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Naima: Hello, everyone, and welcome to the "Healthy Starts Screening Tools Webinar: Getting Ready to Screen Program Participants" beginning in January of 2017." I'm Naima Cozier with the Healthy Start EPIC Center and will serve as today's moderator. We have 90 minutes set aside for this webinar. This presentation will be followed by a question and answer period. Questions are only to be submitted via chat which is located at the bottom left corner of your screen.

In addition, this webinar is being recorded. The recording and slides will be posted to the EPIC Center websites following the webinar. I would like to invite everyone's participation during the webinar and at any point, feel free to chat questions or comments to the bottom left corner of your screen. Immediately following the webinar you will receive an evaluation and we greatly appreciate your feedback. Definitely, it will be used to improve future webinars. Today's objectives are to explain the role of the Healthy Start Screening Tools for care coordination.

We also hope to describe the initial considerations for January 2017 screening of Healthy Start participants. And then finally we hope participants, by the end of the webinar, will be able to list available Healthy Start technical assistance and training opportunities, that will be available through January 2017. Our webinar speakers for today will be Commander Johannie Escarne, Acting Branch Chief in the Division of Healthy Start and Perinatal Services, and she will be providing us with more information concerning the informed consent process.

After Miss Escarne, will have Megan Young of the Boston Public Health Commission, as well as the Healthy Start COIIN representative who will be providing us with an overview of the tools and their link to care coordination. Following Miss Young, I will be providing the EPIC Center training and TA available supports and a summary of those TA and training tools that will be available, and then finally Megan will close the webinar with a message from the Healthy Start COIIN. At the end of all of those presenters we will have a question and answer period, so throughout the presentation feel free to go ahead and chat in your questions.

In addition, I just wanted to mention that a webinar workbook was sent yesterday evening to everyone who registered for the webinar. This workbook includes the screening tool flowchart that will be previewed on today's call. It also provides a little bit more detail into the screening tools standardized surveys and other screening tools that were used to develop many of the questions, and the content that is in each of the

screening tools, so you'll get more of a preview in your workbook on that. And then finally, it does provide a summary of all the EPIC Center training and TA that we'll be discussed on today's call, as well as the screening tool implementation checklist.

This workbook will also be available online with all of the other webinar materials after the call. In terms of the materials that we'll be talking about that will be available in a dedicated space on the Healthy Start EPIC website, that's just for the screening tools, you can right now find the OMB-approved screening tools that you can download, as well as the screening tool flowchart, implementation checklist, the full pilot test report, and a FAQ that has some commonly asked questions regarding the screening tools. So I'd like to now transition to our first speaker and I invite Commander Johannie Escarne.

Johannie: Thank you, Naima and good afternoon everyone. Following the Division conversation call on the November 4th, we would like to provide clarification about the requirements to complete a consent form to use the screening tools. The Healthy Start COIIN developed the screening tools as the first step in a comprehensive care coordination/case management approach to care. Although the use of the screening tools are not mandatory, all data in the screening tools must be collected. All Healthy Start programs are encouraged to use these screening tools to ensure that participants are consistently screened for their comprehensive need. All Healthy Start programs require consent to provide services to participants.

This is a standard practice for any organization collecting information on participants to be used to provide services. Without consent, you are not able to deliver any services to a participant. As a program tool, the Healthy Start screening tools are implemented in the same way as any other screening that you currently do. In other words, provided you have consent to care from the participant, you can use the screening tools. You do not need the participant to sign the IRB consent form to use the screening tools. IRB approval was received in September of 2016. All participants receiving services beginning January 1st of 2017 are eligible to be included in the national evaluation.

In order for participants de-identified data to be shared with the national evaluation, you are required to obtain written consent using the IRB-approved consent form which should be signed by Healthy Start participants. This is standard practice for data collection for evaluation and research purposes. For your convenience, the IRB consent form

incorporates both a consent for care and a consent to share data with the national evaluation. Please note that any participant who consents to share their data can opt out at any time from the evaluation. Again, for clarification a signed IRB-approved consent form is not required to complete the screening tools. However, all Healthy Start programs should already be obtaining written consents from participants to receive services.

This standard consent is sufficient to perform any screening. If you have not implemented a standard consent to receive services, the IRB consent form includes basic language that you should use. It is recommended that you use the IRB-approved consent form without modification that includes consent for both receipt of Healthy Start services and participant data to be shared for the national evaluation. However, if you modify the approved consent form provided, you may not remove language that pertains to the evaluation, completing screening tools, providing individual identifiers, linking to vital records or PRAMS and sharing the identified data with MCHB at HRSA.

Again, I would like to reiterate that the primary goal is to ensure that all grantees are able to consent clients into service and screening tool use and maximize the number clients participating in the evaluation. Grantees can either adopt the single consent form that we've created that provides consent for both screening tool administration and evaluation participation or you may utilize your own consent for screening tool administration or case management and our consent form for the participation in the evaluation. If you have any questions regarding this consent process, the national evaluation or the IRB form, on the next slide you will see contact information for Ms. Jamelle Banks. She is the lead for the Healthy Start National Evaluation and all questions regarding both the evaluation, IRB protocol of consent can be sent to Jamelle. Thank you.

Naima: Thank you, Johannie. Please go ahead and enter your questions in the chat box for what was just covered and while folks are doing that, I'd like to now transition to our next speaker, Megan Young of the Boston Public Health Commission and a Healthy Start COIIN representative. Megan?

Megan: Hi, good afternoon, everyone. So I am gonna spend the next little while walking through the screening tools, the process that we went through, and a little overview of each of the tools and the flow of the tools, as well. So this is collective effort thanks to the efforts of the

Healthy Start COIIN members, JSI and EPIC Center staff, the MCH bureau officers and the Healthy Start grantees, and together we developed and refined a set of standardized evidence-based screening tools that will substantially increase our ability to document the participants needs, for both care coordination and to set aside the reporting requirements for both the benchmarks and the evaluation, and so why standardize?

We standardized the screening process with a goal to ensure the sustainability of the program, in order to mobilize more communities, and create more equity for our families in need. So during the development of the screening tools, the COIIN work groups worked diligently to ensure the tools were built upon the strengths of the Healthy Start Program, so they are rooted in the community, they're multi-disciplinary, they're comprehensive and they incorporate a cultural competence, family-centered approach. They allow for Healthy Start grantees to meet their participants where they are to provide actionable, high-impact services and referrals for services.

So the screening we felt is an important step in care coordination so we screen for multiple purposes. We screen to gauge participants risks. We screen in order to indicate whether further evaluation or assessment is necessary. We also screen in order to be able to indicate which services or referrals may be the most appropriate. So it's, in general, a very broad screening and assessment of a client's needs. We just wanted to also be clear that the screening does not actually do any sort of diagnosis or provide an in-depth assessment. So, for example, we do include questions about depression screening. We do a depression screen.

There's two questions, but we also then encourage that, based on the score of those two questions, that a more in-depth assessment for depression is completed, if the score is high. The same thing occurs in a couple of the other different places throughout the screening tools where an overview is done with a client, but based on their responses we would encourage staff to then do a further in-depth assessment to diagnose or to refer to someone who can. The Healthy Start screening tools were adapted from existing evidence-based screening tools from various different screening tools, including PRAMS, BRFSS from the census.

They address comprehensive risks for each perinatal period. They are the foundation for care coordination and they align with the Healthy Start

reporting requirements. So these tools reflect our effort to incorporate your feedback and the feedback that was gathered from grantees during the COIIN comment period and the OMB public comment process, and while that time period wasn't very long for us to be able to incorporate the feedback, we did our best to address some of the issues that were raised, while at same time, maintaining the evidence-base of each question, the intent, and the flow of each tools, and while thinking about the multipurpose of the tools.

So to meet both case management and care coordination needs, and the evaluation the screening tools have sort of two purposes. First and foremost, they inform the local Healthy Start programs. They inform care coordination. They help facilitate quality improvement projects by using the responses and the performance measures that are built into the tools, and they inform the local evaluation, so data can be used to measure implementation progress, determine impact of your program and for program improvement, and then second, they also inform the National Healthy Start Evaluation. So they both collect the measures used to calculate the benchmarks as well as to inform the national evaluation which help determine the effect of the Healthy Start 3.0 Program.

Particularly in changes to the participant level characteristics such as service utilization, preventative behaviors and other things like that. But for today we're gonna focus first and foremost. on the care coordination piece. So this diagram was developed just to kind of show how these tools are connected to care coordination. So a Healthy Start participant is enrolled and screened through the use of the Healthy Start screening tools and based on participants responses, there may be a variety of things that go on. So there's both internal services that may be provided and then external referrals, and as you can see and you all know we do lots of things with the participants. So we can do everything from health promotion and education. We can connect to primary care.

We connect women to mental health services or other social services, such as SNAP, Head Start, home visiting, if it's not something that the program does and we may also either provide or refer women to evidence-based interventions, such as the Nurse Family Partnership or MOM is a Gateway, Baby and Me, Tobacco Free to dual programs, etc. And so as you all know there are six screening tools. We have a demographic tool, the pregnancy history tool, a preconception tool, prenatal tool, postpartum tool, and the interconception conception and parenting tool. All participants regardless of where they're at in their

perinatal phase will complete the demographics tool upon enrollment, as well the pregnancy history tool.

And then the pregnancy history tool will also indicate whether or not the woman is currently pregnant, and help direct you to then the next appropriate tool to complete. The preconception tool is used with a participant who has never been pregnant or does no currently have any children and the goal is to be able to complete that annually. So if she enrolls program and within a year is not pregnant, you would re-complete the preconception tool to understand the changes, and any sort of movement or progress in her achieving various goals that you may be working on. The prenatal tool is completed with a participant who is pregnant and it would be done with each new pregnancy.

The postpartum tool is completed in the postpartum period which goes up to six months postpartum. However, it's encouraged and designed that the tool be administered as soon as possible after delivery, but ideally before four weeks postpartum, and this is with a goal to be able to make sure that she is connected to care, that she receives her postpartum follow-up visit, and that, again, any issues that come up either from her pregnancy of after delivery can be addressed in that postpartum window.

And the interconception and parenting tool is to be completed if a participant has a child that is between the ages of 6 months to 24 months, and it's completed once for each child in that timeframe, and each tool has screening questions that are specific to the tool's purpose. There's a place in each document to be able to provide follow up and document the follow up that you may be providing, as well as the document provided education or information to the woman, any service or intervention that occurred or was provided, and also to document referrals.

And this is a little schematic sort of walks you through the flow of what I just spoke to. So you'll see that at the top is the participant and she enrolls in the program, as I said before, all women complete the demographic intake tool, as well as the pregnancy status or history tool. If she is pregnant there's a question, "So are you currently pregnant, yes or no?" If she is pregnant, you would move directly to the prenatal tool. If she is not pregnant we ask, "Have you ever been pregnant?" If the answer is no, you would go to the preconception tool. If the answer is yes, we then ask another question as to whether or not she has any children.

If she says no, you go back to the preconception tool. If she says yes, then we then think about how old her children are. So if she has a child that's less than six months, we would direct staff to complete the postpartum tool. If the child is greater than six months, staff would then be completing the interconception or parenting tool. And these are just a couple of reminders before we dive into looking at the tools a little more closely is that they do not need to be completed each time a participant is seen. We know that to do good case management and seeing them more than just once during pregnancy or once in the postpartum period, but there is expectation that there would be update with any sort of status change or referral follow up.

They were not designed to be self-administered, in part because of the way that the questions are designed and also because of the varying degrees of literacy among the participants in the programs. They are designed to be administered by staff so the questions will be read aloud to the participants, and then for the participant to respond and the staff person to then fill in the answer. They also do not have to be completed at one time in one sitting or even the first visit, but the goal is to complete that enrollment process so the demographic, the pregnancy history tool and then whichever screening tool is relevant to that perinatal phase within a 30-day window.

And this is to ensure that you really comprehensively understand the woman's needs and have the longer period of time to be able to work through those needs, and to address those needs before she enters the next perinatal phase. So they should be completed as soon as possible in each perinatal phase because, as I said, it maximizes the amount of time that we then have to work with each participant. As a way to think through using these tools, we have a couple of different scenarios that we thought would be helpful. So there's three different women. Ipsa is a woman who is not pregnant and has no children, but she's miscarried a pregnancy two years ago, and in a few minutes, I'm gonna walk through the tools that would be relevant to her scenario.

We also have a woman, Tammi, who is currently five months pregnant and has two children. One is 5-years-old and one is 16-months-old, and then there is Courtney who is not currently pregnant but has a 3-month-old and a 20-month old. So as I mentioned before, all women who are enrolled in the program would complete the demographic screening tool. It provides general background information. It consists of 10 questions with 14 sub-questions and these sub-questions are based on a

participant's response so at minimum it would be 10 and then based on responses, it would potentially include those additional 14. An estimated time to complete the tool is about five minutes, includes questions such as the date of birth of the woman.

It's where we collect their best contact information and emergency contact info, their education level, their race, ethnicity, their place of birth, and the language spoken in the home. The pregnancy history and screening tool is also completed by all participants upon enrollment and the responses also then determine which screening tools would then be administered after this. This tool contains 9 questions with 11 sub-questions and is estimated to take around 6 minutes of time. And these times are based on the pilot that was done with the screening tools, and so we asked various grantees to pilot the tools and to do a time study also, to let us know how long it took for the participants to complete the too, and so this is where these times are coming from. This tool assesses women's current pregnancy status.

It documents previous pregnancy history and identifies risks in the previous pregnancy such as pre-term birth of low birth weight or pregnancy complications with may impact future pregnancies. So, remember Ipsa, she's not pregnant and has no children, but she did have a miscarriage two years ago and so if you think back to the flowchart that I discussed a few slides, she would be completing the demographic tool, the pregnancy status tool, and then the staff person would sit and work through the preconception tool with her. The preconception tool is to be completed by participants who have never been pregnant or have no children. It's meant to administered upon enrollment and annually if the woman does not become pregnant. The goal is to improve her overall health to prepare for a future pregnancy and to promote family planning. There are 43 questions with 51 sub-questions and the estimated time to complete the tools is 51 minutes.

These are longer screening tools which, again, is why we've mentioned that they do not have to be completed in one sitting, and they're just very comprehensive. They include a lot of different domains and topics, including optimizing women's health behaviors and knowledge before pregnancy. It's to enhance access to care and quality care. This tool helps us facilitate reproductive life planning conversations and to promote education screening, referral and treatment for women with high-risk conditions.

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[Silence]
[00:24:30]

Then there's Tammi. So Tammi is a woman who is currently five month's pregnant and has two children. One is 5-years-old and one is 16-months-old. In the case of Tammi, again, she would be completing the demographic and the pregnancy history tool. Because she is pregnant, we would be completing the prenatal tool which has questions pertaining to mom, and her pregnancy status, and her health related to the pregnancy. But we would also be completing the interconception or parenting tool for the child, and if you look at the tools, the interconception or parenting tool also has questions pertaining to the mom. But since we've already done the prenatal tool with her and the tools are really driven by the mom's perinatal status and phase that she's in, the parenting tool would only be questions that are pertaining to the child.

So we would [inaudible 00:25:27] the prenatal tool that is related to mom and then move to the parenting tool, the parenting section which has some questions about the child, and this would be directly related to the 16-month-old. Because the 5-year-old is beyond the 2 years of when child are eligible to be considered a participant, we would not be asking questions on the 5-year-old, only on the 16-month-old. The prenatal screening tool is meant to be administered with every pregnant participant and with every pregnancy. So if the woman were to be enrolled in your program and you've kept her through the program, after delivery if she were to become pregnant, you actually redo the prenatal screening to again reassess her sort of pregnancy needs. The purpose is to optimize the health outcomes for mom and the baby.

There are 51 questions with 65 sub-questions and the estimated time to complete the tools is 56 minutes. This tool is meant to improve health risk screening for all pregnant women. It provides evidence-based tobacco cessation counseling. It allows places to refer and treat women with substance abuse and mental health disorders, increases, again, access to and quality prenatal care and support comprehensive home visiting programs. So, again, these are things that based on the questions that you're asking a mom, including the questions pertaining to the social determinants of health which have been integrated in all the screening tools, so questions about housing, and stress, and discrimination. These questions are pulled into each of the tools and then based on a woman's responses, we can then provide additional health education and referrals or connect her to additional services.

The interconception and parenting screening tool is meant to be administered to a mother who comes in and has a child between the ages of 6- and 24-months-old. Ideally, it's completed as close to that 6-months window if the mom moves from the postpartum to the interconception period, but really it's done at any point when a woman comes in, and at any age, that her child is as long as the child is between 6-months and 24-months. It's meant to optimize mother and infant outcomes. It consists of 59 questions with 76 sub-questions, and the estimated time is 61 minutes. This tool provides a lot of the same types of things as we've seen in the others, so supporting comprehensive home visiting program. It ensures infants and families are connected to a medical home. It allows for a family to be connected to the benefits and services that they have specified that they might need or want.

It provides child development and parenting education and support, again, based on responses that staff will have learned by asking the questions and there's also an opportunity to ask about the social and emotional development of the child, and refer for additional assessment, if the parent has any concerns about the child's development. And the last woman we had discussed was Courtney and so she is not currently pregnant, but has a 3-month-old and a 20-month-old, and so the tools that she would need to complete are the demographic tool, the pregnancy status or pregnancy history tool and because the mom has a 3-month-old, and she herself would be considered part of the postpartum period, we would the postpartum tool for both the mom and the 3-month-old, and then the interconception or parenting tool, just the child's questions that would pertain then to the 20-month-old.

And this last tool, the postpartum tool, is again meant to be administered to postpartum participants, anywhere from right after delivery through six months postpartum, but ideally, is administered before 4-weeks postpartum and this is to optimize maternal and newborn health. There are 50 questions with 75 sub-questions, and the estimated time is 52 minutes and, again, make sure that mom is connected to quality care for both her baby and for herself, that she's connected to postpartum care. It assesses for postpartum depression. It helps facilitate a reproductive life planning conversation to ensure that she is connected with family planning if that's her choice and discusses things like breastfeeding with the ability to then provide lactation or counseling support.

And something that I just haven't mentioned is if you looked at the tools

anyplace where there are questions about the child, you'll see that there are potentially four spaces to fill in information, and this is to allow for multiples. So if a mom has twins, you would be able to ask the question about each of the children and so we consider Child 1 to be the child who was born first, and so that will be the easiest way to keep track of which child is Child 1 throughout the screening tools, and Child 2 would be the child who was born second. The Child 3 would be the child born third, and Child 4. We only provided four places, since it's pretty rare to have quadruplets, but there is that opportunity to be able to provide responses for each child as part of a multiple.

And so that sort of completes the general overview of the tools and the flow regarding which tools should be completed at which point and there is a question about what to do regarding existing Healthy Start participants. And the understanding that we have is that any person who is considered a client or participant that has come over from December to January would also need to be screened for their current perinatal phase, regardless of whether they've been previously enrolled. So from my understanding, it's that you would have to actually do the similar paperwork as you would with a new enrollee, in order to be able to align your data with the new database and data requirements. I think there's an opportunity too, if you're already collecting some of that data and it aligns with, again, the screening tools and you're able to upload that information into the system, that would be sufficient.

But it's my understanding that if you cannot provide the information to the system you would have to use the tools with our current women who are active to be able to get that information for the database. So that's all I have for now. I know that people have been submitting questions and I think we're waiting to the end for questions, so I'll hand it back over to Naima.

Naima: Thanks, Megan. Next, I'd like to share some of the upcoming EPIC Center supports in terms of training and TA that would be available in December and January. We will also be providing longer term support, and we'll be using these next two months to really gather and figure out what is the highest need for folks and develop some virtual training to support that need. So this is just to give you a preview of the support that we'll be offering, again, in December and in January. We wanted to begin just with a clarification on who's doing what. We know that there's a lot of people at the table and so we just wanted to do an initial clarification that the EPIC Center's initial focus for training and TAs, especially through January will be to support folks with orienting

their staff to the tools. Also, supporting grantees in their assessment of their readiness and help them outline initial implementation steps for the adoption of the tool and we will also be providing individual TA, as well as virtual training opportunities, again, to support the initial implementation of the tools.

We also wanted to take a moment to share some areas of support that DS Federal will be providing and we're sure you'll hear more detail from them, but just since we're here, just to kinda clarify that. So their scope of training and TA will be the XML schema. That includes creating and receiving those XML schemas, as well as the interface to the Healthy Start National Evaluation. Should you have very specific questions around the areas that I covered, that will be under DS Federal. This is the email where you can access and directly send your comments and questions to them there, regarding any of the HSMEB [SP] concerns that you may have.

So now I'd like to do a preview of some of the EPIC Center supports. We will have mechanisms for one-on-one support that will available through the Healthy Start EPIC help desk via email and phone. We also, as always, you will have available to you to put in the request for individual TA requests. In terms of virtual support we will be hosting live and recorded webinar training, and then one thing we're really excited about and I'll talk a little bit more about shortly is, in December and January we'll also be hosting screening tool implementation readiness peer discussion groups. That will be organized around two topics, so grantees that will be integrating the Healthy Start screening tools into their existing data collection systems, and then the second group will be those that have decided to just use the screening tools as written, and I'll provide more detail on both of those groups.

In terms of the one-on-one support, here is the email address for the help desk, and then there is a toll-free phone number as well. The toll-free line operates Monday through Friday, 8:30 to 5 p.m. The staff that are supporting that and staffing that line, sometimes do get called away for meetings and other webinars, so we invite you and encourage you to please leave messages. They'll be returned within 24 hours, but that we have a record that you called or you can go ahead and send an email. If you don't get a person immediately send an email with your question. And then the last area for one-on-one TA support, as I mentioned, are the individual TAs that can be requested through the EPIC Center website.

I wanted to preview one of the webinars. They'll be coming up December 5th is one that's gonna be focusing on an optional data collection tool. It's an electronic data collection tool to support implementation of the screening tools. This webinar and the tools is specifically designed to support grantees who do not currently have a database solution for the data that they'll be collecting, and so, again, if you're interested to learn more about that option, December 5th, 2 p.m., Eastern, will be the opportunity for you to participate in that webinar. We also wanted to take an opportunity to mention the ongoing negotiations with vendors that have been happening for a while now.

And there has been a small group of COIIN members and EPIC staff that have been primarily working with ETO and Challenger Soft to do group negotiations on behalf of grantees who are currently using those systems. So this initial phase of negotiations, again, is really focused on current users of both these systems. There are about 22 grantees that are using Challenger Soft and 11 that are using ETO. Once the initial pricing has been negotiated, it will then be offered to other grantees that currently do not have these vendors supporting their data collection and it will be something that if a grantee does request any customization of the system, beyond what the initial contract negotiations include, then that will be up to the grantee to kinda negotiate anything further from that point. But if you're interested or have questions or would like to learn more, you can contact Yvonne Hamby at the EPIC Center and her contact information is below.

So now to just go a little bit further into these implementation readiness peer discussion groups. These essentially will be facilitated 90-minute discussion groups that will provide an opportunity for Healthy Start grantees to brainstorm some of the implementation challenges with their other fellow grantees, and we're really hoping at the end of the two calls, that grantees would've had an opportunity to review and complete a screening to implementation checklist, that I'll preview in a moment so you can look at what that looks like. And it's also an opportunity for folks to have decided or discussed who will tab what role throughout the implementation process, so think about, if you don't already have your core team established to really guide the rest of this rolling out of the implementation of the screening tools, figure out who those folks will be.

Also think about key actions or strategies that will need to be implemented and the timeline for those and, of course, any core communications and training that will need to happen at each of your sites, in order to implement these tools. We are encouraging that

program directors, program managers, data managers, data entry staff, any staff that are involved in case management, care coordination, such as social workers, community health workers attend these calls, and we will ask that the participants prior to the calls, and again, I'll preview the checklist have an opportunity to review the checklist.

The initial call will be really centered around this implementation checklist. Here's a further breakdown. So there will be a total of four different groups. We did an initial breakdown of grantee sites that will be using the tools as written so there will be one discussion group that will have two calls that are really focused on the paper version implementation of the Healthy Starts screening tools, and the second group within this category will be those that have decided or are thinking about implementing the electronic screening tool that is being offered through the EPIC Center. So that would focus on that specific tool in those groups of folks.

The second category are for grantees who are integrating the screening tools into their existing data collection system, so this will be a conversation about mapping screening tools to existing forms and databases. It will also be, again, a focus on integration and what that looks like, and what are the implications in terms of your current data collection system. This category also has two groups, one that will be focusing on the mapping of those paper forms to your existing data collection forms, and the other will be more database focused, for those of you that have existing databases, and it kinda is diverse, by what we mean by database. So it could be those that are using Excel's spreadsheets, an Access system of some kind, a vendor or any online version as a database to house all of those data.

Your webinar workbook has the call details. It's on pages 20 to 22. These are open calls so all of the webinar information, as well as the call information is listed in the webinar workbook. And we encourage you, if you have more than one group that pertains to you to really you can attend multiple groups, and after you consider selection, of which ones you wanna attend based on your most immediate concerns. One other thing we just wanna clarify before we give you a preview of the implementation checklist is that these discussion groups will not be focused on answering questions on reporting the performance measures or calculating benchmarks or local program evaluation nor will it focus on the national evaluation.

So the next couple of slides I have before we open for Q&A or hand it

back over to Megan for closing the presentation portion of today's webinar is just to give you a preview to the screening tools which is also included in your webinar packet on page 25. And so the discussion groups conversation, especially the first call, will initially be focused around this implementation checklist. It was developed by JSI and we're really hoping that it will facilitate and start our conversation around the brainstorm of implementation challenges and what are some other techniques, what best practices other sites are using to address those challenges.

The tool is designed for sites to self-assess their status on where they are with implementation and set priority areas that they wanna focus on. The tool itself is designed as a sports playbook, so you'll notice the term play is used and that is the term that covers the 14 areas of consideration for your program or your organization, in order to support the successful implementation of the screening tool. Each play has various activities where you can note whether or not you have not started that process, you're working on it, almost complete, complete and then, of course, there's not applicable. You also have space on the implementation checklist to note whether or not written policies are currently in place for each of those activities, and also, you can note will is the lead where will you go for support in particular areas.

This is just a snapshot of the tool. It has the first play or the first area of focus, "Forming a Screening Tool Implementation Team" and then as you go to the right of that column, you can see the related activities that are listed there, and then you have the rating of one to four in terms of where you are in that process whether or not a written protocols and tools currently exist, and who can help, and who will the lead be. And then finally this is a preview of all 14 areas of consideration that are included in the tool. I'm not gonna read those to you, but just to give you an overview of what's included. We are asking that if you're planning on joining the peer discussion group that at the very least, you review the tool.

It'd be better if you have some conversation with some other teammates to think about what is this gonna take to actually implement. We definitely look forward to having these opportunities for having some peer discussions around implementation of screening tools and with that, I am gonna pass it over to Megan to do our closing before we open for Q&A.

Megan: Great, thanks. This is really just on behalf the COIIN members,

kinda this call to action about how each of us can foster the adoption of the standardization of the tools in each of our programs. It's a huge task. As the evaluator for Boston, we are feeling this and we have a lot of questions [inaudible 00:47:24] chat box and have a lot of similar questions. But, in general, I think that we've created these set of tools to really improve and standardize the services that we're providing to women across the nation. And we implore with all of you to serve as ambassadors for this initiative to help colleagues that may not be on the phone to understand the importance of the standardization and that really is about compliance over consistent quality service for participants, to advance Healthy Start by providing data that can drive programs.

Level improvements at our local levels, as well as to validate Healthy Start collectively by demonstrating the effectiveness and the impact those [inaudible 00:48:11] are on our participants through the national evaluation. In particular, this is a type of funding and knowing that in our current political climate there's a lot of uncertainty and so being able to show the value and the effectiveness of our program is important and also just to sustain Healthy Start funding, as I said. The only way we really can do that is by standardizing our data questions and the care coordination that we're providing to the participants. So I think with that, we're opening for questions and I'll toss it back to Naima. Thank you.

Naima: Thanks, Megan. All right, so we have several folks on the line. We have division representation. We have Healthy Start COIIN representation to answer questions. So we're gonna get through as many questions as we possibly can and we will find a way to capture and answer the questions that don't get covered on today's call. But I think we have a good amount of time that we may just get to answer the majority of the questions. So Johannie, the first one is regarding and there are actually a couple regarding the IRB consent form that folks just want clarification on. So the first question is, "Will the IRB consent be translated to other languages or should we take care of that on our own?"

Johannie: So that question has come up on a couple of occasions and Jamelle Banks is looking into it. Right now we only have the English version, so if you have needs in terms of translating them into other languages, I would just ask you to contact Jamelle, to let her know but she is looking into translating those forms.

Naima: Thank you. Another question regarding the consent form and I

think this is another clarification to the statement that you made. It asks, "If we already have a program consent can we continue to use that one?" Two-part question, so that's the first part, "And should a participant want to participate in the evaluation, must they complete the IRB consent forms?"

Johannie: Okay so, if you have consent form already, yes, you can continue to use your consent form for the participant to receive services. However, if they want to participate in the national evaluation which is, of course, a voluntary activity but we are encouraging participants to do that, they do need to complete the IRB consent form in order to be part of the national evaluation.

Naima: Okay, great. And Johannie, there's one more follow up to that. It's a very familiar question. So, "If clients do not consent into the full evaluation what data will sites be expected to document and submit to HRSA on those clients?"

Johannie: You will still be required to submit all of the required data on all participants whether they consent or not to be in the national evaluation.

Naima: Okay, great. All right, next question, "Are we sending de-identified participant data to HRSA?"

Johannie: Yes. So, the way that the XML schemas have been formatted and, again, this is a little bit more technical than what my expertise is, but it is all de-identified data that will be coming to HRSA. We will not know name. We will not know social security number, anything like that. That information will be housed at the Healthy Start Program site, but not at HRSA.

Naima: Okay, great. One other since you mentioned those de-identified data. There's one more question that states, "We do not collect social security numbers therefore we have to list that within the potential..." This is a question in a form of a question, Johannie, "Do we have to list that within the potential identifiers?"

Johannie: So grantees and DS Federal will talk a little bit more about this, probably on the December 8th webinar, so I will make sure that everyone has all the information for it. But we are anticipating that all Healthy Start programs have some kind of unique identifier for the participants, and we are hoping that that is not a social security number.

But if it is, DS Federal I think they have developed some kind of way of creating a de-identified string of alpha-numeric characters.

So that you would have a unique code for each participant, that we couldn't decode and tie it back to a particular participant. So, again, just a little bit of that's part of my area of expertise, but I would go ahead and keep that question. I'll repeat that question on the December 8th call with DS Federal, and they can walk through a better way of how you can create a unique identifier for each participant.

Naima: Okay, great. Thank you. And then the next question is, "Do the screening tools meet our requirements for screening using an evidence-based tool," specifically the two mental health questions is what is mentioned in that question?

Johannie: So, I don't know about the two mental health questions per se and I don't know if someone from the Healthy Start COIIN may be available to respond to that question. In terms of using evidence-based tools, when we in the FOA, expressed the need to use evidence-based tools we listed out quite a few of them and the screening tools were based on variation of different surveys, national surveys, and so the questions were pulled from those. But I would really leave it to someone from the Healthy Start COIIN or JSI to talk a little bit more about the composition of the actual screening tools themselves.

Naima: Okay, great, and Johannie, I think after this question the other questions will be around the specifics of implementation of the tool. But one more before we transition those questions is, "Can we begin collecting the data on the screening tools with new enrollees beginning January 2017 or all participants who are active in 2017?"

Johannie: So what we anticipate is in 2017 as you start seeing your participants as they've coming in for wherever they are in their perinatal phase, you would be completing the screening tools appropriate for them starting January 1st. So you're not retroactively going back to your participants, but as they're coming in and you are seeing them, you would be completing screening tools appropriate for their perinatal phase at that time.

Naima: Okay, thank you. And so I'm gonna transition to some specific questions around the tools the Megan presented just a few moments ago and the first is, "The instructions on the postpartum form say that the optimal time to administer is four to six weeks postpartum. Should it

be before four weeks postpartum as stated in the slide that's titled 'When to Use Each Tool?'"

[00:56:19]
[Silence]
[00:56:30]

Megan: So this is Megan. My understanding there has been sort of shift in the instructions based on the OMB approval where originally we had recommended that it be completed between four and six weeks, but the new recommendation is to complete it actually before that four weeks, so about four weeks since delivery. But the tool can be administered up to six months postpartum, if you for whatever reason can't meet with the woman until let's say two months postpartum or three months postpartum. But the goal is to really do it as soon as possible, so you can address as many of the issues that may come up in that postpartum period, and the same is also for the interconception and parenting tool. The original was to complete at six months, 12 months, and 24 months.

However, my understanding is that the OMB approval is that the tool be completed one time, so if you have followed a woman from their postpartum period to the interconception period, the goal is to do it as close to six months as possible. So, again, it just gives you a longer time to work on sort of issues or address any needs to come up. But if a woman comes in and she has a 12-month-old, you would complete the interconception tool for the 12-month-old, and there's opportunities to then provide updates that I'm not clear on, in terms of how that then gets communicated into the database, so it might be something that somebody else can address. But that you could you then update the data if there is any of those [inaudible 00:58:11] status changes occur throughout that next year.

Naima: Thanks, Megan. I dunno if anyone else wants to add to Megan's answer. Okay. There are two questions regarding the preconception tools. The first is, "Can the preconception period spread over to multiple years?

Megan: Yes, I can't remember what slide it was on, but the recommendation is that it would be completed annually. So if a woman comes in and she is in the preconception phase, and then a year later is still not pregnant and in the preconception phase or even has experienced a loss, that you would then repeat the preconception tool to then make sure you capture any sort of updates or changes within that

year.

Jody: Hi, sorry. This is Jody. I'm sorry to interrupt. Megan, people are having a hard time hearing you. So if you don't mind speaking up while you're answering the questions that would be great. Thank you.

Megan: Sure. I'll just repeat what I just said regarding the preconception tool that, yes, it can go on beyond a year. But if the woman does come in preconception and a year later is still in the preconception phase that you would repeat the tool, to be able to assess any changes in her status or needs that have occurred over that last year.

Naima: Thanks, Megan. So another question that came in is, "Why would we accept a client who was not pregnant and had never been pregnant?"

Johannie: So this is Johannie. Well, the current model of the Healthy Start Program does include preconception women. We have expanded it from the previous Healthy Start model and it clearly states in the FOA that the Healthy Start Program can serve preconception women, and some of the services would probably include things like tobacco cessation or healthy weight activities in order to get ready for a pregnancy. So there are a small number of grantees that are serving preconception women. That is not their primary focus and that is not their primary target, but they do serve preconception women and that is allowed within the new Healthy Start model.

Naima: Thanks, Johannie and Megan, there seems to be one other point of clarification on the interconception and the parenting screening tool. So this is question is, "It says in the final version of the interconception and parenting screening tool, we have the option to get information for up to four children. So do we still have to complete for every baby in the case of multiple births? It is now for a singleton and multiple births."

Megan: There are four places to be able to capture if the woman has quadruplets. So if a person has twins, yes, the goal is to be able to capture their answer for each child, so if you're asking in which position to put your baby to sleep, there's an option for Baby 1 and Baby 2. Baby 1 or Child 1 would be the child that was actually born first, in the case of twins or multiples. Child 2 would be the child born second, and so the tools are designed to be able to capture up to four children, so quadruplets, and yes, the expectation is to be able to capture the

information, a response for each child.

Naima: Okay, thank you, and just a follow up to that. "The pregnancy history screening tool asked for how previous pregnancies ended. It only has a space to document up to five previous pregnancies, so if a participant has more than five pregnancies which one should be reported? Should it be the first five or the most recent five?"

Megan: I'm gonna defer to others on that. I have a similar question. I don't know if Lee or Yvonne...?

Lee: Yes. Hi, this is Lee, and it should be the most recent, the most recent five and that's because what the question is really trying to get at is risk, is risk for a problematic outcome and so the five most recent would be the most relevant. Okay, I'm as close as I can be. Okay so, I said it should be the five most recent pregnancies.

Naima: Okay, great. Thank you, Lee. Let's see here. Okay, just scanning through. "Does miscarriage entail that a woman was pregnant, so we shouldn't use the preconception tool, is that correct?"

Megan: I think there was conversations that go back and forth, and I think there was a recognition that preconception does refer to a woman who has never been pregnant. However, based on the structure of the tools and the fact that the interconception is also sort of a parenting tool and has questions for children, the decision was that if a woman had been pregnant before, but had a loss, that we would have the staff complete the preconception tool because it's the tool that's most relevant to her situation. So the preconception tool is for women who have never been pregnant or may have experienced a loss and do not have any current living children.

Naima: Thank you, Megan. This next question is related to the scenarios that were presented earlier. So in the example of the mother who has a 3-month-old and a 20-month-old, do we give the interconception parenting tool again for the 3-month-old once they turn 6-months?

Megan:Yes, that is my understanding that you would follow through the phases and repeat or not repeat, but move from the postpartum tool to the interconception tool, as the child sort of ages with the tools. I don't know if, Lee, you have a different instruction.

Lee: Nope, that's what I would say.

Naima: Okay, all right. Thank you so far. We have a lot of questions in the queue, so I'm just scanning through. Some of these have already been answered. Okay this is a different topic. "There are more questions in the screening than there are performance measures. How was it decided to add these extra metrics and what will the data be used for? Is there a specific hypothesis associated with each one?"

Johannie: So this is Johannie. So the screening tools are our comprehensive, as we said before, comprehensive tools to capture a lot of different things. If you are using the screening tools and are capturing all the data within the screening tools, you will be able to answer the questions around most of the Healthy Start benchmarks, as well as the Healthy Start performance measure. How we came about this particular methodology in consultation with the COIIN members and their thoughts around screening tools, and what kind of was next for the Healthy Start Program.

We've also consulted with the Office of Epidemiology and Research here in the bureau, and all of us round tabled. JSI was also included. These tools, although the Healthy Start COIIN took the lead in developing these tools, the tools were then brought up to the bureau for consideration and by review of our division, as well as the Office of Epidemiology and Research. We accepted the tools and made some tweaks to them, and sent them in for OMB approval. So that's kind of the timeline of how things came about, and this is where we are now in terms of what OMB has approved for the program and the data elements that are approved for the participants to be collected, the data elements to be collected for the participants in the program.

Naima: Thanks, Johannie, and I think this next one would be one for you to answer as well. "Are there any efforts to either alter the screening tools to collect data that answer all the sections in the EHB, specifically Forms 3 and 5, the CSHCN items and sections A and B or to make the changes in the EHB. These changes would allow us to rely on the screening tools for all reporting requirements, instead of needing forms in addition to the lengthy screening tools.

Johannie: So the answer is yes, the screening tools are not going to be altered. Oh, I take that back. The screening will stand as they are. They are OMB-approved forms and that's what we will be using moving forward, but as all of the questions or the data elements within the screening tools, if you are collecting, again, if you're collecting all of the

data elements within the screening tools, you will be able to answer the questions for the benchmarks which are reported annually in your progress report, as well as the performance reports that are reported into the EHB. So, again, if you have all of the data elements collected within the screening tools, we have already gone through the process of cross-walking the screening tools with our current Healthy Start benchmarks, as well as the updated performance measures, and if you collect all the data in those screening tools, you will have the information to calculate both the benchmarks, as well as the performance measures for reporting.

Naima: Thank you, Johannie. I have a couple of additional questions that look like they'll clarify who should be using or is audience for using the screening tools beginning January 1. So, there's several questions that came in to that. So I'll start with this one, "Please clarify. Beginning in January 2017 and onwards will we use these tools," is the first part of the question. "So, for example, if we enroll 30 participants, then you will have the data for 30 participants for January 2017 not the total number of participants to date," and that's the question for that one.

Johannie: Could you repeat that question for me?

Naima: Yeah, so this person's requesting clarification. So, "Beginning in January 2017 and moving forward from that date will we use these tools" is the first question mark, and then she gives an example.

Johannie: Okay as we stated, you do not have to use the screening tools themselves. So if for example, you are working in a health department and they require you to use specific forms in your health department, then you can continue using those forms, but the requirement is that you will need to collect all of the data elements within the screening tools. So if the forms that you're currently using does not capture all of the data elements that are contained within the screening tools, then you will need to make revisions to your data collection system to make sure that you will be able to capture all of the data elements that are reflected in the screening tools.

Naima: Okay and so, a follow-up to that question, Johannie is that, "Just to clarify is it because grantees must screen all current and new women in 2017 in order to capture all the data in the tools?

Johannie: Yes, and then also, of course, so you do need to screen current and new enrollees starting January 1st, 2017 to capture all the

data, and also if the participant has volunteered to participate in the national evaluation, then we need that IRB consent form to be completed for that participant.

Naima: Okay, great, and this next question, Johannie, is a follow up just to clarify again, "Are the screening tools being used to calculate the benchmarks? If so, are we basically starting over with a new baseline starting January 1, 2017?"

Johannie: So you can use the data in the screening tools to calculate your benchmarks. as long as the data definitions, I believe that all the programs have already received data dictionary for the Healthy Start benchmarks. As long as your baseline was calculated using that same definition, then you would be able to use the baseline that you previously had. If your baseline was defined differently than the current definitions for that particular benchmark, I would say we'd need to talk to the Office of Epidemiology and Research and see how they want to look at those because that would be a difference in definitions, and seeing if that baseline would still be able to count, if it's being defined differently now.

Naima: Okay, thank you, Johannie. And this one is, I think, a question in between, Johannie. You may wanna answer, but it's also related to implementation of the screening tools, interpretation of it. So the question is, "When enrolling a woman that is pregnant and has another baby under the age of 2, the tools are going to capture, for example, how often the child that's under 2 is read. However, the dose..." Let's see if I'm reading this correctly. "On the child with no dose of the Healthy Start programming, isn't that problematic? It would skew results." So let me try to restate that. When enrolling a woman that is pregnant and has a baby that's under the age of 2, the tools are gonna capture data on the child with no dose of the Healthy Start programming. Is that going to be problematic and will it affect the evaluation results?"

Johannie: Well, I would go back to the data dictionary in terms of how we defined reading to a child and anything dealing with that because I believe, I don't remember about the reading one, but I believe we modified some of the definitions to try to capture that type of question. For example, how would a woman who comes in postpartum, how would it have affected her postpartum visit, if she wasn't enrolled prenatally, and the new data dictionary does capture those types of questions? So I would go back to the data dictionary for the benchmarks, and if you there still seems to be a discrepancy then you

can let us know and we'll go ahead and discuss it.

Naima: Thank you, and Johannie, I have two questions regarding Sunday. So, "We are concerned about burden imposed by the new screening tools in terms of the amount of case manager and client time spent on lengthy interviews at multiple points of time, as well as the data entry and any extraction. In addition, we have a homegrown data collection system and do not have the funding to buy or develop a new system. How would you imagine we address these concerns?"

Johannie: As stated in the FOA it was always expected that we would have a uniform kind of data collection system and uniform data elements, and this is the time that we are doing that. So the expectation was that programs would be preparing to update their current data systems based on the approved forms that we have included and all the data elements that we have included. So, in terms of preparing for new data elements, you would need to work with, like the participant said, they have a homegrown system, they would need work with their programmer to update their system to include these data elements and if you are having significant issues, I would definitely say to speak with your project officer. But the expectation is that grantees would be up and running in terms of the data collection by January 1st, 2017.

The date has been changed on several occasions and pushed back because we were waiting for OMB approval, but now that we've received it and the screening tools were accepted by OMB with no changes, we did anticipate the grantees would be able to make the changes to those data systems, and be able to collect all of the data elements within the screening tools and have the opportunity to start data collection by January 1st, 2017.

Naima: And so along that line, just for clarification, this question is a follow-up, "Will grantees receive any additional funding for database development?"

Johannie: So that would be a question that you could work with your project officer about. In terms of current funding depending on what cohort you're in, in funding, you may be able to work with the project officer if you have carryover funds available to do that. In terms of funds outside of what is currently available to grantees, as you all know we are in a transition period in the government right now. We are under a continuing resolution until December 9th, and anticipate another continuing resolution after that until the new administration is in place,

and we do not know what the funding will look like once that new administration is in place.

So, again, we would encourage you if you have carryover available and if you're in a cohort that is currently submitting requests for carryover, you would work with the project officer to see if a carryover of money would be available within a carryover request. If that's not possible, then again contact your project officer and they'll work with the grant's chiefs, either myself or Bonita, to see if there's anything we can do within the current continuing resolution that we're under.

Naima: Thank you, Johannie. This next question speaks says, "Received an email today from a company called Go Beyond MCH about a product that's called the Well Family System, Healthy Start Programming Case Management System which says that it's been cross-walked to the Healthy Starts screening tools." This person has never heard of this company before and wanted to know if you know anything about them.

Johannie: I, too, have never heard of them, so I don't know if anyone else in the Healthy Start community has heard of this particular company or is using them. I would reach out to your other programs to see if anyone has heard of them, but as far as I know no one here at the division has heard of that company.

Naima: Thank you. We have 10 minutes left. This next question asks about the national evaluation and the IRB consent. So it asks, "Are all programs eligible to participate in the national evaluation or just those states where PRAMS has agreed to participate?"

Johannie: So there are two pieces to the national evaluation. The first piece is where all Healthy Start programs participate, and that is the piece where Healthy Start programs are going to be linking with vital records. They're putting some of the data with vital records, so that is the first piece of the Healthy Start National Evaluation. The second piece is the 15 grantees that will also be linking to vital records, but will be taking an extra step, and also doing the PRAMS over-sampling within their states, with those states that have agreed to participate. So all Healthy Start programs are participating in the national evaluation at some level. It just depends on which cohort you're in whether you're in the bigger cohort that just is linking their data with vital records or if you're in the other cohort that's doing both the linkages with vital records, as well as PRAMS over-sampling.

Naima: Thank you. So as a follow up, Johannie, "If a client does not consent to be a part of the national evaluation how would they be differentiated from those that do consent in the system?"

Johannie: So we are working on doing that on our end. We will let you know when we come to a solution, but we are working on somehow flagging those participants that consent and those participants that do not consent in the national evaluation, so we make sure that we have the appropriate groups when we start running data for the national evaluation. So that's something we're working on, on our end, and we'll let you know when we come with a solution.

Naima: Thank you. Lee and Yvonne, this question will be for you, "Will there be an opportunity on the subsequent call to hear from the pilot sites who implemented the screening tools?"

Yvonne: So this is Yvonne. The pilot report is posted to the EPIC Center website under the Screening Tools page. That's just recently been updated with some new information, so you can certainly go there and download the report which documents the framework of the pilot report and the findings, and if that's something that the larger group of grantees would be interested in, we would certainly work with our internal training team to plan that webinar, most definitely.

Naima: Thank you, Yvonne. Okay just scanning through, trying to make sure I get to the questions towards the end that folks asked. Okay another COIIN team question, "It has been previously stated on a COIIN call that the screening tools may be altered in March after an OMB change memo is submitted. Can you provide more information on that?"

Johannie: So the only information in terms of a change memo that I have heard from the Office of Epidemiology and Research is regarding clarification on the IRB consent form. There has not been any talk of any change memos in terms of the screening tools themselves. I will check with Jamelle Banks to make sure that that is correct, but the last I heard, the only change memo that would be going forward would be regarding the IRB consent form, and there might've been one other minor thing. But I wouldn't anticipate any major changes to the screening tools at this time.

Naima: Thank you and I'll take a couple of more, "Are all the data elements that are not tied to the data analysis plan still required, so, for

example, performance reporting, progress report, monthly report or the benchmarks?"

Johannie: Ask that one again. I'm sorry.

Naima: So, "Are all the data elements that are not tied to a data analysis plan still required, for example, the performance report, the progress report, the monthly report, and the benchmarks?"

Johannie: So the progress report is where you would be submitting information around the benchmarks and, yes, that is a still a required report for all HRSA grants. The performance report is separate and that is reported into the EHB. That is also a HRSA-required reporting mechanism that will also continue, and then as I said before, the screening tools, all the data elements in the screening tools have been cross-walked with both the benchmarks, as well as the performance report, so if you are collecting the data within the screening tools, then you should have the information to calculate your benchmarks, as well as your performance measure data.

Naima: Thank you, Johannie. So this next question is a comment but just wanted to get this one. It states, "It takes substantial time to make changes to custom data systems, much longer than a few weeks in order to integrate the finalized OMB form to start in January 1. We will be having to develop interim solutions." So that one was more of a comment. I dunno if anyone wants to respond to that comment.

Johannie: I don't know what the interim solution would be, but you could talk to your project officer and/or the branch chief and discuss that.

Naima: Thanks, Johannie, and this one is about referrals, "Will we be expected to update education referrals as the client receives services or just the initial education referrals?"

Johannie: Education referral, is that...?

Naima: Yeah, it says, "...of the education/referrals, will we be expected to update those once the services are received or only document the initial referrals were made?"

Johannie: So, the screening tools like your monthly data, any updates to the screening tools would be updated into the HSMEB system on a monthly basis. So, for example, if you had a referral for a woman early

in the year, and then another referral for her later in the year, that would be an update to her already existing record, and that would be uploaded into the HSMEB. So similar to the way we are doing the monthly reports, now those records would be updated, would be sent in for upload to the DS Federal on a monthly basis, so just kind of depends on how you're preparing your monthly data, it would be for a particular month and the way we've been doing it now is that, for example, data that was collected in January would be uploaded by February 10th, and we plan to continue with that pattern that we've already established with the grantees.

Naima: Thanks, Johannie, and just to close, "In serving preconception women are they counted as program participants and who long can we serve preconception women?"

Johannie: They are counted as program participants because they are women of childbearing age, and how long, I do not believe that we have a timeframe on how long we can serve a preconception woman. But keep in mind that half of the women you serve must be pregnant, so while your program is open to serving preconception women, you do have to remember that half of your program participants must be pregnant.

Naima: Thank you, Johannie, and with that, we are gonna close the Q&A and the webinar. There are a number of webinars coming up in December and January. Please go to the Healthy Start EPIC website. I'd like to thank all of our speakers for today and we will be documenting and capturing all the remaining questions we did not get to. We do encourage you to please, please complete the webinar evaluation following the close of this webinar and we hope you join use for future EPIC webinars. This concludes our webinar and we thank you for your participation and look forward to hearing from you soon.