

MCHB/DHSPS Webcast

Findings on Interconception Care

April 23, 2009

JOHANNIE ESCARNE: Good afternoon. I'm from the HRSA Healthy Start in the Maternal and Child Health Bureau. On behalf of the division i would like to welcome you to the web cast entitled "Findings on Interconception Care."

Slides will appear at the central window and should advance automatically. The slide changes are synchronized with the speakers' presentations and you do not need to do anything to advance the slides. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messages window.

We encourage you to ask questions to the speakers at any time during the presentation. Simply type your question in the white message window on the right side of the interface, select question for speaker from the drop down menu and hit send. Please include your state or organization in your message so that we know where you're participating from.

On the left of the interface is a video window. You can adjust the volume using the volume control slider which you can access by clicking on the loud speaker icon. Those of you who selected accessibility features when you registered will see text captioning under the video window.

The interface will close automatically and you'll have the opportunity to fill out an online evaluation. Please take a couple of minutes to do so. Your responses will help us plan future broadcasts in this series and improve our technical support. We are very pleased

today to have Kay Johnson. She is the president of Johnson Consulting Incorporated and the senior member of the project team. In order to allow ample time for the presentations, we will defer question and answers to follow the presentation. We do encourage you to submit questions via email during the presentation. If we don't have an opportunity to respond to your question during the presentation, we will address you afterwards. We will begin the presentation. First we'll hear a little bit of an introduction from Maribeth Badura, the director of the division.

MARIBETH BADURA: Thank you. And I'm very glad to start off what we believe is going to be a very exciting activity that we'll be working on together over the next three years. In our discussions in the past, we've talked about the importance of interconception care and 35 of our projects in the period from 2001 to 2005 have the opportunity to do some pilot work in the Interconception Care area. Kay was able to look at all of the progress reports from the 35 projects and pull together a summary for us of what were the -- some of the best and emerging practices we found from the projects. That's what she's going to be talking with us about today. She has had the opportunity to share her findings with all 35 of the grantees involved but this is her first opportunity to share it with the rest of the grantees. This presentation will be the start of a series of presentations that will lead to help you prepare for an event this summer that will be the start of a series of three learning collaboratives on interconceptional care. The first collaborative will be held here in the D.C. area on August 3 and August 4. They will be all day events and we will be sending information about that to you at a later point. We expect that each one of the projects will be bringing about five people to the event so that they've got the -- and you, again, will receive further word about that and some discussion as we move forward in our series of presentations. At each of these learning collaboratives, and many of you have participated in community health centers, some of you are members of city match and

they've had action learning labs. The unique thing about the learning collaborative, and it's really more than a collaborative this time. It's a learning communities that are coming together, is that all 99 of the Healthy Start projects will be coming together and working together to improve the Interconceptional Care component of our Healthy Start Program. We're very excited about this and we can't wait to get started. So I'm going to turn the presentation over now to Kay Johnson.

KAY JOHNSON: Thank you, Maribeth. I'm very pleased to have a chance to talk to you today and I'm speaking today out of both -- as you can see on my title slide, about building on the evidence and the experience that goes before in Healthy Start Interconception Care efforts and we're really hoping and on behalf of the project time, which includes senior staff as well as myself, we're really delighted to be involved in this endeavor and looking forward to working with all of the grantees to make this an opportunity for learning and for sharing. So if we think about what do we know and in general, Mary Beth has given you a little overview around Interconception Care and Healthy Start. We know that many of you have been working on your projects since 1992, many others of you have come along since then and that over time, Interconception Care became one of the nine core components of Healthy Start. We have 35 grantees that started formal Interconception Care components in 2001 and a lot of what I'm going to talk to you today about is really a careful look at what they were doing and what we can learn from them. Then all grantees have been required to have Interconception Care components since 2005 and the active work in evaluating healthy start gives us a little insight into what that experience and evidence has been. So what do we know about the activities and strategies of healthy start Interconception Care components? We know that people were looking intensely at the 35 sites since 2001 and there were some guidance that really was underscored by the examples that you see in this slide and some of the examples were

about risk assessment and screening, what grantees might be doing in those areas, there were examples given my HRSA MCHB about how grantees could use health promotion strategy to improve interconception health. And then there were also examples given in guidance of intervention strategies that were slightly different. It's very interesting to me to go back and think about this and what HRSA MCHB and healthy start grantees were doing in 2001 because over more recent years was initiatives at C.D.C. and across the country, this is sort of the core activity for any interconception health or Interconception Care prompt, whether it's in the community or whether it's in the clinical environment and so for me, Healthy Start guidance really showed us what the three things were likely to be and helped define where we might be going. The other thing that these examples tell us is that this is a complex and interactive set of things that are proposed to be provided for women and that it's not just one stop or one intervention. In 2005 the guidance said that all healthy start programs must demonstrate the core and interconceptional activities would include this community, knowledge, that an understanding of the gaps and a record of completed referrals for interconception and specialty health services. And again, 2005 was before the national recommendations were issued, before a number of things happened and a lot of grantees were really inventing this without a lot of tools, without a lot of guidance and one thing that this prompt is intended to do is to put together the experience of the grantees with now the evidence base that's been published since 2006. Here you can see some of the collected results from the National Healthy Start Grantee Survey and this is work the national survey done by ABT associates and by Mathematica. What you're looking here is about the percentage of women clients and this is across the 90 or so grantees that were included in the survey. If you look at the bar on the left about completed referrals, what proportion of, you know, had 100% complete versus, you know, a smaller, less than 25%, less than a quarter of them in yellow. And what you can see is that about half had about half of their referrals complete. Real progress, really also

opportunities for improvement. In the area of home visits, this is to what extent were grantees using the home visits to serve women and what you can see again is about 65% of women clients were reached through that modality. And then if you go on screening, you can see that about 50% of the clients being reached -- I'm sorry. Not 50%. More than 70% of the clients being reached with the depression screen and really seeing the extent to which these tools were starting to be used and applied. And I'm going to make a point later about how much it helps to get the work done when there are very specific tools. So this is part of the evidence that guides what we're going to do and how we think you can help improve. So what can we learn specifically from the review of the first 35 Interconception Care official grantee efforts? Some of you were doing this before but these were sort of the first official operating under guidance efforts.

Next slide, please. So what I did was a review and synthesis of what the 35 grantees were doing. It was not a formal evaluation. I was looking to find best practices. I had 15 other experts involved with me in the review and we were trying to then synthesize lessons learned. For me this group forms the first large set of efforts aimed at using Interconception Care to reach and serve high risk women and their infants and families and I think it's very important work for all of us to learn from.

Next slide, please. So I have a set of key findings and the first one really is about limited resources. And I think the extent to which grantees have been asked in most instances to add this component without a lot of new money to do this work is clearly a factor in what they were able to achieve. It was difficult for grantees to make the level of effort they might have even hoped to make without all of the resources they needed and not only their own grantee resources but also just the resources available in the community at large. First of all, we know that many of the women that they were trying to serve lost their health

coverage after 60 days because they were Medicaid clients who only had coverage during pregnancy and the 60 days postpartum, that there was a shortage of providers and sometimes that was for primary care but often things for mental health or other specialty care, it was hard for grantees to find providers to meet the needs identified. There was a limited amount of money within the grantee process for case management and likewise, for health coverage for those services. And just back then this last bullet about my earlier point that those people who were doing this in 2001 to 2005, and even those who started in 2005, did not have the advantage of having a lot of preexisting tools and protocols and I think that's a lot of them built their own and I think that's a lot of, again, what we can learn from. We had some findings about who the women participants were in the interconception projects. The target based on the guidance was higher risk women and infants and there was a specific definition of that. A lot of grantees tried to get a little beyond what that definition would have been. We found, however, that the focus was mainly on women who had been prenatal program participants, again, I think this was as a result of the resources they felt they had and their relationships that they had built. In the review that I did, we found that one third of grantees were not able to give priority to other high risk women for interconception care. That does mean that 2/3 were able to do it so, for example, when they identified women who had no prenatal care and others who had outcomes that made them clearly a high risk, they were able to include them. Limited service capacity were the reasons that this one third felt they weren't able to do that add-on. And we also know from the apt work that the findings from the survey of all grantees found that 3/4 of grantees were enrolling the majority of interconception clients during the prenatal period and that survey was done at a later time. Again, we're seeing somewhere in the same range of what people felt they had the capacity to do.

Next slide, please. There were some findings that really have to do with a focus on infant health and by saying this, I don't mean there should not be a focus on infant health but this project in particular is, now that we're launching the learning community, is about focusing a little more on the women. There was a tendency in the early years to focus on infant health and development more than on women's health. And we sort of projected what some of those reasons might be based on what grantees wrote in their reports. First of all, the fact that the child had continuing health coverage, that their Medicaid or CHIP coverage was likely to continue. The fact they had insurance made it easier to get the services for the child. The second, I think, and very important is that there were well defined measures for child health. So if you were setting up a project and you said the children are due for these vaccinations by this age, the well child visits are due by these ages, and here's the content of care that ought to be in the well child visits, developmental screening is due at this time and here are the tools for developmental screening. It's very defined by the academy of pediatrics and C.H.B. and others. It's very specific. It's ages, it's times, it's tools. I think that makes getting the work done for the young children much easier. There's a natural interest in early childhood development so there were probably partners in the community that were focused on developmental screening or early childhood mental health or bright futures, getting kids in for well child visits and so forth. The guidance also mentioned a focus on infant health so rightfully it was a part of what grantees were doing and finally, I think we all know that families with a new baby are pretty much always focused on the new baby and they demand their attention. The moms were more likely focused and maybe families more likely to accept assistance for their child's needs than mean the woman for her own needs. We want to build on this but to broaden on to a stronger focus on the woman's health in the interconception period. Case management is clearly a strategy virtually every grantee was using care coordination and case management is a primary approach to defining interconception health. They were primarily

doing it through individual home visits but also center based efforts and there were some group care methods and some of those have advanced since the day that we have from the evaluation in my review. I think that very interesting is that a lot of grantees have devised what I call tiered levels of care, coordination and case management. That is, they figured out how to use their community base lay health workers and the professional nurses and social workers and others on their staff figuring out how the relationship should work, when does the community health worker do the work, when do they refer to the professional and likewise, when does the social worker making sure that the community health worker is involved in what's going on with the woman and the child and the family. So I think figuring out those relationships was a really promising practice that we could learn from and that we're hoping to build on in this learning community. Next, please. I did a little diagram of what I saw when I was reading all of the documents and the grantee reports, that they were using this array of staff and the more they had protocols and defined relationships, the more they could maximize the capacity of the people that they had available to deliver services, really in that care, coordination, case management sphere. This does not include necessarily the direct clinical services sphere.

Next, please. We have a number of findings about direct services and one of them, a really important finding is that only about half of the grantees were submitting data that allows us to really track the use of direct care services, even in two or more of the five years. And so one thing that we know is there are probably direct services out there we aren't counting. Another thing that I think is a promising practice and something that we can build on is that success in getting the direct care that women need was associated with linkages to what I would call publicly available primary care clinics so community health centers, qualified health centers, free standing hospital outpatient clinics, health department clinics that had primary care. These are sources of care that we know see

women and patients without regard to their ability to pay. They have a sliding fee scale, a zero bottom and also providing primary care. So clearly when we're looking for primary care and other providers to see women who have no health insurance, these are really important sources of care and having strong relationships to them was a key to success for a lot of grantees. And we -- while we don't have all of the data we need, what's very clear is tens of thousands of high risk, low income women were screened for their risks and had adverse health conditions that the screening was generally going on with recommendations but without very consistent or validated or standardized stools. So there's another opportunity there for us to help get the screening done more efficiently. Again, I mentioned earlier that over the past five years or so, we've had an evolution in the understanding of pre and Interconception Care and practice and we talked about the three circles or clusters of things, the screening and assessment, health promotion and counseling and then a set of brief interventions. And these are areas that really are being pushed for primary care providers of women, whether they be family doctors or ob/gyn to look at the three elements they ought to be providing in the clinical setting but we also think these are the areas, and we know from the early guidance, these are the areas for grantees in terms of the Interconception Care practices also. And then a lot of this work can be done through case managers, through healthy start service providers.

Next, please. We have these findings from tools. A lot of different things were in use and it's not clear that what people were doing that was being validated or standardized and I think our evidence suggests that a lot of tools that you've developed have not been shared across grantees. So there's a big opportunity for us to do that. There were grantees who were using very specific dated tools used nationwide, the perinatal periods of risk and the fatality review and I think that's a model for how to have more tools that were ready for all grantees to have available for them and use as they need to in their programs. Very

importantly, we know that healthy start is not really about just what goes on in a clinical setting or even what goes on in the context of an individual home visit with a staff person. It's also really about systems and about the change in the community. And overall, we found that only 32% of grantees reported that postpartum clients had a completed referral. This is, again, from the national survey and we think that indicates, and many of you wrote about it in your reports, a need to think about the systems' issues because it wasn't a lack of desire to have women complete the referrals but not having the dots connected in a way that was failing the women. The fact they lost their Medicaid after 60 days was the most cited barrier to giving them interconception care. We think there are ways to maximize that 60 days of coverage and we're hoping we can learn from that in this learning community. There were a lot of challenges and finding treatments for depression. We think there are some strategies we can help grantees learn that are really evidence based practices that are brief interventions that are being used in home visiting and even by some healthy start grantees that others could learn from. So there's some real evidence based practice there. I think that a finding that has to do clearly with our work in quality improvement is that measuring impacts, short-term and long term is very important. It's important for you as grantees to continuing funding. I think one of the things that we're seeing in the Obama administration is that they're very interested in evidence based practice, all of this talk about comparing effectiveness and very interested in results. I believe that healthy start grantees are doing much more and getting more results than we have yet measured and we are very committed, both Johnson group and apt and in the design of this project to helping you better show the results that you have. Different definitions for measures, poorly defined denominators, different accounts for participants make it impossible for us to show nationwide the level of change that healthy start grantees are causing and the level of positive impact you're having. What do I mean by that? Here's a couple of examples. One about the different definitions. Ongoing primary

care is one of the things that people tried to measure. There were a group of grantees who were measuring that and the way they were measuring it is whether or not the woman had one visit during the 12 month postpartum period. Other grantees were measuring it as whether or not a routine source of care was identified. Those are really different things. It's not that we might not want to measure both of them, but if we don't have one unit about ongoing primary care where we can compare what you're doing, we can't get to an aggregate result that tells at a national policy level about your success. Similarly in family planning, some grantees were measuring it as whether or not a family planning counseling had been received from a case manager. Others, whether or not a method had been initiated and others, whether or not a family planning visit had been completed. Again, all appropriate but not consistent across grantees and so we don't know what to do with some of the apples and oranges that we've been getting in terms of measuring impact and we think that this project over the next three years can really build on your experience, your knowledge and the opportunities to measure your success. So what do we know about the women served through the Healthy Start Interconception Care components? I just wanted to remind us a little bit about what you found when you were screening. And these are data -- next slide.

These are data from the system for 2006. They were prepared by MCHB. These don't come directly from my review but I did think it was worth reminding us of who is being seen and what is being found. So here we can see, you know, these are predominantly young women, they are predominantly in their 20's. And so these are women in what we call their prime child bearing years. Many of them will have more than one pregnancy and the opportunities for serving them well in the postpartum period are really great. They are thinking about them by race. You can see that a majority of the women who were served by Healthy Start and Interconception Care periods, 60% were African-American. You can

see 25% were white, 1% Asian, 4% American Indian and others did not report race. This was a very diverse group. This shows the same population divided by Hispanic ethnicity and that about 22% of women were identified as Hispanic Latino and again, disproportionate to the whole population overall and we know that because these women have been identified in Healthy Start, they're also higher risk women. So I've grouped, because you can't see them all in slides, I've grouped this set of things about the need for interventions. Another way to read the titles of the slide would be what were the things found when women were screened in Healthy Start interconception activities? So this is a set I sort of grouped as one of the sets of medical conditions, if you will. The scale on this one is 20%, the scale does change across a couple of these but what you can see is that, you know, one out of six, one out of seven women had an identified medical condition, whether it was diabetes or asthma, hypertension, all of these things would relate to a risk that would affect not only the woman and her ability to live her own life but any subsequent pregnancies. This shows another group of things that again are medical conditions but they're a little bit different and sort of I put them together because they're each sort of distinct. The scale on this one, notice, is 25%. But the group are bacterial vaginosis, higher than the other slide, S.T.D.s, higher still, H.I.V./aids, 12% being exposed to H.I.V./aids and being exposed to those conditions. Here we have a set of what you might call behavioral psychosocial risks that the women were experiencing, that 15% of them were using alcohol beyond sort of minimal levels. 16% exposed to domestic violence and afflicted by that experience, 12% were homeless, again, 18, 19% using illicit drugs and just over 20% smoking so roughly one out of five of the women was smoking and/or using drugs of some kind, real opportunities for intervening in the course of that woman's life. These are the two measures that we had for mental health. The 26% here really correlates with what we find in studies of high risk minority women across the country, a variety of studies, also very similar to the roughly 25% maternal depression that's been

found in some of the head start population, so this is running very consistent with what we would expect for higher risk, low income women in terms of postpartum depression. We know a very serious set of consequences for women and for others facing mental health problems so clearly, a lot of need for intervention in these areas as well. So how can we use this information to guide the development of a Healthy Start Interconception Care learning community?

Well, next slide, please. Again, we really want to build on the healthy start experience and I just want to say again that I think that grantees have led the way in the development of Interconception Care approaches and it's why I'm so enthusiastic about this project. And think that grantees have a lot to learn from one another and that the rest of the world has a lot to learn from grantees. We also know that case management is a central approach to service delivery. This is a very hot topic across the country right now, a lot of papers being written, a lot of conversations going on, a lot of thinking about how Medicaid and other financing would be available for this. I think you all have a lot to learn from one another and there's a lot to be learned from what has been written about case management as a central approach to delivery. I would also say on that one that many of you are operating defacto home visiting programs and your experience in home visiting has not been well studied or understood nor do I think that the principles in best practices of home visiting have always been available to you as you were doing this case management work. We know from this experience that your clients lack access to care and we think that there are opportunities to improve in that area and that the content of Interconception Care was not well defined at the time you've been doing your work and we really see an opportunity to improve, particularly the way that you're able to work with women with better tools and better guidance that comes from evidence that's come out since. The other thing is a different set of experience and evidence really. We've done for our project a literature

review that reflects overall what we've learned from the evaluations that focuses on your work but also summarizes the case management so this is something that we hope we will be sharing with you and we are looking for examples of best practices from Healthy Start communities that we may not have found in the work that we've done. Some of them may have emerged since our work really doesn't tell us a lot about what grantees have done since 2006 so we're hoping that you can tell us more about your practices and those of others that, you know, there's something that someone else has been doing that you really want to learn about. We're hoping that you can tell us. We have requested input at the healthy start program officers to get their advice about best practices they've observed from their work with you but we want the grantees to tell us themselves about their own and others' best practices, exemplary practices because that will be essential for us to share and learn from one another. So much of what quality improvement process is about is not only about evidence based practice but also experience based practices and shared best practices. So we'll be looking forward to hearing from you on that.

Next, please. So building on the evidence base, there is in December the content of preconception care was published. It was published in a journal. We can share a link with you, all of the articles are available online at no cost. But we'll also be looking to create tools out of this journal, out of this publication. But it defines the clinical content of preconception care. It recommends -- remember my circles? It tells us which things have strong, high quality evidence. What are the things we know will make a difference in the health of the women and their babies? And it also offers an approach to content for delivery, either through primary care or by healthy start staff so it's not just about what goes on in a clinic or what goes on in a doctor's office but also what could be delivered by healthy start staff. The process to get there was a two-year process where dozens of expert reviewers spent two years looking at more than 700 papers and articles and they

looked across 80 topics to really try to look very broadly at what the opportunities were, what the experience was and what the evidence base was.

Next slide, please. We have a table that we'll share with you in the future webinar but this gives you an idea about all of the things that were looked at. So if you looked on the last -- these are sort of the areas in which they clustered the components and actually there are articles about each of those topics. And then you can see the number of sub, if you will, in the component how many things were reviewed. And then I've just given you examples. So let me just try one here. So in health promotion, there were eight topics that they looked at. And three of those eight topics I've listed there so healthy weight, having a reproductive life plan and family planning health promotion were three of the eight things that they looked at in that category. Or if you went down to the medical conditions, they looked at 14 topics and the four of them that I've shown are diabetes, rheumatoid arthritis, P.K.U. and asthma but there were 14 overall so I've only given you examples here. But you can see that they're really a mix of things you think about as medical, things you think about as behavioral, things that are related to mental health, things that are related to psychosocial risk so they also -- they looked at poverty, they looked at domestic violence, they looked at a whole series of things. They also did a whole review of what is our knowledge around men and their preconception health, women with disabilities and other special populations.

So just to wrap up, I want to talk a little bit about our project and the creation of the learning community. And we didn't want to just spend our whole time today introducing that to you. We wanted talk and our reasons for doing this I hope are clear. There's a lot you all can learn from one another. We want to make that learning routine and easy. There's a lot of evidence that's been published that hasn't yet been used to inform your

work which could make it stronger and more effective and finally, that there is -- there's been sort of a gap in the development of consistent and standardized tools and protocols that could make your work easier, more cost effective, more effective overall. So we're looking at a lot of opportunities there. What our project is called for, the basis of what MCHB laid out is that all grantees, all current 99 grantees will form learning teams. Each of those teams will have five traveling members and they will have a larger group of people learning back home. I suspect for many of you, this is a familiar concept where a few people are going to travel and -- but there is going to be a home team that might include a dozen people or so. All teams will have common learning experiences so we will bring some shared learning to all of those teams and a lot of that will go on at the three all-team meetings. First of which Maribeth described to you will be in August. And each of you will also have unique quality improvement projects that you work on, that are -- that focus on a topic that others might be working on but really are your own way of improving your own work. So we want you to learn from one another but we want you to be able to focus on improving the quality of what happens in your project under your grant in your community. So both of those levels will be going on. And I mentioned the learning teams, five people who would include core staff and community partners, would travel and bring back what they learned and home teams would include a variety of stake holders and that stake holder group will probably reflect the topic that you've chosen for your quality improvement projects. Grantees will choose from a number of topics, these key areas in which they want to improve their interconception activities. We're in the process now of refining our list of topics. We have some ideas we're going to give grantees at a future call, we'll talk about those specifically and give you an opportunity to tell us, you know, which have most relevance for you. The important thing to know about this issue of choosing your topic or key area is that we will want you to choose your topic in May, probably, because that will affect who you're going to bring as your learning team in August and how

you're going to get ready to come to us in August. Maybe early June by the time you make the decisions, but that decision will be made in advance of the August meeting so you can prepare. We're looking at three years or three cycles of learning. We'll have the meetings and in between the meetings will be nine month action periods in which you work on your quality improvement projects and then come back together and learn from one another. The ways that we have to support you on this is going to be the all team meetings, it will be written materials, there will be conference calls and webinars as well as individual team calls and we have an expert working group of 18 people who have a lot of knowledge and who are some of the leaders in this field that will help guide our work. I have posted along with today's slides, there is posted sort of a fact sheet about the project, what it is, reviewing what I've just said, little diagram of how it looks when, you know, you're preparing and you're in your action process and so on, but we wanted to start today giving you a grounding and saying between now and August, we've got a series of webinars, a series of materials being prepared for you that will help you get ready for that meeting and then really have your team gel and your official quality improvement work begin after that. So let me stop there and open it up to questions.

MARIBETH: Hi. This is Maribeth again and I wanted to just follow up on what Kay has been saying and talking about with you in terms of the actual contractor for this project is someone that all of you are very familiar with. It's Andrea Brandt and Deborah Klein Walker.

>> Thank you. I forgot to see that. And Lisa LeRoy is also from the apt team. Yes.

>> They pulled together as Kay said an exceptional group. Many of the names -- and I'm just going to briefly give you some names right now but many of the people are people

that have worked with the march of dimes and C.D.C. and the select panel on preconception care, the national summits that have been held on preconception care. So we've got Allison Johnson and Sam Posner, Janice Bearman from the March of Dimes, Mary Kay Mosnellie Korea, Belinda Petafor and our consumer advocate from her project, Sharon Johnson joined us also for the meeting. Michael Lou is part of the expert faculty, mark de peck, we have one of the lead officers from N.I.H. with us, we have someone from the office of population affairs, the director there, Susan Mulikowsky. I probably slaughtered that name. Karen Loo from the association of Women's Health, Obstetric and Neonatal Nurses. It's a broad group, the faculty that will conducting the sessions this summer and over the next three years. We're excited about this and I think we're ready for some questions now. So I'm going to turn this over.

>> Thank you, Maribeth. OK. We will now begin our question and answer session. And the first question is the rates of chronic disease, particularly diabetes and hypertension, are much higher than what has been documented in many other sources, including birth certificates. What do you attribute these rates to?

>> I think a couple of things are going on there. What we know is that those data on birth certificates are not the best data we have on birth certificates, particularly for higher risk women, women who didn't have one routine source of prenatal care so there's a knowledge gap and a voltage drop between what we know might be happening in the prenatal care and now you have this postpartum woman and, you know, now we see, you know, that she does have some ongoing chronic conditions that weren't necessarily identified during that labor and delivery period where a lot of things get written down. I just think particularly for low income and higher risk women, we know that a lot of things don't

get captured because there's missing communication between the prenatal period and the birth certificate.

>> Thank you, Kay. The next question is, is it possible that HRSA will develop an interconception guide for Healthy Start grantees? What will be the end product of this activity?

>> Can I take a first crack at that and say that we will be developing a guide as we go along, looking -- I mean, we'll have, you know, the literature review, the tools, we will have a summary of evidence based practice, we will have sort of a handbook for this work over the next three years. And we will have an end product. And so beyond that, Maribeth?

>> I think also that perhaps there could be a series of articles that we can get into. The public domain via some journal articles that we could develop. But the guide will be developed along the way and it will be a final work product.

>> And I think, you know, Andrea has -- Andrea Brandt, who is our lead project officer for this work at apt is really -- you know, we're already thinking about the outline and the materials that we're putting together. We've already finished this nice literature review which will be interesting for people who want to read a summary of all of the evidence or want to have all of the references in one place. But I think that the handbook that will be evolving, you know, be getting pieces between now and August, a really solid version of it in August and have it evolve the next three years will be the how-to guide with tools and information and supported by evidence. And your own practices.

>> Thank you, Kay. I believe this next question is directed more to Maribeth. The question is, will HRSA provide additional funding to increase healthy start grantees, to help existing healthy start grantees to increase the number of case management staff to improve or focus on quality improvement work with Interconceptional Care Services?

>> At this time we don't have any extra funding to do that. That would be something that we could look at for future years, but at this time, we just are encouraging you to use your travel dollars to bring the staff in. I think your point about increasing the richness of the teams is something that we've thought of, but at this point we've not been able to secure additional funding for that.

>> I don't want to sound Polly Ann-ish about this and I know Lisa LeRoy and others who will be talking to you about quality improvement strategies, I think one of the things that people have found from all of the quality improvement projects that go on is that if you get this quality improvement work going in your project, you really can maximize what you have and you get more work and efficiency from the same staff and better results. They found in community health centers, they found it in early childhood environmental screening, they found it in substance abuse treatment, they found it in some preconception projects, you know, around the country. They just find that there are ways at streamlining the work and I know the two people who were going to talk to you in the next webinar are people who have experience in doing quality improvement work and they're going to share specific examples of how this really can be so much an advantage to you and I know one example that someone uses is saying, you know, we were sure we were doing everything that we could do and we were getting -- you know, getting the most of screening done or whatever. And they said, and then we started working with other people who do what we do, and we found they could do 50% more screening. And then

we found out why. And so there are those aha moments in this process. I know that's no substitute for having money to hire new staff, but I do think it will be really a support and assistance to you as we go forward.

>> Thank you, Kay. The next question is, how much emphasis will be placed upon measuring impact as well as collective -- as well as a collective cohort? For example, translating findings into dollars.

>> Oh, I'm not sure I can answer the translating finding into dollars but a quality improvement process is always about measuring impact so we're going to be looking at you measuring, your own short-term change, look at whether the other 20 grantees who are doing a project sort of like yours, you picked interconception screening that you were going to work on. How do we measure that across 20 or 25 teams that picked that as a thing they wanted to do? And then looking overall, I think at results. Our hope is that this will help you both do small, sort of micro management within your project, that it will help you not only in term of Interconception Care but help you overall have better data reporting mechanisms and better understanding of your own impact. I think that's really one of the greatest hopes for what all of the grantees can learn about this as we go forward, to make that step easier.

>> Thank you, Kay. Just a couple of points of clarification because I've gotten a couple of questions. The dates again for the August meeting are August 3 and 4th. There will be a save the date that will be sent out but those are the dates. It will be held at the Marriott in Washington, D.C. and this will be the only meeting of the healthy start grantees for this year. So there will be no additional meetings planned for at least 2009. OK. Let's see. The next question -- there are just a few of the same types of repetitive questions. OK. Is the

bureau considering a standardized way of collecting medical information from across projects? I will let Mary Beth answer that one.

>> What we are encouraging projects to do in this area is to be on the lookout for the number of awards that -- or grant competitions that are coming out in the area of electronic health record, there's some coming out from the office of rural health here at HRSA, others coming out from our health information technology area. But we do know that there are dollars coming both through federal grants but -- to community health centers, to other groups as health information technology was a major component of the precedence of recovery initiative. And we're encouraging people, you know, to go to grants.gov and type in health information technology, electronic medical records so that you're notified of any initiative that might be coming out and if your parent organization is the one that would have to apply to make sure that they're including you as part of the group that would benefit from an electronic health record. But we think that that's a real creative way right now for many of you to be able to get some of the medical information that you might not have the access to before. We would also encourage when you're talking about your consortium, as you're putting together -- because we expect that those people will be part of your home team, you may look to other providers in the area so that -- that are actually providing medical care and talk with them also about the grants from the office of information technology so the information can be shared at the local level and then aggregated across projects.

>> So not aggregated across projects but two things that I think are worth mentioning here and one is that I'm fairly confident one topic and area for improvement will be about doing Interconception Care screening and capturing that data in a way more useful to you. And the other is a topic that will be about linking to primary health providers and so for those of

you who are interested in that as an area of quality improvement, one or the other of those might be a topic that you would want to work on as we go forward.

>> Thank you, Kay. The next question, in our Florida project, we began providing home visiting case management to preconceptional women but finding getting primary care for the consumers the most difficult. Can you speak more to the opportunities you mentioned for addressing this?

>> Yes. Just what we were just talking about. I think we really see opportunities for developing stronger relationships with the free and no cost primary care providers that are available across the country. It struck me in sort of looking even at the map of federally qualified health centers in the group of grantees that the relationship is not as strong as it should be across the country. I think that they will require more creative individualized and tailored activities. But it's certainly something that Andrea and Debbie, Lisa and I have all had experiences, have a number of people in our expert work group both with thinking about urban and rural opportunities to figure out how to make the primary care connections. We hope it's an area that a number of grantees will choose. I think the home visiting case management in and of itself opportunities for improvement there, but we can learn again from what other home visiting projects have done just as an example, I work with a home visiting project in Ohio that has developed a relationship with a managed care organization and with community based primary care providers so there are a lot of models for doing that and figuring out a good fit will be the strategy there.

>> Thank you, Kay. The next question is, are there any resources or computer programs to use for health information technology improvement? Or people that we should contact

for help? We don't have enough to write those grant applications yet. I think Mary Beth may want to speak to that.

>> I would suggest that if you would like more information on that area to go to the HRSA website and go to our office of health information technology. I do know that they also have some archived web casts that they've done and you may find the information that you're looking for there or you could call or email that area to get some identification of resources if you're interested in this.

>> Thank you, Maribeth. I don't think we have any further questions right now. Do you have anything that you want to add, Kay, while I give the participants a minute or so to --

>> I guess I would really encourage people to download the fact sheet that we've posted. It will be posted with the archives and the slides going back there and getting it. It's just -- you know, it's two sides of one sheet of paper of text with bullets so if you want a little quick and easy reference about particularly the things I've said at the end around the design of the learning of the community, the role of the group and then we have the diagram which actually shows you how we hope to use your talents and support you, so I think that would be a very handy reference for people to have as we're going forward. We will have three more webinars that are specifically related to this project and to preparing for the August meeting so that as I mentioned, the next one will be about understanding the quality improvement strategy and how we're using it and listening to people who have experience in doing that. Another will be about the readiness assessment that each grantee will need to be engaged in before we get to August and then one will be really about the content, the topics and that will be very important for you since we have an expectation that you'll need to have done your readiness assessment and your -- selected

your topic in order to put together your team to come and attend the meeting. So I think if you can get those marked on the calendar, they were in the email that talked about this one.

>> Are there other questions?

>> No. We haven't received anything else. But I do thank you for mentioning the fact that we do have that fact sheet posted up on the website along with your slides so they can easily access that whenever they get a chance.

>> And finally, I would say my email is kKay.Johnson at Johnson gci.com so if there are questions about what we've talked about today or after you look at the fact sheet, send them to me and I will share it with Andrea and the apt team, we would be happy. We just want to be in communication. We will have for this project sort of an online web place for people to share information eventually, but today we just wanted to give you some grounding and how we hope to build on your experience as well as the evidence about interconception care.

>> Thank you, Kay. There is one question that just came in. The question is, I would like to know if there eventually will be required performance measures with short-term impact indicators in addition to those impacts we measure locally. This is important in measuring success and showing Congress. I believe this may be a question. I don't know if you can speak to this question, Kay.

>> I hope so.

>> OK.

>> I hope so. And I think, you know, we really are trying to figure out how we can work toward a better measurement overall of the good work that grantees are doing. I think -- I really am firmly convinced that there's a lot more that we haven't measured and some of the people are really experts in measurement and helping us figure that out. And I think we will learn more and I hope we will learn more that we can say about the program overall that help support it in the political realm, whether it's in the Obama administration, another administration or Congress. I hope so.

>> And I know Mary Beth wants the program to be supported in Congress even if she's not allowed to say so.

>> Thank you. And actually, we're working with -- here in HRSA along with C. D.C. Here in HRSA we're looking to develop for our title V block grant performance measures, a performance measure that would address women's health and I know that in some work that we're doing with the C.D.C. as part of the activities of the select panel, we're also looking for a measurement to look at what might be happening in your community as well as what will be happening in your state. So there's some beginning work to add some performance measures but also some data sources for you to be able to capture that data and not have to collect it yourself but to also compare your program participants between your community and state to show the real impact that you're having.

>> Thank you, Mary Beth. Of course, there are a few more that just came in. One of the first questions is, where were the 35 interconception sites? I don't know if you can rattle those off the top of your head.

>> I have a nice list. If that person would email me or we could post that. Could we post that one page? I have a nice, one page list of them.

>> Sure.

>> If not, if someone just wants to email me, I would be happy to share the summary. We have a nice executive summary of our findings that's only about four pages long that captures pretty much what we said in the slides but also a list of the sites. They were all over the country, they were urban and rural, new and old. They were quite diverse in their size, in the nature of their parent organization and so I think they're really quite representative of your group overall. They included tribal sites and they go from the Mississippi delta to Oakland to Manhattan and all of those grantees had an opportunity to vet my draft findings and tell me where I erred on their data or read their reports wrong. It's a very -- it was a very interesting learning process and maybe to say another word about how we found some of what we found is not only did I use the data reports but -- and read all of your progress reports, but in addition to that we did a computer assisted qualitative analysis of all of those reports so that for all of the reports that were submitted over those five years that those 35 grantees, we searched every one for word like case management and family planning and direct services and community health workers and so on, for many, many search terms. So we really used what you said to get to those conclusions in a very deep way.

>> Thank you, Kay. I think this may be the final question. Can you please restate the timeline so that healthy start project can select the travel team members and get the prep work done?

>> We will be at the next webinar, we will actually be showing you and focusing on the time line but roughly, let me say we've got a webinar today and we are going to be, you know, there will be three more webinars in preparation for the meeting in August. And we have -- at the next one we'll be talking about the quality improvement issues and then we will be -- sorry. I'm trying to pull up the time line. The next one we will be talking about quality improvement, then we'll be talking about readiness assessment and then we'll be talking about topics so that our estimation is that by the middle of June at the latest, you will be ready, you know, from the point of view of thinking about your topic and putting together your team to get ready to start to doing your groundwork for August. But we think that it will take us the next four to six weeks for you to gradually, as we're going through the webinars, really have an opportunity to think about the process and to think about what you want to do, what your topic generally might be, you know, whether you want to work on screening or case management or linkages to primary care and so on. So I think all of those things will be coming and unfolding the next few weeks.

>> Thank you, Kay.

>> Is there something, Mary Beth, to add to that?

>> I don't think Mary Beth wanted to add anything. I was going to let everyone know the dates.

>> If you have the dates in front of you, that would be great.

>> The dates are Tuesday, May 5 and then Monday, May 18 and Thursday, June 4. And it will be the same times, 2:00 to 3:30 p.m. Eastern Time and of course, the reminders will

go out and I believe the registrations. If they're not already posted, they'll be posted for each of those dates already. So nothing else and we don't have any more questions. So on behalf of the division of Healthy Start and Perinatal Services, I would like to thank our presenter, Kay Johnson, and the audience for participating in this web cast. I would like to thank our contractor, the center for distance communication at the University of Illinois, Chicago, School of Public Health for making this technology work. Today's web cast will be archived and available in a few days on the website mchcom.com. We encourage you to let colleagues know about this website. Thank you and we look forward to your participation in future web casts.