY AND FORMULA USED FOR DETERMINING AMOUNT	Most Current "Approved" First 5 LA Funds	Amendment Amount	Total Modified Amount
Families in Good Health				0
Director	10 hours per month @ $58.60 / hour = $5,274	5,274		5,274
Community Worker	80 hours per month @ $26.50 / hour = $19,080	19,080		19,080
	267 miles per month @ $0.585 / mile = $1,404	1,404		1,404
				0
Regional Perinatal Programs (LB Memorial Medical Ctr)				0
Coordinator	22 hours per contract year @ $48.50 / hour = $1067	1,067		1,067
				0
				0
				0
Wilmington Community Clinic				0
Registered Nurse Practioner (Brooks)	14 hours per month @ $57.34 / hour = $7,225	7,225		7,225
Medical Assistant	48 hours per month @$13.79 / hour = $5,957	5,957		5,957
				0
				0
				0
The Children's Clinic				0
Interconception Clinic Care	10 clients (bi-monthly visits) @ $100 per visit = $4,000	4,000		4,000
Diabetic supplies	$20 per month per patient - monitoring test kits = $1,800	1,800		1,800
				0
St. Mary's Mary Hilton Family Clinic				0
Health Educator	80 hours per month @ $22 / hour = $15,840	15,840		15,840
				0
				0
USE ADDITIONAL SHEETS IF NECESSARY	**Total Contracted Services:**	**$61,647**	**$0**	**$61,647**

FIRST 5 LA
Champions For Our Children

Agreement # OO667
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Section 3

Equipment

Agency: City of Long Beach

Project Name: Best Babies Collaborative YEAR 4 BUDGET (9 months)

Agreement Period: 10/1/08 to 6/30/09

Equipment description of item	Quantity	Unit Cost	Most Current "Approved" First 5 LA Funds	Amendment Amount	Total Modified Amount
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
		Total Equipment:	$0	$0	$0

USE ADDITIONAL SHEETS IF NECESSARY

FIRST 5 LA

Champions For Our Children

Section 4

Printing/Copying

Agency: City of Long Beach

Project Name: Best Babies Collaborative YEAR 4 BUDGET (9 months)

Agreement Period: 10/1/08 to 6/30/09

Printing/Copying include description	Quantity	Unit Cost	Most Current "Approved" First 5 LA Funds	Amendment Amount	Total Modified Amount
Printing and copy costs / color, brochures, mailers,etc.	850	1.00	850		850
Printing and copy costs / color, brochures, mailers,etc.	1275	1.00	0	1,275	1,275
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
		Total Printing/Copying:	**$850**	**$1,275**	**$2,125**

USE ADDITIONAL SHEETS IF NECESSARY

FIRST 5 LA
Champions For Our Children

Sections 5 & 6

Space & Telephone

Agreement # OO667
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Agency: City of Long Beach

Project Name: Best Babies Collaborative YEAR 4 BUDGET (9 months)

Agreement Period: 10/1/08 to 6/30/09

Space include description, cost per square foot	Footage/Quantity	Unit Cost	Number of Months	Most Current "Approved" First 5 LA Funds	Amendment Amount	Total Modified Amount
Computer workstation - Information services* (Salomon-Lopez)	1.00	165.00	9	1,485	0	1,485
Computer workstation - Information services* (Campos)	1.00	165.00	9	1,485	0	1,485
Computer workstation - Information services(Schwartz)	1.00	209.00	9	1,881	0	1,881
Computer workstation - Information services (Parra)	1.00	209.00	9	1,881	0	1,881
				0	0	0
				0	0	0
				0	0	0
				0	0	0
				0	0	0
			Total Space:	$6,732	$0	$6,732

Telephone include # of lines and cost per line	Quantity	Unit Cost	Number of Months	Most Current "Approved" First 5 LA Funds	Amendment Amount	Total Modified Amount
Display 16 button 2-line telephone w/ voice mail	2	50.00	9	900	0	900
6 button 1-line telephone w/ voice mail	3	30.00	9	810	0	810
Cellphone for Salomon -Lopez	1	30.00	9	270	0	270
				0	0	0
				0	0	0
				0	0	0
				0	0	0
				0	0	0
				0	0	0
			Total Telephone:	$1,980	$0	$1,980

USE ADDITIONAL SHEETS IF NECESSARY

FIRST 5 LA
Champions For Our Children

Agreement # OO667

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Sections 7 & 8

Postage & Supplies

Agency: City of Long Beach

Project Name: Best Babies Collaborative YEAR 4 BUDGET (9 months)

Agreement Period: 10/1/08 to 6/30/09

Postage include description	Quantity	Unit Cost	Number of Months	Most Current "Approved" First 5 LA Funds	Amendment Amount	Total Modified Amount
First class stamps	86	0.42	6.00	326	(109)	217
First class stamps	250	0.44	3.00	0	330	330
				0	0	0
				0	0	0
				0	0	0
				0	0	0
				0	0	0
				0	0	0
				0	0	0
			Total Postage:	$326	$221	$547

Supplies include description	Quantity	Unit Cost	Number of Months	Most Current "Approved" First 5 LA Funds	Amendment Amount	Total Modified Amount
General Office Supplies	1	48.90	9.00	440	0	440
General Office Supplies	1	90.00	3.00	0	270	270
Client incentives	28	5.00	9.00	1,260	0	1,260
Client incentives	50	5.00	3.00	0	750	750
				0	0	0
				0	0	0
				0	0	0
				0	0	0
				0	0	0
				0	0	0
				0	0	0
			Total Supplies:	$1,700	$1,020	$2,720

USE ADDITIONAL SHEETS IF NECESSARY

FIRST 5 LA
Champions For Our Children

Sections 9 & 10

Employee Mileage/Travel & Training Expenses

Agency: City of Long Beach

Project Name: Best Babies Collaborative YEAR 4 BUDGET (9 months)

Agreement Period: 10/1/08 to 6/30/09

Employee Mileage/Travel include description	Mileage Quantity	Unit Cost per Mile	Most Current "Approved" First 5 LA Funds	Amendment Amount	Total Modified Amount
Mileage (500 miles per month)	6,605	0.55	3,633	0	3,633
Increased mileage	908	0.55	0	499	499
Travel (airline & taxi)City MatCH Training (1 person)	1	550.00	0	550	550
City MatCH Training - lodging (1 person, 4 nights, 5 days)	1	1,002.00	0	1,002	1,002
MCH related trainings (3 persons)	326	0.55	0	179	179
			0	0	0
			0	0	0
			0	0	0
			0	0	0
	Total Mileage/Travel:		**$3,633**	**$2,230**	**$5,863**

Training Expenses include description, # of people	Quantity	Unit Cost Per Training	Most Current "Approved" First 5 LA Funds	Amendment Amount	Total Modified Amount
Monthly Core Collaborative Meeting	9	30	270	0	270
City MatCH training registration fees	1	449	0	449	449
Breastfeeding training & Course materials	1	2,096	0	2,096	2,096
Postpartum Depression Workshop (Hosted by LBWBBC)	1	1,500	0	1,500	1,500
MCH related trainings (3 persons @ two per year)	6	90	0	540	540
Car Seat Certification Training	1	550.00	0	550	550
			0	0	0
			0	0	0
			0	0	0
		Total Training Expenses:	**$270**	**$5,135**	**$5,405**

USE ADDITIONAL SHEETS IF NECESSARY

FIRST 5 LA
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Section 11

Evaluation

Agency: City of Long Beach

Project Name: Best Babies Collaborative YEAR 4 BUDGET (9 mon

Agreement Period: 10/1/08 to 6/30/09

Evaluation Contracted Services	Quantity	Rate of Pay	Most Current "Approved" First 5 LA Funds	Amendment Amount	Total Modified Amount
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
Other Evaluation Cost	**Quantity**	**Unit Cost**	**Original First 5 LA Funds**	**Amendment Amount**	**Total Modified Amount**
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
			0	0	0
		Total Evaluation:	$0	$0	$0

USE ADDITIONAL SHEETS IF NECESSARY

FIRST 5 LA

Champions For Our Children

Sections 12 & 13

Other Expenses & Indirect Cost

Agency: City of Long Beach

Project Name: Best Babies Collaborative YEAR 4 BUDGET (9

Agreement Period: 10/1/08 to 6/30/09

Other Expenses include description	Quantity	Unit Cost	Most Current "Approved" First 5 LA Funds	Amendment Amount	Total Modified Amount
Transportations Vouchers Taxicab	20	25.00	500		500
Transportations Vouchers Bus Passes	50	2.50	125		125
Hospital grade breastfeeding pumps	4	2,500.00	0	10,000	10,000
			0	0	0
			0	0	0
			0		0
		Total Other Expenses:	$625	10,000	$10,625

*Indirect Cost include general purpose for this cost		Most Current "Approved" First 5 LA Funds	Amendment Amount	Total Modified Amount
Indirect costs 10% of wages	10%	20,893	1,485	22,378
		0	0	0
		0	0	0
		0	0	0
		0	0	0
	Total Indirect Cost:	$20,893	$1,485	$22,378

USE ADDITIONAL SHEETS IF NECESSARY