

MCHB/ DPSWH Healthy Start Grantees Meeting

October 6, 2004

MARIBETH BADURA: Good afternoon. I'm Maribeth Bedura. I'm the director of the Division of Healthy Start and Perinatal Services. It really is a pleasure to welcome each and every one of you today. We know that many of you got very short notice of this meeting. The HRSA Preview, which announced the meeting, didn't come out until about two weeks ago. So we know that people have made changes in plans to be able to get here. We also are planning, as you can tell, to videotape this meeting. It will join then a series of other presentations that we prepared to help you in applying for grants in the upcoming cycles on our MCHCOM.com website, and I'll go into further detail about that later. But I'd like to take the opportunity now to welcome each and every one of you to this third technical assistance meeting. With me, presenting for this first section, is Benita Baker. She's one of our project officers. And many of you have had the opportunity to meet her.

This is our 2005 open competition. I'm going to be speaking most directly about the group of dollars that will be available for June 1st, 2005. Some of you, I know, also have grants, are current grantees who will have a start date of February 1st, 2006 for a new project period. This technical assistance session will also cover those projects. We teasingly say now: To get an award in HRSA it takes about as long as it is to give birth to a baby. So that that group for February 1st, 2006 will have to have their applications in September of 2005. So just to sort of give you the framework. I'll go over briefly what we're going to cover today, and then we'll get started on the session. Each of you should have a notebook. The slides are in the notebook. And they will be available to download from the website also. But we'd like to sort of go over real quickly, what's the program, what are the current funding opportunities. Who is eligible? How do I apply? How is

my application reviewed? And we're going to spend a lot of time on that at the end of the meeting, because we want you to hear from people who have done reviews, what are the important and essential elements. What do I absolutely need to address in my application? How can I spend the money when I get it, and are there things I can't spend the money on? Are there other federal policies I should be aware of? Where can you get more help? And some other resources.

So without any further ado, let me get started. The grants in the Healthy Start open competition address a problem that I think everyone that's here is acutely aware of. And that is, the disparity in racial and ethnic areas in terms of infant mortality. 13.6 in 2002, in the African American. 8.3 in the native American. 8.2 in Puerto Rican. Hawaiian, 9; Filipino 5.7 7. Years ago, for 2010, and as you can see and sometime we have a disparity here of almost three times. So these grants set out to address those disparities. Broadly, they cover reducing the rate of infant mortality. That's a long-term goal, eliminating disparities in perinatal health, innovative community-based systems, assuring that every participating woman and infant gains access to and remains in a healthcare delivery system, and provides strong linkages with other systems in your community. The program started in 1991 to improve healthcare access. We funded at that point 15 sites. They were to be for five years. We got an extension on that, and we ran through 1997. And in 1994, seven sites joined us, a much smaller scale than our original 15 sites.

In 1998, congress said, this is working. We want you to replicate the best models, the lessons learned from the demonstration phase. And they actually said that the existing sites should serve as resource centers. So in that competition, in 1998, 20 of the original 22 sites were awarded funds to be mentors. And 50 to 70 new communities joined us in the next three years. We looked then in 2001, our national evaluation of the first sites was released. Net national evaluation, along with an internal assessment by national consultants, Noah Kotelchuck and Amy Fine, and the Secretary's Advisory Committee on Infant Mortality, which has as one of its explicit charges,

oversight of the Healthy Start program, agreed on some common elements from that demonstration phase. Real briefly, they identified some elements for success, strong never heard based outreach and case management models work, that we need to focus on service integration and links to the clinical care system, the interventions need to be based as much as possible on evidence-based practices. And that one of the strongest predictors of success is consistency in program implementation across and over time.

Our original sites had some dramatic impact on communities, but they had an even more dramatic impact on program participants. And as we move into the 2001 area, we separated more clearly than we did in the first set of grantees that we really expect the outcomes on our program participants and in the long run we will have outcomes that affect the community. But what is different from Healthy Start and remains one of the hallmarks is it's not just a medical model, it's a model that involves the community planning and implementation over time, that the answers aren't from experts but they arise from the strengths and assets from each one in the communities. So those groups decided what our new focuses should be. And we decided, looking at what we know what impacts on infant mortality in the high risk populations, that services should begin in the prenatal period, but we also know that many of the women that are the highest risks really may not be in the care system the way they should be before they become pregnant. And they do enter into the care system during the prenatal period.

We decided that those high risk women were women we wanted to keep in the system, and we had a golden opportunity for women who might not have accessed healthcare and services in the past to keep them linked with the system and support them in the first two years of life. And so we're saying that services with the Healthy Start program go from beyond postpartum to the entire interconceptional period from the end of one pregnancy to either the next pregnancy or to two years post-delivery. Many of our projects prior to 2001 may not have been able to follow the

woman who had a fetal demise, who had lost an infant. We're saying these women are to be followed now. They're the highest risk women in our communities. We were authorized under the Children's Health Act of -- 2000 actually. And we're authorized for a set period through fiscal 2005. We face reauthorization for continued funding after 2005 for the 2006 budget. And what Congress said in that legislation is: Yes, reduce infant mortality, but they broadened it to say improve other perinatal outcomes, and they said that the (inaudible) project areas with high annual rates of infant mortality which the program has traditionally defined as one and a half times the national average.

They require in the legislation a partnership with a TITLE V Bloc grant and other community services. And the required -- this is one of the first pieces of legislation with this type of requirement -- a community-based consortium, that includes, but is not limited to, and probably the thing here is it includes women that are served by the program, consumers of project services. So it's not only the medical community, but right in the legislation we want the women, we want to empower the women to make choices about the care system for them, their families and significant others. We also want the traditional players to be involved. And we want other community leaders. And congress recognized that and included it actually as part of the legislation. Where are we now? We're in 36 states, the District of Columbia, Puerto Rico. The Virginia Islands is finishing out a grant with us. They will be ending -- and we also serve, we've called indigenous populations, and they've now have rechristened their group, so to speak, as the Native People Council.

Here we are across the United States. Concentration where there are rural communities but where there's poverty across the country. And what are we doing right now and what are you all here to hear about? In 2005, 71 grantees who are currently funded for four years under eliminating disparities in perinatal health will be ending. The competition that's occurring is for

those 71 grantees and any other community that meets the eligibility standards. In 2002, January 31st of that year, 12 additional projects were funded. Those projects will end in 2006. Their competition due date is September 2005. And we just got completed funding six grantees for a four-year period going through 2008. We also have four projects that concentrate on border Alaskan and native Hawaiian communities. We funded two grants, and they will be up for competition again as part of this in 2005. We also will have a series of grants that we just funded this past period and they will go through 2002. We had available funds in the past to fund three other competitions with Healthy Start funds, including screening and treatment for perinatal depression, high risk interconceptional care and a series of domestic violence/family violence grants.

Unfortunately, with our current level of appropriation, we cannot continue those grant funds. So there is no competition for them this year. Something we feel very bad about, but there are not the dollars available from congress at this time. So what's the summaries, why are you here; what are you going to be applying for? A four-year project period, a maximum of 750,000 annually for new projects and a current Healthy Start grantee, what we'll call existing continuation, which is federal jargon for existing grantees, may apply for an amount up to their current funding level in their disparity's grant. We anticipate the project start date of June 1st, 2005. And our commitment at the division is we'll have the notices of grant award started through the system by May 1st of 2005. We're going to be funding, depending on the amounts that people are requesting, up to 68 projects in the eliminating disparities. We have about 35 grantees that currently receive over a million dollars. We used as the average in doing the calculations 750. So depends on how many grantees. We have some grantees above \$2 million. Depends on how many grantees are successful and what their funding level is, but we'll fund as many applications as we can, as possible. And in the eliminating disparities in perinatal health for the border, Alaska, Hawaii, we'll fund up to two projects.

An existing competing continuation applicant, I want to make sure that first of all you all get the directions to check the continuation box on the face sheet of your application. That's very important for you to be able to carry funds over from one project period to another, and you're going to type in -- we're being very explicit so nobody has a problem -- competing continuation. Those projects now are the projects that were funded from the project period of June 1st, 2001 to May 31st, 2005. We do also have some grants that are now not continuing through May 31st, 2005. And they would fall under this category. They're continuing with no cost extensions. A new applicant: And this may be some projects may choose to come as a competing and new applicant, including previously funded projects are considered a new applicant and should check the new box on question number eight. Now, who can be an eligible applicant? Consortium or provider, local government, tribal organizations, agency sustained governments, faith and community-based organizations.

We will accept grants from competing applications for the same project period. But we will only fund one grant for one project area. So you may compete, but you will not get funded for the same project area that another grantee is being funded for. And, very basically, unless you've done your homework at home, you're not going to have the community support to have two competing applications. What do you need? For the non-border, we want verifiable three year average data for the period of 1999 to 2001. We use that period because that's the last period for which we've linked vital records at the national level that give us ethnic and racial breakouts by county level. You must, in your application, clearly address your eligibility for this time period. In your needs assessment, you may go further with data showing a trend, but you must meet the eligibility for that period. And it's not for the entire community area. It is for one or more racial, ethnic, geographic or other disparate populations. The data must be verifiable, so you can continue to report on it in a given period. And believe me, we do check every data element on eligibility. If an

applicant does not make the eligibility cut off of 10.58, they will not go to the objective review panel.

They must also show, and it's not the quality at this point for eligibility. That's part of the review. They must show they've got a linkage to TITLE V, and they must say in their application they have an existing consortium or a plan to create. If an applicant does not meet any one of these three areas, then their application will not go to the objective review committee. It is returned unreviewed and uneligible. For the border area, they too must have linkage to TITLE V and existing plans or consortium to create. For the actual border, they must fall within 62 miles of the Mexican border, or are there two sides there that are eligible, are projects located in Alaska and Hawaii? Because of problems with data in the border area and with some of those other populations, we don't have accurate infant mortality data and a way to reliably change the data so that we know whether indeed an individual for the border area, remember the babies go back in their first year of life to the Mexican side of the border, we don't know what the infant mortality rate is among that population.

For the native Alaskans and Hawaiians, we don't have an ability to correct for those babies that are born whose mother may be white, African America or another racial ethnic group, but whose father maybe native Hawaiian or Alaskan or Filipino or one of the Asian Pacific groups. And that's the reason for the second set of criteria. For the period 1999 through 2001, so we have consistency, those projects must need, to be eligible, three of the following criteria. And I'm not going to go through them. But they are criteria that we developed with border health that accurately reflect the maternal child problems in that population. Now, how do I apply? You're going to have a unique opportunity to apply this year. You are going to be able to apply on line, a web-based system. I'm not going to spend a whole lot of time on that; Chris Dykton will join us later and talk with you about it. The forms that you had normally filled out on paper, on your home

computer, you're not going to fill out electronically. You'll type your application up the way you always do. You're going to copy that application and paste it into your new web-based application.

But this is where you can get the application to download the forms and this is the link also that will send you to our electronic website. Now, to get a grant, though, you have to register. And some of you may have done this already, because you have other federal grants. You will need what is called a Dunn's number. And if you go to HRSAgov.grants, just on that face sheet it will say you need a Dunn's number. You click the link and it walks you through the system for applying for your Dunn's number. You also must have a federal government central contractor registry number. Again, you'll go to the HRSA website and you're going to just follow the instructions there. Before you do that, make sure your applicant organization does not already have these numbers. Because once you have them, you don't need to get another set. These numbers will be good for all federal grants that you as an applicant organization may be applying for.

Now, for the electronic submission, you're going to go to the grant's website and you'll click on the link and it's going to take you to a log in. And you're going to register that you want to submit an application for the HRSA grant eliminating disparities, and you're going to register -- you can register a number of your staff, but you're going to be registering your executive officer of your organization, who normally signs as the executive. So if you're a state government, it may be the director of health. It might be the Governor's office. If you're a city or county level, you may have a mayor or a county supervisor. If you're a nonprofit organization, it will be the executive director. But you need to know that the authorizing individual is going to be really key to making sure your application gets to HRSA if you're doing it electronically. So you're going to tell us who that individual is and you're going to make friends with their secretary or administrative assistant. Because it is this individual that must submit the application electronically to HRSA. Not you as project director. The authorizing official for your organization.

So believe me, you're going to want to make friends with whoever that person is, if this person is the chancellor of their university, there's probably somebody that they will assign this road to and you need to find that person or their administrative assistant to make sure your application gets in. Now, if you've got other problems with our web-based system, there's a call center. It's available 8:30 to 5:30 eastern standard time. It is Monday through Friday usually. And it's not open on holidays also. But really they are very helpful in walking you through the system. Now, if you're doing a paper copy, you're going to mail it to our HRSA grant application center. And, of course, we've changed the address this year. So this is the new address. It's in the guidance. It is in Gaithersburg, Maryland. And, again, when are you going to have this to us? This is not a date I chose. It's a computer-generated date, because all of our time lines at HRSA now are based on days. So this is 275 days before the award. That's what this date represents. December 28, 2004, at 5 p.m., you must have submitted your application electronically or have it postmarked by that time.

This is the second reason you're going to want to make friends with somebody in the authorizing official's office. Because they're not going to be around the week between Christmas or New Year's or this holiday time to necessarily submit this application and sign it that day. So you're going to want to do it early. And you have plenty of time because you have over three months to get your application together. Now, I'm going to go back a minute and tell you that we've put some safeguards in the system so we know that if you've started an application and you think you've submitted it, but the authorizing official hasn't, five days before December 28, sort of like Christmas Eve-ish, the system will do an automatic run and send you an e-mail, anyone that's registered for that application, and say: Your application has not been submitted yet. They will do that four days out and they'll do that two days out.

The important thing is they do not do it the day before or the day of the application. And we did have problems with some other grant cycles in which the applicant submitted it, project director sent it to their authorizing official on the day that the application was due. They didn't start their application on line to that day. They did it on that day, loaded it up, hit what they thought was the submit button, but it was not. It was submitting from the project director to the authorizing official and the application never reached HRSA. So I'm going to stress to you many, many times, please make friends with your authorizing official. If you're not on a first name basis, get on a first name basis with their therapy secretary, administrative assistant. Because that's going to be key to your getting your application in. That individual is also the individual that will get the e-mail notification of the notice of grant award. So that's the other reason you want to make friends with this person. Do we have mics available?

UNIDENTIFIED SPEAKER: I just wanted to know (inaudible).

MARIBETH BADURA: I would suggest you not do both, only because our application center can't say which is your real application. So they will actually enter both applications and we don't know which one you would want to go to the objective review committee.

UNIDENTIFIED SPEAKER: (Inaudible).

MARIBETH BADURA: I'm sorry. I will. The question was: Can we do one or the other or should we do both? And my response is please don't do both because you'll confuse -- the objective review committee won't know which application you want to have them reviewed. You can do a paper submission. They are strongly encouraging you to do an electronic submission. And I will tell you a clue, because there is a page limit. We have increased it to 160 pages. HRSA actually

wants us to have an 80-page application. So we actually received permission especially for this competition to have 160 pages. If you do the performance measure data, Chris will be talking with you about later, electronically on the web and then print it out with a paper application, it saves on the pages on your paper application. If you're using the electronic system, prints it so there's more on a page. So I would encourage you, at least if you're doing a paper application, to make sure that you do the performance measures and the required reporting forms on the web-based, print it out and then send it in.

We are told that the application should be available at this point for the web. Chris will go into further detail on that. They're really strongly encouraging you to do this and it does help our objective review committees because when you send in the hard copy they have to scan the entire application into the system before we can send it to the review. But it is a new system. I am told that we are strongly to encourage the electronic submission, but you can do a paper. And I'm sure you'll hear a variety of discussion about which works better from your colleagues. Let me just take you through our Healthy Start model. This is our logic model. It looks at what we believe are the important areas. And these are the areas that were seen noted in the guidance. In your needs assessment you're going to describe the context, why you need, why your community needs this particular grant. You're going to look at it the demographic data, the reproductive data, the characteristics of the community and your national, state policies, your Medicaid policies, your human resource policies.

You're going to put that in the grant application. Provide the cost for four services, some systems building services. And you're responsible for the program infrastructure, the staffing, the contractual arrangements, quality assurance. We're going to go into greater detail on the core services. But basically they're outreach, case management, health education, screening and referral for maternal depression. Interconceptional continuity of care. In systems building, you

have your community consortia, a local health action plan, coordination with TITLE V and down here sustainability. Your outcomes, and these are the Healthy Start outcomes, for the services are going to deal with utilization, referrals, the intensities of services, the behavior changes in the families and whether they indeed have access or have a health home for that entire period. You're also going to tell us about your system changes, and you will use the new performance measures to help you express many of these things.

What do we expect is the long-term outcomes? Reduce disparity and access and utilization of healthcare, improved consumer voice and improved local system. In the Healthy Start population, we expect, and those are the women you're serving, changes in birth outcome, maternal health, in the length of the intervals between pregnancy and child health. You're also going to move towards reduced disparities in the entire community. But we recognize that that is a long-term objective, not something short-term that can be done within a four-year period. Here's a little bit more on what we see each of the core services doing and what sort of outcomes we link that to. I know this slide is busy and hard to read, but under the last tab in your notebooks the slides are reduced, so you don't have to worry about that. So the first three areas in your notebook. We also then have a systems activity. Local action plan. The consortium. Your work with TITLE V. Throughout it, real key, community participation.

And here are some examples of the systems activity, coordinating, influencing policy, developing a sustainability. And the changes you will have. Some with direct impact on your participants and some very major larger systems changes that you're going to work with your community and your consortium on. This is how the program fits together. And our guidance flows from that. Now, there's one, I've mentioned program participants, and over the years we've struggled with who is Healthy Start serving and we've come to the conclusion as a group that there are two levels of participants: One is the woman, the family, the infant that you're having a lot of direct contact with.

On a systematic ongoing basis. It's not just one or two, but there's an ongoing relationship. But we also know that many of you have a lot of community participants. Perhaps it's someone attending a health fair. Perhaps it's someone participating in your consortium. Perhaps it's somebody that sees your public service ad or attends some of your health education classes, a more sporadic community level participant.

We expect your outcomes to be measured in the program of participants. When we get to the performance measures, we very clearly say which measures are at the community level and which measures are at the program level. So what are the requirements? I want you to start there, because one of the things that you need to do when writing an application is you need to look at the review criteria and then what we say the program narrative should address. So there are seven HRSA required criteria that all HRSA grants must address: Need, response, evaluation, impact, resources and capabilities and support requested. These are consistent in that order in all of HRSA applications. So whether you're dealing with Healthy Start or Healthy Tomorrows or a grant perhaps from the Bureau of Health Professions, you will see the same basic HRSA criteria. Your need criteria are going to relate to your community assessment. Your response criteria related to your core service intervention.

Your evaluation, we talk about not only the national evaluation and how you work with them, but it will also talk about your local evaluation and how you will monitor the project to make sure it's on target. Your impact relates to the core systems innovations, your resource capability, and management of the project. And the support requested, of course, budget and budget justification. I'm going to turn over the presentation now to Benita Baker. In the guidance, the review criteria are listed all at one particular point under objective review. But as we go this presentation, we want you to be very clear that you're always writing your application to make sure you're meeting

the review criteria. So we've interspersed into our presentation the criteria and content that you will be addressing in your application to address those criteria.

BENITA BAKER: Thank you. Good afternoon. As Maribeth Bedura said, I'm going to go over the criteria that you will be utilizing. I'm not going to go over each individual paragraph on the criteria. I'll just read, 20 percent of the score, and the extent to which the application describes the problem and associating, contributing factors to the problem. And it can include the extent to which the demonstrated need of the target population should be third are adequately described and supported in the needs assessment and some arise in the problem statement. And you can read those for yourself. But the community assessment must describe the current assets and resources of the community. The current needs of the community, the service area for the project, the target population and the comprehensiveness and quality of service delivery system for the target population. It should include a copy of quality services. That includes all partners necessary to ensure access to a full range of services that is identified by the community.

This can include prevention, primary and specialty care, mental health, substance abuse, HIV, AIDS, MCH and dental care. It should have established referral arrangements that's necessary for the quality of care. Response. That's 15%. The extent to which the proposed project responds to the purpose included in the program description. The clarity of the proposed goals and objectives and their relationship to the identified project. The extent to which the activity, scientific or other, described in the application are capable of addressing the problem and attaining the project objectives. Your objective indicators should identify the project objectives which are responsive to the goals of the program and they must include at a minimum the OMB performance and outcome measures. If you're not familiar with those -- well, you should be familiar with those, but those who are new they're in the application packet. Objective statements must clearly describe what is to be

achieved, when it is to be achieved, the extent of achievement and the population that you are targeting.

Each objective must include a numerator, a denominator, time frame, data source, including year and date line data. These are Healthy Start performance measures. One is the percent of MCHB supported programs that are satisfied with the leadership of and services received from MCHB. If I'm not mistaken, Maribeth, one and two will be performed by outside contractors?

MARIBETH BADURA: Right.

BENITA BAKER: Okay. One, two and five, I believe. So two is the percent of MCHB customers or participants of MCHB programs that are satisfied with the services received from MCHB supported programs. Five is the percent of MCHB supported projects that are sustained in the community after the federal project period is completed. Seven, the degree to which MCHB supported programs ensure family participation in and policy activities. 10 is the degree to which MCHB supported programs have incorporated cultural competence elements into their policies, guidelines, contracts and training. 14 is the degree to which communities are using morbidity and mortality review process and MCHB assessments, quality improvement and data capacity building. 15 is the percent of very low birth rate infants among all live births. And 17 is percent of all children birth to age two, participating in MCHB's programs, they have a medical home.

20 is the percent of women who is participating in MCHB supported programs who have an ongoing source of primary and preventive services for women. 21, the percentage of women participating in MCHB supported programs requiring a referral, who received a completed referral. 22 is the degree to which MCHB supported programs facilitated self providers screening of women participants for risk factors. 35, the percent of communities having comprehensive systems for

women's health services, and 36 is the percent of program pregnant program participants of MCHB supported programs who have a prenatal visit in the first trimester of pregnancy. And some of these performance measures have absolute detail sheets that go along with them that you need to fill out and score. And Chris Dykton from ASIC will go over that when he shows you the new system. Some of our Healthy Start outcome measures for program participants is the infant mortality rate per 1,000 live births, the neonatal mortality rate. The perinatal mortality rate. The percent of live singleton births weighing less than 2500 grams.

Okay. Now your response, your project interventions should include strategies and interventions to accomplish meeting the proposed objectives. They should include target dates for starting and completing the activities and the persons or organizations involved in completing those activities. And it should reflect the funding requested in the budget justification. Okay. Core services, as Maribeth said, our outreach case management health education screening and referral for depression, interconceptional continuity of care. So for each core intervention we'll give you a definition, the essential elements, the specific requirements, linkage to performance measures, correlation of national evaluation.

UNIDENTIFIED SPEAKER: I have a question

BENITA BAKER: Sure.

UNIDENTIFIED SPEAKER: (Inaudible).

BENITA BAKER: Performance measure 14?

UNIDENTIFIED SPEAKER: (Inaudible) the program with (inaudible).

BENITA BAKER: Program, right. Okay, for each core intervention, there's a series of questions that need to be answered that's within the guidance. For example, who is the target population? Who will provide the service? Where will the service be provided? When will it be provided? And how many program participants or community participants will be served. And you should code your responses to each question. Let me give you an example. This is an example of a question, if you can see it, it's brackets, outreach one. So when you answer your question it would be in brackets, outreach one, and then your answer to that question.

MARIBETH BADURA: I think helpful advice for people, so they're sure they're addressing the indicators, is to just take, you'll get the stack of the award electronically, or a friend of yours will get it for you electronically in Word. Paste the questions in the narrative and then address the question. If you need more space at the end, then you're sure you're giving the objective review committee, the full answer to that question, if you need space as you get to the end, then go back and delete that until you get or keep some key words in. But really a trick of the trade is answer the questions that are there. And so one of the easiest ways to do that is to paste it in, answer the question and then go back and tighten it up.

BENITA BAKER: Okay. Definition of outreach is the division of case finding services that actively reach out into the community to recruit and retain perinatal and interconceptional clients into a system of care. And the purpose is to identify, enroll and retain clients most in need of Healthy Start services. Case management is the provision of services in a coordinated approach through client assessment, referral, non trained facilitation and follow-up of needed services. And this is to coordinate services for multiple providers to ensure that each family's individuals needs are met to the extent that resources are available and the clients agree with the scope of the planned

services. Case management includes a multi-disciplinary term, can include, outreach workers, social workers, para-professionals nutritionists and healthcare providers. It should include adequate personnel that consider the risk status of the clients.

If you're serving all high risk clients, then you know you would probably, your case management team needs to include social workers or a social worker coordinator in charge. Also, it includes service delivery at sites both in the home and in the community. It includes a broad circle of services including education, prevention and intervention, and proactive partnership between case managers, families service providers in the communities. And it also includes individualized needs assessment with the client that is developed with the family and the client. Also, it includes service intensity that matches the level of risk. Health education. Includes not only instructional activities and other strategies to change health behavior but also organizational efforts and policy directives, economic supports, environmental activities and community level programs. And the purpose of that is that the Help Education Campaign is to help disseminate information with the goal of improving the audience knowledge, attitudes behaviors and practices regarding the particular area of health promotion.

It includes public information and education campaigns, provider of training of healthcare workers, consumer or client education packages, collaboration with the experienced community organizations and a feedback process for the evaluation of the training. It also includes opportunities for education and training to enhance the development of the community. Okay. Perinatal postpartum depression. A depressive disorder is defined as an illness that involves the body, mood and thought. It affects the way a person eats and sleeps, the way one feels about one's self and the way one thinks about one's self. Okay. Your postpartum depression piece should include effective screening and referral for further assessment and treatment. Perform skilled screening, successful, successfully engaged pregnant and postpartum women who are

experiencing depression and other disorders in appropriate mental health services. And it includes community education on the impact of perinatal depression and resources available to women and their families.

Okay. Interconceptional care. I'm not going to go through all that. But it includes outreach in case management for women to assure they're enrolled in ongoing care and obtaining necessary referrals. That means make sure they have a medical home, that their risk status is assessed; that they have available services to them, integrative services. And also the health education needs to include mental health substance abuse services, smoking, HIV/STD information. And basically for the infants you want to make sure they're enrolled in a medical home, obtaining necessary referrals also, obtaining early intervention; that they are receiving appropriate screenings and immunizations and things of that nature, especially specialty care, and health education for the child and parent, includes child development and parenting. Okay. Evaluative measures, 10 percent. It's the effectiveness of the method proposed to monitor and evaluate the project results.

Evaluative measures must be able to do two things: One, to what extent do the project objectives have been met and, two, to what extent can they be attributed to the project? It includes a commitment to participate in and cooperate with the ongoing evaluation of the implementation and outcomes of the maternal and child's health bureau's national Healthy Start program and MCHB's performance management system. Local evaluation protocol should be capable of demonstrating and documenting measurable progress towards achieving the stated goals and it should be able to be used for ongoing quality improvement and monitoring other projects on different aspects of the project's administration, fiscal and contract management, consortium service delivery, partnerships and impact upon perinatal indicators. And when (inaudible) and sustainability. Impact are the core systems and efforts.

The extent and effectiveness of plans for dissemination of project results and the extent to which the project results may be national in scope and/or the degree to which a community is impacted by delivery of health services and the degree to which the project activities are replicable and/or sustainability of the program beyond federal funding. And Maribeth Bedura put this here just to remind you of this model, the Logic model that she went over. So just refer back to that when you're talking about your evaluation. Okay. Also, the core systems efforts -- I can't see, is that 10 percent? It's cut off. Core system building, consumer and consortium involvement, and policy formation and implementation, includes your local health system action plan. Collaboration with TITLE V and sustainability. Okay. Maribeth mentioned that you have to have a community consortium in place or plan on developing one. And it includes individuals and organizations, including, but not limited to, agencies responsible for administering bloc grants under TITLE V, consumers and project services, public health departments, hospitals health centers under Section 330. That includes the homeless and other significant sources of healthcare services.

The consortium galvanizes the political world of community and stakeholders to affect change within the community and the project, provides a broad based policy advice to the grantee. It institutionalizes a consumer voice which is women or men served by the project and the development and delivery of services in the community. Mobilize the stakeholders and others to leverage or expand funding resources. Should have structures in place to ensure ongoing community and consumer involvement, development of leadership skills, scheduling of activities to increase participation, staff support. You can have operational guidelines such as bylaws and conflict of interest divisions. Another requirement is the local health system action plan. It's a realistic but comprehensive plan of achievable steps within the four-year funding period that will improve the functioning and capacity of local health system for pregnant and parenting women and their families. It includes again all partners necessary to assure access to a full range of services

as identified by the community. And it also should have in place all referral arrangements necessary for quality care.

Should be a family friendly system, culturally and linguistically responsive to the needs of the community served. The local health system action plan, the essential elements are targeted intervention based on assets and gaps in the current service delivery system identified in the needs assessment. But intervention should ensure that the system is accessible responsive and culturally competent, and the plans should be updated annually. So sustainability. We don't actually require a sustainability plan, but you need to outline how you're going to possibly sustain the program after the funding is up in four years. It integrates activity into current funding sources. Maximizes third party reimbursement. Leverages other funding sources. And these funding sources could include state, local, private and in kind contributions. Resource capabilities. That's 20 percent. The extent to which the project personnel are qualified by training and/or experience to implement and carry out the project.

The capabilities of the applicant organization and quality and availability of facilities and personnel to fulfill the needs and the requirements of the proposed project. Applicant organizations should have qualified and appropriate staffing to carry out the plan's interventions. Sound systems, policies and procedures in place for managing funds equipment and personnel to receive grant support and the capacity to monitor the progress of the project towards these objectives.

Especially monitoring contract deliverables. Support requested. It's 15 percent. That's your budget. Your budget justification. The reasonableness of the proposed budget in relationship to the objectives, the complexity of the activities and the anticipated results. And I like to use this: If you document transportation as a critical need in your community when you talk about, in your needs assessment, and that's something that you want to, that's an activity that you want to work on and you develop an objective for transportation because there's no prenatal care or OB/GYN

doctors in the community you're serving and they are way across town, you want to develop some kind of system to get your moms to the doctor.

Well, that should be in your plan all across the board in everything that you do as far as case management, outreach, your budget, your objectives. So in your budget, if you know you are going to have, you want to provide transportation, then in your budget the reviewer should be able to see something in there concerning transportation, meaning leasing a van, hiring of a driver, not a chauffeur driven limousine see but, you know, something reasonable. So okay, the requirements for the use of funds, activities that could be supported with Healthy Start funding offering a more efficient and effective comprehensive delivery system for the uninsured and underinsured through a state and network providers, single registration eligibility system, integrating preventive or mental health substance abuse services. HIV/AIDS maternal child health services within the system, bloc grant funded services, other DHHS programs, state and local programs. Also they can be used to develop a shared information system along the community safety net providers.

The tracking, case management, medical records, the financial records. They could be used for projects that salaries, consultant's support, MIS, project related travel and other direct expenses for integration of administration, clinical and MIS or financial functions and program evaluation activities. The funds may not be used for substituting or duplicating funds currently supporting similar activities. They can't be used for construction, reserve requirements for state insurance licensure. Okay. Collaboration and linkage with TITLE V, 10 percent. It's the extent of actual planned involvement of the state TITLE V, local MCH and other agencies serving the proposed project area. You have to make that clearly evident of how you're going to collaborate with your TITLE V and other stakeholders in the community. The extent to which the project is consummate with overall state efforts to develop comprehensive community based systems of service and

focuses on service needs identified in the state's MCH services TITLE V five-year comprehensive plan.

Okay. Now I'm not sure why you have the -- this is just the data that's necessary, the requirements for the data. That's the annual progress report. Every year at the end of your cycle -- well, when you come in for your continuation, you detail your progress in the previous budget period. So that's a requirement. And also the performance measures are a requirement. I went over those. They're in your -- they'll be in your application packets. I think they're in the binders. Also they include MCHB financial and demographic data forms. There's forms that need to be filled out that are -- yeah, Chris Dykton will go over all those forms for you. But these are forms that are required to be turned in.

UNIDENTIFIED SPEAKER: (Inaudible) 10 percent or 15 percent. Does that mean in the scoring of those, how much does it (inaudible).

BENITA BAKER: You answer that really quick.

MARIBETH BADURA: It is the way, Kevin, percentage, the way the objective committee gives to that criteria?

UNIDENTIFIED SPEAKER: (Inaudible).

BENITA BAKER: Shouldn't be. Finishing.

MARIBETH BADURA: We'll check that for you.

UNIDENTIFIED SPEAKER: Okay.

UNIDENTIFIED SPEAKER: I have a question. On the slide that you showed (inaudible) for those that have, we wouldn't show our list. That's for a historical perspective, how does that (inaudible) or is this not a case of that at all? Is that somehow –

MARIBETH BADURA: Again, the HRSA application guidance will have a standard format, and this particular element in the guidance that's required tells you all the data that you are required. It might be different from another application. They would all have annual progress report but they may have other additional things. So this particular section just really lists the data elements that you're going to be required to report on either with this application as you're applying or in subsequent years. And for the progress report, this is what you're going to, if you receive an application, you will be required to do that in subsequent years. We think it's important for the objective review committee to really have a history of what you as a community have been doing in the area of infant mortality reduction. And what lessons you've learned from that experience. How you are shaping your model based on that experience.

And so we actually have added one question in each of the sections that say- we're using the question format so we can do comparisons across all the communities, so that we have standardized data to help us in the evaluation of the project. But we added a question at the very end of every section that basically says: If there's something that you feel that's important for the objective review committee and for HRSA to know that contributes to the success of the project, why it is you're doing something, we gave you two pages to do that in, to give us that additional flavor of what's happening if you feel the questions you've addressed aren't clear. So it's not that you don't have to submit if you are continuation grantee that's competing. A progress report with

this particular application, this is just letting you know that you're going to have to do it in the future. But we did, because of feedback we received, we did add additional questions so you can tell us what it is you're doing and why and what your successes have been. And that's consistently the last question in every one of the sections.

When Benita was talking about transportation in the budget, what we really want to say to you is don't stick something in the budget you haven't explained in your program narrative. And please remember that I may be reading your application. I may not know your state reimbursement system. I may not know what acronyms are. So spell those out. Don't tell me you need a nutritionist in the budget and not say to me I need this nutritionist because to get case management reimbursement in my state I must have a team that includes a nutritionist, and I've got the other players, I need to add a nutritionist. An objective review committee doesn't know your state, doesn't know your particular circumstances. Please, the budget is not to be used as a program narrative. And when we were talking about transportation, that's another example. Many times we'll find transportation in the budget and you won't tell us it's a need in the community. Everything must link together. This is reminding you that our performance measurement system here at MCHB relates to a pyramid of direct health services, enabling services, population based services and infrastructure building. And our performance measurement system and other data elements are set up that way. Sandra, do you have a question?

UNIDENTIFIED SPEAKER: (Inaudible) five pages...

MARIBETH BADURA: We did not come up with that same calculation. We did that calculation as a basis for, we believe there's about 100 pages for the program narrative.

UNIDENTIFIED SPEAKER: What I'm saying...

MARIBETH BADURA: As I said, we have done that as part of it. So I'm also encouraging you to use the web-based system because that does shorten it.

UNIDENTIFIED SPEAKER: (Inaudible).

MARIBETH BADURA: I don't believe we say that you have to include the report in the application.

UNIDENTIFIED SPEAKER: I will check that. I will check that.

MARIBETH BADURA: You do have to have a system for that and agree you're going to do it. But you don't have to complete a full report. It's a requirement if you receive a grant. But it's not required that you submit one as part of the application package itself to HRSA.

UNIDENTIFIED SPEAKER: (Inaudible).

MARIBETH BADURA: We'll check that through, too. That's a good point. It's something of course that's far too much detail than an objective review committee is going to want.

UNIDENTIFIED SPEAKER: Okay. The next thing is (inaudible).

MARIBETH BADURA: On that, if I could just, if it's on that data element, can we wait until Chris does his presentation for clarification on that?

UNIDENTIFIED SPEAKER: Good.

MARIBETH BADURA: On any questions dealing with the performance measures. Let's let Chris get a chance to go through the forms with you. Matthew?

UNIDENTIFIED SPEAKER: If an existing continuing competing cycle would like to expand its targeted area, could it be considered new? Is there an option to go either way?

MARIBETH BADURA: If you are serving the same project area, you're serving the same project area and you are a continuation. If you are adding a new project area and continuing to serve the same project area, you could compete for two grants, one is a new and one is an existing. And several current projects have more than one current grant. In DC, department of health operates two grants. North Carolina have several grants. So you make that decision, but each application must stand alone. If there's overlap in the budget, we'll handle that after the award is made. But each application has to stand alone and will be approved on its own merits. So that's a downside also if you're applying as an existing or competing, is that you may not get approval for both or you might not get approved and funded for both. But that is an option that you do have.

UNIDENTIFIED SPEAKER: Could we expand the area and still be continuing? The way we are now.

MARIBETH BADURA: Yes, you can. For the same amount of money as you currently have.
Question.

UNIDENTIFIED SPEAKER: I just want a clarification on how (inaudible) new service area. Let's say for example you added additional population, so doesn't that just -- is that still completely continuing or would that be (inaudible).

MARIBETH BADURA: The population is residing in the same area. It's an additional target population same geographic area, and then it's a continuation. You're just doing more intense services for two populations rather than one population.

UNIDENTIFIED SPEAKER: On the service area, there would be looking to reduce the geographic area, it's continuing?

MARIBETH BADURA: Correct. Because you may not -- some of you have additional funds under let's say family violence, depression or high risk interconceptional care, or it may be that the resources in your community have changed. There's been major Medicaid cut backs. You may have been getting case management services through in-kind support from your local health department and those services are no longer there. You need to do the necessary budget adjustments so your services are reasonable for the dollars you're receiving. And we do expect there will be changes that way. If your population has shifted just slightly in its boundaries, and you're moving to accommodate that shift, that really isn't a new project area. But you need to tell us real clearly the population has shifted a little bit. You can still be considered a competing continuation for that. And as I said, the advantage of that in terms of grants administration is the funds can be carried over from one project period to another project period. That does not happen if you are a new grantee.

UNIDENTIFIED SPEAKER: I have another question. If the data -- if there was language added about area, talk about differences in terms of education, income, disabilities or living in rural isolated areas, when you're talking about education (inaudible) real isolated area.

MARIBETH BADURA: No, those are all definitions in Healthy People 2010 of what a disparate population is. So you may have women who have a low income in an urban area and a rural area.

But one of the disparities that Healthy People 2010 addresses and that the department addressed is access to care and rural areas. That's a disparate population.

UNIDENTIFIED SPEAKER: So you could confuse, for example (inaudible) it would be up to the project to define (inaudible).

MARIBETH BADURA: Right. It's up to the project to define the ethnic racial disparate group, but you have to be able to give data on that on a consistent basis. And I would say that some of your data about infant mortality, you may not be able to have it done on a consistent basis on income. It depends on the capabilities of your local health department, your data system.

UNIDENTIFIED SPEAKER: One more question. In the infant mortality rate, are you saying you could use racial data. If you use race data are you tying it to the race of the mother or the race of the infant?

MARIBETH BADURA: The link birth data now is tied to the birth of the infant. We don't require you to use link birth profile. We believe that's the richest source of some of the disparities. We use it nationally so that we are able to check for verification of eligibility. And that is the best resource that we have. It is your strongest data set, but we don't require you to use that. We need you to use vital record data that is going to prove, that's used in your state or community. Question way in the back.

UNIDENTIFIED SPEAKER: (Inaudible).

MARIBETH BADURA: No, you actually are capped at your current level. If you want to come in for a new service area in addition to one you're currently serving, then you can exceed and ask for 750,000 in the new area.

UNIDENTIFIED SPEAKER: (Inaudible).

MARIBETH BADURA: You're coming in as a competing application from one grant and you can expand under another grant. It has to be a separate application.

UNIDENTIFIED SPEAKER: (Inaudible) I'm confused about how to get started (inaudible).

MARIBETH BADURA: If you are, have an existing source of financing, other than this grant; you can't say, oh, gee, I know have a Healthy Start grant and I'm going to pay for case management in this target area and move my MCH funds or my other third-party reimbursement to another part of the city. If you had case managers funded under something else prior to Healthy Start, you've got to use that as a base and add on the services of Healthy Start. You can't take the money away and use it somewhere else. That's what it's really talking about. It's called supplantation, right.

UNIDENTIFIED SPEAKER: (Inaudible).

MARIBETH BADURA: If you had services perhaps under a local health department reimbursement system, let's say your state gave you some money, that money is no longer there, that's a different situation. But you need to say that this money is no longer available to us, and an auditor needs to be able to verify that that, if they would ever do an audit. Your audit would need to say that that money is no longer there. Way in the back, I think.

UNIDENTIFIED SPEAKER: (Inaudible)develop a Healthy Start program (inaudible) provide services to the Healthy Start participants who qualify for (inaudible).

MARIBETH BADURA: If they were serving additional, you're increasing the case load, yes, that's reasonable. We just need to know what's funded under one and what's funded under the other.

UNIDENTIFIED SPEAKER: Thank you. Another question.

MARIBETH BADURA: I hear a voice, but I can't quite see anyone here. We have one up front and then there is a hand up in the back, too.

UNIDENTIFIED SPEAKER: (Inaudible) this is more on eligibility of applicants of (inaudible). Could you elaborate on that?

MARIBETH BADURA: Okay. Let's say that we have three counties and one applicant comes in for three counties and another applicant comes in for two of the three counties. We're only going to fund one applicant. We've also had for the same project area two different applicants coming in. Now, the consortium hopefully would resolve that issue because you would have to have the same stakeholders involved in both consortiums. But in case that happens, we're saying to you we're not going to fund more than one project for the same area. Does that make sense? Way in the back, then we have some questions in the front.

UNIDENTIFIED SPEAKER: I just want to know, I think the question before last, where you were talking about somebody that has other funding (inaudible) but we had funds that would basic Healthy Start services in a part of the community. And those funds are inadequate for a number of

the, not only the poor services, but some other very central services such as women who are substance abusing, those kinds of things. Can we build on the response we're already getting? That's an avid role (inaudible).

MARIBETH BADURA: And I presume when you're saying Healthy Start, you mean a state or a --

UNIDENTIFIED SPEAKER: State public Healthy Start program.

MARIBETH BADURA: Healthy Start, just for clarification for the entire group, is sometimes a Medicaid program in a state. In California it's a health education program, in the school system. In some states it is an MCH activity. So you need to be clear. And you're talking about state Healthy Start.

UNIDENTIFIED SPEAKER: Florida.

MARIBETH BADURA: Yes, Healthy Start are the gap filling to make your service system complete. So if you don't need the dollars for case management or outreach because someone else is doing that. You need very clearly to describe that you've got adequate resources currently. And these are the gaps in your community. Question up here and then one in the middle. Lisa.

UNIDENTIFIED SPEAKER: I had two questions(inaudible) concern for patient to patient. When you have a (inaudible) do you have any suggestions on how we could prevent that (inaudible) in terms of what's provided and what's not. That's the first question. And the second thing had to do with (inaudible) my main question about that is do you think (inaudible).

MARIBETH BADURA: The state point of contact, is that -- I'm sorry repeat that again.

UNIDENTIFIED SPEAKER: (Inaudible) the independent review panel. Reviewed independently of -- (inaudible).

MARIBETH BADURA: The objective review committees look at each application individually, on its own merit against the criteria.

UNIDENTIFIED SPEAKER: Okay.

MARIBETH BADURA: And your first question is in subsequent year contractor budgets, or if you've got the same agency with very similar budgets, do a cross-reference to cut down. So, in other words, if all your contractors are using the same formula, let's say for their services, you're contracting for case management. And they all have a similar case management system that you're reimbursing them from. You can footnote that that's similar and cross-reference where it's discussed in the first contractor. If all the services are different, you're going to have to give the budget justification for each one of the contractors.

UNIDENTIFIED SPEAKER: Then can we say (inaudible)?

MARIBETH BADURA: Yes. But be real clear. Link it back to the narrative in case someone wants to look at it. And if you're increasing anything, tell us why you're increasing it or decreasing it in the up years.

UNIDENTIFIED SPEAKER: For the existing project, if they don't have any prior applications to read(inaudible). We don't have to say we're an independent agency because they will already have that, so we can say –

MARIBETH BADURA: Right. It's within your current, for all applicants, whether they're competing or new applicants, they should say what their current contractual system will be for the current budget. If you're changing it within the project period, in other words, in year two you're going to add a contractor or you're changing the dollar figure in year two, that's when you need to explain the changes.

UNIDENTIFIED SPEAKER: Okay. Thank you.

MARIBETH BADURA: I think there was one in back of the room and then up here.

UNIDENTIFIED SPEAKER: Could you clarify something questions (inaudible) we had some questions back here, getting back to (inaudible) the continuation. Can you choose to or (inaudible) and I don't know if you can still even (inaudible).

MARIBETH BADURA: In other words, you're adjusting your service area to meet your dollar needs?

UNIDENTIFIED SPEAKER: Yes.

MARIBETH BADURA: Yes.

UNIDENTIFIED SPEAKER: Second piece of that is...

MARIBETH BADURA: But you can't apply then to serve the remainder of that project area as a new grant.

UNIDENTIFIED SPEAKER: This is an important question. Not very many (inaudible) but let's say (inaudible) zip codes ad nauseam (inaudible) for the criteria. We just are (inaudible).

MARIBETH BADURA: Julie Ann, repeat that again.

UNIDENTIFIED SPEAKER: If you're decreasing your current system by let's say one or two, and they're not eligible (inaudible) there's a one or two other zip codes you want to serve, but you just said it, right, you're currently set it. The question is, can you put those in with your current or separately because of those two areas?

MARIBETH BADURA: If you're adjusting your service area to meet -- because populations shift. And you can do it within the same dollar figure, it's essentially the same service capacity, you don't have to come in to expand your zip code. I mean we all know that sometimes people move from one part of the city or one county to another and you need to do some adjustment of your census tractor zip codes. That definitely is something that we would consider as a competing continuation grant. If you're going to serve a completely new area and you don't have them, that's different. But if you're following the population that you're currently serving and just tinkering with the boundaries of that service area, that's a competing continuation. There was another question in the back and then up front.

UNIDENTIFIED SPEAKER: (Inaudible). Current grantees they know (inaudible) they said contract (inaudible).

MARIBETH BADURA: To be a competing continuation, we would need the current grantee to say this is the successor in interest grant.

UNIDENTIFIED SPEAKER: (Inaudible).

MARIBETH BADURA: As part of the application, yes. We'll check further with grants management on that, but that is my understanding from them of what they would need. Question closer up front here.

UNIDENTIFIED SPEAKER: (Inaudible) population. On in the (inaudible) period.

MARIBETH BADURA: If your needs are met for the prenatal interconceptional period, yes, there are some projects in which those needs are met. We really do expect that you are going to be serving the prenatal and interconceptional women that are the reason you're eligible in the community.

UNIDENTIFIED SPEAKER: (Inaudible) we have a thing called Healthy Start system.

MARIBETH BADURA: Right.

UNIDENTIFIED SPEAKER: (Inaudible).

MARIBETH BADURA: Right?

UNIDENTIFIED SPEAKER: (Inaudible).

MARIBETH BADURA: We have something similar sometimes in California that they cover post partum, infant visits in the first year of life. You need to state real clearly you've got the resources,

the assets within your community that you don't need to provide those services under Healthy Start. So you must do that for each of the core services. Then if you want to spend your dollars on something else that's related to the project such as preconceptional care, that's very definitely an allowable expense. And we have some projects that have done that very effectively. Sometimes, because they've got prenatal services, sometimes because they have case management after the baby and mom.

UNIDENTIFIED SPEAKER: (Inaudible) normal outcome performance measures (inaudible).

MARIBETH BADURA: You would not be reporting on low birth weight to program participants for that woman because she's not pregnant.

UNIDENTIFIED SPEAKER: Okay.

MARIBETH BADURA: But you would use the performance measures that would be applicable, such as a woman having a medical home. There would be other performance measures that it would be applicable for. And we're going to really get into the data elements, but your question does relate to the narrative as Chris goes through his presentation.

UNIDENTIFIED SPEAKER: Okay.

MARIBETH BADURA: A question over here. Linda, wait for that mic, please.

UNIDENTIFIED SPEAKER: I just wanted to make sure that I have (inaudible) I think I do. That for a continuation application (inaudible).

MARIBETH BADURA: Correct, you're shifting, you're serving a similar population to what you're currently serving, but they perhaps have moved in the community.

UNIDENTIFIED SPEAKER: So, for instance, where I currently have a project (inaudible) but I (inaudible) improve it today but it's (inaudible).

UNIDENTIFIED SPEAKER: (Inaudible) Maribeth, you know, my situation. (Inaudible) because (inaudible) I cannot with the funding (inaudible) I cannot serve the size project currently. My project area (inaudible) still qualifies (inaudible).

MARIBETH BADURA: You need to be able to provide the services and you may need to reduce your area based on the needs of your population.

UNIDENTIFIED SPEAKER: So what I plan to do is to reduce my project area size for the continuing application and then I want to submit a new competing application for counties that I don't have (inaudible) in my own project area.

MARIBETH BADURA: I'm afraid in that case you would not be able to apply in the same year that you're applying for a competing continuation.

UNIDENTIFIED SPEAKER: So what I would have to do is expand that application, would have to be a different project area if it included all the counties that (inaudible) in my project?

MARIBETH BADURA: If you're decreasing your service intensity because you do not have the dollars available in the new application to continue to serve the same project area --

UNIDENTIFIED SPEAKER: We can't hear.

MARIBETH BADURA: I'm sorry. The question is, I think, and I want to make sure I'm characterizing this right, their particular grant has both a disparity grant and another grant under Healthy Start. If they continue to provide the level of service that the women need in their disparity grant, because of the decreased dollars that they're not getting let's say in high risk interconceptional and the fact that these women still need intense services, she's questioning whether she can, A, reduce her area to provide service that meets the needs of the highest risk population. And yes she can. But she cannot come in for the same, the areas she's dropping as a new grantee.

UNIDENTIFIED SPEAKER: So, if I add counties (inaudible) project area, a modification, will I be able to?

MARIBETH BADURA: If you're adding -- will you be able to do what, I guess?

UNIDENTIFIED SPEAKER: (Inaudible).

MARIBETH BADURA: If you are serving a new service area.

UNIDENTIFIED SPEAKER: Serve the area that (inaudible) no.

MARIBETH BADURA: No.

UNIDENTIFIED SPEAKER: (Inaudible) (inaudible).

MARIBETH BADURA: Let me just do a quick sort of reality check, because it's getting close to 3:00. How many people in this room represent a group that is not a current grantee? We do have some (inaudible) okay. The particular -- this is being videotaped, so we're going to go over issues here so that you know that your questions that you're asking are going to be also part of the videotaping. So I just want you to all be clear on that at this point. And we have to be clear in our responses, because the people who may not be here may not be current grantees. So we're going to try to be as consistent as we can in our responses so it will be easy for someone who is downloading this or watching the webcast to be able to track and follow things. Are there more questions about what we have covered so far? Yes.

UNIDENTIFIED SPEAKER: (Inaudible).

MARIBETH BADURA: It's coming, Elizabeth.

UNIDENTIFIED SPEAKER: Hi. If I understand correctly, each project must have a minimum of 15 objectives. Minimum set of objectives have to include the performance measures and outcome measures. So we'll all have a minimum of 15, plus any additional things we're tracking?

MARIBETH BADURA: Yes. And as I said before, the forms compact easiest in the web-based application. They take up less space. So if you're doing a paper application, please use that. Just trick of the trade to get in under the page limit of 160 pages. I just want to complete some other elements of the application and I'll take additional questions and then we'll take a break. We've given you a glossary of terms for each performance measure. We've given you a detailed sheet that explains everything, and if there is, for any of the performance measures that read "to the extent of," "degree of," that means that there's a self-assessment form that you will do to give yourself a baseline data. We also have instructions for each form. And Chris, the material that

Chris will be giving you, the material that's included in your folder that you got, not with the guidance, that's included in the folder, the new material that is formatted differently, is the most recent version of the performance measure and data system. It's been updated since we sent the guidance through the system.

So you have instructions for every form. These are the review criteria again. I want to go over briefly the review process with all of you. The applications will be reviewed by objective review committee. Its experts are qualified to do that. They are people who are not, no reviewer can be a reviewer if they are applying for a grant under this competition. Reviewers that are consultants and appear in the budget will also not be allowed. That's a conflict of interest. And we don't want any of the applications or reviewers disqualified. So please do not agree to a review if you're consulting in writing a grant or you're appearing as a consultant in one of the grant applications. You will not be eligible to sit on the objective review. That objective review is not operated by the bureau. It is operated by our new division of independent review.

Our program staff are there to hear what's going on, but we provide no input into the decision making and we really just give clarification on the guidance elements. We can provide no information about the current grantee. We never have been and we cannot still do that. The objective review committee will standardize the scores across panels if we have multiple applications. We, of course, are going to be operating 10 to 15 multiple review panels. They will standardize those scores with a statistical method. Those objective reviews will be forwarded to the bureau in rank order, and we will fund on that rank order. (Inaudible) you have a question.

UNIDENTIFIED SPEAKER: The consultant piece, would you repeat that?

MARIBETH BADURA: If someone is a consultant in writing one of the applications that's going before the review committee.

UNIDENTIFIED SPEAKER: Any application? Any application?

MARIBETH BADURA: A competing application. If they're writing an application that is coming to that objective review panel, they cannot serve as a reviewer. Someone who is a consultant or a staff member cannot serve as a reviewer on another application because there really is a conflict of interest there.

UNIDENTIFIED SPEAKER: I understand that it's a conflict, with the individual application that they are, with the grantee that they're working with. And what I think I'm hearing you say, it's a conflict with the overall process, which is different, correct?

MARIBETH BADURA: They have a conflict because they have written an application that they were paid to write. They may not be reviewing that application. But that application is going for funding. So there is a potential for conflict of interest. And we do not -- we then must have that person not serve on the review committee. That decision is made by, the reviewers are made by the -- the decisions are made by the division of independent review, but they are being very careful on that area so that no one is placing any of the application process in a position where there could be potential conflicts of interest. I'm just briefly going to highlight some resources for you and then we'll take additional questions and a break. There's a lot of good data available for you on the TITLE V discretionary information system. And here are the two web pages that give you those links. If you have an electronic copy of the application, these are hot linked that when you click these on -- let me get out of -- it will automatically take you to that site. But these are all, if you enter this address, it will get you there.

What's coming soon is the discretionary grant information system. We have a library and we will pass out to you after break a handout that really describes our MCH library. It's an excellent resource for you. It is where we have cataloged all of the past Healthy Start grants. The Healthy Start resource center that we used to have has been merged into this MCH virtual library. The virtual library has knowledge (inaudible) excellent bibliographies and links to other organizations. They've done one on maternal morbidity and mortality. And they updated the one on infant mortality. A lot of good data there. We have an MCH neighborhood link that lists other sites that have excellent information for you. This presentation, a presentation done by Dr. Michael Lu on disparities and the whole concept of how disparities fit into the life span perspective; a presentation that Jan Figert from our Tulsa project did last year that we thought was very beneficial to the grants that were applying is on that website.

Chris's presentation and Mimi Brown's presentation from today will be available on that website. You will be able to download the slides. You will be able to view the webcast presentations. We really see this spot as a real resource for people that are applying for the current grant application. And it is open to the public. With funding from the federal government, the March of Dimes has just opened a new website, Parastat websites. It will even allow you to compare your community to other communities. And in some areas like New York it has the data broken out by year, by girl. Some larger cities, it's by census track and zip code. There are over 50,000 states, cities and counties that are now incorporated into this data element. And I would encourage you to use that data source at the March of Dimes as one of your resources.

There are also two other sites that I'd like to recommend. One of them is www.communityresources.net. And I will put the exact sites up when we go on break. That particular site has excellent tool kits for program evaluation and logic models. I would encourage

you to do that. The Kellogg Foundation, again, has excellent downloadable material on Logic models and a handbook of program evaluation. So I would encourage you to use those free websites in developing your application. I will also encourage you to make sure that you have your application done on time and then you're going to want to give it to somebody who does not know your project. And you're going to say to them, does this make sense to you. That is critically important to having a sound application. Because we all speak a certain language and jargon, perhaps, and it may not translate from one community to another. So you've got plenty of time now. The questions are questions I think most of you are familiar with. This guidance is very precise. So I really hope you take advantage of getting it done early, having somebody else read it who is not as familiar with your project. Question.

UNIDENTIFIED SPEAKER: (Inaudible).

MARIBETH BADURA: Yes, that's our MCHcom.com site. That's where we do our webcasts from that we do every month from the Division of Healthy Start and perinatal systems, but we're also using that site to upload this videotape of this particular TA meeting as well as the other materials I talked about. And that's this MCH distance learning. It's at the University of Illinois in Chicago. But this is not a password protected site to access this information. There's a lot of other good material that's available to you there. Just excellent. Yes, question. I'm sorry, the last speaker asked me about distance learning and that's why I clarified that. Yes.

UNIDENTIFIED SPEAKER: I'd like a little more information about the review process. When it goes through the objective review process, and all of the applications are scored, then they make, they send their recommendation to the bureau. Is there any more process of review with either formal or informal criteria once it gets to the bureau?

MARIBETH BADURA: I mean what the committee does now, and Mimi will go into more detail, the committee has a certain number of applications they review over a time period. There are three reviewers of every application and every member of the review committee receives some information on all the applications and they have access to the complete application. The committee as a whole will write for each review criteria what they see as the strengths and limitations of your particular grant against each of the individual review criteria. That material is edited by the committee before they leave Washington D.C. or wherever we're having the objective review, and that's the information that you receive as a result of the review process, whether you are approved unfunded or not recommended for approval. They then individually will score each application. That is done individually. It is not tabulated at the meeting. The scores are not shared among the reviewers at that time. Each member of the review committee gives each application a score in each one of the review criteria areas and a total score. Those are then averaged across the review panel for that particular application and then they're standardized when we have multiple panels. So you will get that number and you will get the individual element by element need, response, impact evaluation. You will get the strengths and limitations of your application. And we get a composite ranking system and we fund in order of ranking. I can still see you're confused.

UNIDENTIFIED SPEAKER: I guess once it gets to you from the objective review panel, it's done. It's clear at that point, right at that point who is going to be funded? Is that correct?

MARIBETH BADURA: Yes. And we go -- you know we do it by the funding ranking. There are -- the way this competition is announced, there's nothing done, there are no priority or preference points given for existing grants. And if that's what you're addressing, we have not announced that as part of the open competition. So there's no adjustment of the scores from the objective review

committee that is done by the program. If there would be an adjustment such as priority or preference, that does have to be stated up front as part of the competition. Yes.

UNIDENTIFIED SPEAKER: This is a page limitation question. In regards to the biographical sketches in the appendix, is the minimum one page per sketch or is it three pages, because the guidance states two different requirements. On the top of page 21 it states the maximum is one page. However, page 53 states not to exceed three pages.

MARIBETH BADURA: I'm sorry for that inconsistency. But it's not to exceed two pages.

(Laughter) Now, if you can do it in one page, that does help you with your page limitation.

UNIDENTIFIED SPEAKER: Maribeth, in some spots in the application there's duplicate questions, meaning they ask the same thing.

MARIBETH BADURA: If you find that you've already answered the question in another section, just cross-reference it. Don't repeat it to save. Tell the reviewer what page it's on and perhaps what it's coded under, what response they should look at so they can easily find it. But you do not have to repeat the information.

UNIDENTIFIED SPEAKER: Okay, thank you.