2022 Annual Assessment of Healthy Start Sites
Healthy Start Performance Project

National Institute for Children's Health Quality (NICHQ)
Technical Assistance & Support Center (TASC)

January 2024

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1. Background

Amaka Consulting and Evaluation Services (ACES), LLC is a certified Minority Business Enterprise (MBE) and Women Business Enterprise (WBE) with the Massachusetts Supplier Diversity Office. Since its incorporation in 2016, ACES has provided invaluable expertise in areas such as health and racial disparities, maternal and child health, program evaluation, grant writing, and mixed methods research. With over 60 consultants representing various public health disciplines, the composition of research associates within ACES reflects the diversity of technical skills and content knowledge to meet clients' needs across many domains.

As a MBE and WBE certified firm, many ACES team members bring a cultural depth and sensitivity to our work in, for, and with underserved communities. ACES evaluation work is grounded in our commitment to health equity, racial and social justice, and inclusion. ACES prides itself on maintaining a team of evaluation experts with diverse expertise and backgrounds. Our team members are people of color, immigrants, first-generation college students, and folks from low-income backgrounds.

ACES' ability to integrate a client-centric approach, **public health experience and expertise positions ACES well to work collaboratively with the National Institute for Children's Health Quality's (NICHQ) Healthy Start TA and Support Center (TASC)**. NICHQ is a nonprofit organization aiming to improve the lives of children and families through innovative, community-based, equity-driven initiatives targeting parental and child health. One of NICHQ's largest initiatives is the Supporting Healthy Start Performance Project (SHSPP), a program aimed at technical assistance and capacity building for the Healthy Start (HS) program, a community-based federal program to eliminate perinatal and infant health disparities consisting of 101 grantees across 34 U.S. states, Puerto Rico, and Washington, D.C. The SHSPP is made possible through a cooperative agreement with the Maternal and Child Health Bureau Division of Healthy Start and Perinatal Services and the Health Resources and Services Administration.

Between September and November 2023, ACES worked closely with NICHQ SHSPP's team to design and implement an **opt-in survey** to assess the progress made by each HS site in the 2022 grant year. The annual assessment provides the Healthy Start Technical Assistance & Support Center (TASC) an opportunity to improve its delivery of high-quality technical assistance and identify future priority. The goal of the assessment is to understand Healthy Start projects' organizational structures, satisfaction with TASC offerings, programmatic needs, progress toward benchmarks and key objectives, data capacity, and progress towards sustainability.

The findings in this report are based upon sites who chose to respond to the survey (*N*=87 grantees) and *are not* intended to be representative of all Healthy Start sites (*N*=101).

Furthermore, the responses given by the staff member from sites that completed the survey are not meant to be inclusive of all the perspectives of staff members at their site.

NOTE: Although the survey was completed by 87 unique grantees, there were 126 survey records, meaning that many sites completed the survey more than once. Most likely, either multiple people from the same site completed the survey, or the respondent started the survey and returned to it, opening a new instance of the survey. For quantitative questions, the most complete response (most questions answered) from a site were used. All qualitative responses (open-ended questions) were included for analysis.

2. Abbreviations and Acronyms

ACES	Amaka Consulting and Evaluation Services
CAN	Community Action Network
CEU/CME	Continuing Education Unit/Continuing Medical Education
CHW	Community Health Worker
CLC	Certified Lactation Counselor
COIN	Collaborative Innovation Network
DHSPS	Division of Healthy Start and Perinatal Services
FIMR	Fetal and Infant Mortality Review
FP	Family Partner
FPC	Fatherhood Program Coordinator
HRSA	Health Resources and Services Administration
HS	Healthy Start
HSMED	Healthy Start Monitoring and Evaluation Data
MCH	Maternal and Child Health
MSW	Master of Social Work
PSI	Postpartum Support International
QA	Quality Assurance
QI	Quality Improvement

SMART	Specific, Measurable, Attainable, Relevant, Time-bound
TA	Technical Assistance
TASC	Technical Assistance and Support Center
WIC	Women, Infants, and Children

3. Participants and Staffing

Survey respondents (n=87) represented **86.1%** of the 101 HS grantees across the United States. Respondents served primarily urban areas (n=69; 79.3%), with many grantees serving rural areas (n=21; 24.1%) as well as a handful of grantees serving tribal (n=4; 4.6%) and border (n=2; 2.3%) communities. A list of all participating sites is shown below (Table 1).

Table 1. List of Participating Sites.

Albert Einstein College of Medicine. Inc.	County of Los Angeles	Northeast Florida Healthy Start Coalition. Inc.
Albert Einstein Healthcare Network	County of Lucas	Northern Manhattan Perinatal Partnership. Inc.
Baltimore Healthy Start. Inc.	County of Maricopa	Nurture KC
BCFS Health and Human Services	County of Multnomah	Palmetto Health
Ben Archer Health Center. Inc.	County of Onondaga	Pee Dee Healthy Start. Inc.
Birmingham Healthy Start Plus. Inc	County of Sedgwick	Piedmont Health Services & Sickle Cell Agency
Boston Public Health Commission	County of Tulsa	Project Concern International
Centerstone of Indiana. Inc.	Crescent City WIC Services. Inc.	Public Health Solutions
Centerstone of Tennessee. Inc.	Dallas County Hospital District	REACH UP. Inc.
Central Mississippi Civic Improvement Association. Inc.	Delta Health Alliance. Inc.	SGA Youth & Family Services NFP
Children's Futures. Inc.	Family Road (of Greater Baton Rouge)	SHIELDS for Families
Children's Hospital Medical Center	Family Tree Information Education & Counseling Center	South Carolina Office of Rural Health
Children's Service Society of Wisconsin	Five Rivers Health Centers	Southern Illinois Healthcare Foundation. Inc.

Table 1. List of Participating Sites. (cont.)

City of Cleveland	Florida Department of Health	Southern New Jersey Perinatal Cooperative. Inc.
City of Columbus	Fort Wayne Medical Society Foundation. Inc.	Spectrum Health
Cobb County Board of Health	Gift of Life Foundation	The Corporation of Mercer University
Colorado Nonprofit Development Center	Government of the District of Columbia	The Foundation for Delaware County
Community Health Center of Richmond. Inc.	Great Plains Tribal Chairmen's Health Board	The Health & Hospital Corp of Marion County
Community Health Centers. Inc.	Hamilton Health Center. Inc.	Tougaloo College
Community Service Council of Greater Tulsa	Healthy Start. Inc.	Union Hospital. Inc.
Connecticut Department of Public Health	Indiana Rural Health Association	University of Arkansas System
County of Alameda	Institute for Population Health. Inc.	University of Houston System
County of Clayton	Inter-Tribal Council of Michigan. Inc.	University of Illinois
County of Cook	Johns Hopkins All Children's Hospital. Inc.	University of Miami
County of Fresno	Little Dixie Community Action Agency. Inc.	University of North Carolina at Pembroke
County of Genesee	Louisville-Jefferson County Metro	University of North Texas Health Science Center at Fort Worth
County of Ingham	Maternity Care Coalition. Inc.	Urban Strategies
County of Kalamazoo	Missouri Bootheel Regional Consortium. Inc.	Visiting Nurse Services
County of Laurens	Newark Community Health Centers. Inc.	West Virginia University Research Corporation

Staff members at participating HS sites varied greatly. The positions most commonly employed on full- or part-time staff were **Program Director** (n=71; 81.6%); **Fatherhood Coordinator** (n=61; 70.1%); and **Program Manager** (n=61; 70.1%), while the positions least commonly employed on staff were **Nutritionist** (n=3; 3.4%); **Medical Doctor** (n=5; 5.7%); and **IT Technician** (n=8; 9.2%). The positions most commonly employed on contract were **Evaluator/Data Analyst** (n=43; 49.4%); **Doula** (n=26; 29.9%); and **Fatherhood Coordinator** (n=18; 20.7%) (Table 2).

Many HS sites reported plans to hire **CAN Coordinators** (n=25; 28.7%); **Evaluators/Data Analysts** (n=21; 24.1%); and **Fatherhood Coordinators** (n=19; 21.8%) in the next year. The positions that the fewest HS sites planned to hire in the next year were **Medical Doctor** (n=1; 1.1%); Nutritionist (n=1; 1.1%); and **Midwife** (n=4; 4.6%) (Table 2).

Turnover varied by position, and the positions with the highest rate of job turnover in 2022 were **Case Manager** (n=27; 56.3%); **Community Health Worker** (n=25; 43.1%); **Care Coordinator** (n=10; 38.5%); and **Fatherhood Coordinator** (n=25; 32.9%). Details about each position are shown below (Table 2).

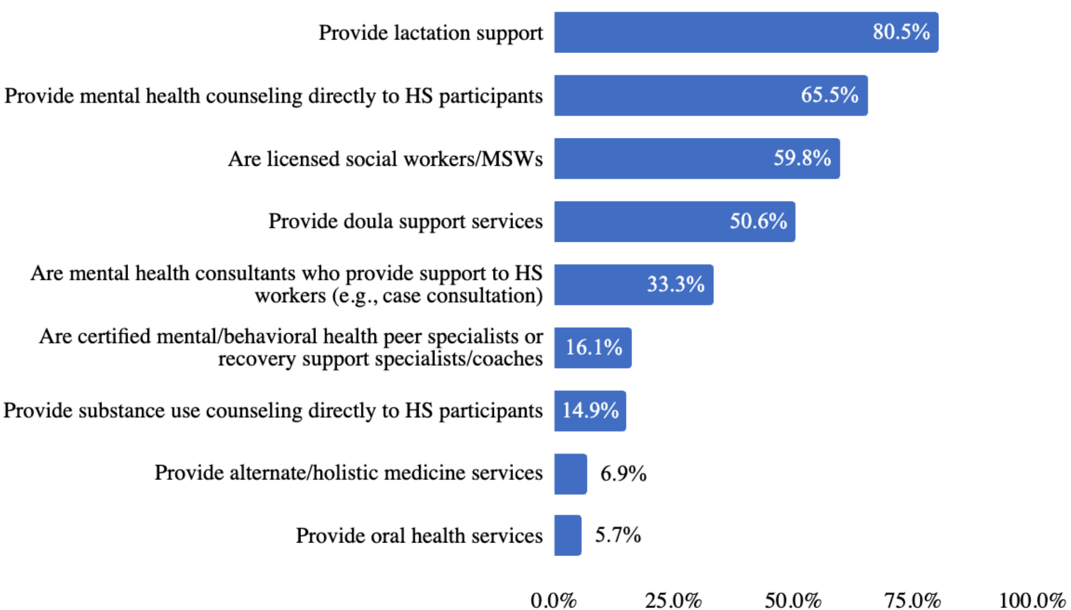
Table 2. Staffing of Specific Positions at HS Sites in 2022.

Position	At least one staff member *n (%)*	At least one consultant/contractor *n (%)*	Plan to hire in next year *n (%)*	Position turned over in 2022* *n (%)*
CAN Coordinator	40 (46.0)	13 (14.9)	25 (28.7)	15 (28.8)
Care Coordinator	25 (28.7)	6 (6.9)	10 (11.5)	10 (38.5)
Case Manager	47 (54.0)	7 (8.0)	13 (14.9)	27 (56.3)
Community Health Worker	52 (59.8)	7 (8.0)	15 (17.2)	25 (43.1)
Doula	19 (21.8)	26 (29.9)	7 (8.0)	5 (15.2)
Evaluator/Data Analyst	49 (56.3)	43 (49.4)	21 (24.1)	14 (19.7)
Fatherhood Coordinator	61 (70.1)	18 (20.7)	19 (21.8)	25 (32.9)
IT Technician	8 (9.2)	12 (13.8)	6 (6.9)	0 (0.0)
Medical Doctor	5 (5.7)	5 (5.7)	1 (1.1)	1 (10.0)
Midwife	10 (11.5)	4 (4.6)	4 (4.6)	1 (6.7)
Nurse	22 (25.3)	12 (13.8)	10 (11.5)	10 (25.6)
Nurse Practitioner	17 (19.5)	9 (10.3)	6 (6.9)	3 (12.5)
Nutritionist	3 (3.4)	6 (6.9)	1 (1.1)	2 (22.2)
Program Director	71 (81.6)	6 (6.9)	15 (17.2)	8 (9.9)
Program Manager	61 (70.1)	4 (4.6)	11 (12.6)	7 (10.6)

* *Only grantees reporting staffing of each position were used to compute turnover rates.*

In addition, respondents provided details on the services provided by staff who received HS funds in 2022. **Lactation support services** were most commonly supported by HS funds, with 70 respondents reporting at least one staff member providing lactation support receiving HS funding (80.5%). **Mental health counseling** was supported by HS funds in 65.5% of responding sites (n=57), and 59.8% of sites supported at least one **licensed social worker/MSW** with HS funds (n=52). **Oral health services** were least commonly supported by HS funds (n=5; 5.7%), followed by **alternate/holistic medicine services** (n=6; 6.9%) and **substance use counseling** (n=13; 14.9%) (Figure 1).

Figure 1. Services Supported by HS Funds by Percent of Sites Reporting.*



** Choices not mutually exclusive.*

4. Results

I. Grantee Participation Trends and Future TA & Support Preferences

Of all the activities provided by TASC, HS grantees have most frequently participated in **grantee webinars** (90.8%); **training and certificates** (55.2%); **learning academies** (47.1%); **cohorts** (47.1%); and **networking cafés** (44.8%). A large proportion of grantees also participated in **one-on-one TA** (36.8%) and **COIN** (28.7%) (Table 3).

Table 3. Grantee Participation in TASC Activities by Type (*N*=87).

Support Activity Type*	*n (%)*
Grantee webinars	79 (90.8)
Training and certificates	48 (55.2)
Learning academies	41 (47.1)
Cohorts	41 (47.1)
Networking cafés	39 (44.8)
One-on-one	32 (36.8)
Collaborative Innovation Network (COIN)	25 (28.7)
Other	4 (4.6)

** Choices not mutually exclusive.*

When asked about future TASC offerings, grantees' preferences paralleled their participation trends, with **webinars** (86.2%), **training and certificates** (79.3%), and **learning academies** (59.8%) ranking in the top three preferred future offerings. Other common responses for future offerings included **networking cafés** (57.5%); **one-on-one TA** (55.2%); **cohorts** (54.0%); **COIN** (40.2%); and **PSI HS support groups** (39.1%) (Table 4).

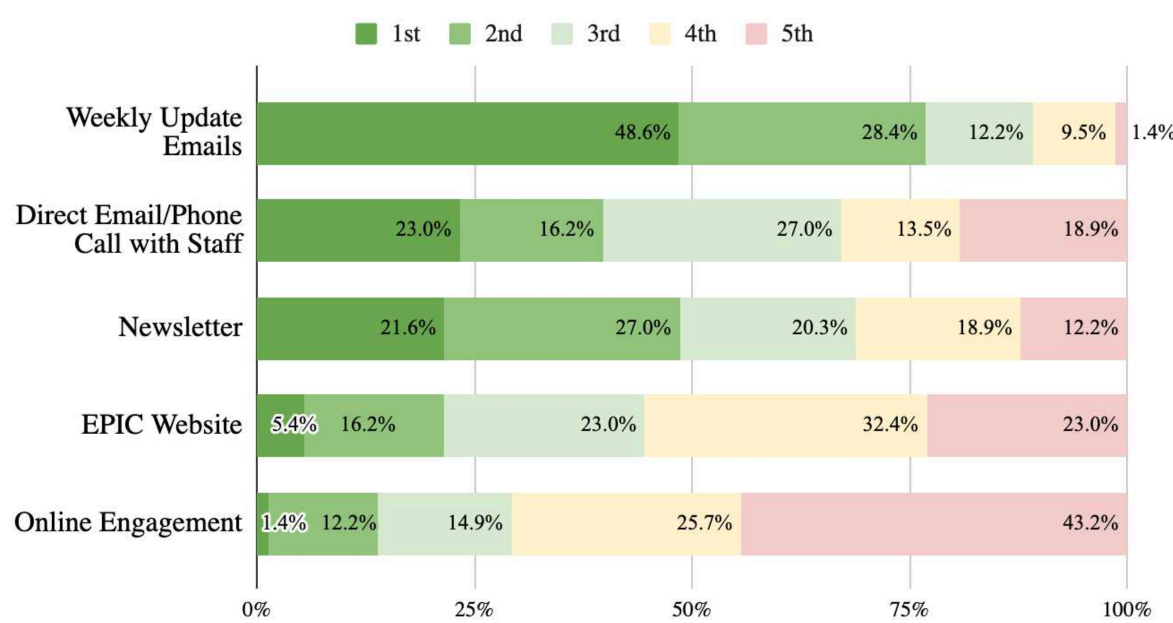
Table 4. Grantee Preferences for Future TASC Offerings (*N*=87).

Support Activity Type*	*n (%)*
Grantee webinars	75 (86.2)
Training and certifications	69 (79.3)
Learning academies	52 (59.8)
Networking cafés	50 (57.5)
One-on-one	48 (55.2)
Cohorts	47 (54.0)
COIN	35 (40.2)
Postpartum Support International (PSI) HS support	34 (39.1)
Other	8 (8.1)

** Choices not mutually exclusive.*

When asked to rank five different communication methods commonly utilized by TASC, **weekly update emails** were most commonly chosen as grantees' first choice (48.6% of responses), followed by **direct phone calls/emails with staff (23.0%), and newsletters (21.6%)**. Hardly any respondents chose **EPIC** (5.4%) or **online engagement** (1.4%) as their first choice communication method (Figure 2).

Figure 2. Grantee Preferences for Mode of Communication with TASC (*N*=74).



Taking all rankings into account, **newsletters** were slightly more popular than **direct phone calls/emails with staff.** The overall average ranking is shown below (Table 5).

Table 5. Ranking of Grantee Communication Preferences.

Mode of Communication	Average Rank	Overall Rank
Weekly Update Emails	1.7	**1**
Newsletter	2.4	**2**
Direct Email/Phone Call with Staff	3.0	**3**
EPIC Website	3.7	**4**
Online Engagement	3.9	**5**

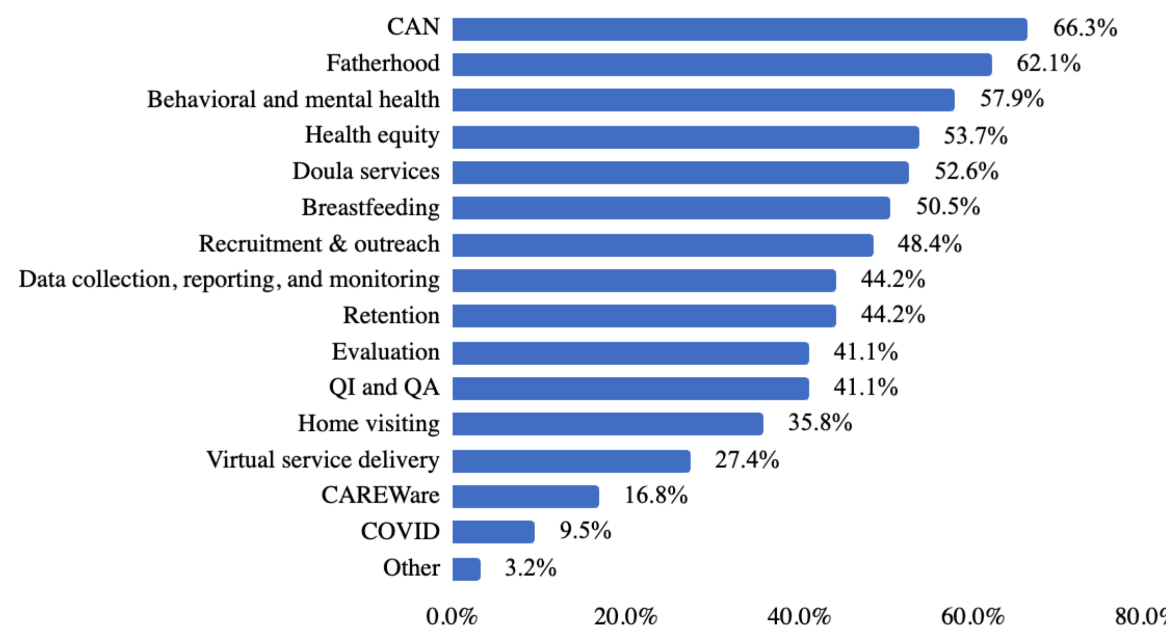
Qualitative responses concerning communication with TASC were generally positive. Regarding the EPIC newsletter, one respondent noted:

"I have been very pleased with the support and communication that I receive that allows me to lead our [redacted] HS team in a good and informative way."

When asked which topical areas they prioritized for TASC support, grantees endorsed a large number of key areas, averaging between 6 and 7 selections from the list presented. The most commonly selected priorities were **CAN** (66.3%); **fatherhood** (62.1%); **behavioral and mental health** (57.9%); **health equity** (53.7%); **doula services** (52.6%); and **breastfeeding** (50.5%). Of

the given list, the priorities selected with the least frequency were **COVID** (9.5%); **CAREWare** (16.8%); **virtual service delivery** (27.4%); and **home visits** (35.8%) (Figure 3).

Figure 3. Grantee Priorities for TASC Support.



** Choices not mutually exclusive.*

II. Grantee Satisfaction with TASC Activities

Grantees were largely satisfied with the TASC, with a high proportion reporting they were *Satisfied* or *Very satisfied* with **TASC overall** (86.1%) and with **TASC's overall responsiveness** (77.0%). The activity with the highest degree of satisfaction was **webinar offerings**, with which 94.1% of respondents reported being *Satisfied* or *Very satisfied*. The majority of respondents also reported satisfaction with **newsletters** (83.8%); **resources on EPIC** (81.2%); and **1:1 consultation TA** (73.4%) (Table 6).

Table 6. Grantee Satisfaction with TASC Activities/Resources		**_n (%)_**
TASC overall (n=85)		
	Very satisfied	29 (34.1)
	Satisfied	**45 (52.9)**
	Neutral	10 (11.8)
Webinar offerings (n=85)		
	Very satisfied	36 (42.4)
	Satisfied	**44 (51.8)**
	Neutral	4 (4.7)
	Dissatisfied	1 (1.2)
One-on-one consultation TA (n=53)		
	Very satisfied	18 (34.0)
	Satisfied	**22 (41.5)**
	Neutral	12 (22.6)
	Dissatisfied	1 (1.9)
Resources on EPIC (n=83)		
	Very satisfied	26 (31.3)
	Satisfied	**42 (50.6)**
	Neutral	12 (14.5)
	Dissatisfied	1 (1.2)
	Very dissatisfied	2 (2.4)
Newsletters (n=82)		
	Very satisfied	23 (28.0)
	Satisfied	**45 (54.9)**
	Neutral	12 (14.6)
	Dissatisfied	2 (2.4)
Overall responsiveness (n=83)		
	Very satisfied	26 (31.3)
	Satisfied	**39 (47.0)**
	Neutral	15 (18.1)
	Dissatisfied	3 (3.6)

In regards to webinars, respondents noted that the CAN webinar series was "phenomenal" and prompted further interest in TA. Others said the webinars were "excellent" and provided them opportunities for interactive conversations. One respondent noted a desire for more advanced notice of webinars.

When speaking to one-on-one consultation, there was general positivity towards TASC staff members. Many respondents noted their thanks for specific staff members who had helped them. One suggestion was for sites seeking consultations to be able to access the "primary consultant" to ask their questions directly:

"During 1:1 TA consultation, I would prefer to have direct access to connect with the primary consultant if I have questions, rather than a TA support person acting as a middle man to filter communications through."

Areas of Improvement for the TASC

In response to open-ended questions, participants offered insight into some challenges with the TASC, particularly when their rating indicated they were not satisfied. The sub-themes from those responses are in the following sections:

Response Timeliness

Open-ended responses about the timeliness of support from the TASC were mixed. Most open-ended responses noted there was not sufficient timeliness in receiving responses to emails sent to TASC. One example given was that the resolution of program or CAREWARE issues are often not timely. One respondent noted that the lack of timeliness contributed to staffing orientation delays for new staff hires.

"[Ways to improve include] communication regarding CHW training models on the Epic Center website, and the timeframe of responses has contributed to orientation delays for HS New Hire staff."

"I received some delays in response time when submitting a TA request, would love to see a quicker response time."

Others felt the TASC was efficient, responsive, and overall supportive.

Updates & Monitoring

There was some mention of a lack of updates to certain resources or information being outdated. For example, one respondent mentioned that the webinar/activity calendar is not updated regularly. The EPIC center was noted as a resource that is not updated regularly and overall, not user friendly, though the resources on the website were noted as good content. Suggestions included a live chat feature on the EPIC website for more direct and timely support.

CHW Courses

There were several mentions of issues with CHW training modules. Respondents specifically noted delayed access to the CHW modules/courses (activation email delay) and the program generating blank certificates (without names) upon completion. Respondents also felt there was an overall lack of communication regarding CHW training modules.

"[We've had] Problems with receiving the activation email for the CHW Course through EPIC. I always have to reach out to get someone to manually do it."

Localizability & Cohort-Specific Learning

Open-ended responses indicated mixed views regarding the relevance of TA for their site-specific needs and context. For example, some noted that webinars were not always applicable to the site's target population. Others felt the TASC provided a great variety of resources, support, and educational tools that were tailored to the needs of the grantees:

"TASC offers relevant and useful education, which supports the success of Healthy Start grantees. This then enables the mission of Healthy Start to be obtained."

Learning in cohorts seemed to be a well-received model to balance the need for more specific topics to be explored at length, such as Fatherhood and CAN cohorts, both mentioned and appreciated.

Others suggested opportunities to learn and engage with programs with similar attributes or geographic proximity. This idea seemed to stem from similar offerings in their state or territory:

"We have participated in several learning collaboratives over the past couple of years mostly involving programs in [state names redacted] that have not necessarily been limited to Healthy Start but have enabled us to foster strong relationships with them and the state as a result."

"The work we do in a collaborative nature is also beneficial. The grantees in [state name redacted] convene outside the traditional way and standards. We connect through working together and leading by example through coming up with alternative ways to connect the dots with the families we serve."

One respondent encapsulated the mission of the TASC and the technical assistance it provides needing to move toward a 360-degree way of assisting in the work that they do:

"We would like to learn about all TA opportunities and not just those that are identified as a struggle or challenge. This would help us to be more proactive and to strengthen what we already do."

III. Quality Improvement, Data Collection, and Capacity Building

Grantee Perceptions of Quality Improvement and Capacity Building in 2022

Respondents were asked to report on improvement of their program in terms of the quality of and their capacity for evidence-based services. The vast majority of respondents (90.5%) reported that the quality of their evidence-based services improved over the 2022 grant year, and a large proportion (78.6%) reported that their program's capacity to implement such services had also improved (Table 7).

Table 7. Grantee Quality Improvement and Capacity Building Over the 2022 Grant Year.

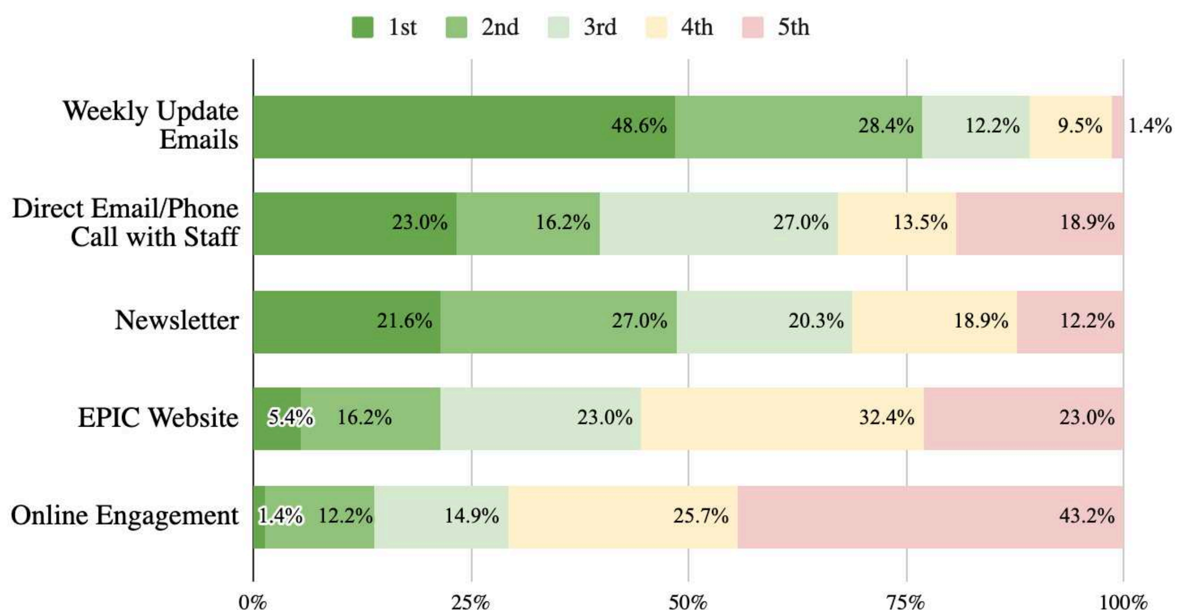
"Has the quality of your evidence-based services and those based on best practices improved over the 2022 grant year?" (*N*=84)	
Yes	**76 (90.5)**
No	8 (9.5)

"Has your program's capacity to implement evidence-based services and those based on best practices improved over the 2022 grant year?" (*N*=84)	
Yes	**66 (78.6)**
No	18 (21.4)

Effect of TASC Support on QI, Data Collection, and Capacity Building

When asked the extent to which TASC impacted their program, grantees reported that TASC support improved many of their program activities to some degree (Figure 4). Grantees endorsed the highest level of improvement in workforce capacity, with 45.9% of respondents reporting that TASC support **increased workforce capacity** either *A lot* or *A great deal*, compared to **promoting synergy among HS grant recipients** (43.9%); **increasing health equity capacity** (43.9%); **increasing project capacity on data collection** (42.9%); **increasing project's capacity to deliver evidence-based services** (35.7%); and **increasing project improvement and monitoring** (28.6%). Of the included metrics, TASC support had the smallest effect on **project improvement and monitoring**, with 16.3% of respondents reporting no increase (compared to between 4.1-7.1% of respondents for all other metrics) (Figure 4).

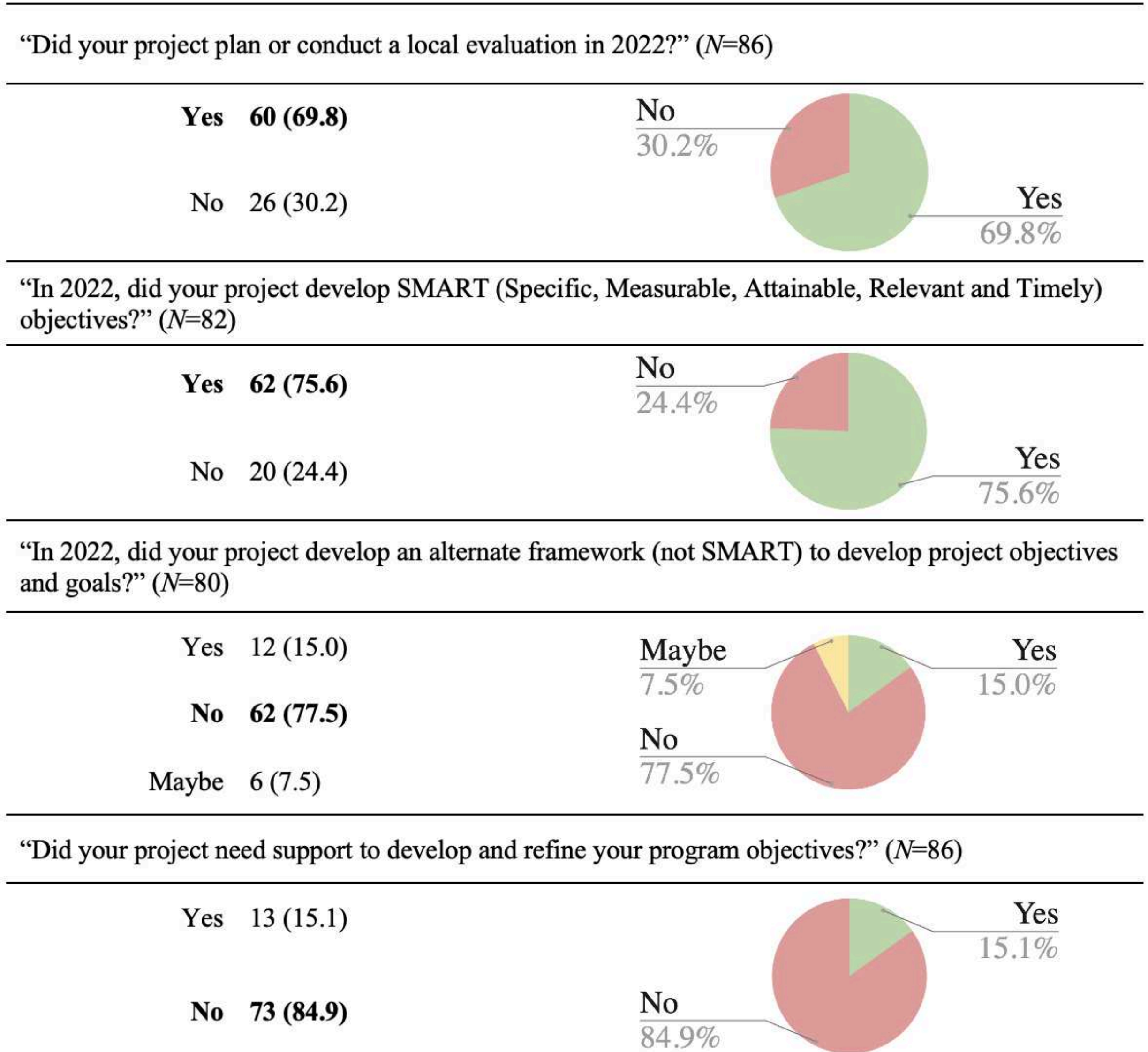
Figure 4. Effect of TASC Support on Grantee Operations.



Program Planning and Evaluation

The majority of sites (n=74; 85.0%) reported developing a framework to conceptualize project objectives and goals, either via SMART goals (n=62; 71.3%) or via an alternative framework (n=12; 13.8%). However, of the 87 sites surveyed, only 58 (66.7%) reported planning or conducting a local evaluation in 2022. In addition, 13.8% of sites (n=12) reported needing support to develop and refine program goals (Table 8).

Table 8. Grantee Program Planning and Evaluation.



"Did your project plan or conduct a local evaluation in 2022?" (*N*=86)	
Yes	**60 (69.8)**
No	26 (30.2)
"In 2022, did your project develop SMART (Specific, Measurable, Attainable, Relevant and Timely) objectives?" (*N*=82)	
Yes	**62 (75.6)**
No	20 (24.4)
"In 2022, did your project develop an alternate framework (not SMART) to develop project objectives and goals?" (*N*=80)	
Yes	12 (15.0)
No	**62 (77.5)**
Maybe	6 (7.5)
"Did your project need support to develop and refine your program objectives?" (*N*=86)	
Yes	13 (15.1)
No	**73 (84.9)**

Data Collection

The vast majority of respondents utilized a data collection system (n=83; 95.4%), although only 24.1% (n=20) were required by their site to do so. Data management systems most commonly used were the Go Beyond MCH/Well Family System (n=26; 29.9%); CAREware (n=14; 16.9%) and REDCap (n=12; 14.5%).

Participants were asked about factors helping and hindering data collection. The most commonly endorsed facilitators to data collection were **standardized data collection forms** (n=68; 78.2%);

staff resources specific to data collection (n=68; 78.2%); and **other data management systems (outside of the systems provided by HRSA)** (n=67; 77.0%). The least endorsed facilitator was **DHSPS responsiveness**, which was only reported by 12 sites (13.8%).

Common barriers to data collection included **training related to data collection/submission** (n=19; 21.8%); **staff resources specific to data collection** (n=17; 19.5%); and **resources for technology** (n=16; 18.4%). Despite being the least commonly chosen facilitator, **DHSPS responsiveness** did not appear to be a significant barrier either, as it was only chosen by 4 respondents (4.6%). A full list of barriers and facilitators to data collection as reported by participating sites are shown below (Table 9).

Table 9. Barriers and Facilitators to Data Collection.

Factors influencing data collection	Helped *n (%)*	Hindered *n (%)*
Access to technology	63 (72.4)	-
Patient privacy rules	24 (27.6)	12 (13.8)
HRSA-provided data system	31 (35.6)	-
Other data system	67 (77.0)	-
Standardized data collection	68 (78.2)	15 (17.2)
Staff resources on data collection	68 (78.2)	17 (19.5)
TASC responsiveness	52 (59.8)	5 (5.7)
DHSPS responsiveness	12 (13.8)	4 (4.6)
Training on data collection	-	19 (21.8)
Resources on technology	-	16 (18.4)

Grantee Suggestions for Capacity Building

Respondents were also asked open-ended questions about how capacity could be maximized, giving rise to a few key subthemes, summarized below.

Collaboration: Collaboration was an often-mentioned strategy to overcome challenges, such as low numbers of referrals. While collaborating with clinical sites and partners were perhaps the most mentioned, some respondents worked toward building the CAN network, better collaboration with community partners and increasing those partnerships, collaboration among programs internally. One example of internal collaboration was the efforts to increase the fatherhood program involvement while implementing the new fatherhood curriculum.

Creativity and Flexibility: In open-ended responses, many sites spoke of the values of being creative in addressing challenges and the overall need to be flexible. Many noted adapting to the

needs of new populations served. Some examples given included utilizing contracted CHWs, allowing more flexibility, and using more virtual platforms to provide telehealth or virtual services, particularly during COVID-19, in addition to in-person care when feasible.

Cross-Training & Furthering Resources: Wraparound services were noted as a particular advantage, specifically doulas, perinatal mental health workers, CHWs, and lactation consultants. Some of these roles had been cross-trained, such as doulas being trained as CLCs. Other sites allocated staff more intentionally, such as assigning one CHW to focus on pregnant women only. Respondents noted that clients appreciated education on topics like doulas (leading to the uptake of doula services) and offering classes that use evidence-based curriculums.

Training & Continuing Education Opportunities: Scholarships toward training opportunities for staff development were well-received. Another suggestion was to ensure that training and certifications come with CEU or CME credit.

Data Collection and Reporting: Data collection and reporting, while valued, presented challenges. Respondents most often noted training around data as well as 1:1 TA support with data as helpful. Others noticed in-house client data systems. Requiring staff to attend training relevant to their work was one strategy. Train the trainer offerings were one suggestion for the TASC as well as more training from midwives and lactation consultants.

IV. Progress Meeting HS Benchmarks

HS grantees are required to collect data and report performance on 19 key benchmarks each year. Respondents were asked about their progress meeting benchmarks, and if they reported not meeting a certain benchmark, they were asked to indicate whether they were making positive progress towards, struggling to meet, or had not yet addressed that benchmark during the 2022 grant year.

Most (n=16; 84.2%) of the benchmarks were met by the majority of respondents. The most commonly met benchmarks in 2022 were **benchmark 19** (*Increase the proportion of HS programs who establish a QI and performance monitoring process to 100 percent*; 91.6% met); **benchmark 4** (*Increase the proportion of HS women and child participants who have a usual source of medical care to 80 percent*; 88.1% met); and **benchmark 1** (*Increase the proportion of HS women and child participants with health insurance to 90 percent (reduce uninsured to less than 10 percent)*; 84.7% met).

The three benchmarks that the majority of respondents did not meet in 2022 were **benchmark 3** (*Increase the proportion of HS women participants who receive a postpartum visit to 80 percent*; 60.7% unmet); **benchmark 8** (*Increase the proportion of HS child participants whose parent/*

caregiver reports they were breastfed or fed breast milk at 6 months to 61 percent; 87.0% unmet); and **benchmark 14** (*Increase the proportion of HS women participants who demonstrate father and/or partner involvement (e.g., attend appointments, classes, etc.) during pregnancy to 90 percent*; 62.4% unmet). Respondent progress meeting all 19 HS benchmarks (reported as met vs. not met) is shown below (Table 10).

Table 10. Progress Meeting HS Benchmarks.

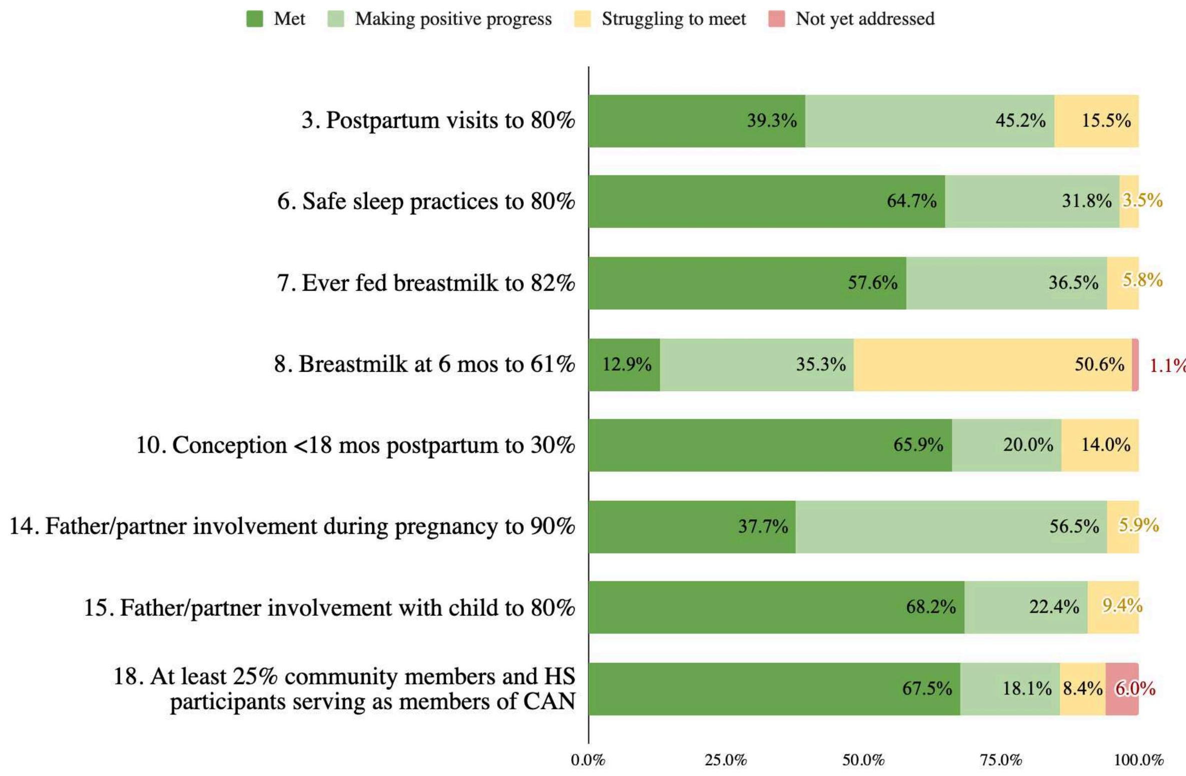
Benchmark	Met *n (%)*	Not met *n (%)*
1. Increase the proportion of HS women and child participants with health insurance to 90% (reduce uninsured to less than 10%).	**72 (84.7)**	13 (15.3)
2. Increase the proportion of HS women participants who have a documented reproductive life plan to 90%.	**65 (76.5)**	20 (23.5)
3. Increase the proportion of HS women participants who receive a postpartum visit to 80%.	33 (39.3)	**51 (60.7)**
4. Increase the proportion of HS women and child participants who have a usual source of medical care to 80%.	**74 (88.1)**	10 (11.9)
5. Increase the proportion of HS women participants who receive a well-woman visit to 80%.	**65 (77.4)**	16 (19.1)
6. Increase the proportion of HS women participants who engage in safe sleep practices to 80%.	**55 (64.7)**	30 (35.3)
7. Increase the proportion of HS child participants whose parent/caregiver reports they were ever breastfed or pumped breast milk to feed their baby to 82%.	**49 (57.6)**	36 (42.3)
8. Increase the proportion of HS child participants whose parent/caregiver reports they were breastfed or fed breast milk at 6 months to 61%.	11 (12.9)	**74 (87.0)**
9. Increase the proportion of pregnant HS participants who abstain from cigarette smoking to 90%.	**62 (72.9)**	22 (27.0)
10. Reduce the proportion of HS women participants who conceive within 18 months of a previous birth to 30%.	**56 (65.9)**	29 (34.0)

Table 10. Progress Meeting HS Benchmarks. (cont).

Benchmark	Met *n (%)*	Not met *n (%)*
11. Increase the proportion of HS child participants who receive the last age-appropriate recommended well-child visit based on the AAP schedule to 90%.	**70 (82.4)**	15 (17.7)
12. Increase the proportion of HS women participants who receive depression screening and referral to 100%.	**60 (70.6)**	25 (29.4)
13. Increase the proportion of HS women participants who receive intimate partner violence (IPV) screening to 100%.	**59 (69.4)**	26 (30.6)
14. Increase the proportion of HS women participants who demonstrate father and/or partner involvement (e.g., attend appointments, classes, etc.) during pregnancy to 90%.	32 (37.7)	**53 (62.4)**
15. Increase the proportion of HS women participants who demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/childcare) with their child participant to 80%.	**58 (68.2)**	27 (31.8)
16. Increase the proportion of HS child participants aged <24 months who are read to by a parent or family member 3 or more times per week to 50%.	**60 (70.6)**	25 (29.4)
17. Increase the proportion of HS programs with a fully implemented CAN to 100%.	**68 (81.0)**	16 (19.1)
18. Increase the proportion of HS programs with at least 25% community members and HS program participants serving as members of their CAN to 100%.	**56 (67.5)**	27 (32.5)
19. Increase the proportion of HS programs who establish a QI and performance monitoring process to 100%.	**76 (91.6)**	7 (8.4)

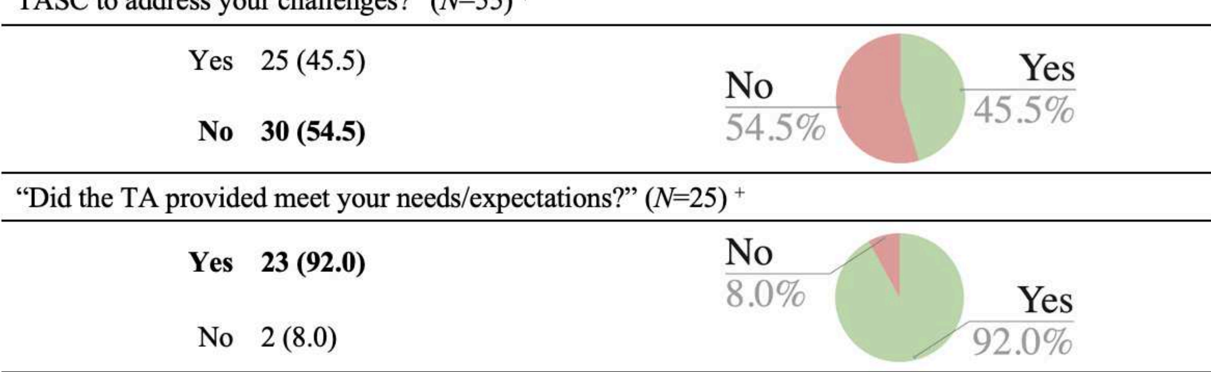
Of the 19 benchmarks, 8 (42.1%) showed less than 70% grantee compliance in 2022. This included the three least commonly met benchmarks reported above (**benchmarks 3, 8, and 14**), as well as **benchmark 6** (64.7% met); **benchmark 7** (57.6% met); **benchmark 10** (65.9% met); **benchmark 15** (68.2% met); and **benchmark 18** (67.5% met).

Figure 5. Progress for HS Benchmarks with <70% Grantee Compliance.



Grantees who reported struggling to meet benchmarks in 2022 were asked whether they had reached out to TASC to address their challenges. The majority of respondents (n=30; 54.5%) did not reach out to TASC, while the remaining respondents (n=25; 45.5%) did. Of the 25 respondents who did reach out to TASC to assist them in meeting benchmarks, 23 (92.0%) reported that the TA provided met their needs and/or expectations (Table 11).

Table 11. Grantee Utilization of TASC When Struggling to Meet Benchmarks.



"If your program was struggling to meet any benchmarks in 2022, did your HS program reach out to TASC to address your challenges?" (*N*=55) +	
Yes	25 (45.5)
No	**30 (54.5)**
"Did the TA provided meet your needs/expectations?" (*N*=25) +	
Yes	**23 (92.0)**
No	2 (8.0)

+ *Question only displayed to grantees struggling to meet benchmarks.*

Regarding whether or not those who struggled to meet benchmarks in 2022 reached out to TASC to address the challenges faced, the majority of respondents noted that breastfeeding was one of the most complex challenges. Breastfeeding initiation and at six months has been a historically unmet benchmark, noted a respondent. Another described the nuances within the goal:

"Breastfeeding itself is a very challenging goal overall for women, especially African American women and we worked with our NP to establish strategies for working to improve the goal. We are making strides with father involvement during pregnancy."

Others believe that the goal was unattainable for the population they served. Still other spoke of solutions and strategies to address these challenges:

"Barriers to breastfeeding are well understood by our staff and stakeholders. Innovative relationship-driven approaches such as Breast Friend, Midnight Milk Club, doula care, and lactation consultants are in place. There will also be staff attending the Blactation Educator training."

The overall consensus seemed that breastfeeding is a consistent challenge that involves several factors. Grantees require guidance on how to access/work with breastfeeding consultants/lactation counselors who can support mothers who often desire but struggle to breastfeed their children until the programmatic benchmarks.

Some respondents disclosed that they did not reach out to TASC to address their challenges because they utilized webinars, and training events to address some of their needs. Internal efforts, such as quality improvements, went a long way in improving results:

"[We] internally identified quality improvement efforts to improve their benchmarks and actively worked to improve their ability to meet benchmark goals. Over the course of 2022, their team had the internal capacity to identify opportunities for improvement and internal expertise to move QI efforts forward."

Programs never anticipated the restrictions that would be put in place due to the pandemic. There were many innovative work-arounds created by the grantees during this time. NICHQ should collectively decide if sharing these ideas with all sites would be beneficial for sustainability.

Needs to Achieve the Target Benchmarks

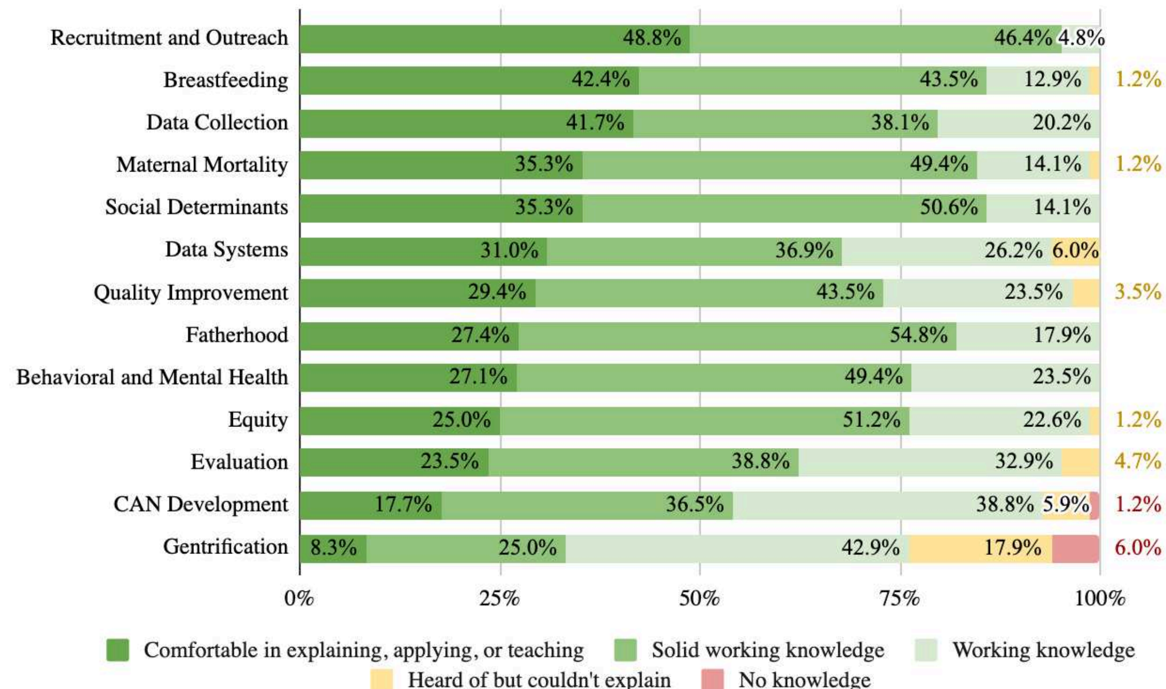
Furthermore, when asked what the grantee needed to achieve the aforementioned target, many noted full-time employees (specifically case managers), individual TA, support from staff, and programmatic leadership, shared innovative ways to partner with other departments in our facility who support pregnant woman and babies, staff retention tactics (more funding), organizational and CEO support, innovative modes of communication to meet the needs or clients.

V. Grantee Content Area Knowledge

Grantees were asked to provide insight into their site's working knowledge of a handful of key topics, including behavioral and mental health, breastfeeding, recruitment and outreach, and fatherhood. The highest level of working knowledge was defined as *Comfortable in explaining, applying, or teaching*, followed by *Solid working knowledge*; *Working knowledge*; *Heard of but couldn't explain*; and finally, *No knowledge*.

Content areas with the highest level of knowledge were **recruitment and outreach**, about which 48.8% of respondents reported that they were comfortable explaining, applying, or teaching. **Breastfeeding** was also commonly endorsed as a topic HS sites were comfortable explaining, applying, or teaching (42.4%), followed by **data collection** (41.7%), **maternal mortality** (35.3%), and **social determinants** (35.3%). **Gentrification** seemed to be the least commonly understood topic among HS sites, with only 8.3% of respondents feeling comfortable explaining, applying, or teaching relevant content and 23.9% of respondents saying they either had no knowledge of gentrification or wouldn't be able to explain it. The levels of knowledge for each of the 13 content areas asked about are shown below (Figure 6).

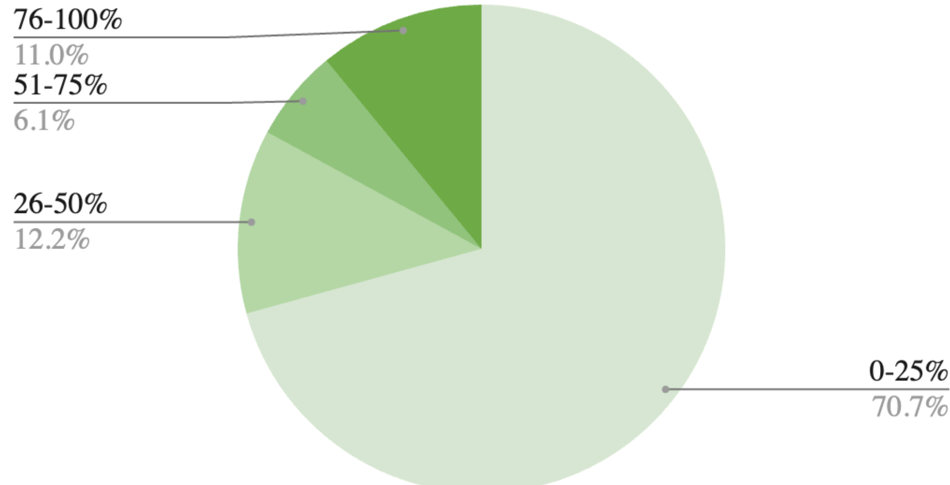
Figure 6. HS Content Areas by Site Knowledge Level.



VI. Fatherhood Involvement: Challenges and Opportunities

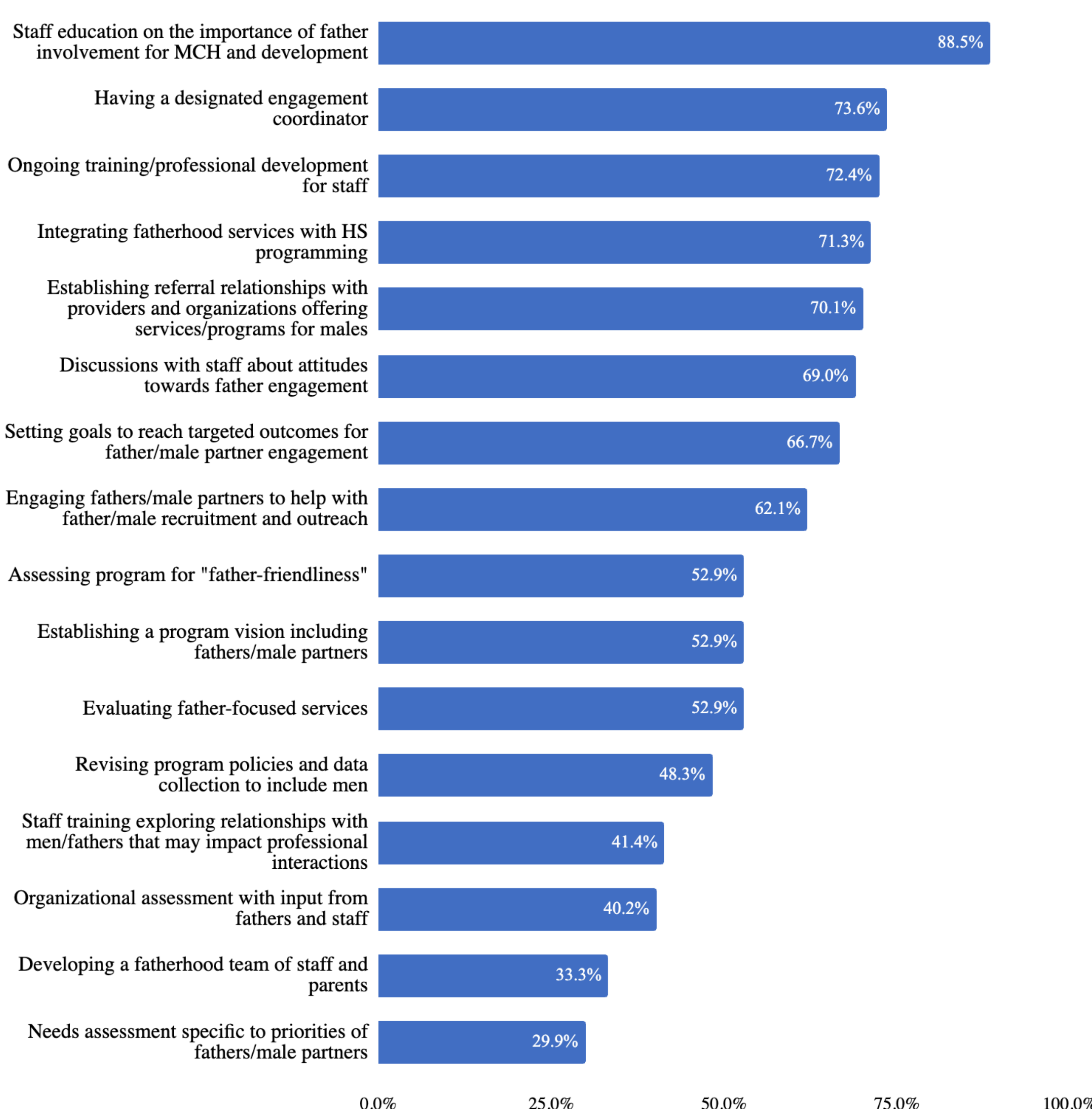
On average, HS sites reported that 80.1% of their participants had father or partner involvement. Respondents were asked how much their HS program increased father and/or partner involvement during pregnancy. Although the largest proportion of participants reported a **0-25% increase** in father/partner involvement (70.7% of respondents), many programs showed a larger increase. In fact, 11% of respondents reported a **76-100% increase** in father/partner involvement in 2022 (Figure 7).

Figure 7. Percent Increase in Fatherhood Involvement in the 2022 Grant Year.



Participants also reported significant effort to implement fatherhood groups, build capacity for father involvement, promote co-parenting, and work with community partners for fatherhood. 80.7% of respondents (n=67) reported working to implement fatherhood groups based on evidence-based criteria either *Occasionally*, *Frequently*, or *Very frequently*. On the other hand, 7.2% of respondents (n=6) reported never making any effort towards evidence-based fatherhood groups. Respondents endorsed several strategies to build capacity for father/male involvement, with the most popular strategies being **staff education** (n=77; 88.5%); **having a designated engagement coordinator** (n=64; 73.6%); and **ongoing training/professional development for staff** (n=63; 72.4%). The least commonly endorsed strategies to build capacity for father/male engagement were **conducting needs assessments specific to the needs of fathers/male partners** (n=26; 29.9%); **developing a fatherhood team of staff and parents** (n=29; 33.3%); and **conducting an organizational assessment with program data and input from fathers and staff** (n=35; 40.2%). The frequencies of each of the listed fatherhood engagement strategies are shown below (Figure 8).

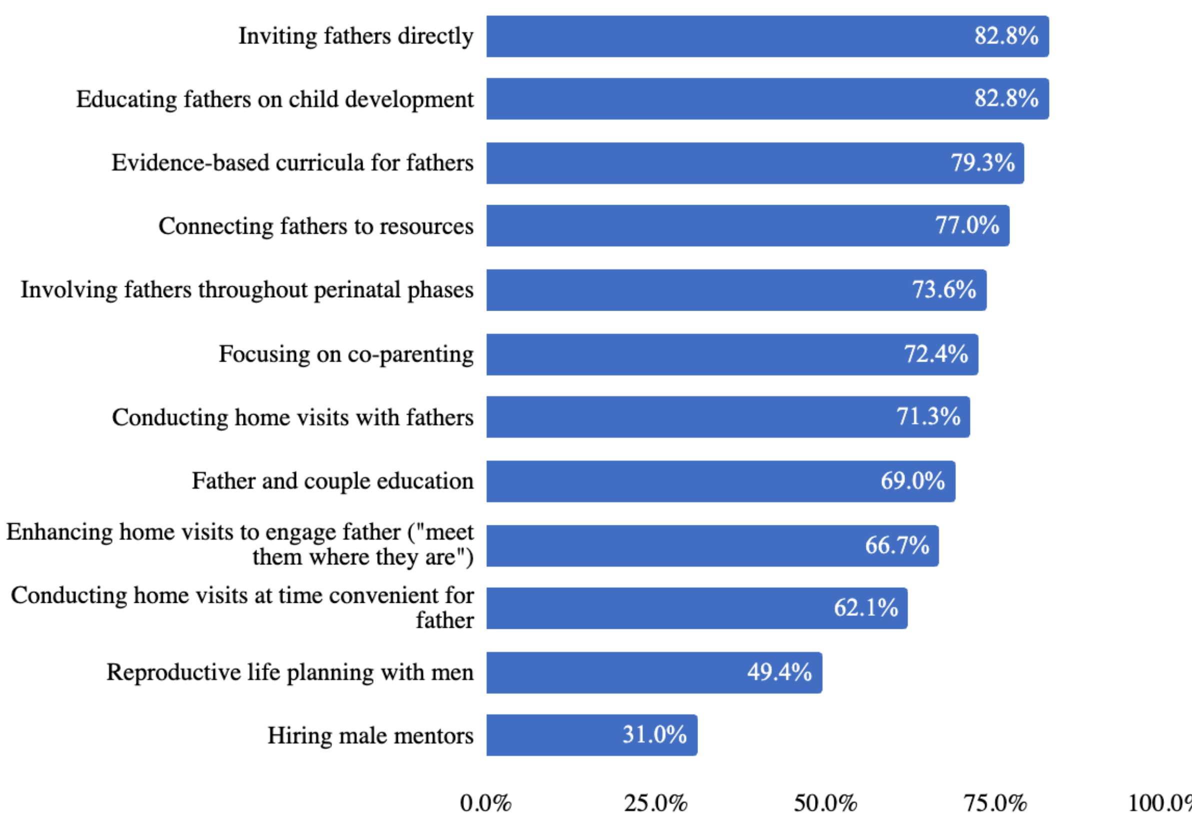
Figure 8. Strategies to Increase Father and Male Partner Involvement by Frequency.*



** Choices not mutually exclusive.*

Respondents also reported on services and education their site provides to promote co-parenting. Of the list provided, the most commonly endorsed items were **inviting fathers directly, not only through the mother** (n=72; 82.8%); **educating fathers on child development** (n=72; 82.8%); **evidence-based curricula to engage fathers** (n=69; 79.3%); **connecting fathers with resources** (n=67; 77.0%); and **involving fathers across all perinatal phases** (n=64; 73.6%). Less commonly implemented activities to promote co-parenting included **reproductive life planning with men**, which was endorsed by fewer than half of responding sites (n=43; 49.4%), and **hiring male mentors to conduct home visits with fathers** (n=27; 31.0%) (Figure 9).

Figure 9. Services/Education Provided by Sites to Promote Co-Parenting.*



** Choices not mutually exclusive.*

Sites also reported working with community partners to develop father-friendly services. The most commonly endorsed collaborations with community partners were **community events for fathers** (n=60; 69.0%); **developing a local network of supportive individuals, organizations, and agencies** (n=57; 65.5%); and **considering incentives to market enhanced father services** (n=49; 56.3%). On the other hand, few sites (n=14; 16.1%) actively worked with community partners to **advocate for parental leave**. Data on community collaborations for fatherhood are shown below (Figure 10).

Figure 10. Community Collaborations for Fatherhood.*

Collaboration	Percent
Community events for fathers	69.00%
Developing a local network with supportive individuals, organizations, and agencies	65.50%
Considering incentives to market enhanced services for fathers	56.30%
Community events for families	54.00%
Adding services for fathers and men to CAN's list of priorities	44.80%
Community events for fathers and children	41.40%
Including father/male indicators in community needs assessment	32.20%
Advocating for parental leave	16.10%

0.00% 20.00% 40.00% 60.00% 80.00%

** Choices not mutually exclusive.*

Respondents spoke at length about the **challenges, opportunities, and strategies** to **increase fathers' involvement** and **meet the goal of 100 fathers enrolled.**

Challenges

Several challenges were noted in recruiting, enrolling, and retaining fathers in the program, making the goal of enrolling 100 fathers unattainable for some sites. Respondents offered several plausible sources of friction: appropriate staffing, a limited pool of fathers to draw from (due to an overall reduction in referrals to the program), systemic barriers to enrollment – both internally and externally, and limited awareness of the program were among the most oft-mentioned issues.

Staffing challenges rose to the top as the most-mentioned issue. Turnover was high among staff, overall, and many of the Fatherhood Coordinator positions were vacant for months at a time. Not offering competitive salaries or having enough funding to make additional hires were noted as compounding staffing challenges. Without dedicated staff in place, the responsibility to grow and maintain the program fell onto other staff. Sometimes, this caused discomfort:

"We don't have a fatherhood coordinator, but rather ask each CHW case manager to enroll fathers in the same way they enroll mothers. However, some staff are not as comfortable as others."

Even with a staff member in place, the role of overseeing all the fathers was described as daunting.

Wider systemic issues challenged the program, as well. As one respondent summed it up: "generational trauma challenges, trust, and system challenges." These root causes are systemic. For example, respondents noted that the clinical prenatal care system is not historically set up to engage fathers. Along the same lines, other programs and services in the community are not normally focused on fathers. Furthermore, fathers are disproportionately affected by homelessness and incarceration. Other times, fathers are weighed down by the expectation of being the "breadwinner" for the family, working jobs with long and often unpredictable work schedules, further complicating their engagement.

Some of the systemic barriers, respondents said, were internal to the program itself by way of eligibility criteria. For example, several respondents said the requirements for enrollment were confusing or they were unaware of them. Even when clear, enrollment criteria can still get in the way:

"We reached 100 dads. However, it is challenging when the fathers must have the partner of the baby enrolled in services as well. This limits the eligible father referrals."

Respondents noted they would like more clarification as to how HRSA intends for the program to work with fathers. Others wanted more meaningful measures:

"A systematic way to capture how fathers were participating in their partner's and child's lives was missing from HRSA. Enrollment cannot be the only measure."

Thus, it seemed that programs were reaching fathers (with one program estimating around 800 fathers reached) yet translating that reach to enrollment seemed to be a common challenge. Thus, the measure of 100 enrolled was deemed unattainable by some sites:

"This number is unrealistically high, especially since we weren't informed that all fathers have to receive case management services in order to be counted until months into the first grant year."

One respondent summarized the interacting challenges well:

"The project onboarded its first Fatherhood Coordinator in 2021 in which he and the project received technical support with onboarding and the launch of the project's fatherhood program. Much of 2022 was spent building relationships in the community with other organizations

serving fathers and educating staff and the community about the importance of fatherhood involvement. This became a tougher process than expected as there were very few father serving organizations and the project struggled to engage others in the process."

In terms of the limited pool in which to recruit fathers from, reasons noted included an overall decline in referrals, women disclosing that the father has not been very involved in the pregnancy, COVID-19 decreasing the amount of in-person visits, men are not attending visits with their partner, domestic violence, and fathers not wanting to participate.

Fathers, it was noted, did not want to participate for a variety of reasons. Some enjoyed groups but did not want to be enrolled in case management services. Some were too busy. Others were turned off by the lengthy data collection forms, and still others were hesitant to become involved with agencies due to legal involvement regarding child support or the fear of deportation. Even when engaged, fathers tended to drop off, resulting in lower retention.

Solutions & Strategies

Some of the strategies to abate these issues were training family partners in engaging fathers during enrollment, family partners being aware of their own biases and how it impacts their outreach to fathers, the Fatherhood Coordinator providing training to family partners and care coordinators, and making the goal it an program-wide effort:

"Recruitment and Retention strategies for fatherhood engagement was a team effort. The fatherhood coordinator worked hand in hand with the case managers and community health workers to enroll father's into the program. The fatherhood coordinator would also attend outreach events and deliver presentations about the program. Bi-weekly fatherhood support groups were delivered via Zoom."

Other strategies included the Fatherhood Coordinator and case manager doing more outreach, case managers attending home visits in order to outreach to fathers, maintaining monthly contact with fathers (retention), outreaching to the TASC for help, offering more incentives, providing welcome bags at the time of enrollment or dinner at each class, celebrating milestones within the program or making sure to invite fathers to all events, offering incentives to mothers when fathers enroll and participate, pairing newer fathers to the program with existing ones, and reinforcing assurances that more fatherhood involvement would not result in legal ramifications.

Other times, reaching out to specific groups to help went a long way. The involvement and encouragement of the mother or CHW helped as well, like mothers attending the "Understanding Dads" class, asking for the father's information at the point of referral, and fathers attending the intake session. An increase in referrals and support from partners and clinicians helped with overall volume, and several respondents mentioned recruiting while visiting the clinical care

setting, working with care coordinators in clinics, other health department divisions, community colleges, social service agencies, jails and local barbershops, WIC offices and apartment complexes, churches and daycares, and involving Community Advisory Boards, the CAN, and its partners.

Promotion of the program and work within the community also proved fruitful. Respondents noted trying a variety of ways to promote the program such as street outreach, a network dedicated to housing community events/tabling aimed at involving fathers, attending youth sports programs, and recruiting from other program classes, posting culturally-sensitive flyers around the community gathering spaces, canvassing, offering visits in the evenings and on weekends, marketing the program as a "family" program, expanding eligibility, developing a "reservoir of community goodwill," trying to shift community norms to include fathers, holding 24/7 Dads meetings in community places or offering flexible scheduling, promotion using social media, male involvement rap sessions, educating fathers on the benefits of the services, asking fathers who have been through the program to engage in peer outreach as advocates of the program, and outreaching to other fatherhood organizations, collaboratives, commissions or initiatives in the community or within the state.

Staffing and funding helped, as well. Respondents benefitted from more funding to hire fatherhood case managers, weekly enrollment goals and tracking, creating a "Fatherhood Taskforce" within program and asking other staff to unite in efforts towards this goal, providing excellent case management (retention), offering incentives like diapers (retention), hiring Spanish-speaking and race-concordant CHWs and coordinators, updating brochures and program materials, offering empathy and good listening skills, and webinars on how to engage fathers.

Adjusting the model of service delivery came up as a solution, as well:

"[The] ability to choose the model of service delivery for fathers that works for us. If we were required to do group work for fathers, we would have failed."

Along with offering wraparound services important to fathers:

"Fatherhood clients were offered the following services with hopes of retaining them in the program, vocational services, mental health, substance abuse, employment assistance, and parenting and Mommy, Daddy, and Me groups, as well as male support groups."

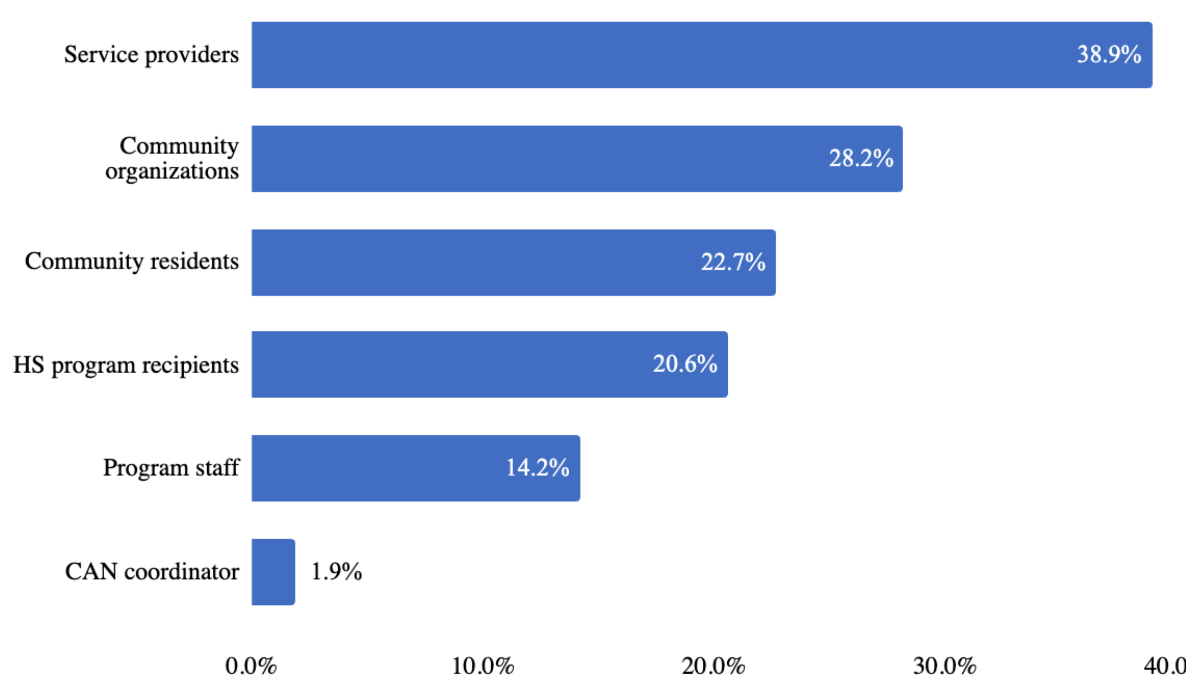
VII. CAN Membership Trends

Respondents were asked to provide details on the members of their CAN. Service providers and HS program staff were the most commonly endorsed groups comprising the CAN (both reported in 83.9% of responding sites), while only 62.1% of respondents reported a CAN coordinator

taking part in their CAN. On average, sites reported ~58 CAN members, ~23 of whom were CAN members from the community (39.7%).

The group comprising the largest proportion of CAN members was **service providers**, making up an average of 38.9% of CANs. **Community organizations** also made up a large proportion of CAN members (28.2%), followed by **community residents** (22.7%). CAN coordinators were the group with the least representation in CANs, with most sites only reporting one CAN coordinator (Figure 11).

Figure 11. CAN Representation by Member Type.*



** Choices not mutually exclusive.*

VIII. Challenges and Opportunities

Outreach, Referrals & Target Enrollments

Increasing outreach was both an often-deployed strategy as well as a challenge for many. Several cited the need for increased outreach and marketing of services in the community, in response to a decline in referrals. However, referrals didn't necessarily lead to enrollments. Staffing challenges complicated this:

"We had multiple staff vacancies over a 6-8 month period that caused a backlog of potential participants who were referred but not enrolled. Staff vacancies and the fact that we had a waitlist kept us from doing outreach activities for that period of time, as well."

Staff, like CHWs, who accessed a variety of sourcing for outreach and enrollment seemed to be particularly useful:

"... [Using] Community Health Workers who required access to pregnant persons in other clinic settings such as partnering with a Federally Qualified Health Center to enroll new people. The Medicaid Health Plans were supportive in sending [redacted] referrals."

Not all sites felt they had enough access, however, to best source referrals:

"[Challenges included] staffing due to COVID-19 and our program is not included in the State [state name redacted] Coordinated Intake and Referral program. We have to locate our own referrals."

Other times, clients presenting late to prenatal care led to a decline in enrollments (though the early postpartum period seemed to be a good source of referrals). The strategy to amend this was more partnerships with clinical settings, hospitals and clinics, and other agencies.

One respondent noted that services rendered did not necessarily align with enrollment, either:

"We served close to that number but did not enroll that number. Since it is based on enrollments, that is where the challenge is in meeting the numbers."

Other strategies included over-sampling by increasing referral sources, thereby not being dependent on fewer referral sources. Coaching and encouragement went a long way as well:

"We did not need external assistance, although coaching and encouragement from our Project Officer, especially after a leadership change, helped us get back on track. We were able to fill all staff vacancies and will meet all targets in 2023."

Retention was closely related to meeting targets and goals. One detriment to retention was the lack of non-Spanish-speaking staff. The strategy to amend was to hire more bilingual staff.

Staffing

When asked what challenges grantees experienced in meeting the target of serving at least 300 infants/children up to 18 months, preconception women, and interconception women per year in 2022 many respondents noted that COVID restrictions, staffing recruitment and retention were contributing factors to the unmet goal:.

"Staff turnover made the target number unachievable for the amount of staff/salary funds supported by the grant amount". *"COVID-19 made it challenging to recruit through local community events that attract target population for HS enrollments. We have developed plans for the outreach efforts to improve as COVID numbers are reduced."*.

In fact, staffing came up as t**he most persistent challenge,** exacerbated by several factors, like COVID-19, an uptick in staffing turnover, and lack of competitive salaries. Respondents noted that hiring and training new staff, finding quality candidates, and having to repeat these processes unceasingly with every new hire was a detriment to achieving programmatic goals.

When asked what the grantee needed to achieve the target of serving at least 300 infants/children up to 18 months, preconception women, and interconception women per year in 2022 respondents noted: full time employees (specifically case managers), individual TA, support from staff and programmatic leadership, shared innovative ways to partner with other departments in our facility who support pregnant woman and babies, staff retention tactics (more funding), organizational and CEO support, innovative modes of communication to meet the needs or clients. One respondent suggested training on unique ways to keep clients engaged after the services had been rendered.

Others felt the amount of HRSA funding available was not sufficient to hire the appropriate number of staff, making the goals or targets of the program thereby "unachievable." Several respondents spoke of efforts to apply for non-HRSA funding, such as state grants, or funding for programs outside of the service area. The boost in funding for supplements also proved useful:

"With the Maternal Mortality Supplement funding, we were able to host centering pregnancy prenatal care to participants. Also, with participants having more willingness to meet us in person, we were able to bring in paper curricula materials to support education and have more organic conversations."

Still others mentioned staff being at capacity, particularly with the model striving to stay with clients until their baby reaches 18 months of age. This trajectory limits the capacity for new clients and overall caseload. Several mentioned caseloads were high for the staff available. This was helped, in part, by hiring staff to support case workers:

"For example, hiring a Behavioral Health Clinician created space for FP's to process their experiences in supporting families and getting emotional support."

Changing requirements also provide a challenge:

"Capacity improvements are rooted in access to additional technical training and time doing the work…it does take a few years to ensure protocols and activities flow smoothly. Every time requirements change, or we lose staff, we start over."

Some respondents summed up the relationship between enrollments, training and staffing succinctly:

"The main drivers of our ability to reach enrollment targets include the number of staff available, high caliber of staff (training) that increases demand for our services, and our ability to select and pay for the services we know are wanted and impactful locally. For example, the inclusion of doula services is a driver of demand and also improves birth outcomes."

"[Redacted] increased our staffing capacity by the addition of a new case manager. This increased our total case manager staff to eight case managers, serving seven counties. We ensured case managers were appropriately trained. Staff are encouraged to attend web-based and in-person training related to our benchmarks."

Of interest, one respondent noted that goals were not met because of the misalignment of the goal and the interest of the clients:

"Participants would say that breastfeeding was challenging and would end sooner, or that their goals were met by breastfeeding for less than 6 months. We have direct support of a 24/7 hotline to consult with CLC or lactation professionals, but families didn't feel the need to call for support."

Impact of COVID

COVID and its resulting impact was an oft-mentioned driver of challenges, both internally at the site and externally among clients and their communities. COVID had a substantial impact on recruitment and retention efforts, due to not being able to recruit face-to-face, though some sites abated this by procuring more partnerships to help with recruitment. Clients faced challenges around increased homelessness/housing insecurity and others were more mobile and moved outside of the site's catchment area. Others may have declined services because there was hesitancy letting staff into their homes (some sites strategized by moving services and support to virtual platforms).

Internally at sites, COVID-19 stretched already-strained resources even further, with competing priorities for both staff and clients during the pandemic. Many staff were redirected to other COVID-related activities, furthering the strain, though this was alleviated some upon staff

returning to their original roles. Normal sources of referrals discontinued outreach options due to the pandemic. Hiring during the pandemic became a struggle due to several factors including vaccine mandates, individuals choosing to leave the workforce to care for their families, and salaries becoming more competitive. One site strategized by surveying salaries of comparable jobs and increased starting salaries as a result.

Many respondents noted that both the program and the community are still dealing with the "aftermath of COVID" and resuming the new "normal." Although, some hope is on the horizon as one site noted that in 2023, they have seen a significant increase in their numbers and have reconnected to all their referral sources.

Data Management System

When asked to describe how the data management system aided and/or hindered the collection and submission of client/participant-level data for 2022 the majority of respondents noted having positive experiences with the data collection system. The following positive and challenging experiences were noted:

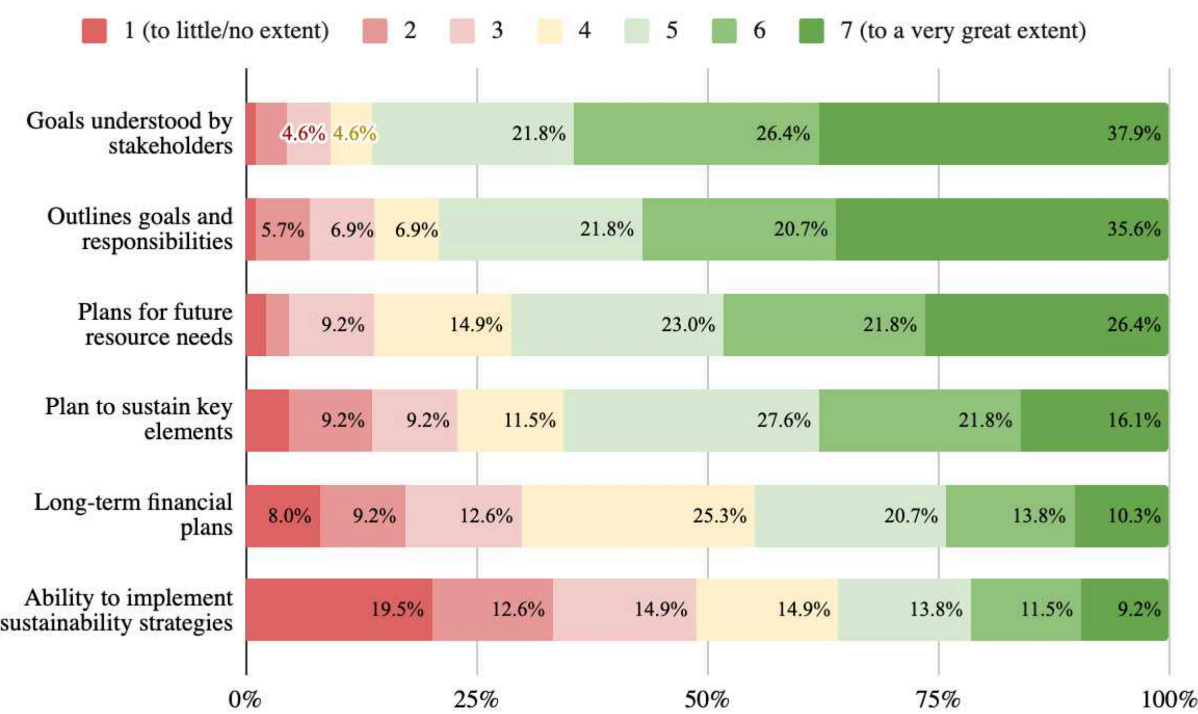
- *"It has been a great help to our program. Well Family System submits our HSMED reports. They also make it* ***user friendly;*** *we can download our performance measure reports, monthly reports, check encounters and attempts, check demographics and more".*
- *"Helped us keep all* ***referrals and forms in one place****."*
- *"The* ***interface is extremely friendly****, staff enjoy working in the database. The system also* ***allows us to make changes*** *and create unique reports without needing a consultant".*
- *"Careware* ***saved us money*** *to put towards more high-priority issues. We had staff turnover, and* ***learning the new database system took some time****".*
- *"It is easy to navigate and allows us to make changes as needed".*
- *"The system is created to meet the data collection and analysis needs of Healthy Start. A* ***challenge is keeping it updated*** *to meet HRSA/Healthy Start's changing needs".*
- *"A very agile system with* ***quality and effective back end support*** *and responsiveness to HRSA requirements, schema and program data entry, management and data mining needs".*
- *"Worked fine to collect data.* ***Not good for pulling via reports****. Not a case management software. We will change to WellFamily".*

Sustainability

Sites were asked to rank aspects of their program's direction, goals, and strategies in 2022, specifically looking to the future sustainability of the program. Respondents ranked statements on a Likert scale from 1-7, with 1 being *To little/no extent* and 7 being *To a very great extent*. The

highest ranked statement (mean: 5.7) was related to **stakeholders' understanding of program goals**, with most respondents endorsing that all stakeholders understood their programs goals *To a great extent*. The lowest ranked statement related to the **project's capacity for sustainability** (mean: 3.6), with the largest proportion of respondents (n=17; 19.5%) reporting that their project could implement sustainability strategies *To little/no extent* (Figure 12).

Figure 12. Grantee Perceptions of Program Sustainability Metrics.



Respondents noted a few areas where specific support would be needed from TASC in order to establish and/or enhance their sustainability plans. First, TASC would need to confirm each site has or is working on a sustainability plan. This can be inquired via the five-year assessment. Next, many noted their need for training on how to link services to Medicaid. Respondents noted that support to bring reimbursement funds to support their work is vital, and grantees seemed interested to know how the TASC can assist them in this. Other references to Medicaid included:

> "*Unfortunately, many agencies rely on grant funding to sustain programming. While our agencies are advocating for Medicaid reimbursement for CHWs, the earliest that would*

be implemented in [state name redacted] would be in 2025 through a state plan amendment".

"Medicaid reimbursement for Community Health Workers is less than a living wage in [state name redacted]. Not certain what other states are doing. Can TASC assess if Community Health Workers reimbursement for care coordination services is comparable to [state name redacted]?"

Others spoke of the value of cohort learning:

"Learning from other project directors and processing how they have gone about creating their sustainability plan would be helpful. This would be my first time creating one for this project."

In essence, guidance across the board on building out a sustainability plan is needed.

Additional Funding Resources

There were many examples given describing additional funding resources that currently support the respondents beyond the federal Healthy Start grant, that help provide additional capacity and/or that allow for extended services. Additional funding resources mentioned by respondents included federal, state, county, and city **government funding**; federal, state, foundation, and philanthropic **grants**; **reimbursements** through FIMR, Title V, and Medicaid; **in-kind donations** from corporations, local organizations/agencies, and individual donors; and **service integrations** with Title V, Medicaid MCOs, and other clinical service lines. These supplemental funding streams were used to support a variety of services at HS sites, including doula services, fatherhood programming, clinical services, lactation services, transportation for clients, and provision of physical supplies such as diapers, toothbrushes, and car seats. In addition, these funding resources allowed for capacity building in regards to service area expansion, increased staffing, support for sustainability efforts, and increased referral partnerships.

5. Summary and Conclusion

Response and Participation

In sum, the results of the 2022 Annual Assessment show a number of successes and some areas for improvement in the operation of the TASC. **Participation was strong in that survey respondents (n=87) represented 86.1% of the 101 HS grantees across the United States**.

Although a large majority of grantees were represented in the findings of this report, future surveys aiming for a higher yield could make use of financial incentives in order to increase participation rates.

Successes

Overall, grantees were satisfied with TASC and TASC activities in 2022, with high percentages reporting *Satisfied* or *Very Satisfied* (86.1%) and approval of the TASC's overall responsiveness (77%). Respondents specifically mentioned benefitting from the webinar offerings, reporting a high level of webinar participation, high satisfaction, and preference for future TASC activities to be webinars. Participation in training and certificates was also relatively high, and many grantees also requested training and certificates and learning academies to be offered by TASC in the future. Priority topics included the CAN, fatherhood, behavioral/mental health, health equity, and doula services. Similarly, respondents most preferred weekly update emails as a method of communication going forward.

Most respondents reported improved evidence-based services and increased capacity to implement such services over the 2022 grant year. Notably, nearly half of respondents felt the TASC aided in their improved capacity *A lot* or *A great deal*. Several sub-themes came up in terms of capacity-building such as using program-wide collaboration towards meeting goals, creativity and flexibility, cross-training roles, bringing in wraparound resources, and training and continuing education. Notably, most of the benchmarks (84.2%) were met by the majority of respondents.

Mixed Results

There were a number of mixed feedback results, as well.Respondents had varied communication preferences; however, weekly update emails were the most popular method of communication. Data collection and reporting also had mixed results, with some respondents noting their appreciation for opportunities like 1:1 consultation, while others said more training and assistance was needed. Breastfeeding, especially, was noted as a historically unmet benchmark with complex and historical underpinnings of racism for African American or Black families; however, it was among the highest rated of topics sites felt comfortable explaining, applying, or teaching (42.4%). **Finally, while sites struggled to fill or retain staffing positions related to fatherhood, HS sites reported that 80.1% of their participants had father or partner involvement. In fact, 11% of respondents reported a 76-100% increase in father/partner involvement in 2022.** This may speak, in part, to the program-wide collaborative efforts to make this goal a success. It may also speak to the oft-mentioned strategy of engaging more partners and promoting the program "on the ground" in several community settings.

Opportunities for Improvement: Sites

By far, the common challenge that was a thread among several different indicators was related to staffing: *vacant positions, struggles to recruit quality applicants, non-competitive salary offers, and staff being reallocated in the aftermath of COVID-19*. **The highest staffing turnover was among Case Managers (n=27; 56.3%), Community Health Workers (n=25; 43.1%), Care Coordinators (n=10; 38.5%), and specifically, Fatherhood Coordinators (n=25; 32.9%).**

While the sites performed well overall on meeting benchmarks, three stood out as the least met: having a postpartum visit, breastfeeding at six months postpartum and father involvement were among the least met benchmarks. Of the 19 benchmarks, 8 (42.1%) showed less than 70% compliance in 2022. When asked what the site needed to achieve unmet targets, many noted full-time employees (specifically case managers), individual TA, support from staff, and programmatic leadership, shared innovative ways to partner with other departments in our facility who support pregnant woman and babies, staff retention tactics (more funding), organizational and CEO support, innovative modes of communication to meet the needs or clients.

Opportunities for Improvement: TASC

Room for improvement was evident in a number of indicators, which may lend well to exploring further in the five-year assessment. For instance, **TASC utilization was relatively low among grantees who struggled to meet HS benchmarks, with a little over half (54.5%) not reaching out to the TASC to request assistance. This finding is perhaps one of the most compelling in that the sites that needed the most support were also the least likely to seek it.** There could be a number of drivers of this low uptake, such as internal capacity and staff turnover, so it warrants further exploration.

Another area of improvement includes response timeliness. Despite the overall satisfaction with timeliness being high, open-ended responses which probed more showed mixed results. Furthermore, other open-ended responses indicated a strong desire for updates to resources, monitoring of outdated online content (e.g., webinar calendar), a smoother process for the CHW training modules, and more localized, tailored, or applicable content, which could be furthered by creating cohorts based upon topical areas or geography.

While the TASC has much to celebrate in terms of increasing the overall capacity of the site to perform services, there are some areas where TASC could expand their assistance. One area, which respondents said the TASC had the smallest effect on was project improvement and

monitoring. Similarly, there were some areas of improvement for knowledge among sites, such as gentrification, which was least commonly understood among sites, with only 8.3% of respondents saying they would feel comfortable explaining it.

External and HRSA-related Challenges

Another common thread among responses was external challenges exerted among the populations served by HS sites or challenges related to how the program was measured by HRSA. Sites spoke of an overall decline in referrals, women presenting late to prenatal care, the need for bilingual staff, wider systemic issues facing families they serve - particularly fathers, and the aftermath of COVID-19 as some of the external forces they had to contend with in reaching their goals. Others noted that the benchmarks set forth by HRSA were unattainable, not capturing the right information, not well explained or clear, and/or not indicative of engagement, which may or may not result in enrollment. Resoundingly, several respondents felt the amount given to support the program was insufficient to hire the necessary staff and retain them.

Conclusion

In sum, the 2022 Annual Assessment was well-utilized, offering a mix of scales, choices, and open-ended questions to elucidate the successes and challenges of the HS sites that year. Results on successes show the strengths of the TASC and the sites in meeting their respective goals and benchmarks. There are several opportunities for improvement, as well, and the five-year assessment can be a useful tool for looking more intentionally at the mixed results.

6. Appendix

Appendix A. Assessment Questions and Corresponding Tables/Figures.

Question	Number on Qualtrics	Table / Figure
"Please tell us your project name."	Q2	Table 1
"Please provide details on your staff."	Q4	Table 2
"You may have staff paid for with HS funds and some which are not paid for with HS funds. How many staff were paid with HS funds in 2022. Check all that apply by completing this sentence: 'Staff who…':"	Q5	Figure 1
"What types of support provided by the TASC have you participated in over the 2022 grant year? Please visit the EPIC Website for more details on these activities and check all that apply."	Q7	Table 3
"How would you like to receive support and technical assistance in the future? Please visit the EPIC Website for more details on these activities and check all that apply."	Q8	Table 4
"Please rank all modes of communication in the order that you prefer to get information from the TASC."	Q9	Figure 2, Table 5
"Please rank your overall satisfaction with TASC and its activities/resources for the 2022 grant year. If you did not use the TASC or its offerings, please indicate 'N/A.'"	Q10	Table 6
"Please rate the extent to which the support you received from TASC impacted the following capabilities at your site over the 2022 grant year."	Q13	Figure 3
"Which priority areas do you anticipate will require further support to sustain their services beyond the funding period? Please check all that apply."	Q14	Figure 4
"Has the quality of your evidence-based services and those based on best practices improved over the 2022 grant year?"	Q16	Table 7
"Has your program's capacity to implement evidence-based services and those based on best practices improved over the 2022 grant year?"	Q18	

“Did your project plan or conduct a local evaluation in 2022?”	Q59	Table 8
“In 2022, did your project develop SMART (Specific, Measurable, Attainable, Relevant and Timely) objectives?”	Q60	
“In 2022, did your project develop an alternate framework (not SMART) to develop project objectives and goals?”	Q61	
“Did your project need support to develop and refine your program objectives?”	Q62	
“What has helped your project's collection and submission of client-/participant-level data in 2022? (Check all that apply)”	Q53	Table 9
“What hindered your project's collection and submission of client-/participant-level data in 2022?”	Q54	
“Indicate your status by the end of 2022 toward meeting the following benchmarks.”	Q21	Table 10 Figure 5
“If your program was struggling to meet any benchmarks in 2022, did your HS program reach out to TASC to address your challenges?”	Q22	Table 11
“Did the TA provided meet your needs/expectations?”	Q23	
“For the following question, please think about your HS program staff as a whole or the majority of the team when responding. Please select your program's overall level of knowledge of the following content areas at the end of 2022.”	Q41	Figure 6
“In 2022 did your team increase the proportion of Healthy Start women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) during pregnancy? Please provide your best estimate (percent increase).”	Q44	Figure 7
“In 2022, did your project include strategies to build capacity for father/male involvement (check all that apply):”	Q48	Figure 8
“In 2022, did your project include strategies to build capacity for father/male involvement that include but are not limited to the following subject areas (check all that apply):”	Q49	

“In 2022, did your project provide services, education, and support tailored specifically for fathers/males, and promote co-parenting of infants and children in the following areas (check all that apply):”	Q50	Figure 9
“In 2022, did your project work with community partners to develop and promote father-friendly services, policies, and events involving the following areas (check all that apply):”	Q51	Figure 10
“Please indicate which type of CAN members you worked with in 2022, and how many of each partner.”	Q40	Figure 11
“On a scale of 1-7 (1 being "to little/no extent" and 7 being "to a very great extent"), please describe how your program guided its direction, goals, and strategies in 2022.”	Q64	Figure 12