Becoming a Mom® Implementation Introductory Webinar

Hello. Welcome to the Becoming a Mom/Comenzando bien Implementation Introductory Webinar. I'm Stephanie Wolf. I'm the Maternal and Child Health Perinatal Consultant with the Kansas Department of Health and Environment Bureau of Family Health. I'm also the coordinator for the Becoming a Mom® Implementation here in Kansas.

My intention with this webinar is to provide you with a high-level overview of the Becoming a Mom® curriculum and the model for its implementation here in Kansas. I'll be describing the core components for implementation and identifying infrastructure support that's provided by KDHE to assist you at the local level with implementation as well as identifying what local partners are really necessary for the implementation and what their roles might be. I'll then identify next steps that are needed in order to start the implementation process in hopes that following the review of this webinar as well as the other resources that are included in this website, your community decides to move forward with the implementation of Becoming a Mom® and the collaborative in your community.

I will start with an introduction to Becoming a Mom®. This will include an overview of the curriculum and the delivery here in Kansas.

The original curriculum is created and owned by the March of Dimes which many of you are very familiar with, and March of dimes is a nonprofit organization that has a longtime history here in our state of being dedicated to improving the health of babies by preventing birth defects, premature birth and infant mortality. It is designed for pregnant women in a supportive group setting to learn about having a healthy pregnancy and a healthy baby, and we will talk more about this group setting here a little bit later in the webinar.
It was actually originally two separate curriculum, the Pregnancy Workshop and Comenzando bien®.

In more recent years the curriculums were combined into one bilingual curriculum known as Becoming a Mom/Comenzando bien®. The curriculum comes with a nice instructor's manual that includes lesson plans that are written for use with any audience. It also includes appendices with information for facilitating the sessions with different racial and ethnic groups. It provides a lot of the background and kind of the rationale for the teachings as well as a lot of adaptive information, so it really does provide a lot of comprehensive information to help facilitators in providing the curriculum to their audience.

The curriculum goals are really very straightforward. One of the primary goals is to teach women about having a healthy pregnancy and this is done through the provision of information around risk factors, exposures and behaviors that they would want to avoid that increase the risk of pregnancy complications as well as providing information around healthy behaviors and things that they would want to engage in and have a part of their pregnancy to improve the chance of having a healthy pregnancy. The environment is really designed very intentionally to be supportive and to promote healthy behaviors and this is done so through the support of peers around them in the group setting. It again is very intentional about, you know, setting up an environment around them that helps them overcome barriers, to care and become assertive and informed consumers of prenatal care services. So we'll talk more about the model here in Kansas a little bit later in the webinar, but again, it's very intentional in helping to connect them

with other services and really, really doing a very good job of informing them and encouraging them to communicate with their provider. That is one of the ongoing themes throughout the curriculum and throughout the sessions, that they're always encouraged to go back to their provider and to engage a conversation around the concerns they might have or some of the topic areas that have been discussed.

So who can implement the curriculum? Well, really anyone can implement the March of Dimes Becoming a Mom/Comenzando bien® curriculum. The original curriculum is free and downloadable from the March of Dimes website. What we're doing here in today's webinar and on this website however is promoting the model for implementation here in Kansas. KDHE has worked very closely in partnership with March of Dimes to develop a unique and comprehensive model for implementation of the curriculum here in Kansas.
If you would decide to forward with implementation of the model here in Kansas, you will be provided access to a private website that KDHE is providing to local communities implementing for the Kansas model where there will be a wealth of implementation resources. One of these resources will some additional webinars that will go much more in depth into the implementation of the curriculum, so for now I just want to provide a very high-level overview of the curriculum and how it was adapted for the model here in Kansas, so on this screen you will see in the lower right-hand corner there is an image of the cover for the original Becoming a Mom curriculum from the March of Dimes. You will also see images of what that looks like here in Kansas now. Again, we have worked in partnership with the March of Dimes to protect the trademarked curriculum but to also adapt it for Kansas use where we have integrated additional supplemental materials. The original curriculum from the March of Dimes is a wonderful product. It is evidence-based medical information on pregnancy health that is very, very thorough, but one of the things that we found with our early pilot sites is that there appeared to be some gaps around some of the Title V priorities, so Title V is a program that KDHE implements under the Bureau of Family Health and there are priorities. For example, one of the priorities is breastfeeding, and with the original curriculum, it has one handout on breastfeeding, but in Kansas because that's one of our priorities, we really felt we needed to go much more in depth than that and so we contracted with a state partner, the Kansas Breastfeeding Coalition, to develop a full two-hour session on breastfeeding and infant feeding, and so that is an example of one of the adaptations we've made. Another example is that we're doing a lot of priority work around safe sleep messaging and there was a gap around that in the original curriculum and so that's another topic area that we have supplemented material into the original March of Dimes curriculum. Again, we've done this in very close partnership with the March of Dimes to protect the trademarked curriculum, so you will see here again an image of this document but on the website you will be able to access the document and thoroughly review it. So there is a document that outlines the curriculum content so you will be able to see each of the sessions and the handout headings. Each of the supplemental handouts for the Kansas model have been identified with an asterisk so you can take a look at that and again, we will talk more in depth about that and the implementation of it in the webinars on the private website if you decide to move forward with implementation.

As I mentioned on the previous slide, we have been working very closely with state partners to develop the implementation model as well as expand the curriculum for use here in Kansas. This work would not be possible without the partnership with March of Dimes, with the University of Kansas School of Medicine Wichita Department of Pediatrics who was very instrumental in the development and identification of supplemental handouts as well as the

translation of all of the supplemental handouts in Spanish. We also really want to acknowledge and call out our partnership with Sunflower Health Plan who has been instrumental in making the curriculum available to all of our program slides at no cost. They have been a funding partner for providing the curriculum across the state for the past several years and we hope that that partnership will continue in the future.

As I have mentioned previously and will expand upon further in this webinar, KDHE has been working with state partners to develop infrastructure that supports local communities in delivering the curriculum in a standardized fashion that insures program fidelity. We want to be able to assure that from program site to program site across the state, women are receiving the same quality education. As I've mentioned, this includes supplemental handouts and integrated resources that are the product of many partnering entities and really the content experts in the state. Again as I've mentioned, the curriculum is evidence-based and I want to assure you that it is reviewed and updated on an annual basis. March of Dimes reviews the original curriculum and provides those updates as well as KDHE has a team that reviews and makes updates on an annual basis. This work is very time intensive to do the research and the review it takes to identify the new recommendations and changes in guidelines as well as new resources and materials that are available, and so KDHE is really committed to doing this work for you. We realize that historically especially in communities of smaller size that have fewer staffing resources, this is work that just has not been able to be done, again because of the time intensity behind it, and so this is something that we are very committed to doing and this is a component of that infrastructure support that KDHE promises.

The model in Kansas promotes the curriculum being delivered by trained facilitators in a group setting that serves as a source of social support. It allows the opportunity to connect with other mothers in a similar situation, so what we've been seeing is that as these pregnant women and their support persons attend the group sessions over a period of time, they really begin to develop relationships and by the end of program completion, by the end of that sixth session many of them are often asking, so when do we get to meet again? You know, we've really grown to look forward to this opportunity and really want to stay connected, and so that's been a really neat benefit to see come from the program. It also builds rapport between providers and program staff and the participants, so in the design, again often the medical providers themselves, nursing staff from hospital labor and delivery and public health department staff are all working together to facilitate the sessions or co-facilitate, and so this really again helps create a greater relationship among the providers and really reduces some of the historical barriers between really, you know, that close communication and making referrals and just really working together to serve the pregnant woman. It also creates connections with community resources. Again, the model design has been very intentional to create opportunities for different community resources and agencies to come in and just speak very briefly about the services they have available and it really puts a face with a name and helps decrease that fear and hopefully remove that barrier to women accessing those resources. It also produces a greater reach. By providing this education in a group setting, it allows staff to reach a far greater number of women in a reduced amount of time, so over the course of the six sessions, 12 hours of education and support is delivered to a great number of women through this group design which is very comprehensive. This will meet the needs of most women, and through the interaction with the women in the group and the different screenings that are conducted, they are also able to identify those women that are at greater risk and who need additional resources, and certainly the staff can work, too, then provide that greater connection with those women

outside of the group setting and to refer to other services that might be needed to meet the needs of those individuals, but again, by and large the needs of the majority of the populations are really met and really exceeded through these 12 hours of content and support.

The Kansas Perinatal Community Collaborative model really supports Becoming a Mom/Comenzando bien® implementation far beyond the curriculum itself. Where the community collaboratives are serving as a backbone for a program implementation, this is really leading to a much greater collective impact. So as I've been mentioning before, the model really takes a holistic approach to caring for the family by pairing education and support with clinical prenatal care, so this is very different than our historical approach to delivering the services which have typically been very much in silos and isolation of each other. The model helps women enhance their wellbeing and pregnancy health by improving the opportunity for healthy birth outcomes.

The key design is to promote healthy pregnancies through two core components. The first one is cognitively which provides accurate and timely information about prenatal care, pregnancy healthy, postpartum and infant care, so traditionally we have had childbirth education programs that really focus on labor and delivery and maybe a breastfeeding class that again is really focused primarily on just breastfeeding, so with this model, our approach is to provide one comprehensive program that covers that content as well as it's covering health and promotion of healthy behaviors throughout the entire perinatal period, so covering from the prenatal period through the health of the pregnancy, postpartum recovery, care of the infant and infant feeding as well as through the interconception period, really hoping to promote the health of the mother before the next pregnancy. Also behaviorally, we are promoting changes in prenatal health behavior such as seeking prenatal care, taking prenatal vitamins and eating healthy foods as well as other health behaviors such as breastfeeding and placing baby on its back to sleep, so it's been really exciting to see some of the outcomes we've seen with this education.

Impact and Outcomes. So this is the part that I get really excited about and I could talk about this for two hours, but I know you don't have that time so in respect of your time, I will try to keep this pretty short and sweet. So in a nutshell, we have seen overwhelming program satisfaction. We've seen statistically significant increases in knowledge pre- to post-assessment, in reported improvements in personal health habits, in reported change in behavior and in increased breastfeeding rates, so I want to pause here for a moment to have you look at the figures on the left-hand side of the screen. So you'll see in the first figure there, Figure 25, it's showing the improvement or the increase in the number of women pre- to post-intervention that know about available resources that can support her with breastfeeding in the community, so you see that there's a very stark difference pre to post in a very significant improvement. In the second figure there, Figure 24, it shows again that stark improvement or increase in the confidence of the mother and her ability to breastfeed pre- to post-intervention. These two factors, or these are two key indicators really that can predict a mother's success rate with both initiation and continuation, so two key factors that again you're seeing a huge improvement pre- to post-program. Figure 23 there at the bottom shows the change from pre- to post-program in a mother's plan to breastfeed or not, so again we're seeing that increase in the number of women who plan to breastfeed following the education that they receive around the topic. So back to the list here on the right, we're also seeing that there is early prenatal care access, access to other health and support services, so again through the very intentional integration of other community resources and again that collaborative backbone between the different

providers in the community that I've spoken to previously. We're seeing reduced disparities, reduced pre-term birth and reduced infant mortality, and I'll speak to this in just a moment on the next slide. It's also producing permanent NCH infrastructure, so you know, the design again is really to help promote long-term program sustainability to leveraging existing resources so we're not bringing in a new grant that's going to go away in a year and the program's going to fall apart. It's really all about using that permanent -- or that existing resources among the collaborative partners to really each contribute their role in providing the program, and this goes back to the other webinar where we talked, you know, in great depth about that collaborative backbone. It's also producing coordinated systems of care that provide greater service delivery and from that we are able to identify emerging community needs more quickly, again because we have all of the partners there in the community working together. We're reviewing the data in our community and we're able to identify those trends or what appears to maybe be becoming a trend much more quickly which allows us to respond to that more quickly as well.

Again speaking to the collaborative backbone that is behind the implementation of Becoming a Mom® in the Kansas model, it is believed that the spirit of collaboration across agencies and programs is contributing to a much greater collective impact than any one agency working in isolation could do on its own, so again, historically we have all been working in silos or in isolation of each other, all working on the same,
you know, on the same issues, but it's not been -- it's not been coordinated and the work has not been, you know, cohesive. It's been very segmented and so we really do believe that this collaborative structure and this really -- this movement towards working on this together across agencies and across entities in the community is producing this greater collective impact. And as testimony to this, we have seen the infant mortality rate decreasing over five-year periods from pre-program implementation to post-program implementation in the counties of our two longest-running collaboratives, so you'll see here where we have highlighted Saline County and Geary County, they have had significant decreases in their IMR prior to the collaborative buildout and the implementation of Becoming a Mom® to post-implementation, and again, we are not saying that Becoming a Mom is responsible for this, but we feel that again the collaborative nature where everyone is contributing and you know, is messaging the same message to the women and really putting momentum behind the effort is really causing this change.

So now that I have provided an overview of the curriculum and the model for implementation in Kansas, I would like to move into the actual implementation of the curriculum. Again I'm just going to provide a high-level overview because once your community might decide to move forward with implementation, you will take steps that will allow you to access to the private website which will provide resources for implementation. Among these resources are a number of webinars that will go much more in depth into each of the next components, but for now we'll just provide again that quick level overview, so I'd like to start with partner roles.

As I have been alluding to, a community is going to have much greater success in implementing Becoming a Mom or really any one of the other targeted interventions that we spoke to in the collaborative webinar. If you do have that collaborative backbone structure behind the implementation of these targeted interventions versus it being the sole job or responsibility of one entity, so it's really again much more successful if we have partnerships and each of the different entities identifying and providing a role, so we want to make sure to include local

public health departments, collaborating OB and family practices, other community agencies that are serving the same NCH population so possibly there's home visiting programs in your community, and certainly delivering hospitals, so again, as we begin to move through the different roles, each of these agencies should be able to identify what they might be able to contribute to the collaborative effort behind the implementation of Becoming a Mom®. There's also a number of maybe non-traditional partners that you'll see listed here and these are organizations or entities that maybe traditionally you haven't worked real closely with, but you really might want to consider as each of them could really play a role in this effort. Employers, especially large employers, we have seen play a very strong role in some of our sites. For example, in southwest Kansas, National Beef has gotten behind the effort and they have partnered with the hospital and with the public health department who is providing Becoming a Mom and they are making it a requirement of each of their employees that are on their company health plan to attend Becoming a Mom, and as an incentive, if they complete all six sessions they waive their copay for their prenatal care and delivery, so that is quite an incentive and really is a great example of an employer really again getting behind the effort and really promoting and incentivizing this for their employees. Transportation and retailers and corporations, faith-based organizations, childcare, early childhood and volunteer groups and civic groups, all of these entities can certainly play a role in helping support the success of the program and reducing barriers possibly to women attending, so for example in some communities transportation may be a barrier so looking at a partnership that might help be able to provide that, and again I'll speak more in detail to these in some of the other webinars, but just want to give you a high-level overview here, so retailers and corporations, they might be able to support the efforts by providing some of the incentives or maybe making a financial contribution to the funding of the program. Again, some of these others like faith-based organizations, volunteer groups and civic groups, there are so many different roles that these organizations can play. They can help for example maybe provide snacks during the sessions. They are two-hour sessions so it's really nice to be able to provide healthy snack and this is a key opportunity that one of these groups could get involved. Just as an example of some of how our existing sites have utilized these organizations, for example maybe they've produced little goodie bags that go with one of the sessions and you'll learn more about that when we talk about the incentives, but this is where some of these organizations and groups have really been able to get involved and either contribute the contents of some of those incentives or putting them together, maybe even putting together the binders that provide the actual handouts to the participants or even coming and volunteering to help get women signed up or registered and enrolled in their first session, so again a lot of different opportunities there that we'll talk about more in depth in some later webinars. Childcare and early childhood partners -- so again they might be utilized to help reduce a barrier. If you're seeing that there is a need for child care for the women to be able to attend the sessions, you can -- there's potential to partner here to be able to provide child care on site as well as these organizations can come in and present as a co-presenter or a guest presenter I should say to just kind of highlight the services that they have available in the community. Often Becoming a Mom is a great opportunity to segue into some of the early childhood programs that are available in the community and home visitations, so it's great to get them involved as well.

As I've been speaking to the importance of partnerships at the local level and each of those partners identifying their role and what they can contribute to the collaborative backbone and to the implementation of Becoming a Mom there locally, I want to now speak to KDHE's commitment. We promise to continue to partner with local communities to provide

infrastructure support that supports you and assists you in your efforts there locally. We will continue to provide staff support such as myself. I'm available to field questions and provide guidance via phone call or email. A lot of my time is also spent developing and updating the different components of the infrastructure support that I'll speak to here in this slide. One of those components is hosting the websites. One of those websites is the one that you're on currently which we provide to interested communities to learn more about the collaborative model and the Becoming a Mom curriculum and its implementation here in Kansas. As I've mentioned previously, there is also the private website that once you have committed to implementing Becoming a Mom per the Kansas model, you will receive access to that website that houses all of the many different implementation resources that we've made available. I'm going to speak to those in some of the upcoming slides, so I'm going to move on now to speak briefly to training and technical assistance that we will continue to provide. This is provided in a number of different ways. We do this through webinars and through in-person contacts. The webinars we've traditionally held on a monthly basis and I recently sent out a survey to the existing program sites to determine what schedule might be helpful in the future, so it looks like we're going to be moving to a quarterly schedule. We also sought input on topic areas that they would like some TA on, so we will be providing information in those areas. We also sought input on interest for a one-day kind of conference-style event, and there was a lot of interest on that so we are currently working on developing this one-day event. We will be bringing some national speakers as well as we will have local experts there to present as well as we will be incorporating a time for the sites to communicate with each other for some of our sites to highlight some of the successes they've had and provide those ideas to some of the other communities as well as maybe some of those that are struggling in some different areas to have that opportunity to kind of brainstorm with some of the other communities that have maybe already kind of worked through some of those issues, so just really a good time for them to -- you know, to be able to have some face time together to be able to share ideas. So also we are committing to continue the work that we've done to support a data system and evaluation support. I'm going to be speaking to this again in a few slides so I'll kind of table that for now. We do believe very much in this model as we have seen much success with it and have seen the outcomes and so we will continue to promote and expand the model in the state as well as provide support to local communities to sustain what they have in place. We will continue to update the curriculum and to develop new integration tool kits on different priorities that come to be a major part in the work that we're doing. All of this infrastructure support really provides new and existing sites up-to-date information for program implementation, so it really takes that burden off of you always having to -- or not reinvent the wheel. We don't want you to have to go to that effort so we are providing that for you. It decreases the burden on new sites and existing sites as their staff turn over. We know that that's a real challenge as new staff leave and new staff come on, the extensive amount of time and resources it takes to train new staff, so that's part of why we are moving to more of this online training system so that we can provide webinars that new staff can access as there is that staff turnover.

It also establishes greater consistency of messaging delivered site to site and from facilitator to facilitator. We've identified that in different areas of the state, it's very common for participants to move from one location to another or to maybe want to attend a session in a community where they're receiving prenatal care or maybe at times where they're residing versus where they're receiving their care, so by providing that consistency across sites, we can allow for that movement between the program sites and the continuation in a program. It also improves fidelity and opportunity for achieving promising practice or evidence-based recognition, so I've mentioned earlier that the curriculum itself is evidence-based and there's medical evidence-

based, but the model itself has never been established as such. The curriculum for March of Dimes was just that, a curriculum. There was no model for implementation at a national level. It's being delivered differently in each state, therefore the difficulty in establishing evidence-based for the model, and so that's what Kansas hopes to achieve in the next years. Now that we've been in existence for several years and getting additional sites started, we're developing the data that is needed to achieve this, so we are working to do that and again this is beyond the curriculum but it's really about the model for delivery.

As I speak to roles, I want to speak to location because location is certainly a role that a community partner can contribute to the collaborative effort. The program can be implemented really in a number of settings including all of these listed here. These are all examples of settings in our existing communities where the program is implemented. In some communities that are large enough, it's implemented in multiple settings so it really depends on what the community's need is. As you're considering location and you're working with your collaborative partners to identify who has space available or where would it be the ideal location, consider things like classroom size, access to internet and the different technical components that are needed. Also consider maybe a neutral location where it's definitely a well-received location in the community where there aren't any maybe territorial boundaries which of course we hope do not exist but maybe something that needs to be considered in some communities. Another thing to consider is access. We want to make sure that the location is in an area where there is easy access by our disparity populations, so again in some communities that are large enough to support multiple locations, you may find that for example maybe within a church location we may able to provide better access to some of those disparity populations, so this is definitely something to work through with your community partners and really do some great brainstorming around where these locations might be best.

Program Coordination. It's absolutely essential that there be a lead agency to coordinate the program. This actually may be split between a couple of different entities or agencies so you can identify that there locally and what best fits your community, but we absolutely need an agency to step up and to commit to taking on that role as Program Coordinator who is responsible for assuring that the program is advancing, that it's being implemented as designed. They're going to be the one that's really in charge of program promotion and the coordination of referrals and class schedules, assuring that the clinical tie-in piece is there and that each of those partners is following through with the role that they promised to contribute, really kind of holding their feet to the fire if they're not doing that, so really essentially taking on the role to assure that the effort doesn't lose momentum and that again everyone is effectively contributing to the roles they've identified. They're also responsible for the group sessions, assuring that there's a location, that there's facilitators or instructors, that the curriculum is available and the resources and the incentives are there as well, so there is a lot of oversight. Initially is where the most time is spent, you know, in pulling all of this together and then it really moves into maintenance mode for the most part, but again a lot of up-front work to get all of these components in place. Also they have a role in assuring that the evaluation component is in place, assuring that the data is being collected, that it's being entered and that they're responding to the -- what the data shows and disseminating the reports to the collaborative members so that they can effectively complete that evaluation process and plan for the next year of implementation.
We also need to have project site managers and who these people are is these are the individuals at each of the partnering agencies. They are the individuals that oversee their role as

a partner in this collaborative effort, so they're the point of contact for that agency with the program coordinator. So this is the person the program coordinator communicates with at that agency, and then that individual assures that the communication is going to occur within her clinic or agency to assure that all of the staff are on board and again assuring that their designated role is being carried out. So if their role is to provide referrals or to actually schedule in their prenatal patients into the sessions, really assuring that that's being done and to develop and set up a system that does assure that that's done. For example, it might be setting up the schedule in the clinic's EMR to assure that that's not missed. If their role is to facilitate, they're assuring that they have their facilitators or instructors there or it may be to provide a donation of an incentive or something along that line. Whatever that role is, this project site manager is really responsible for that.

Group Facilitation. So the group facilitator or instructor is responsible for overall facilitation of the BaM group session. They instruct or educate the participants on the curriculum content and the associated resources so this needs to be somebody who has the education and the background, really is familiar with the content and can answer questions from the participants related to the content. It also needs to be somebody who is comfortable with facilitating a group session. Not everybody is comfortable with this so it's really important that we find somebody that really has a love for teaching and a real passion for this type of work. They need to be able to support positive group dynamics and to be able to build rapport that allows them to really assess the needs of participants. They're going to over time begin to develop a relationship with them that will assist them in identifying those that maybe have some greater needs that aren't served completely in that group setting and that staff person needs to be able to make connections with other staff or agencies to be able to refer the woman for maybe services that can assist in helping those needs outside the group session. They also will support the evaluation components of the program, so they will work with other support staff to assure that these components are being completed as required at the appropriate times. So I have here that nurse credentialing is the minimum requirement or as appropriate to content, so I'll discuss this here a little bit to try to provide some clarity and it's also covered in the FAQ document because we've had a lot of questions around this as programs are getting started. In our early program sites, often the facilitation was provided by one individual and although that worked very well and still continues to work in those communities, as we really began to evolve with the collaborative model, we identified that really different partners could be contributing to this to really kind of lessen the burden if you will on one entity or one agency to provide facilitation for all of the sessions, plus it better utilizes the experts that we have in the community to deliver related content, so it is encouraged that within your collaborative to identify different partners that could maybe provide facilitation for the different sessions, so for example the hospital might contribute staff time for their labor and delivery nurse to facilitate the labor and delivery session. And it might be that WIC contributes a dietician to facilitate session two which a portion of that is on diet and exercise and that kind of thing, so there's opportunities for different agencies to contribute to this. One thing I do want to caution on -- or actually two things I want to caution on is just making sure that we have the right individual for the right content and that they can -- you know, they've got the education and the background that they need to be able to answer questions throughout the content of that session.
We also want to assure as we have different facilitators possibly for the different sessions that there is also staff that is consistent from session to session, so maybe it's support staff or maybe it's kind of the lead facilitator or program coordinator that is the same face every time participants come back for the different sessions. A big component for this model is providing

support and we know that we decrease the support that's provided if there's constantly a new face every time a participant's coming and there is no familiar face. We've learned that through some of the sites that had begun to kind of operate in this fashion that the feedback on the surveys around feeling supported had diminished a little bit, so again just a little note to make sure that if you are using different partners to provide the education and the facilitation for each of the sessions that we assure that there are some consistent staff there as a part of those sessions.

Nurse credentialing is identified because KDHE has been working with Medicaid to try to establish a mechanism for reimbursement for the Becoming a Mom sessions, this model of prenatal education delivery in the state. This conversation is in process right now. We are currently developing a white paper to present to them. The conversation has gone further than it has in the past but we are currently going through another administration change with a new governor, so I don't know where this will end up, but I do want to mention that we're working on that and as a part of that effort, it was essential for us to identify the credentialing requirements around who can be reimbursed for delivering or providing the facilitation, so we say nurse credentialing, but a dietician, really kind of that professional-level credentialing as a minimum requirement, certainly a nurse practitioner, a physician assistant, a physician, and again across the program sites that we have we have seen all of these different individuals contribute to the facilitation and it has made for a very strong, robust program.

Again, the key is to really identify those individuals who have a desire and a passion for teaching and sharing maybe their expertise and you'll find a lot of success with that.

Guest Presenters. This is an opportunity for partnering agencies to become involved in the effort. They would present as a guest during the group session. They would speak for maybe five to ten minutes. They are there to represent maybe a highlighted resource, so an agency or a service. So for example, in session two and session six, we speak a lot to mental health in the perinatal period and so possibly having a mental health provider in the community, maybe the community mental center, you know, have a representative there to just again just give a quick highlight of the resource they have available, what services are provided and it really puts a face with name so it really again decreases that barrier or that fear in reaching out to this resource. They may also serve as a content expert, so for example it may be a car seat technician or local highway patrol or sheriff's department, somebody that comes in and speaks briefly to safe car seat installation. It could be that you have safe sleep instructor in the community that you invite in to cover that content or for example, the oral health component is best provided by a dental hygienist there in the community that can come in again as a content expert and just speak briefly to that component of the curriculum.

Program Support. So it's really important to have great support staff during the BaM sessions. Again as I mentioned before, it could be that this is the staff that's really consistent from session to session and really becomes a familiar face and the staff that builds rapport with the participants, so they're responsible for the overall duties outside of instructing and facilitating so the check-in and tracking of participants and support people to assure that the evaluation components of the program are being completed, so for example the initial survey and completion survey is being completed. So it's going to be their job to monitor this actually between the sessions as well so they can assure if somebody is coming through and is due to complete that they're getting that completion survey and getting that completed as a required component of the program. They will assist the facilitator or the instructor with any kind of AV equipment, room setup, special needs of the participants. You know, often there's those that are coming into the session late or there's disruption of one kind or another so it's really important

to have the support staff available to assist with those needs so it doesn't distract the facilitator and allows her to -- or him to continue facilitating the session. Snacks -- that's a big important piece of the session so just being able to get those set up and make sure that's available. Scheduling of the next session, so again assuring that they participants have the schedule for the next sessions, that they are scheduled into them and anything that might be needed around that, if they need transportation set up or anything along that line. Also we have fields in the initial survey that help identify possible KanCare or WIC eligibility and so having staff that are available to assist with that is very helpful. Support staff between the BaM sessions. So this is staff that's responsible for the program duties outside of the group session, so it goes beyond the group session, again that tracking component of the participant attendance and survey completion. This -- we've got some pretty amazing reports built in our data system which I will highlight here a little bit later, but they are developed to assist staff in this tracking process so it really tracks the attendance of the participants and helps staff identify if their due date is going to come about before they are able to possibly complete all six sessions. It identifies them so that the staff can get them the appropriate evaluation tools to complete before they've maybe completed all six sessions, that have been identified that it's time for the completion, so just really again tracking them, identifying maybe those that have missed a session or two, maybe reaching out with a phone call to reengage them and get them back into the classes before their due date arrives. They assist with scheduling, reminder postcards, texts, phone calls, that kind of thing, and again, this can be shared by the different partners in the collaborative so it may be some of the OB clinic staff or front desk staff of some of the agencies that assist with this type of work. It may be something that they're already doing within their agency and so adding this task on for Becoming a Mom is not a real -- you know, a real extension of their effort if you will. Purchasing or picking up donations, snacks, incentives, all of those little extra components that are needed, just something to keep in mind that that does take some staff time or it takes volunteers to do that as well, possibly, so just thinking about that as you're thinking through the roles and who can contribute what. Schedules and promotional materials to partners, so we need to make sure that everybody is up to date with the latest schedule and have materials in hand, the brochures, posters, that kind of thing so that they can continue to promote and engage participants in the program. Scheduling and reminding guest presenters, so somebody's got to keep track of that, give those little reminders to the guest presenters that it's their week to present. Arranging child care and transportation, if that's something that's a need in your community and you have a relationship worked out with an entity to assist in providing that, you know, just working through arranging all of that. The binders for the curriculum and the resource sleeves, these things again I'll talk in more detail on the private side when we get into the webinars that give more detail here, but there is within the curriculum, most of the sites used, what we call a resource sleeve. It's usually a clear page protector where they will insert brochures from different services or resources that are available that's related to the content of that session, and so this is something that is added to the curriculum binders so it takes a little bit of time to put this together so we don't want to leave that out in our planning as we identify the different roles. So somebody available to maybe pick up those brochures from the different agencies or if there's copying that's needed, again this is great role for volunteers, so really utilizing those organizations in your community that might be able to provide that volunteer piece. Data entry is another component that we don't want to miss planning for as we are preparing to implement, so there as I have mentioned, there are different evaluation tools, the initial survey completion survey and birth outcome which again, I'll go into a little more depth later, but these are forms that certainly need to be collected during the sessions and then that date needs to be entered into the electronic system, so again identifying who maybe is already

doing this for another program within your organization or one of the partnering organizations, and is this something that they could take on for the collaborative effort for Becoming a Mom®?

Support Services. So case management, specialized services, these are those services that really go beyond the Becoming a Mom group setting but we may be identifying women during that setting that need these services, so those that are responsible for program duties outside of the group sessions for high risk individuals, those that have special needs or special needs for particular resources or maybe those that are a loss to follow and require a little bit of tracking down to try to reengage in services if there's been concerns about them. Referrals for services such as mental health or substance abuse. As an example in Becoming a Mom®, one of the integration of the Edinburgh Postnatal Depression Screening. It's really important before implementing this that we have established relationships in the community that provide for those follow-up services following the screening. So we may screen in Becoming a Mom but we need to assure that we've got referral processes in place to refer the woman back to her provider or to a mental health specialist for diagnosis and treatment with a positive screen, so it could be that you have MOUs in place or that you get established so that you've got those specialized care providers in the community identified to provide those services. I know in one such community, they have an MOU in place where the mental health specialist is actually on an on-call basis there available to provide services in any given situation where that might be needed, so just thinking about how you might address some of these issues and assuring again that those referral processes are established and the service providers are identified.

Evaluation. So I've spoken to this already briefly. I will expand just a little bit more here and then we'll cover this much more in depth on the private side in the program coordination and evaluation webinar, so I just want to call out again the need for the completion of the evaluation tools. Some of these will be completed during the Becoming a Mom group sessions. Others will need to be collected either during a patient appointment or possibly a home visit or directly from the patient record, so in particular, the birth outcome collects data following the birth of the baby. There's both subjective and objective data that can be collected from the individual or from the birth record. This information needs to be collected likely in partnerships with the collaborative partners. For example, if there is home visitation services that are available in communities, it's ideal to partner with that provider of those services to be able to collect the birth outcome data during that home visit. If that's not available in a community or if the individual has not accepted that home visit service, being able to collect that information during a patient appointment, for example the six- or eight-week postpartum follow-up visit or while at the hospital before discharge or from the patient records from either of those locations, so again it's very important to be talking about this here in your implementation planning and establishing those partnership roles in being able to collect that data. There's also the need to enter the data into the secure database, DAISEY, which I've mentioned already. There is the opportunity to do direct entry into the system. I won't go into that now, but what we find most of our communities doing is that they collect the information via paper form and then they have a staff person who does the transcription of this data from the paper form into the electronic data system, so identifying who -- again across your partnering agencies might already be doing this type of work to where it wouldn't be a huge extension of their role to add this piece on for Becoming a Mom. I've also already mentioned the participant tracking, but I just wanted to come back to that here to show you an example of the tracking form that I've mentioned is available through the tableau reports in DAISEY, so it is really important to identify staff that

will be following the program completion status of the individuals between the sessions so they can identify when they're about to complete or if their due date is approaching, that we assure that those -- that the completion survey is completed and all of the evaluation tools are completed. So you'll see in the screen shot here on the right of the screen -- I know it's small but this is just a quick little screen shot of the participant activity completion report. I have whited out all of the identifying information so the caregiver ID, their name and the provider, but know that that is listed there as well, and then you can see you can follow across and identify which forms or evaluation tools have been completed as well as the Edinburgh and the tobacco use survey. There's a column that is checked if they have completed four or more sessions. In the guidance, you will see that there's a requirement or criteria to complete four or more of the six sessions in order to be considered complete and in order to collect the completion or the evaluation data. So that is marked there on the form. When you live online using this form, you're able to hover over each of those Xs and it provides more information about it, so for example it provides the date that the form was completed and that type of information. So we've worked very hard to try to assist you in this process but it is important for you to identify staff that will be monitoring and assuring that this work is done. I mentioned the final birth outcomes so that is the piece again that requires that collaboration with other partners to assure that we're getting that. That is very key to the process, the evaluation process, to establish the effectiveness of the program to see if it really is having an impact on behavior and ultimately birth outcomes. It is very important to form an evaluation committee. This is comprised, or should be comprised of your local perinatal community collaborative members, staff in previously listed roles that we've talked about, representatives from hospitals, partnering clinics and agencies, educational institutions, funders, faith-based organizations and program participants or former participants or participant support persons. It's very important to have their voice at the table as well, so the role of the committee is to review the evaluation data and the reports that are provided by KDHE so that the committee can make recommendations for program improvements and implementation as well as recommendations for broader collaborative work so it's essential that you utilize the data that's available to you to really be identifying any trending data that you as a community should be acting on. You know, maybe it may or may not be related to anything you can do in Becoming a Mom, but it may very well be broader than that, so looking to KDHE to see if there are any targeted resources through our integration tool kits that might available to target some of these areas where we might be seeing some data that's trending in a negative direction or if it's not available, again reaching out to us to see if it's on our radar and if there is anything available or within your community brainstorming around this and you know, engaging others in the work to try to bring about -- whether it's system changes or implementing other interventions to try to stop that negative trend and move things in a positive direction.

Moving on with the implementation overview, we will now discuss program promotion and scheduling.

Program Champions. So I can't say enough about how important it is that you have champions for this initiative in the community. Belief in the initiative and promotion is crucial to its success. It's really, really important from the beginning that prenatal education and prenatal care must be seen as a package and not as separate entities. We need to have providers that are promoting it as new prenatal care of their practice. This is how we're doing it now. Patients will see the provider and they will attend the prenatal education component, so this is different than how we've done it in the past. It really requires a change in mindset so no longer should

providers be putting a brochure in a packet and calling it good, but they need to be engaged in it. They need to be encouraging and promoting of it. They need to be following back with their patients at the next session to see if they attended. Again it needs to be embraced as part of prenatal care. We've had at different times when we've presented on this, initially we hear from communities that, well, I don't know about the idea of doing prenatal education because those childbirth education classes that we provide, nobody even attends those any more. They don't think there's a need for it. They have access to all the information they need online. You know, they don't even need to leave their living room. Yes, to some degree that is the mentality, but it's our job to change that mentality. We know that there's benefit for pregnant women or anybody for that matter getting outside their home, interacting with other individuals, being connected with different services and resources and be provided education. We know that not everything online is true and accurate, so it really is important and it is important that we embrace this new model. I can tell you that this model is not like the old childbirth education. The way the classes used to be, the ones I'm familiar with, we maybe had a childbirth class that was very focused on labor and delivery and maybe there was a separate breastfeeding class that focused on breastfeeding and that was it, and a lot of them are not very dynamic or interactive or very engaging, but with this model it's very intentional with the design of it that the sessions are very interactive. There's activities built into them. They're very engaging. I promise you if you will get your patient there the first time, they will return. By and large the majority do. We do have those that do not for many different reasons, but by and large participants will come back because they want to. They get there and they get engaged, it's been fun, they've learned all kinds of new information and they want to come back. So again, it's about really championing the program. I want to give you just a couple of quick examples where I have seen this in communities have such an impact and I can't say enough about the importance of physicians themselves, the medical providers embracing and promoting the program. So one example is that in one of our early pilots, the community health department was partnering with the FQHC in the community that was also a family practice residency program so they had residents that were coming through and providing care, and what they had found as a trend over the course of a couple of years is that in general we had a pretty high engagement rate so about 67 percent, around there is the percent of prenatal patients at this clinic that were engaged or enrolled in Becoming a Mom and the trend that we would see is that would stay pretty consistent and then somewhere around June, July, August we would see this dip where the enrollment rates would drop to like 20 percent which was a significant decrease. So it took a couple years for us to figure out that this was a trend and what we identified was that the residents were changing over in the summer. New residents were coming on in July and they were not receiving information about the program until we were scheduled to come and visit with them in October, and so what we were seeing again with the trend is after we visited in October, then the enrollment rates would increase back up to around 60-70 percent. So once we identified that, we changed the time that we presented and we got in there in July when the new residents came in and it totally changed that negative trend that we were seeing, so that told us how important it was for the physicians to be behind it and be engaged in promoting it with their patient and following up with them to see that they attended.

Another trend that we saw with this same clinic is that we can look by provider the number of referrals, and we saw consistently that one individual provider was having about 80 percent of his patients attend Becoming a Mom® whereas other providers, their rate of enrollment of patients was much lower and so spoke to him to see what was the difference and this individual provider absolutely believed in the program and he made it a point at every visit to ask how the sessions were going, so by him doing that, that had such an effect on the patient's view on the

program and the understanding that that was an important part of their prenatal care and thus led to engagement in the service, so absolutely the physician championing this has a major effect so I just really wanted to call that out and really challenge you all to think about that and really try to assure that is a part of your practice, to promote and encourage and follow up with the participants.

I think I spoke quite a bit here to the idea of promotion in the previous slide but I just want to touch on a couple of other points, so there is a brochure that we encourage for lead agencies to either develop or use the template that's provided by KDHE that will be shown in another slide so that that's produced and then shared among all of the agencies and referral entities in the community. We encourage an event to launch the initiative in the community and then have ongoing periodic media releases and that kind of thing to continue to promote and encourage attendance. Promoting through other community groups and committees -- we're all a part of numerous different committees, so wherever there is that opportunity, continue to promote the program and the collaborative, the efforts of the collaborative, and to engage those other partners in the community. Of course promoting it with all of your patients and clients as I spoke to in the previous slide, I used the example of the physician provider but certainly even in other settings, so for example WIC. That's a huge opportunity to promote and to refer clients. Other home visitation programs, really any different setting is all an opportunity for promotion and engagement. Providing extra prenatal services as incentives, so for example we've had communities where provider practices or the hospital is providing a sonogram as an incentive, for example maybe after the completion of four sessions or an oral health screening is being provided at no cost. Again that's their contribution to the initiative. It might that another entity is providing smoking cessation sessions that maybe they would ideally charge for but in this kind of a collaborative effort, they are providing those at no charge as an incentive. Another piece that I really want to just speak to briefly here is the patient history and special needs during a pregnancy. This is something that is very, very helpful if this can be communicated between provider and to Becoming a Mom staff. The Becoming a Mom® staff, again they're spending up to 12 hours with these individuals. Yes, it's in a group setting but there's so much opportunity to reach out and to speak to these individuals before or after the sessions so there's a real opportunity that they can provide some additional support, so having a provider that's willing to communicate and let them know maybe their concerns around a particular patient can be very, very helpful as well as things, you know, conditions like diabetes or a previous pre-term birth.
One of the things we do screen for as part of our initial survey is risk for pre -- a subsequent pre-term birth and so, you know, being able to communicate again between provider and Becoming a Mom staff, that these women have been identified, they're at risk and other services may be eligible to them to help kind of monitor and hopefully lower those risks, for example the utilization of 17P. That's a whole 'nother subject, but this is just example of where that communication and partnership between the different partners as part of this greater collaborative can be really, really beneficial to the patient.

So I mentioned on the previous slide that KDHE has provided a template for promotional materials so this is just a quick look at those. These are available on the private website. They're intended for local programs to adapt and customize. They're for your community. They're available in English and Spanish. There is just a little criteria around assuring use of the trademark symbol with Becoming a Mom and giving recognition to the March of Dimes, but all of this criteria is laid out in the guidance documents that we go into much more in depth

on the private website, but just wanted to show you these resources are available and we hope you take advantage of them and use them.

So promotion as part of prenatal care, again I think I've already spoken to this pretty heavily so I won't go into more depth here, but just a reminder to assure that the brochures and every new patient -- you know, new patient paperwork is included with that. We don't want it to just be put in a folder with other resource brochures and not spoken individually, so we need to identify staff within that setting that can actually call out the brochure, go over it and discuss it, answer any questions they might have and actually go as far as to scheduling if that's something that can be done there in that setting, so we'll speak to the scheduling more in another slide. So it is really important to review the session calendar with each patient to consider times that are related to the patient's due date, their work schedule and transportation needs, child care, et cetera to really determine the sessions that they need to attend, so are they coming into care later in their pregnancy? Let's identify the sessions that we can get them into immediately to try to get the most information to them before they deliver. This is a disparity program and so really I'm trying to provide a schedule that is available to them around their work schedule or coordinating with child care, those kinds of things, just being very intentional and very aware of those needs and really trying to schedule the session maybe along with the next provider appointment, so for example in some of our communities we have women traveling a distance of an hour or greater to their prenatal appointment, so if we can be very intentional about scheduling that appointment on the day of the Becoming a Mom® session, if they're enrolled that would be really, really helpful so they can make one trip to the community for both the appointment and the class versus having to come back on a couple of different days. And I know that takes staff time to be intentional with that, but it's something that can be really, really, beneficial and is very much appreciated by the patient and makes access much more available.

So I'll expand on scheduling just a little bit more here to call out a couple of key points, but know that I will go much more in depth on this and actually provide some sample schedules on the private website. So options for scheduling really need to meet your local population needs and fall in line with the resources you have available for offering them, so of course in a larger community where you're serving a great number of women, you may need to offer more sessions. In a smaller community or smaller hospital where you're delivering fewer women, you won't need to offer it as often. So again, there's some flexibility here and it's very much based on your needs. The criteria is that you follow the six two-hour session format that is part of the Kansas model. I know this sounds like a lot but I will tell you there is so much valuable information and very rarely do we have anyone that has given feedback that it was too much. Again, we have a high retention rate for the state where we usually hover around 75 percent that complete the program and they're just really engaged and it is very critical that we follow this six two-hour session format so that we are protecting program fidelity. We can't have in one community where they're getting through the content in one hour and in another community where they are barely getting through in two. It's that's apples and oranges, and from an evaluation standpoint, we just can't compare the two. I can assure you that there is enough content to fill the two hours. Actually in a lot of the communities, you know, the feedback is that they struggle to get through in two hours. I will also say that the lesson plans and the power points, all of the content that is provided is designed to be the most inclusive and then communities are encouraged to kind of customize that, so based on their audience they may find that they spend more time on one content area and less on another but it's all provided as a

part of the lesson plan and as part of the power point so that -- and the resources -- so that you have what you need. We don't want you to have questions and needs and not have the resources available to you, so again, it's very comprehensive but I think you will find that it is very, very well received. The design is not specific to gestational age although the first two sessions are really more ideal at the beginning of the pregnancy, but we wanted to be very flexible with this so that we can capture women where we can. When they engage in services, we're able to get them in and we're not held back by the need to follow a particular schedule or to cluster them in a particular cohort group based on their gestational age.
We want you to consider afternoon or evening session times, maybe even if you're offering multiple sessions, doing rotations or sessions on different rotations just so we have that flexibility to provide sessions and have them available based on different shift work, you know, needs around that, again trying to reach the disparity populations that may have more barriers and difficulties in getting to for example a middle of the afternoon session, so again, just be very intentional as you produce your
schedule to try to meet those needs. Also we want to really coordinate the scheduling within the clinic and among all the participating clinics, so again in a community where you have multiple providers or even multiple hospitals in a really large community, being able to communicate that and coordinate it, again so that there's opportunity for participants to attend at different locations if they need to based on their schedule or a quickly-approaching due date, that kind of thing. There's opportunities to share a schedule. We've not found any that are perfectly ideal but just one example is to maybe share the calendar on Outlook, a calendar -- set up a calendar that's specific to the Becoming a Mom sessions, but again, we can talk in more detail about that on the other webinars.

Incentives are not required but are promoted as part of the Kansas model. Research does support the benefit of incentives and increasing engagement and in stimulating behavior change. This is why many insurers and worksite wellness programs incorporate the use of incentives and why we are promoting this as part of the Kansas model. So it's up to program sites' discretion and based on resource availability as to the type of incentives or the number of incentives that are offered. A couple of points we want you to keep in mind: we'd like them to be multi-pronged in their approach, so for example, we encourage incentivizing a participant to both attend their doctor appointment and the group session. So for example, if they attend their provider appointment and then they come to the group session, they may receive a little bag of say, you know, five diapers for example. We also want to support or to promote support person attendance, so again, if they attend and bring a support person, the support person may receive this little bag of diapers or whatever other incentive has been identified, so again there's a multi-pronged approach to the incentive. We also encourage that you have a primary incentive or the main incentive that the big incentive is cumulative so it's based on the number of sessions completed, so I've mentioned multiple times there are six sessions in the series. An individual must complete four or more sessions to be included in the evaluation and to be considered having complete the program. Ideally, they complete all six, so we want to offer an incentive that where it's the amount or the value of it is increased based on the number of sessions they attend, so if they attend all six of course they would get the most valuable item, but you may kind of have it a tiered level, so for example if they complete four sessions they maybe get an incentive that's of maybe a $30 value and if they complete at five sessions, instead of that item they get one that's maybe of a $40 value, and if instead they complete at six sessions they get an item that's maybe a $50 or $60 value, so again I'm just throwing out numbers there, but hopefully you get the point that it increases in value. And I would suggest

setting a point where they have to complete at least a particular number like halfway or complete that minimum of four sessions before they earn any incentive. We would like to see that the incentives support the program messaging, so for example maybe providing a Pack 'n Play crib that is a safe sleep environment so it promotes that messaging or for example, an infant car seat, some things along those lines, but again there's no real criteria around this. When to deliver or provide this cumulative incentive again is up to the local community, but what we have learned is that it's more ideal if it can be tied to the collective of the birth outcome, so when they deliver and they complete the birth outcome, they then receive their incentive for having completed the program. Now that's not ideal in every situation, for example if they're relying on the Pack 'n Play crib for the primary sleeping location, we want to assure that they have that before the baby is born, but if there is a way to connect that. Where we've seen this most successful is in the communities who have home visiting services available. There is that partnership with the home visiting services that they deliver the incentive when they collect the birth outcome evaluation data during that home visit, or it may that if it's being collected in the postpartum visit that they receive the incentive there or during a WIC appointment, but again this is up to communities to decide, but just providing a coupe of examples here for you.
There are also communities that provide incentives as part of a session, so for example when we're providing education around safe sleep, they may provide a swaddling blanket or a halo sleep sack. There are some programs that they have had some volunteer organizations that have donated the goods and have put together some little personal care goodie bags that have little lotion and lip balm and things like that for provision during the labor and delivery session. We've also had communities where they have again a partner in the community like a dental provider might provide little travel toothpaste and toothbrush kits that they can provide when they speak about the oral health component, so lots of opportunities if those resources are available, but again I just want to clarify that this is up to the communities and the availability of resources, but we have had some communities be very, very creative with this and have had some amazing organizations and communities step forward to provide these incentives, and again working with faith-based organizations is really helpful in this area as well. A couple of other ideas are to provide some possible coupons, maybe for a dental hygienist visit or a sonogram as I mentioned previously where they're given a coupon for maybe at some milestone point in the sessions and then they can redeem them for those services at no charge. Possible drawings during sessions, and that -- for example anyone who has completed so many sessions is eligible for the drawing or anyone that's there at the session that day would eligible. Also communities have incentivized dual program enrollment and actually on the private website, we have an integration tool kit for WIC, the integration of WIC into Becoming a Mom® so we really want to support dual enrollment in the programs and have been able to incentivize that as well. Another example would be a pregnant woman who is smoking, incentivizing her enrollment in a smoking cessation program, so again just a few examples, but we've seen some pretty creative communities and some wonderful organizations that have stepped up to provide resources for these incentives.

Moving on to the curriculum and the actual implementation resources. Again we're just going to provide a high-level overview of this and there's much more available on the private website.

As I've mentioned previously, access to the curriculum and the implementation resources provided by KDHE on the private website does require commitment to protecting program fidelity, and that commitment is in the form of a signed memorandum of understanding or

MOU, and this is not a legally binding document but it's really a voluntary commitment to implementing the program per the Kansas model as I've been describing here in this webinar so I've got just a -- you know, a quick image of this here as a screen shot that you are able to view this document and access it for printing and signing here on this website. Also it requires adherence to the guidance document. These are available on the private website so I've just provided a little screen shot here, but of course on the private website we go much more in depth into this, but again it's really just around protecting the trademark of the original March of Dimes curriculum and protecting the program fidelity.

So I've mentioned multiple, multiple times the private website that provides access to the curriculum and the implementation resources, so I've provided a screen shot here of the home page of the private website. Now when I say "private" what I mean by this is we don't share this website publicly. We ask as I've shared on the previous slide that you sign an MOU before we give you the URL for this website and then we ask that you not share it publicly. Of course we want you to share it with your collaborative partners that have a role in implementing Becoming a Mom®, but again we really want to protect the program fidelity so want to assure that not anyone has access to it but really only the programs that have committed to protecting that fidelity have access to these resources. These resources have been the work, as I've mentioned before, many state partners. It's been huge investment by KDHE of over the course of the past three years to develop all of these different resources, so they're here for you. We want you to use them, but we also ask that you protect them. So here is a list of the different resources, so of course the curriculum handouts, so this is the March of Dimes original handouts
as well as the supplemental handouts that have been integrated as part of the Kansas model. There are power points for each of the sessions, lesson plans, activity plans. As I said the intention is to be very interactive so we have different activity plans that are a part of each of the sessions. There's a resource bank that has many different resources available that you can provide in addition to the curriculum or integrate in different ways. I've shown you already the templates for marketing and promotional materials that are available. There's training and TA webinars. I've mentioned them several times. There's a webinar for program coordination, a webinar for group facilitation and a webinar on evaluation and then there is also additional webinars on the evaluation component on the DAISEY solutions website which again we'll speak to later. There is also the link there for the integration tool kits, so this is where we have integrated the different targeted resources that were spoken to in the collaborative overview webinar, so for example the mental health, tobacco cessation, safe sleep, breastfeeding, oral health, just to list a few. So all of those very specific to integration in the Becoming a Mom group setting are located there on the private website so you can a lot of great resources that we hope will be of value to you in your community. We hope these help you feel supported in implementation and does not require you to reinvent the wheel and do all of the work from ground zero. Again this is a major component of the infrastructure that KDHE has invested in providing to you at the local community level.

We are in the home stretch now here as we begin to talk briefly about evaluation and reports.

There are actually a total of five additional webinars dedicated to the evaluation process, so I'm not going to go into a lot of depth here, just again a very, very high-level overview. DAISEY is data system that I have mentioned multiple times. It is a shared measurement system designed by social scientists to help communities see the different they are making in the lives of at-risk

children, youth and families, so this is provided out of KU. They have been our partnership for several years here with the development of DAISEY and supporting our grantees and utilizing this data system and it's been very, very valuable to us at the state level as well as to local communities in really being able to do greater program evaluation.

Again just another high-level overview of the evaluation component. It is a required component of implementation. We have to evaluate to know if there's any benefit to this initiative. The evaluation certainly assists us in getting greater support from other state partners for this and in really just supporting continued efforts. I mentioned previously that DAISEY is the state-supported data system. Within DAISEY, we have built tableau reports that assist sites in participant tracking and program management, so these are reports that make the data available to local communities in real time so that you can access that data on a daily basis and really be able to do your own program evaluation and participant tracking. Sites are required to enter data into DAISEY on a monthly basis following their BaM sessions or as I mentioned previously, they can do via direct entry by the participant. Again that's another discussion, but just do know there is that requirement to enter the data on a monthly basis for your benefit as well as ours. We can't have program sites that are months behind in data entry. It's just not of value to either one of us, so as I mentioned, the data is available to the sites for access on a real time basis through the tableau report so that allows you to have access to that data as you need and not wait on KDHE to get you an annual report. We do also have KDHE and KU evaluators that are available to provide technical assistance through DAISEY and through KDHE as well. We do at KDHE provide an annual site report to each of the individual sites as well as a state aggregate report. We have gone through some transition with these reports here this year, so I cannot at this time tell you the exact timeframe that these reports come out. We are anticipating later summer to early fall. Within transition has included is previously we have in the reports, we have compared the current year BaM data to county level and state level data from the previous year. That's valuable to a certain extent, but we have worked very, very hard to establish a process for being able to link the data to the live birth records and vital statistics as well as to be able to provide to a current year county and state data, so this is going to be of huge value to you at the local level as well as to us at the state level in really evaluating program efforts. However this does produce a delay in the timing of when the reports will be provided to you, so historically they were usually provided in March following the end of the year and data submission the first part of January, but we will not have access to vital statistics data until July so that will create that delay in release of the reports to the local community, so I would say you can anticipate these reports being available around September -- August or September, but again because at this point as I'm recording this webinar we are just newly into this process, I don't have a definite timeframe for that but these reports you will find to be of great value and I'll show you a screen shot of them here in the next slide. So as far as reporting from sites, there's not additional reporting that's needed. Any community that's receiving Title V MCH aid to local funds, we ask that you incorporate the reporting as a part of your plan because this should be the work that you're doing -- a part of the work that you're doing for your MCH application for that year, so it makes sense that that be integrated into that. Also I mentioned previously the convening of the local evaluation committee or your perinatal coalition, the value of them really reviewing the data and developing programing plans for the next year so I've spoken to that already so that wraps this piece up.

So here is just a couple of quick screen shots of the evaluation tools. The evaluation tools include the initial survey which is essentially a pre-test, the completion survey which is

essentially a post-test and it would be completed after the completion of four or more sessions, and then the birth outcome card which is the collection of the birth outcome data following the birth of the baby. What these tools measure is knowledge change, behavior change or the intention to change behavior and birth outcomes, so you see the larger image here is an example of the initial survey in printed paper form and then in the lower right-hand corner there an image of this initial survey online, and so again it can either be direct entry by a participant or it can be collected in the paper form and then transcribed into the electronic system. The tools are very user-friendly once you get acquainted to them.

And here are just a couple of screen shots of Becoming a Mom® reports. In the lower part of the screen, you will see the active participant risk status report, so this is a sample report in DAISEY -- so this is a tableau report. I have whited out the identifying information there you will see in the middle of that kind of white column where I have blocked out the identifying information, the names and identification numbers, but this is an example of a very useful report that identifies questions or fields from the initial survey that assessing risk factors, you know, risk around a pregnancy. So for example, have they engaged in prenatal care yet? Have they been told they have a high-risk pregnancy? Do they smoke? Do they have any other health problems and have they had a history of a previous pre-term birth? So this report helps local program staff identify at a glance any individual participants that might have these risk factors. The intention is then that they are easily identified and then they can follow up with them following their enrollment or at the next session to provide any additional resources or services that might be needed and also to engage in conversation with that partner and provider around their care. The other two images are of the state aggregate report, so this is just an image of the cover and then just one example of one of the pages where there are several figures. These are really looking at demographics and their -- when they initiated prenatal care, but there's numerous figures. They are taking the data that we've collected in the evaluation tools and presenting it back to the communities or in the state aggregate, it's a look at the state as whole to see if we're on track with targeting that disparity population and then as far as program outcomes and, you know, program evaluations, so there's a lot of narrative that is included in the report as well. The epidemiologist does a lot of interpretation of the data that's included so I think you will find these reports to be of great value to you and your community partners.

So what are the next steps if this is indeed a model that your community is interested in implementing?

Before identifying the next steps, I'd like to do a quick recall of the four criteria for implementation of Becoming a Mom® according to the Kansas model. We really strongly encourage and promote the development of the collaborative structure or a backbone behind the implementation of Becoming a Mom®. This to your community's benefit that you have multiple entities or partners working together to implement this initiative. We also really encourage that you take a multi-pronged approach integrating prenatal care education and support. We require a minimum professional level staff as the primary group facilitator. This assures that the staff has the education and the content expertise to adequately deliver the curriculum as well as answer questions. We require that you use the standardized Becoming a Mom® curriculum for the Kansas model which includes the original Becoming a Mom® curriculum from the March of Dimes as well as the supplemental handouts that have been integrated into the Kansas model. This curriculum is available on the Becoming a Mom® private website. We also require that you follow the six two-hour session format to protect

program fidelity across sites and across the state. We also require that you participate in the evaluation components. This simply shows the effectiveness again at the local community level and across the state.

One topic I realized I have not discussed yet and I know is always a concern and question among communities that are looking at implementation is what is the cost and how is it funded? I do speak to this on the FAQ document so certainly please do reference that document as I give some ideas on what some of the cost components are, but really the cost of implementation varies from site to site. It depends on the program or participant size. It also largely depends on local resource availability and in-kind donations. Again the intention of the collaborative approach is that resources are shared by collaborative partners already serving the MCH population so this decreases the cost burden on any one entity and really supports long term sustainability, so again it's not been our intention to bring in a new grant that's going to support this program for one year and then we're going to pull the funding and the program's going to go away. The approach is that to use local funding, local resources that are already present -- for example public health Title V funding that's in your community and funding through all of these other organizations listed below to implement this initiative as a part of the work that you're already doing. We're just going to do it in a little bit different way, so local communities are encouraged to identify the existing funding sources allocated for these like services as well as soliciting funding and in-kind donations from the non-traditional partners that we've spoken to here throughout this webinar.

For any other questions that you might have after reviewing all of the resources that are provided here on this website, you can email us at BaMinterest@ks.gov and we will get back to you with a response as quickly as we can. Also don't forget to review the comprehensive FAQ document that's on the website. I've provided just a screen shot here but you can link to that document here on the website. It's a quite extensive document that is a compilation of questions that we've gotten over the years as new sites have been -- beginning their implementation process.

So the next steps include review and completion of the implementation planning checklist that is available here on this website. You'll also need to complete the online readiness survey. That again is available on this website and this just assists us in better assisting you. You will also need to sign and submit the memorandum of understanding that is available on this website and you will then be provided access to the KDHE Becoming a Mom® private website that I have spoken to through this webinar where you will have access to all of the implementation resources that have been developed and briefly shared with you here in today's webinar, so thank you for taking this opportunity to learn more about this model. I hope that your community is still interested and has maybe gotten a little better understanding of the model and the implementation process and I look forward to working with you here in the future as you begin the implementation process. Thank you so much.