Supporting Healthy Start Performance Project Conversations with the Division Webinar Q&A

This document captures answers to the questions asked during the October 16, 2019 *Conversations with the Division* webinar. We had aimed to distribute this Q&A document to grantees by January 1st, 2020, hoping to have had more completed answers for you before doing so. At this point, we would like to honor our commitment to get something to you, but are still working on obtaining more comprehensive answers to your questions. We expect to share that information with you at our next *Conversations with the Division* webinar in February. Please stay tuned for the date and time of that webinar. We appreciate your patience and again, apologize for the delay in distributing this document.

Please note, questions that were repeated or similar in nature may have been combined or only represented once in the document. The webinar slides and recording link, as well as a copy of this Q&A document, can be found here.

Data Reporting & Screening Tools:

Q: What is the state of the National Healthy Start Evaluation? When will we able to see its results?

A: The Division is finalizing the evaluation and creating a dissemination plan for sharing the results. Public distribution is anticipated in 2020.

Q: Is there a source for grantees to see annual Healthy Start aggregate data for all grantees?

A: No, not at this time.

Q: Please describe how HRSA expects reconciliation between the non-Demographics Tools' XML record counts and the 1c Monthly Aggregate Report totals, given the year crossover between these tools.

A: When uploading client level data, each grant recipient must select if a client is active or inactive, by selecting the status at the beginning of the demographic tool/HS screening tool #1. If a client was enrolled in 2018 and remains active throughout 2019, that client is selected "active", as an enrolled client throughout 2019. Aggregate total numbers are to include all clients who were "active" within the calendar year.

Q: If changes are needed for aggregate data that has already been reported, how do we report those changes?

A: Please send an email to the Healthy Start Data Mailbox (healthystartdata@hrsa.gov) with a clear subject line that notes revisions to data. Grantees should also include in the body of the email that they are submitting a revision to the data. Please title the excel template in a way that notes revisions to data. If you are sending multiple revisions, please keep version control in mind and make sure that the subject line is clear. Please submit CY2019 aggregate data changes no later than 01/31/2020.

Q: Can women that were served prenatally Jan-March in 2019, but not after April 2019, be counted towards the pregnancy goal number?

A: No.

Q: Is the data dictionary still relevant for numerator/denominator of the benchmarks?

A: Yes. No definition changes have been made to benchmarks that remain the same, from the previous project period.

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Q: For reporting pregnant vs. non-pregnant, in the aggregate data reporting, do we report if a woman is pregnant at the time of the enrollment, or pregnant at any time during the calendar year, even prior to program enrollment?

A: Yes, you report if a woman is pregnant at the time of enrollment. You also report if that woman becomes pregnant any time during the calendar year *while enrolled/participating in the program*. You do not need to report if a woman was pregnant prior to program enrollment. When a woman becomes pregnant while they are enrolled and receiving services, she is to be added to the pregnant count and subtracted from the non-pregnant count where she was previously counted. In addition, if in the same calendar year a woman who was pregnant receives services in the postpartum phase, continue to include her in the pregnant count throughout the calendar year – that count should include women who were *ever* pregnant while enrolled during the calendar year.

Q: For those clients who were already in the program and the child is older than 18 months, is there any way to include them in the monthly data?

A: No.

Q: The monthly report is due beginning the 10th of the month, but we have until the end of the month to submit – is that correct?

A: Yes.

Q: Do you want us to report, if we have an enrolled participant who dies during birth/complications from birth*?*

A: Although not a requirement, grant recipients are strongly encouraged to share this information with the assigned HS Project Officer and in a monthly aggregate data report template, via the "7. Data Notes" column, emailed to the Healthy Start Data Mailbox (healthystartdata@hrsa.gov).

Q: Will we prorate the CY2019 aggregated total clients served for 9 months, instead of 12 months, as current project period started April 2019?

A: Yes. Shortened CY2019 (04/2019 – 12/2019) proration is 525 total clients served (225 pregnant women, 225 infants/children/non-pregnant women, and 75 males).

Q: Are we to close a client out of Healthy Start once her child turns 18 months?

A: Not necessarily. The grantee may continue to serve a client once her child is over 18 months old, but can no longer count the child as a Healthy Start enrollee or participant.

Q: How long can a woman remain in the program as preconception?

A: A preconception woman can remain in a Healthy Start program for as long as the HS grant recipient allows, and as long as the woman is receiving ongoing services (e.g., health education) and the program continues to collect data on that participant. It could also depend on available resources to serve this category of women clients.

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Q: What is the definition/timeline for a postpartum visit? 4-6 weeks or 4-8 weeks?

A: 4-6 weeks.

Q: Is the expectation that grantees will continue indefinitely to have three separate monthly reports: Call Template Report for Project Officer, Monthly Aggregate Report, and HSMED Client Data Upload?

A: No. All referenced data reports are not indefinitely expected. The Division continuously evaluates Healthy Start program data quality and validity. When there is confidence in the reliability and accuracy of the data submitted, the Division will re-evaluate the need for all data reports.

Submission Due Dates:

Q: As we near the end of the year, what cut off for December data do we use for CY2019 data? For example, if a screening tool is completed 12/30/19, can we include that in our 01/2020 report?

A: 12/31/2019 is the cut off for December data.

Q: Should we not enroll towards the end of December in order to get data in on time?

A: Continue to see clients through December and upload your CY2019 data for any client you have enrolled up until 12/31/2019.

Q: In the Healthy Start Data Announcement, it stated we must submit all CY2019 HSMED data by 12/31/2019. How are sites able to revise data and submit data for a timeframe that has not yet ended?

A: CY2019 data cannot be collected after the current screening tools expire. All CY2019 data must be loaded, to the HSMED, by 12/31/2019, as the OMB approval is expiring on the current screening tools on that day.

Q: If the data are collected by 12/31/2019, could we still enter it after 12/31/19?

A: All projects are required to have all data submitted by midnight on 12/31/2019.

Q: Is the 12/31/2019 deadline for the Monthly Aggregate Data Report (i.e. monthly aggregate data from April through December of 2019)?

A: No. The due date for missing CY2019 aggregate data (04/2019 – 12/2019), to be submitted to the Healthy Start Data Mailbox, is 01/31/2020.

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New HS Screening Tools (to be called "HS Data Collection Forms"):

Q: After December 31, 2019, what screening tools should be used?

A: We expect the revised HS Screening Tools, which will be called 'HS Data Collection Forms,' to be OMB approved sometime in 2020. These will replace the currently used set of tools, which will no longer be used to collect data after 12/31/2019. Grant recipients will receive an update on what will happen between the expiration date of the current screening tools and approval of the new data collection forms.

Q: Will there be an opportunity for grantees to have input on the new data collection forms before they are finalized.

A: Yes. There was a Federal Register Notice published announcing a 30-day public comment period that closed on December 9, 2019.

Q: Do we continue to use the existing screening tools until we have the revised screening tools, even if we do not receive the new forms until after 01/2020?

A: Grant recipients will receive an update on what will happen between the expiration date of the current screening tools and approval of the new data collection forms.

Q: When will we receive the new data collection forms so they can be built into our database systems? Considering the time that it takes for our program data collection system to be updated, are we expected to start using the new screening tools on 01/01/2020 and stop using the old screening tools 12/31/2019?

A: The old screening tools will not be used after 12/31/2019. The OMB-approved revised data collection forms are expected to be approved in 2020. We anticipate that there will be time between when the forms are approved and when they will be implemented by the grantees. Release date and implementation to be determined soon.

Q: Will there be a webinar to train grantees on the revised data collection forms?

A: Yes. A rollout plan will be shared with HS grant recipients, and will include information/training sessions for the different forms. A timeline will be shared when it is available.

Q: Which of the new screening tools should be used for preconception patients?

A: Instructions/guidance and training on the new data collection forms will be provided and will include all possible program participant types.

Q: Will we need to rescreen all enrolled clients with these new forms?

A: A decision is pending, and will be shared soon.

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Fatherhood Screening Tools (to be called "Data Collection Forms"):

Q: Are screening tools (i.e., new data collection forms) for enrolled males/partners being developed?

A: Instructions/guidance and training on any new forms will be provided and include all possible patients/program participant type.

Q: With the new screening tools, will there be more guidance for male involvement/fatherhood programming?

A: More information will be provided as we lead up to implementation of the new screening tools (to be called Data Collection Forms).

Q: Is there any data required to be collected from enrolled males/partners? For example, benchmark data, interconception/parenting tool, and demographic tool.

A: If a male/partner is an active client participant, he will complete the Background Information form. There are two (2) father involvement related performance benchmark measures. When revised data collection forms are shared, the required data for fathers will be clearer.

Q: Do you have recommendations for administering the interconception/parenting tool to enrolled males/partners? Some questions are clearly targeted to women. Is this f/orm currently required for enrolled males/partners?

A: It is not required to screen males with the current screening tools, but it is anticipated that they will complete the Background Information form. The anticipated new Background Information form can be appropriately completed by both male and female participants; however, it has two sections at the end on pregnancy history and previous births that only enrolled women will complete. In terms of the current screening tools, these cannot be modified to add questions for enrolled males/partners. Many questions are geared toward women, so do your best when using this tool with fathers.

Q: Will HSMED accept males/partners if they complete the background information with the revised data collection forms?

A: We will share additional information when it becomes available.

Q: If a male/partner is filling out the Background Information form, will that male/partner's client ID link to the mother's ID?

A: All participants, both male and female, will have a unique client ID. A male/partner's ID will be linked in the database to an enrolled woman or, if there is no enrolled woman, then to an enrolled infant/child.

Q: Do males/partners have to link to an enrolled woman or child, or can they be enrolled on their own?

A: HS programs can serve unlinked men based on program resources, **BUT IN ORDER TO COUNT IN THE REQUIRED 100 MALES/PARTNERS, THEY WILL NEED TO BE LINKED TO AN ENROLLED WOMAN AND/OR AN ENROLLED INFANT/CHILD. BELOW IS GENERAL GUIDANCE ABOUT INCLUDING MALES IN THE REQUIRED 100 MALE COUNT:**

- If a male has a child enrolled in HS, then he will be linked to that child and count as an enrolled male.
- A single father/male with full custody of his child can enroll as a primary participant and will be linked to his enrolled child.
- A male who does not have an enrolled child can count if he is linked to a woman enrolled in HS.

Q: Will the father have his own ID number?

A: Yes, all enrolled fathers as well as all enrolled children and enrolled women will have their own unique participant IDs.

Q: Are TA requests available for fatherhood?

A: Yes, please submit any TA requests regarding fatherhood through the TA form on the Healthy Start EPIC Center. In addition, once the new data collection forms have been implemented, TA regarding fathers will be provided.

Evidence-Based Practices:

Q: Are the approaches and evidenced-based practices up to date on the EPIC Center?

A: All approaches and evidence-based practices were verified when added to the EPIC Center in prior grant cycles. The TA Center will be working with a team of experts to continue to provide grantees access to evidence-based practices and resources.

Q: What evidenced-based programs do you suggest using to promote women's health?

A: We will be sharing information about evidence-based, evidence-informed and promising practices of strategies and interventions to reduce maternal deaths and morbidity via the website that will be created by the University of North Carolina - Chapel Hill's Maternal Health Learning and Innovation Center.

Another MCHB-supported initiative is the Women's Preventive Services Initiative (WPSI), which funds an external committee of experts that reviews evidence to recommend guidelines for preventive services that, if approved by HRSA, are then available to women through insurance without cost-sharing. Click here for a list of HRSA-approved women's preventive services that are covered by insurance with no out-of-pocket costs to women.

Healthy Start projects can help women get access to these important preventive services by ensuring that all program participants have access to health insurance, and if they do not, they can help them navigate that system and enroll. When they are insured, Healthy Start should help women access well-woman care or primary care if they have not already, where they can get these evidence-based preventive services for free.

We also recommend you review the two AIM Maternal Safety Bundles that are focused on the provision of high-quality postpartum care and can be accessed here.

Q: Is there a specific program for this rather than a variety of EBP for women's wellness? We'd like to have a preventive wellness program for preconception and interconception women but according to the EPIC Center, it appears there are a variety of approaches and education but not a one size fits all program. Any suggestions?

A: At this time, we are not aware of a "one size fits all" program focused on improving women's wellness. Healthy Start Projects will need to choose an approach or combination of approaches or strategies they feel may be effective when working with the women participants within their service area.

Other:

Q: Will there be any financial reimbursement to grantees providing TA? Short-term TA and participating on webinars are doable without additional funding, but some TA can involve extensive time commitments.

A: The TA Center will be identifying a group of individuals as Faculty Members and Subject Matter Experts (SMEs) to support our provision of training and technical assistance for Healthy Start grantees. Some faculty and SME's will have contracts and the TA Center will support travel and expenses if needed for individuals who need to travel to provide TA or trainings.