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Megan: Hello, everyone, and welcome to the orientation webinar for Healthy Start for Frontline Staff. I'm Megan Hiltner, with the Healthy Start EPIC Center and I'll be moderating today's event. We have approximately 60 minutes set aside, and this webinar is being recorded. The recording, along with the transcript and the slides will be posted to the EPIC Center's website following the webinar. The purpose of this webinar is to provide you with an overview of the Healthy Start Program, to review expectations, and to have an open forum for questions to assess how we work together with the Healthy Start community.

Before I introduce your great speakers for today, I just have a couple of housekeeping announcements. We want your participation, so at any point if you have any questions or comments, please check them in, in the lower left hand corner of the screen. Then we will respond to your questions, during the Q&A session at the end of the presentation. If we don't get to all of your questions, we'll include them in a frequently questions document that we'll post with the webinar on the EPIC Center website. Also we do want your feedback, so please take a moment following this webinar, to complete the brief survey that will pop up on your screen, right after the event.

Let me do a quick introduction of your great speakers for today from the Division of Healthy Start Maternal and Perinatal Services. First off is Dr. Hani Atrash. He's the Director of the Division. We also have Miss Angela Hayes-Toliver. She's been working with the Division for the longest period of time, and she is a Project Officer with the Division. Miss Madeline Riaz, she's Acting Branch Chief, and also serves as a Project Officer for the Division. Miss Kimberly Sherman is the Public Health Analyst with the Division, and also a Project Officer

And also responding to some questions, you may hear another voice. That's Captain Dr. David de la Cruz, and he's the Deputy Director of the Division. So without further ado, I'm going to turn it over to you Dr. Atrash for your opening remarks.

Dr. Atrash: Oh, thank you very much, and good morning. Good afternoon, to all of you. On behalf of our team here at HRSA, and on behalf of the team at the EPIC Center, I would like to welcome you to this webinar titled Healthy Start 101 for Frontline Staff. This webinar is in keeping with our decision to strengthen our communications with you and to address your concerns, and particularly it was brought to our attention, that some frontline staff are not fully aware of all the new changes at Healthy Start; what we now refer to as Healthy Start 3.0 or Transform Healthy Start.

I hope that the following presentations will answer some of your questions. That's the purpose of this webinar today is to provide an overview of the Health Start Program to frontline staff, including an historical perspective, a description of Healthy Start 1.0 and 2.0 and a discussion of the current program or Healthy Start 3.0. We will also discuss program expectations for frontline staff and provide information on professional and organizational development opportunities. I and the rest of our team will be available to answer any questions you may have following the presentations.

We do encourage you to ask questions, and at the end of the presentations. However by all means, if you have questions that were not answered today feel free to contact any of us at any time. Thank you, and have a good webinar. I'd like to now hand it over to Miss Angela Hayes-Toliver to give you a perspective of the history of Healthy Start.

Angela: Thank you, Hani. Good afternoon. I'm Angela Hayes-Toliver and just as a point of reference, I am the longest federal employee of the Healthy Start Program. Healthy Start started in 1991, and I came aboard in 1993. So now my unofficial title is the historian for the federal Healthy Start. But I am a Project Officer and a Senior Public Health Analyst.

So when did Healthy Start begin? Healthy Start began as a Presidential initiative in 1991 as a five-year demonstration project. It was actually built upon other infant mortality initiatives from 1965 through 1987 and those are mentioned on the slide. There was a federal interagency White House Task Force that was setup to look at reductions in infant mortality in '89.

So in 1991 again, Healthy Start was established to reduce infant mortality by 50% in five years, and to also include a national evaluation of its successes, after the five years. So 15 communities were awarded Healthy Start grants, and I'm just going to go over them quickly; Baltimore, Maryland, Birmingham, Alabama, Boston, Massachusetts, Chicago, Illinois, Cleveland, Ohio, Detroit, Michigan, the District of Columbia, New Orleans, New York City, Pittsburgh, Northern Plains, which was the tribal sites which included four states; North and South Dakota, Iowa, and Nebraska, Northwest Indiana, Oakland Healthy Start, PD Healthy Start, which is located in South Carolina, and the Philadelphia, Pennsylvania Healthy Start.

So you can see we covered quite a few areas, and those were the first 15. Currently there are 14 of those 15 that have gone on to be included in the 3.0. The overall structure of the initial Healthy Start was to focus on a community driven strategy where the communities actually identified what they felt were the causes of infant mortality in their particular community and come up with ways of trying to reduce that. So it involved innovation, community commitment and involvement, increasing access to care, service integration, and promoting personal responsibility.

Some of the key components, initially were the consortium. All programs and communities had to submit a needs assessment. There was a service package, a service systems plan, a big focus on public information, and education, and also evaluation, and at that time we also included local evaluators. There were nine replication phase intervention models. These were models that communities were allowed to come into and request, as they had identified the needs in their particular community to reduce the infant mortality.

They were the community-based consortium, the care coordination case management, outreach, and client recruitment. The family resource centers, enhanced clinical services, risk prevention and reduction. Facilitating services, such as transportation and childcare, training and education, and adolescent services. The 15 sites selected received $4.6 million, over the course of 15 years. The start of the National Healthy Start movement became authorized in 1998 as part of Title V legislation, which was the start of the actual National Healthy Start Association.

Prior to the national evaluation results, Healthy Start began its growth in 1996. Smaller levels of funding, with more modest interventions, and that's when we brought on a large number of Healthy Start Programs, between '96 and '97. The national evaluation also showed some professional implementation, improved prenatal care, but no or limited impact on birth outcomes or disparities. I just want to mention that the National Healthy Start Association's founding took programs also in a little different direction.

That's when they began to focus on the politics of the program, not just the service delivery. The Healthy Start initiatives, strategic assessment and policy options, Mel Cottle, [SP] Chuck and Amy found a reference tier and they actually did a study and analysis of the Healthy Start Program, and had 38 specific recommendations, and it rebalanced the federal and local leadership. So at this time, this became what we called the 2.0 time period and this provided new direction. It was to continue to focus on improving reproductive health, but place an emphasis on what should be implemented, and needed in every high-risk community.

So that it was a little more prescriptive than in the past, than what I read earlier about the nine areas that people focused on. It extended Healthy Start's focus from conception through 2-years of age. It organized programmatic initiatives around three core ideas and nine required components. It strengthened the local health systems and this was through the local health systems action plan,

sustainability and improve linkage to Title V. It brought a consumer community voice to efforts to improve maternal and child health through the consortium, and programmatically institutionalized, community voices.

And just to note the actual consortium started in the first phase of Healthy Start and has continued through all three phases of Healthy Start, as a critical element to reducing infant mortality. New and improved content-focus, such as the direct Health Service content and provision of interconceptual care collaboration, maternal depression, treatment, and referral, and new topics, such as father involvement and preconception health, as well as disparities came about as we evolved in the Healthy Start second wave.

The continued expansion of sites, there were four rounds of expansions, including border sites. At that time, during 2.0 there were 105 sites receiving monies of $500,000 to $1 million-plus funding annually with no change in the nine core components that were mandated. Extensive, comprehensive health services continued to be delivered by the Healthy Start sites. Now I will turn it over to Madeline Riaz to talk about our progression into 3.0.

Madeline: Thank you, Angela. My name is Madeline Riaz, and I'm the Acting Branch Chief for the East Branch, and also a Project Officer. As Angela mentioned, previously the Healthy Start Program was established as a Presidential initiative in 1991, and it began as a five-year demonstration project, targeting communities with high infant mortality rates and other perinatal outcomes. It was initially focused on community innovations and creativity. So how have we done? In 2010 over 90% of Healthy Start's sites were implementing all four components of the program. Most offered additional services and perinatal outcomes significantly improved.

Infant mortality rates were 4.78 compared with 6.15 nationally; 11.63 for African Americans, low-birth weight rate was 10% compared with 8.1% nationally and 13.53% for African Americans and very low-birth weight rates

was 1.7% compared with 1.5% nationally and 2.98% for African Americans. Next slide, please. Why did we change the Healthy Start program?

To keep pace, align with, and coordinate efforts, and support current to the Department and Agency programs and priorities, such as the Maternal/Infant and Early Childhood Home Visiting Program for [inaudible 00:14:28] and other HHS community-based grantees, such as Early Head Start, Fatherhood, and breastfeeding activities, in collaboration with CDC and NIH, National HIV/AIDS strategies, and screening for sickle cell disease to maximize the impact of Healthy Start on reducing infant mortality by integrating current, and emerging evidence-based approaches.

Changes in the Healthy Start Program were introduced to apply lessons from emerging research and to add some national recommendations. Healthy Start was reframed in response to both the Secretary of the Advisory Committee on Infant Mortalities recommendations, and National Healthy Start evaluation findings, emphasizing the need for strong and ongoing evaluations, and accountability at the local and federal levels, to show effectiveness and community impact.

The Healthy Start approach builds on the longstanding program structure of focusing on individual family health, adding greater emphasis, to evidence-based practice, standardized approaches, and quality improvement. Additionally when looking at similar programs, other areas related to program structures surfaced to the top as needing change. We found that in order for our grantees to be comparable to other programs, we needed to provide measurable objectives, focused on specific health indicators and through interventions that were based on the most recent research.

We also saw the need to focus in on increasing the skillsets of the Healthy Start workforce, and clearly define activities, based on funding amounts. Another area we saw to be crucial to grantee success is using the data collected for quality improvements, so that we're always working towards improvements.

These things allow us to demonstrate more effectively program outcomes and success, assist in sustainability, and show impact in the communities that we serve.

The main changes to the Healthy Start Program include a place-based approach to healthcare. The program will be accountable, not only for it's clients, but for the entire community. An expanded focus on population health, not just focused on patients seen in exam rooms, but on the health of people in their neighborhoods or communities. A focus on quality by requiring core competencies, and standardized interventions. An expansion to improve women's health, not just during pregnancy, but before and after, as well. Engaging both parents in the future of the child, and on family resilience, to address some of the stress that underlies many disparities in birth outcomes.

A focus on the overall, collective impact that Healthy Start Programs have in their communities. Programs can potentially serve as community hubs, and organizations that can collaborate with others to drive collective improvements. And finally a focus on accountability with performance measures, and rigorous evaluation platforms to drive improvements. We now have five approaches to the Healthy Start model. Improve women's health, promote quality services, strength and family resilience, achieve collective impacts, and increase accountability through quality improvements, performance monitoring, and evaluation.

Healthy Start grantees provide individual services and community support for women, infants, and families, using one of the three levels of funding, that reflect escalating levels for engagement, and competencies. You report to Level I as a community-based Healthy Start. Grantees here are funded up to $750,000 annually. Minimum program participants served per year is 500. Level I grantees supports the implementation of the essential Healthy Start Program activities needed to achieve the five approaches of the Healthy Start model, and Level I is responsible for individual level assessment.

Level II is our Enhanced Services Healthy Start. Grants are funded up to $1.2 million per year. Minimum program participants served per year is at 800. It supports the implementation of the essential Healthy Start Program activities needed to achieve the five approaches listed under Level I and Level II. Grantees engage in additional services and activities, such as FEMA, PPOR, and/or [inaudible 00:19:38]. They're accountable to reach the entire community thereby driving collective impacts, and supporting community-level change.

Finally Level III is our Leadership and Mentoring Healthy Start Project. They're funded up to $2 million per year. They serve a minimum of 1000 program participants per year. In addition to Levels I and II activities, Level III also supports the provision of expanded maternal and women's health services, and supports the development of a play space initiative that will serve as a backbone or hub organization, for achieving impacts. They serve as a resource site for state, regional, and national actions, in support of other Healthy Start grantees and organizations working to improve perinatal outcomes.

Level III projects also serve as leaders, and participate in the development of state, regional, and national programs and policies. They participate with other Level III Leadership and Mentoring grantees, to support the Healthy Start Performance Project, and lead in the development, and implementation of a Healthy Start collaborative, innovative improvement network to Healthy Start clients. Here is the current grantee profile demonstrating the number of grantees in each level, depending on type of grantee, whether continuing or new and the population served. There have been [inaudible 00:21:13].

Lastly at the Division, we have taken a regional approach to program management of Healthy Start. Each Project Officer covers his state, and in our states close in geographic proximity. This approach allows more collaborative capacity building for Healthy Start Programs. To further this approach, in addition to multi-individual calls, Project Officers conduct quarterly regional calls with all assigned grantees, and will hold a regional meeting.

The idea behind the quarterly calls and regional meetings also provides an opportunity for peer mentoring and information sharing among grantees, working toward achieving correct eventsNow I will turn over this presentation, so that Kimberly Sherman will talk more about frontline services. Thank you.

Kimberly: Thank you, Madeline, for the review of Healthy Start 3.0 and good afternoon to everyone. My name is Kimberly Sherman, and I am very proud to serve as a Project Officer for the Healthy Start Program. I want to continue to presentation by talking about how you, the Health Start workforce help us to achieve the overall goals, of the Healthy Start Program, of improving perinatal health and reducing infant mortality.

First, and foremost, the Healthy Start workforce combines skills from individuals at varying levels and backgrounds which include social service programs, those with clinical skillsets, and those well versed in a variety of public health issues. Within our 100 Healthy Start Program sites we find that most team structures include the following, a Project Director, a Program Manager Coordinator.

And then Frontline Staff, which is comprised of community health workers, case managers, health clinical and nonclinical health educators, fatherhood leads or coordinators, local evaluators, and then the community liaison which supports the implementation of the community action network. One person left off this slide would also be the Program Manager or the Grants Administrator. So each of our participants has a very critical role with establishing, and implementing the Healthy Start Program in your own community.

The Program structure that's implemented by your own Healthy Start site was outlined in the 2014 grant application that was submitted by each organization. The purpose of this webinar really it to focus on the critical role that our frontline staff play in reaching our goals and objectives. There are some basic responsibilities that all frontline staff members have, specifically those that are

outreach workers, case mangers, community health workers, and health educators.

These tasks, roles and responsibilities include assisting with program outreach, raising awareness about your Healthy Start activities in each, and every community that you serve, recruiting program participants that include women, both during the preconception, prenatal, interconception, and parenting phase of their life, infants up to the age of 2, and their male counterparts. Our frontline staff also provide case management services directly to the clients enrolled in our programs, and they provide individual and/or group health education services that come in a variety of formats.

In the next few slides, I would really like to talk about the five approaches that Madeline provided an overview of and how they each pertain to the role that you play in Healthy Start Programs. So the first approach of the Healthy Start Program is to improve women's health. The activities under this approach are facilitated mainly through our case management services which is why you are so vital when you work directly with the women, and children, and fathers who interact with the program.

Mainly so because you are the direct connect or that link to other community connections. Some of the activities that you might employ as outlined by the Health Start 3.0 includes supporting our families through enrollment into state health insurance programs, assisting with reproductive life planning to promote birth spacing. The support of prevention activities and also quick coordinating or facilitating access to healthcare services for the women that are served.

The second programmatic approach is to promote quality services and our frontline staff do this through service coordination by linking participants with other community activities or services that are provided via health, social, or mental service programs. Then also connecting with these partners and organizations that serve the same population as the Healthy Start Program serves.

The third approach is to strengthen family resilience and as a frontline staff member you assist participants in improving their parenting skills, understanding the effects that stress can have on the family and by promoting a trauma-informed care, and lastly by promoting involvement by fathers in infant and child development.

The fourth approach that was mentioned earlier is to achieve collective impacts and you do this by promoting and supporting community collaboration, and engaging program participants in our community action network meetings, and just making sure that their voice is heard, so that the program can be refined to address their needs.

The fifth and final approach is to increase accountability through quality improvement, performance monitoring and evaluation, and here it's critical that you understand the importance of quality improvement and the QI process, as a feedback loop to improving the implementation of your Healthy Start Program, by reviewing and looking at the data for quality improvement, and program improvement. Then by using that data to show program impacts at the local level.

So how are we building on the knowledge capacity of the entire Healthy Start workforce? Primarily we're doing this through training. We're really invested in building the Healthy Start workforce, as part of the re-envisioning of Healthy Start 3.0. While most training is really at the individual level at each of your sites, there is also an opportunity would be training in technical assistance and other ways as well, and through other venues.

First, and foremost we have the Healthy Start EPIC Center which provides opportunities for grantees to receive both organizational and professional training and technical assistance through various venues. That could onsite, in-person, at any of our regional or annual meetings. It could also be online via

webinars and on-demand training. We also have a third component that maybe we'll talk a little bit more about in the Q&A, but it's a new activity for the year which is going to be community workshops.

These workshops will be community driven, so you as a frontline staff member could say, "I really would like us to spend time on streamlining our case management process." You would then work with your Project Officer in the Healthy Start EPIC Center to build that community workshop and to look other partners in the community who would be interested in attending that workshop. And if you're interested, if there's a topic you'd like to bring to your own community please let us know. You can do that via email or just by calling us.

Additionally if there is a particular topic that you have in mind, and you really need more assistance with, your Project Director can request some professional training from the Healthy Start EPIC Center using the online training request form. So we'd really like to hear from you, but before we just wrap up this presentation, just some concluding thoughts. We are here to assist you. As a Project Officer, I work directly with the program leadership.

That might be your Project Director or your supervisor, case management supervisor, but we really want to hear from you. You're the frontline staff. You are the direct connect to the clients that are community serves and you really are that link that is going to make sure that are providing evidence-based services, and that we're outreaching to the community. So please, feel free to sit in on a call with your Project Officer or to contact the EPIC Center if there are training needs or something that you need assistance with.

We really do want all of our projects to succeed. We want to make sure that we have a strong, Healthy Start workforce and the only way we can do that is with a continued communication loop. So you have to be a part of that conversation. If you have any issues or questions that you'd like to raise, you can do so now via the chat box.

We'll take your questions for as long as we have on time on the line. If you're question's not answered during the time allotted, please speak with your Project Director and your Project Officer and together we can discuss any issues that you might have on an upcoming site visits, monthly calls, and through the implementation of future training for community workshops and our regional meetings. We really are here to help and we will only grow stronger with your continued support. So I'd like to turn it back over to our leadership, Hani, for Q&A.

Dr. Atrash: Thank you, Kim. I also want to remind you to please signup for the list serve at the EPIC website .org. We do have ongoing training seminars, informational webinars, etc. and we would like for you all to attend and join us anytime you're able to. Please also encourage your colleagues, your peers within your program to signup just to know what's going on and make sure that you are able to take advantage of the training opportunities that are offered on an ongoing basis. So if you have any questions we will be glad to answer them, if we're able to. I assume the slides will be available online, Megan?

Megan: Correct. That's correct, Dr. Atrash. We'll post the slides...

Dr. Atrash: You just give them the link.

Megan: Exactly. So if you want to be on the Healthy Start list serve where you'll get emails about training opportunities and other updates, you can click on that direct link I put in the chat box, you can also just email us at the EPIC Center and we can make sure that you're on there. That's healthystartepic@jsi.com and I can put that in the chat box, too. I'll put that in the chat box, but we do have our first question, Dr. Atrash.

Dr. Atrash: I see that. The impact its had on infant mortality and maternal mortality since it started. We know that, I think, showed you a slide early on that showed that infant mortality rates in Healthy Start communities had gone down. I'm going to put the slide up again. The infant mortality rate as reported to us by the Healthy Start community was 4.78 compared to 6.15 nationally and we know that many of our communities are African American population rate was 11.6 in 2010. So we know that, at least from what was reported to us, that infant mortality rate was reduced.

Remember that the communities shared by Healthy Start, by definition had a rate that was 1.5 times higher than the national average to eligible for the grant. So to the extent that those numbers are accurate, that means that the Healthy Start Programs have been able to reduce infant mortality rates, probably by 50% since they started with a rate of 1.5 times or higher. Now that is in question by the scientific community.

What they tell us is that many babies born throughout the Southlands, we don't know what the outcome is because they are born, and many women do not come back for postpartum visits. And therefore if their baby dies at 5-months, or 6-months, or 9-months of age, we may not know about them. Therefore to respond to that criticism. In the new system for the evaluation and information systems, first we are encouraging Healthy Start Programs to make sure that they follow up babies born up to 3-years of age, and make sure that at least 90% of women will come back for the postpartum visits, and if they don't please reach out to that, number one.

Number two, as a component of the evaluation of Healthy Start we will be linking Healthy Start records to birth and death records in selected states. So that if a baby was born to a Healthy Start client and died before the age of 1-year, we will know about them through that mechanism, and we will make sure that we will ascertain or have better ascertainment of the numbers of babies born to Healthy Start clients, and also those infants who died before their first birthday.

So from what we have now we assume that we have had a serious, significant impact in infant mortality rates. When it comes to maternal mortality rates, though, it is very, very difficult to measure that because on the average maternal mortality rates are 10 per 100,000, maybe 20 per 100,000 live births. But we know that we serve about 35,000 to 40,000 per year or pregnant women per year, so the numbers are so small that in an average Healthy Start community you may see one maternal death every 5,10, 20, or 30 years.

So the numbers are too small to help us evaluate maternal mortality rates. Therefore in the new information system, we'll be collecting information about maternal morbidities and complications of pregnancy. These are much more common and we should be able to get higher numbers to see if the program has an impact on maternal health, as well as infant health.

Megan: Great, thank you, Dr. Atrash. Here's a question about site visits and this may be a question for the one of the Project Officers. Can you explain more when and how the site visits are scheduled?

Dr. Atrash: Let me give it the first try and then hand it over to Madeline. So unfortunately because our travel resources are limited, we are able to make maybe 10-15 at most 20 trips a year and therefore we are unable to have a formal site visit to every grantee. So therefore the focus in the first year was to do site visits to new programs or programs who needed assistance, and requested assistance. So for the first year we waited a few months to give people a chance to get started, and we are now approaching the end of the first year of this new grant.

So that's why most of the visits happened between May and now. As we move forward we will identify programs that are in need of a site visit. Now that said we also appreciate the need to have an in-person contact with every grantee that we serve and that's where the regional site visits come in. So we're not able to

visit everyone, but through the regional site visits, we are trying to get all grantees together in a central location or a location where we are planning to have a site visit. Let's say in Georgia for example, we brought in all grantees in Georgia and Florida who are being supported by one Project Officer to one place, for two days.

And then the Project Officer stayed then for another three days to do a detailed site visit to the grantees who hosted that regional site visit. So we're trying to be able to provide hands-on, direct support to all grantees. Our limitation is travel funds, so we're not able to do that. But if anybody feels that they need support, let us know. We could do that by phone, through a site visit, or through the EPIC Center. The EPIC Center is able to provide assistance with specific issues, if a grantee feels that they need assistance. So the timing of the site visits is a decision that is made jointly by the program and the Project Officer.

Megan: Great, okay.

Kimberly: This is Kimberly. Can I just add something?

Dr. Atrash: Yes, please do. I actually wanted somebody to add something.

Kimberly: I think other people will have something else to say. But when it comes to site visits, as far as frontline staff, that's one of the main reasons we come out. So when your Project Director may tell you that a federal site visit is being scheduled, it's not something for you to be worried about. But to have an opportunity to raise any concerns or to talk about your clients. It's really just to see how things are working onsite, and so again, I know that most folks always tell me, "We're so scared when you guys are coming out," but there's no need to be scared whatsoever. Madeline or Angela, did you want to add anything?

Madeline: Yeah, I agree with Kimberly. We receive applications. We receive the progress reports, but I know personally for me, the part that I enjoy with my job is going out to the sites and really seeing how the sites are implementing now these five approaches. So we don't go out there to scare anyone. We really want to see what you're all doing because you're all doing a great job in your communities.

Angela: This is Angela. I would agree with both my colleagues here. We've been doing site visits for a very long time. The Project Officers in all those phases that we talked about as Healthy Start 1.0, 2.0, and 3.0 and it's critical to our understanding of what's really going on in your community. Because we don't know all of those things by reading the application or reading the progress report and we do specifically meet with the clients there, in groups, or through actually doing home visits, so we have opportunities to interact with the clients there on all of our site visits.

Madeline: One other thing I wish was mentioned is just, if you are frontline staff and you're trying to figure out what other Healthy Start Projects are in your area, in case you're just interested to know like, "What kind of trainings are they attending?" There might be a community breastfeeding training that you might want to connect with them on. If you go to the Healthy Start EPIC.org there is a map that lists all 100 Healthy Start sites and the contact information, just in case you're interested.

Megan: Great. So there's another question here that I think brings up really great points about getting frontline staff up to speed on developing competencies and skills and this person referred to this as, onboarding as a component of entering the staff are able to know these important skills, especially in their first 90-days on the job. This person says that he's aware that each program has their own distinct onboarding protocol, but is there something that ties the position that you've outlined in these slides that can help programs onboard new frontline staff related to competencies, and information, and resource, and skills? Dr. Atrash, I don't know if you want to say anything about...?

Dr. Atrash: One of the issues we had in the faced in the past is that the different programs had a huge variety of staff with different skills, and backgrounds, and knowledge, and expertise, and what we're trying to do moving to our evidence-based and uniformity in practice is to define better what the minimum skills and competencies that the staff workers should have to deliver the services that are required through this program.

So the EPIC Center is working with us and with you, the programs, to better define what the qualifications and competencies that are needed by community health workers and we're trying to actually have a better understanding of what a community health worker is. So that it is clear and to us what does it take for a community health worker to provide the services defined by the program, whether it's family planning or reproductive life planning or interception care or breastfeeding or fatherhood, etc.

So we are moving in that direction. We are trying to make it uniform implementation practice so that in the future we're hoping that many more communities would like to implement Healthy Start, at that time we will tell them here are the interventions, and here's what it will take, and here are the qualifications that are expected to be for your staff to provide those services.

In terms of onboarding and orientation, we will be hosting orientation webinars, maybe quarterly. Maybe more frequently if needed, so that people who are new to the program will get the same message from a central location and understand that the grantees, Project Directors, may have their own programs that are also right for them to hear from us, as well.

Megan: Did any of the Project Officers want to comment on this at all? Well, I'll go on to the next question. So this person was wondering if you could say more about the role of the local evaluator, specifically about how our Level I program is expected to have a local evaluator.

Dr. Atrash: That's a really good question. We spoke about functions and not people. Every program Level I, Level II, Level III is expected to have an ongoing evaluation and understanding of whether their program is first, doing the right things, and second, doing things right. That's why we will have an information system, hopefully implemented soon. We do need to make sure that people are doing what they're supposed to be doing and that we're achieving the results that we hope to achieve. That is across the board.

Now how much effort and what kind of skills you need to do that is a different question. So some programs may have staff onboard who can analyze better. Some of the information that they have or that we will be helping them develop that will tell them, give them the information they need to better understand who's being served, what their conditions are, where are the gaps. We for example, what proportion of women are coming back for postpartum. If it's 30% or 40% only you need to intensify the efforts there.

You could look at proportion of babies who are low-birth weight or preterm, etc. So if you have somebody on your staff who can do that, that's great. If you think somebody at the local university could help you produce that information, within an hour a week or a day a month or something, that's fine. If you feel you need a full-time evaluator, which I don't think that's really needed, that's fine. That's up to you. But performing ongoing evaluation, quality assurance, and using information for decision making and to monitor and run your program is expected of all Levels, as much as Level III's or II's, but also I's as well.

Angela: This is Angela. I just wanted to add something to that. We have been working with in our Technical Assistance Group we have worked with the EPIC Center, also to identify some former Healthy Start or current Healthy Start evaluators that are working with programs or have worked Healthy Start and know its differences from other evaluation programs.

And those consultants are available through the Healthy Start EPIC Centers, to get technical assistance. So that if for some reason, you don't have a local evaluator or are having problems identifying one, or need some kind of assistance bringing a new one onboard, there is actually technical assistance available at the Healthy Start EPIC Center.

Dr. Atrash: Thanks, Angela. Actually that applies to everything else. If you need help in any other area that's why we have the EPIC Center. If you need help with evaluation or training for breastfeeding or proactive life planning or whatever feel free to contact the EPIC Center directly or also contact them through your Project Officer as well. So we're here to help you as Kim has said. We're all in this together. You are doing work that we were asked by Congress to do.

We're here to support you, not only financially, but also technically and the EPIC Center exists because there are only 15 of us, and there are 100 of you, and there's no way we could do all the work. So the EPIC Center is an extension of our programs and they exist to support us and you and many of these programs. So any time you need any help let us know. If can provide it to you, we will be happy to. If not we will work with you in identifying any source to help you in that area.

Megan: Great. I do want to share a positive comment that somebody said about site visits. This person says that our site visit with McKeever wasn't scary at all, and she gave us helpful advice, and suggestions as to how things can be done, and changes that needed to be. We enjoyed the visit. So just wanted to share that positive comment. Are there any other questions or comments? If you have them, please chat them into the chat box, lower left hand corner of your screens. And just to remind everybody we'll be posting these slides on the EPIC Center website, following the webinar.

Dr. Atrash: So as Megan said, "Feel free to call by phone or contact any of us by email." My phone number which rings at my desk is 301-443-7678 and my

email address is, H-A-T-R-A-S-H@HSRA.gov. But if you forget one of those, contact your Project Officer. I will be glad to talk to you at any time.

Megan: So there's another question that came in to the chat box and we do have about ten minutes left. So Dr. Atrash, are you able to say more about the Healthy Start electronic system?

Dr. Atrash: We have been planning from the beginning when we did the Healthy Start submission to establish and implement an electronic system. The main idea is to collect information on every client that is case managed by Healthy Start. Information about women and babies, but the demographics have profiles, services received, outcomes of their pregnancies, etc. We finally put out information about billing for a contract. A contractor is/was selected in the past few days, I think, and an offer will be made, hopefully early next week.

We will know who that contractor is. They will have the job for all of that contractor is to work with all of you in collecting individual patient records, of client records that this information will pooled and made available to us for the whole 100 grantees. Every project will be able to access their data and analyze the data and use it for their personal monitoring and evaluation.

We, centrally will be able to pool all that data, so we can get a good idea of what the program is doing nationally. Now there are many questions about this. Some of you have an existing information system that they're help you with. Some of you belong to an organization, like a university or the Community Health Center who are required to use that system, and some of you may want a new system. So if you're looking for a new system we encourage you to use the data collection form, commonly referred to as the Three P's to collect your data.

If you have an existing system that you love and want to stay with, our contractor will work real closely with you to develop an interface where the computer program will abstract better from your system and populate the forms

that we have. Now some of you may not be collecting all the data elements that we have developed working with our Advisory Group or our Technical Expert panel. In that case we would like for you to add the questions that are missing to your existing form. But we will be working with all of you. We're hoping that system will be implemented starting October 1, and gradually scaled up. Maybe starting to work with some of you and then hopefully within two months everybody will be onboard.

Megan: Great. Well, there are no more questions in the Q&A box at the moment. So unless any closing remarks from you, Dr. Atrash, or any of the other Project Officers.

Dr. Atrash: Just again, we are here to help you. Call us. Email us at anytime. Your Project Officer's job is to support you and should always be working together to serve the community and achieve our goals. Those changes we made, they will ensure that we have a well-defined program that we could scale up and replicate in other communities. We do need to measure what we are doing because that's what Congress is asking us for.

That's what we need to do to make sure that what we are actually doing is making a difference and can change results. So we encourage you to continue to be in touch through the list serve, come listen to the seminars, as always, if you have time. Again, contact us anytime you have questions and/or the EPIC Center. So if others have any comments, please go ahead. Kim, I know McKeever cannot speak today. Angela, or David, or Bonita, or Madeline. Thank you for being with us.

Kimberly: This is Kimberly. I just wanted to add that when I go out on site visits, I really like to speak to the frontline staff because it's so critical to allowing every one else to do their jobs. So for instance, you're a Project Director even here as a peer at the federal office, we need to make sure that any issues you have are being addressed, so that the work can continue. Again, the programs only funded for five years, so we've got to make the five years count.

If you're one of the projects in my states of Arkansas, Louisianan, I'm here to help. So please don't be afraid to reach out to us at any time.

Madeline: This is Madeline. I just want to thank everyone for joining us.

Megan: Great. Well, thanks all, for your participation. Thank you so much to the Division for all of your remarks. I do want to remind everybody please get connected on the list serve to receive the E-newsletter. They have a lot of information summarized into one document, that will give you monthly updates on the training and other opportunities going on with respect to Healthy Start. So please do that and if you need any support in getting signed up email us at healthystartepic@jsi.com. Thanks again, to everyone. This includes our webinar. Have a great rest of your day.

Dr. Atrash: Thank you, all,