Supporting Healthy Start Performance Project 2020 Annual Assessment Report Grantee Version



Acknowledgement:

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS), Grant #UF5MC32750. The contents of this report are those of the author(s) and do not necessarily represent the official views of—nor an endorsement by—HRSA, the HHS, or the U.S. Government. NICHQ has been funded to serve as the Healthy Start TA & Support Center supporting 101 Healthy Start grantees across the country.

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Table of Contents

INTRODUCTION

Launched in 1991, as a response to the nation's high infant mortality, the federal Healthy Start (HS) program has created partnerships and linkages to services, and improved systems of community care to address disparities in perinatal outcomes for communities "with the greatest risk of losing their babies" in the first year of life. The HS program grantees currently represent 101 distinct communities exhibiting higher than average rates of infant mortality and consist of three Tribal Nations, at least one Appalachian community, and a mix of urban, border and rural communities across the country serving populations of predominantly African American and Latino/a families. The HS communities' common thread is poverty, lack of resources, and a need to address a constellation of social determinants of health, including housing, education, economic inequality, transportation, poor access to high quality food, high crime, racism, and racial bias that are contributing to poor maternal and infant health outcomes.

To address these community challenges, HS grantees deliver a core set of evidence-based services; these services are effective because they are tailored to the geographic, social, ethnic, and cultural needs of the populations served. The program has been an important resource for families, providing them with a pathway to information and services starting during pregnancy and continuing through the first 18 months of a child's life that, often, they would not have otherwise accessed. In addition to service to individuals, HS programs are tasked with mobilizing various community stakeholders (e.g., residents, service providers, local organizations) through Community Action Networks (CAN) to coordinate and integrate services and steer local action to address social determinants of health related to poor birth outcomes. The HS workforce, including community health workers (CHW), play an important role in the success of these programs, and as such, the national HS program prioritizes staff and CHW development, improvement, and monitoring.

During the current funding cycle (2019-2024), the National Institute for Children's Health Quality (NICHQ) leads the Supporting Healthy Start Performance Project (SHSPP) and serves as the TA & Support Center (TASC) to foster improved service delivery by HS program grantees across the country. To meet the diverse needs of grantees, NICHQ will deliver capacity-building assistance (CBA) to:

1. Improve the consistency and quality for content of HS services delivered through CBA for HS staff in the core competencies and concepts central to the four HS approaches.
2. Increase the delivery of evidence-based services and those based on best practices.
3. Ensure that the HS workforce has appropriate knowledge, and demonstrable skills and competencies to provide services.
4. Increase data collection and data use for QI, performance monitoring and local evaluation.
5. Promote synergy among HS grant recipients through meaningful collaborations that are aimed at improving perinatal outcomes and reducing disparities.
6. Support grantees in the development of specific, measurable, attainable, realistic, and timely (SMART) objectives, as well as sustainability and succession plan.

NICHQ conducted the Annual Assessment to understand projects' organizational structures, satisfaction with the TASC, programmatic needs, progress toward benchmarks and key objectives, knowledge of the four HS approaches, data capacity, strength of partnerships and progress towards sustainability. Like the Needs Assessment from 2019, this year's Annual Assessment sought to identify salient programmatic activities for the TASC. In this report, we describe the Annual Assessment's methods and results, synthesize findings, and describe next steps for the TASC.

METHODS

In August 2020, staff from NICHQ's Department of Applied Research and Evaluation (DARE), in close partnership with TASC leadership, began to develop the 2020 Annual Assessment. Building from the 2019 Needs Assessment and leveraging the TASC's overall evaluation plan, DARE identified domains for evaluation and inclusion in the Annual Assessment, which align with the aforementioned goals of the SHSPP:

- Organizational structures (location, personnel)
- Satisfaction with the TASC
- Programmatic needs
- Progress toward benchmarks, key objectives, and targets
- Knowledge of the four HS approaches
- Capacity for data collection and use
- Strength of partnerships
- Progress towards sustainability

Throughout Fall 2020, DARE drafted and refined Annual Assessment items within these domains to ensure rigorous measurement and identification of themes critical to the TASC's work and success of grantees to meet their objectives. Prior to finalization, NICHQ disseminated the draft Assessment to and discussed it with leadership at the Division of Healthy Start and Perinatal Services (DHSPS), Maternal Child Health Bureau (MCHB) at several junctures. Although the 2019 Needs Assessment was utilized as a starting point for this year's Annual Assessment, numerous edits and additions were made to enhance the TASC's understanding of the challenges and issues most salient to grantees and to elicit data on satisfaction with the TASC.

The Annual Assessment included 67 items and was administered to project directors of all 101 HS grantees on November 17, 2020. The Assessment remained open throughout the month of December 2020 to provide grantees sufficient time to complete to the Assessment amidst many competing priorities. During the seven weeks of Assessment administration, TASC staff conducted extensive outreach with HS grantees to bolster response rates. Reminders were sent through TASC newsletters and staff made targeted phone calls and sent emails to project directors who had not yet completed the Annual Assessment. Throughout this process, DARE staff identified duplicate and incomplete (less than 75% complete) Assessment responses and, in partnership with project directors, attempted to generate a single, complete response for each HS site. DARE staff identified cases of incorrect site attribution in preliminary Assessment data as well. In two cases, a duplicate was noted for a single site, but the responses represented unique site responses and required that grantee names be corrected.[1] The Assessment closed on January 8, 2021. DARE included 75 responses from HS grantees in the analyses presented here. Responses from HS grantees that were less than 30% complete were not included in these analyses.[2]

RESULTS

Below we present the overall results of the 2020 Annual Assessment, which reflect findings from quantitative and qualitative analyses. Where possible and pertinent to the TASC's programmatic activities, we compare Assessment results across 2019 and 2020. We recognize that direct comparisons across years may not be feasible for many Assessment domains, as different grantees responded to the Assessment in 2019 and 2020 and, in many cases, Assessment questions were updated.

[1] For one of these two cases, DARE did not hear from the grantee in question before January 13, 2021, and their response was omitted from the analysis.

[2] Data from three HS grantees were excluded from analyses due to incomplete responses (County of Cook at 26% complete, Health Care Coalition of Southern Oregon. Inc. at 4% complete and Public Health Solutions at 4% complete)

OVERALL SURVEY FINDINGS

Personnel / Staffing

Across the 75 grantees that responded to this Annual Assessment, over 820 distinct staff paid by HS funds were reported. The staff role that was reported with the highest frequency was Case Manager (n=201 across all responding grantees), followed by CHW (n=167). An additional 60 staff are slated to be hired in the coming year, predominantly in roles including Program Manager (12% of all responding grantees) as well as Care Coordinator, CHW, Evaluator/Data Analyst and Fatherhood Coordinator (for each position, approximately 11% of all responding grantees). When asked about the types of services various staff paid by HS funds provide, almost three-quarters of grantees reported staff that provide some type of lactation support, and over half (59%) have paid certified lactation consultants (CLC) or International Board-Certified Lactation Consultants (IBCLC) on staff. Most grantees employ licensed social workers (60%), as well as staff that provide mental health counseling directly to HS participants (51%), are mental health consultants and provide support to HS workers (33%), provide substance use counseling directly to HS participants (24%) or are certified mental/behavioral health peer specialists or recovery support specialists/coaches (15%). Nearly one-fifth (19%) of grantees have staff paid by HS funds that provide doula services as well. Additional data on personnel is provided in Appendix X.

Staff Type	Number of total staff reported across all grantees
Case Manager	201.50
Community Health Worker	167.75
Other	71.40
Nurse (LPN, RN, APN)	62.40
Program Director	62.25
Program Manager	59.00
Care Coordinator	58.80
Fatherhood Coordinator	54.00
Evaluator / Data Analyst	48.00
Nurse Practitioner	29.25
Medical Doctor	7.00
Nutritionist	2.00
Total	**823.35**

Services provided by staff paid with HS funds	% Grantees
Provide lactation support	72.0%
Are licensed social workers/MSWs	60.0%
Are CLCs or IBCLCs	58.7%
Provide mental health counseling directly to HS participants	50.7%
Are mental health consultants who provide support to HS workers (e.g., case consultation)	33.3%
Provide substance use counseling directly to HS participants	24.0%
Provide doula services	18.7%
Are certified mental/behavioral health peer specialists or recovery support specialists/coaches	14.7%
Staff role categories are not mutually exclusive; grantees could select more than one staff role category.	

Though the Assessment questions in this domain were modified from 2019 to 2020,[3] we remark on some broad, year-to-year trends. For example, a greater proportion of grantees report having staff members that provide mental health and substance use counseling as well as having certified mental/behavioral health peer specialists or recovery support specialists/coaches on staff in 2020, compared to 2019.

[3] In the 2019 Needs Assessment, personnel questions were limited to an overall item examining the total number of all staff employed by HS as well as items related to fatherhood coordinators and lactation consultants. In the 2020 Assessment, the personnel section was expanded substantially. Items were added to ascertain the number of numerous staff types paid for by HS funds and the specific services they provide. Intention to hire across multiple roles was examined in 2020 as well.

Satisfaction with TA & Support Center

Of critical importance to the TASC is the degree to which HS grantees are satisfied with the technical assistance (TA) and support provided, and several Assessment items addressed this topic.[4] When asked which type of TA and support grantees participated in throughout the past year, nearly all reported participating in webinars and trainings (96% and 91%, respectively); 28% of respondents participated in virtual one-on-one TA and a quarter (25%) participated in other forms of TA.[5] Similarly, when asked which type of TA and support grantees *wished* to participate in in the future, the vast majority indicated that they would continue to join webinars (93%) and trainings (92%). Interestingly, 64% of grantees indicated that they would like to participate in virtual one-on-one support going forward. Roughly one-fifth (19%) reported that, in the future, they would like to engage with other forms of support.[6]

The Annual Assessment ascertained overall satisfaction with the TASC and various TASC activities and resources in the past 12 months as well. Grantees reported high levels of satisfaction with the TASC overall, webinar offerings and the EPIC website; approximately 80% of respondents indicated they were very satisfied or satisfied with these forms of assistance and support. When it came to CoLab, just under one-quarter (24%) of grantees indicated they were very satisfied or satisfied, and 64% of respondents reported not yet using the platform.

[4] In addition to the Annual Assessment, the TASC examines satisfaction through other surveys, such as the satisfaction survey related to one-on-one TA.
[5] Grantees did not choose to elaborate further on these other forms of TA.
[6] Grantees did not choose to elaborate further on these other forms of TA.

Overall satisfaction in past 12 months	TA & Support Center	Webinar offerings	EPIC website	CoLab
Very satisfied	36.0%	34.7%	37.3%	5.3%
Satisfied	44.0%	53.3%	40.0%	18.7%
Neutral	18.7%	10.7%	17.3%	13.3%
Dissatisfied	1.3%	1.3%	4.0%	0.0%
Very dissatisfied	0.0%	0.0%	0.0%	0.0%
Have not used / Did not attend / Not Applicable	0.0%	0.0%	1.3%	62.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Percentages represent the proportion of grantees among all Assessment respondents				

To better understand grantee satisfaction, we asked participants to share additional comments and/or feedback about the TASC from the last 12 months. A subset of respondents provided qualitative data that revealed that one-fifth of these responses (21%) reported positive and successful experiences with the TASC, noting that the support received was accessible, timely, relevant, and responsive. Roughly the same proportion of grantees (16%) also expressed appreciation for the TASC's support, specifically guidance during COVID-19 and support related to Fatherhood programming. Another 16% of respondents noted concerns with the support received, such as a long wait time for support to be scheduled, unclear instructions, and the TA not always being applicable to the program. A smaller proportion of respondents (13%) mentioned issues with webinars and trainings, such as having limited advanced notice about or challenges registering for events. Other qualitative feedback included satisfaction with webinars, trainings (including the CAREWare training), and the Virtual Grantee Meeting, as well as a need for improvements on the EPIC website and support for data collection and reporting.

Healthy Start and COVID-19

16% of grantees expressed appreciation for the TASC's support and guidance during COVID-19.

As discussed further in this report, the Annual Assessment examined grantees' progress with benchmarks. The Assessment also ascertained the extent to which the TASC supported grantees' in attaining these benchmarks. When asked, if struggling to meet benchmarks, did the HS program reach out to the TASC, 27% of respondents reported "yes", 55% reported "no" and 19% reported "does not apply". Among those who indicated that they did reach out to the TASC for support around benchmarks, 75% indicated that the TA provided met their grantees' needs and expectations, whereas 25% reported that the TA provided did not meet their needs.

Programmatic Needs

The Annual Assessment captured the programmatic needs of and delivery of evidence-based services by HS grantees. Many of the priority areas that grantees reported as being areas that would require support throughout the upcoming year mirrored the topics identified in the 2019 Assessment. For example, this year and last, the areas of fatherhood; recruitment, outreach, and retention; CANs; and data collection, reporting, and monitoring were reported to be the highest priority for HS grantees.[7] This year, behavioral and mental health (BMH) and COVID-19 also rose to the top of the priority list. Quality improvement (QI) and assurance, evaluation, and

Healthy Start and COVID-19

45% of grantees identified support around COVID-19 would be need in the upcoming year.

[7] Assessment questions relating to priority areas were worded differently in 2019 and 2020. Therefore, we are not able to provide a direct comparison across years nor present the extent to which priority areas changed from 2019 to 2020.

breastfeeding were salient topics for grantees in 2019 and 2020 as well.

Another way in which the Annual Assessment ascertained the programmatic needs of grantees was to inquire about grantees' overall level of knowledge of the specific content areas. The content areas for which grantees reported the highest levels of knowledge[8] include recruitment and outreach, data collection and systems, breastfeeding, social determinants of health (SDoH), and maternal mortality and morbidity (MMM). Grantees reported relatively lower levels of knowledge on the topics of CAN development, equity, evaluation, fatherhood, and gentrification. Although it is challenging to compare data on staff knowledge across years because the 2019 and 2020 Assessments inquired about different topic areas, it appears that staff knowledge of fatherhood and data collection has remained fairly consistent over time.

Areas that require support next year	% Grantees
Fatherhood	60.0%
Recruitment and Outreach	52.0%
Retention	49.3%
Behavioral and Mental Health	46.7%
Community Action Network	46.7%
COVID-19	45.3%
Data collection, reporting, and monitoring	44.0%
Quality improvement and assurance	36.0%
Evaluation	34.7%
Breastfeeding	24.0%
Other	4.0%

Priority Area categories are not mutually exclusive; grantees could select more than one Priority Area category.

Nearly all (96%) HS grantees reported actively delivering evidenced-based services and those based on best practices to their clients during the 12 months prior to the Annual Assessment. Importantly, over half (53%) of grantees also reported improved capacity to implement these evidence-based services, and two-thirds (68%) indicated improved quality of these services in the same period. Qualitative data suggest that staff trainings and increased staff were major drivers of these improvements in capacity and quality. Additionally, grantees reported that the evidence-based services themselves improved by increasing staff training and development using evidence-based curricula and offering services that utilize evidence-based curricula. Additional information on qualitative responses can be found in Appendix X. Over 80% of HS grantees reported that they did not need additional support from the TASC to demonstrate the effectiveness of these evidence-based services.

Content Areas	No knowledge	Heard of topic / Could not explain or apply it	Working knowledge / Could explain what it is	Solid working knowledge / Could demonstrate how to apply to work	Confident and comfortable in explaining, applying, and teaching	Missing	Total
BMH	0.0%	4.0%	26.7%	42.7%	25.3%	1.3%	100.0%
Breastfeeding	0.0%	0.0%	20.0%	34.7%	45.3%	0.0%	100.0%
CAN Development	1.3%	9.3%	29.3%	36.0%	22.7%	1.3%	100.0%
Data Collection*	0.0%	1.3%	17.3%	49.3%	32.0%	0.0%	100.0%

[8] Here, we describe those content areas in which more than 70% of grantees had solid working knowledge or confidence/comfort explaining, applying, and teaching the topic.

Equity	0.0%	4.0%	29.3%	41.3%	25.3%	0.0%	100.0%
Evaluation	1.3%	5.3%	32.0%	40.0%	21.3%	0.0%	100.0%
Fatherhood	0.0%	0.0%	37.3%	37.3%	25.3%	0.0%	100.0%
Gentrification	9.3%	14.7%	44.0%	17.3%	14.7%	0.0%	100.0%
MMM	0.0%	0.0%	26.7%	30.7%	42.7%	0.0%	100.0%
Recruitment and Outreach	0.0%	1.3%	12.0%	37.3%	49.3%	0.0%	100.0%
SDoH	0.0%	5.3%	20.0%	34.7%	40.0%	0.0%	100.0%

**Data Collection includes data collection forms and/or data systems.*
Percentages represent the proportion of grantees among all Assessment respondents.

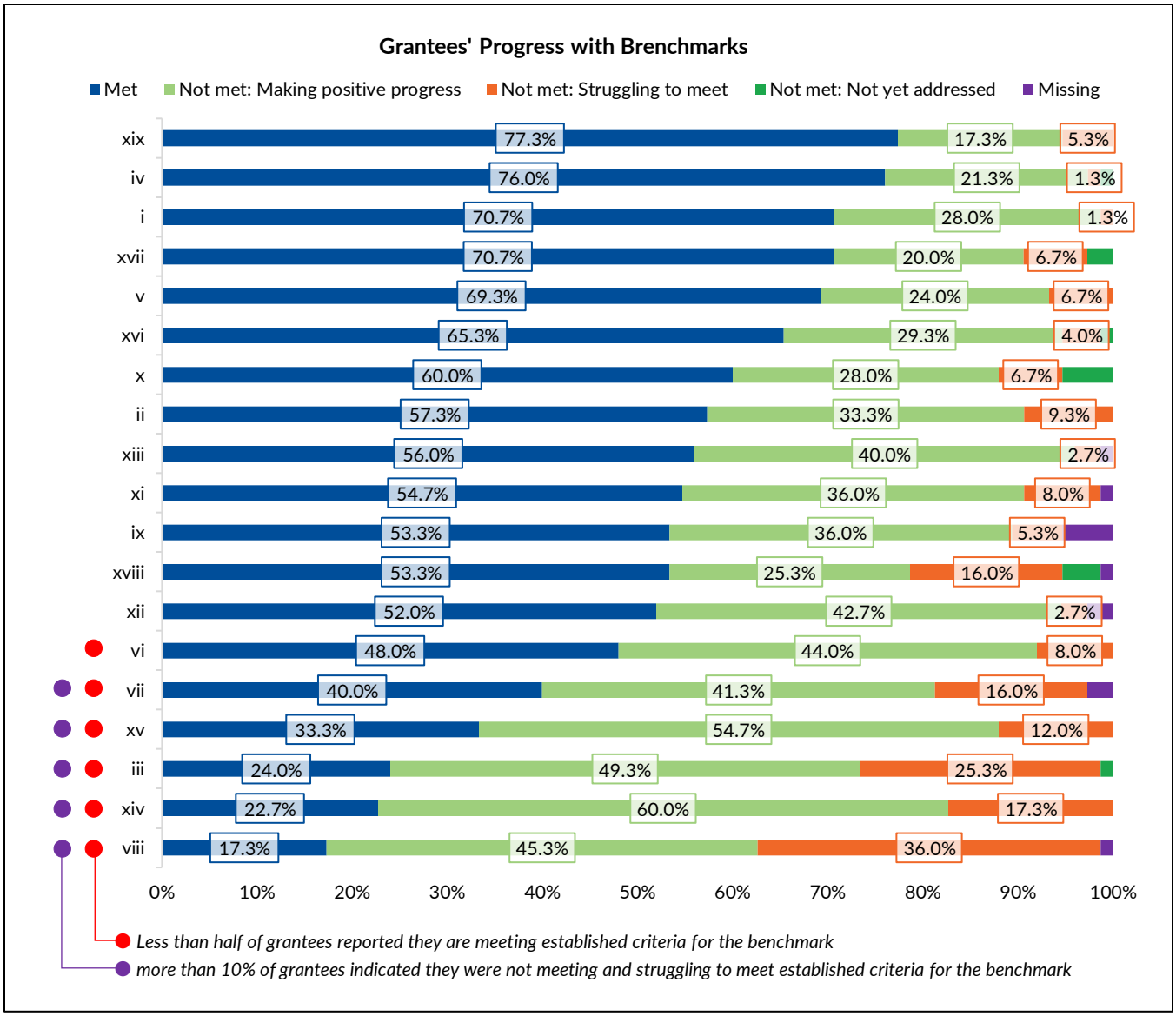
Benchmarks and Targets

Grantees provided critical information related to their successes and challenges with achieving the 19 HS benchmarks and meeting targets for number of individuals served in this year's Annual Assessment (see full description of benchmarks in the table below). For each benchmark, grantees reported whether they 1) met; 2) did not meet but were making positive progress in 2020; 3) did not meet and were struggling to meet; or 4) did not meet and not yet addressed in 2020.

Of the 19 benchmarks, over half of the grantees reported that they were meeting 13 benchmarks. In the chart below, we note with a ● the six benchmarks for which less than half of grantees reported they are meeting established criteria set forth by HRSA/MCHB. These six benchmarks focus on the following programmatic areas: postpartum visits, safe sleep, breastfeeding and father or partner involvement. Aside from benchmark vi relating to safe sleep, these are the same benchmarks for which the lowest proportion of grantees reporting meeting in the 2019 Assessment.

We note with a ● benchmarks for which more than 10% of grantees indicated they were not meeting and struggling to meet established criteria. These benchmarks overlap greatly with those noted with a ●, with the exception that benchmark xviii relating to CANs appears to be a benchmark that grantees struggle to meet; just over half of grantees indicated meeting this benchmark. Related, examining benchmark data in 2019, the benchmarks for which grantees struggled to meet exhibited great overlap across years.[9]

[9] Note: It is not possible to directly compare benchmark data from 2019 and 2020 because the response categories were changed meaningfully from 2019 to 2020. In 2019, grantees struggled most to meet benchmarks vii, viii, xiv, and xv, which are the same benchmarks highlighted for 2020 (in purple) except for benchmark iii.



For a table with the results by benchmark, see Appendix X.

Almost 90% of grantees reported that COVID-19 impacted their ability to meet benchmarks and, as discussed previously, only half of grantees struggling to meet benchmarks reached out to the TASC for support. Of those that did not reach out to the TASC, qualitative data reveals that many grantees did not reach out due to COVID-19 related issues. This included having difficulty with benchmarks due to COVID-19 and not knowing if TA would address COVID-19/local issues, staff burnout, Zoom difficulties and meeting conflicts, issues with participant/consumer participation. We also note that some grantees reported that they had internal quality improvement and/or evaluation plans to address challenges with benchmarks and did not need to

Healthy Start and COVID-19

Majority of grantees reported that COVID-19 impacted their ability to meet benchmarks.

reach out to TASC and/or used outside resources, such as the EPIC website. Additional information on qualitative responses can be found in Appendix X.

Assessment data reveals challenges in meeting targets for number of individuals served in 2020 as well. Almost one-half (49%) and one-third (32%) of grantees reported not anticipating meeting targets for 300 pregnant women and 300 infants/children per year. Nearly two-thirds (62%) of grantees indicated that they did not anticipate meeting the target of 100 fathers/male partners per year. Qualitative data suggests that COVID-19 as well as recruitment, retention and outreach challenges were omnipresent in 2020 and contributed to not meeting these targets. For the fathers/male partners target, staffing was an additional concern for grantees.[10]

Anticipate meeting target	300 pregnant women per year in 2020	300 infants/children per year in 2020	100 fathers/male partners per year in 2020
Yes	50.7%	68.0%	36.0%
No	49.3%	32.0%	62.7%
Missing	0.0%	0.0%	1.3%
Total	**100.0%**	**100.0%**	**100.0%**

Additional Support and Mentoring

Grantees provided qualitative data about additional funding resources that support the HS program beyond the federal HS grant, help provide additional capacity and/or allow for extended services. Grantees most commonly received state and local funding (see Appendix X). To a lesser extent, grantees reported receiving federal or private funding. Related, grantees provided details about other initiatives the grantees participate in which complement HS, including programs related to infant and child health, infant mortality (i.e., FIMR), maternal mortality and morbidity, perinatal health, breastfeeding, postpartum health, fatherhood, and mental health.

Finally, to further support grantees in their programmatic initiatives, the Assessment examined interest to serve as mentors for newer grantees. Just over half (52%) indicated a willingness to serve as a mentoring project to newer projects in the future. Potential mentors shared how their expertise aligned with the HS approaches (see below for more information about these approaches). Most commonly, potential mentors possessed expertise in Approach 1, followed by Approaches 4, 2 and 3.

Mentoring areas related to HS Approaches	% Grantees
Approach 1: Improve Women's Health	42.7%
Approach 2: Improve Family Health and Wellness	29.3%
Approach 3: Promote Systems Change	25.3%
Approach 4: Impact and Effectiveness	34.7%

Knowledge of the Four Healthy Start Approaches

To identify future TA needs, we seek to track knowledge of the four HS approaches and leveraged the Annual Assessment to collect data related to these approaches. Furthermore, for Approaches 1, 2 and 4, knowledge of the benchmarks relevant to these approaches was assessed.

1. Improving women's health
2. Improving family health and wellness

[10] The 2019 Needs Assessment did not examine targets specifically.

3. Promoting systems change
4. Assuring impact and effectiveness through workforce development, data collection, quality improvement, performance monitoring, and evaluation

Approach 1: Improving women's health

More than 90% of all grantees reported an excellent or good understanding of benchmarks related to Approach 1 (benchmarks i, ii, iii, v, ix, x, xii, xiii). Of note, 100% of the 75 HS grantees that responded to the Annual Assessment reported an excellent or good understanding of benchmark v (increase proportion of HS women participants that receive a well-woman visit to 80 percent). Furthermore, approximately 95% of grantees reported an excellent or good understanding of how a woman's health impacts family and infant outcomes as well as how social determinants of health impact women's health.

Understanding of how woman's health impacts family and infant outcomes	% Grantees
Excellent	72.0%
Good	24.0%
Fair	1.3%
Poor	0.0%
Very Poor/ No knowledge	0.0%
Missing	2.7%
Total	**100.0%**

Understanding of how social determinants of health impact women's health	% Grantees
Excellent	54.7%
Good	40.0%
Fair	5.3%
Poor	0.0%
Very Poor/ No knowledge	0.0%
Missing	0.0%
Total	**100.0%**

Understanding of benchmarks related to Approach 1	Excellent	Good	Fair	Poor	Very Poor or No knowledge	Missing	Total
i. Increase the proportion of HS women and child participants with health insurance to 90% (reduce uninsured to less than 10%)	73.3%	21.3%	2.7%	0.0%	0.0%	2.7%	100.0%
ii. Increase the proportion of HS women participants who have a documented reproductive life plan to 90%	65.3%	30.7%	4.0%	0.0%	0.0%	0.0%	100.0%
iii. Increase the proportion of HS women who receive a postpartum visit to 80%	61.3%	33.3%	4.0%	1.3%	0.0%	0.0%	100.0%
v. Increase proportion of HS women participants that receive a well-woman visit to 80%	65.3%	34.7%	0.0%	0.0%	0.0%	0.0%	100.0%
ix. Increase the proportion of pregnant HS participants that abstain from cigarette smoking to 90%	66.7%	30.7%	2.7%	0.0%	0.0%	0.0%	100.0%
x. Reduce the proportion of HS women participants who conceive within 18 months of a previous birth to 30%	64.0%	29.3%	6.7%	0.0%	0.0%	0.0%	100.0%
xii. Increase the proportion of HS women participants who receive depression screening and referral to 100%	74.7%	24.0%	1.3%	0.0%	0.0%	0.0%	100.0%
xiii. Increase proportion of HS women participants who receive intimate partner violence (IPV) screening to 100%	68.0%	26.7%	5.3%	0.0%	0.0%	0.0%	100.0%

Approach 2: Improving family health and wellness

Like Approach 1, more than 90% of all grantees reported an excellent or good understanding of many benchmarks related to Approach 2 (including benchmarks vi, vii, viii, xi, xvi). The proportion of grantees with an excellent or good understanding of benchmarks of xiv and xv was just under 90%, at 87% and 89%, respectively. Nearly 95% of responding grantees ranked their programs' understanding of how social determinants of health impacts family health and wellness as excellent or good.

Understanding of how social determinants of health impacts family health and wellness	% Grantees
Excellent	58.7%
Good	36.0%
Fair	4.0%
Poor	0.0%
Very Poor/ No knowledge	0.0%
Missing	1.3%
Total	**100.0%**

Understanding of benchmarks related to Approach 2	Excellent	Good	Fair	Poor	Very Poor or No knowledge	Missing	Total
vi. Increase proportion of HS women participants who	64.0%	33.3%	2.7%	0.0%	0.0%	0.0%	100.0%

	engage in safe sleep practices to 80%							
vii.	Increase proportion of HS child participants whose parent/ caregiver reports they were ever breastfed or pumped breast milk to feed their baby to 82%	60.0%	38.7%	1.3%	0.0%	0.0%	0.0%	100.0%
viii.	Increase proportion of HS child participants whose parent/ caregiver reports they were breastfed or fed breast milk at 6 months to 61%	52.0%	42.7%	5.3%	0.0%	0.0%	0.0%	100.0%
xi.	Increase proportion of HS child participants who receive the last age-appropriate recommended well child visit based on AAP schedule to 90%	62.7%	37.3%	0.0%	0.0%	0.0%	0.0%	100.0%
xiv.	Increase proportion of HS women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, etc.) during pregnancy to 90%	53.3%	33.3%	12.0%	1.3%	0.0%	0.0%	100.0%
xv.	Increase proportion of HS women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/childcare) with their child participant to 80%	50.7%	38.7%	9.3%	1.3%	0.0%	0.0%	100.0%
xvi.	Increase the proportion of HS child participants aged	58.7%	37.3%	4.0%	0.0%	0.0%	0.0%	100.0%

Approach 3: **Promoting systems change**

For Approach 3, the TASC was most interested in understanding the ways in which grantees promoted systems change. We found that CANs were the predominant method for promoting systems change, followed by regional networks, local health system actional plans, Title V and national networks. Qualitative data mirrored these results; when asked which areas related to Approach 3 would require support from the TASC in the future, most grantees responded that they did not need support with their CAN.

How program currently promote systems change	% Grantees
Community Action Network	97.3%
Regional networks	78.7%
Local health systems action plan	65.3%
Title V	53.3%
National networks	38.7%

Approach 4: **Assuring impact and effectiveness through workforce development, data collection, quality improvement, performance monitoring, and evaluation**

Over 93% of grantees reported that they possessed an excellent or good understanding of benchmark xix related to Approach 4 (see table below for full benchmark description).

Understanding of benchmarks related to Approach 4	Excellent	Good	Fair	Poor	Very Poor or No knowledge	Missing	Total
xix. Increase the proportion of HS programs who establish a QI and performance monitoring process to 100%	52.0%	41.3%	6.7%	0.0%	0.0%	0.0%	100.0%

Capacity for data collection and use

Most (77%) grantees reported planning or conducting a local evaluation during this funding cycle. Similarly, 88% of grantees reported having developed SMART (Specific, Measurable, Attainable, Relevant and Timely) objectives, which is up from 56% in last year's Assessment. A small proportion (8%) of grantees indicated that they developed objectives using an alternate framework, including SMART with Inclusive and Equitable (SMARTIE) and SWOT Analysis (an evaluation technique used to identify strengths, weaknesses, opportunities, and threats during the project planning process). Over three-quarters (79%) shared that they did not need support from the TASC to develop and refine program objectives.

Factors relating to collection and submission of data	Helped	Hindered
Other[11]	90.7%	38.7%
Other data management systems	89.3%	0.0%
Access to technology	85.3%	0.0%
Standardized Data Collection Forms (formerly called screening tools)	78.7%	37.3%
Staff resources dedicated to data collection/submission	62.7%	20.0%
Training or TA webinars related to data collection/submission by MCHB/DHSPS	60.0%	21.3%
Responsiveness of DHSPS staff	28.0%	13.3%
Responsiveness of TASC	26.7%	6.7%
Patient privacy rules and regulations	22.7%	14.7%
HRSA-provided data management system (CAREWare)	9.3%	0.0%
Missing	0.0%	17.3%

The TASC was interested in understanding the factors that helped or hindered grantees' collection and submission of client-level data in the past 12 months. Data management systems helped data collection and submission among 91% of grantees. Access to technology, standardized data collection tools, and staff resources and trainings also contributed greatly to the successful collection and submission of client-level data. Additional write-in responses that grantees provided included strong staff and internal operations (staff meetings, trainings, etc.) to support data collection and submission. Similar factors were also described as facilitators to data collection and submission last year. Standardized data collection forms hindered the collection and submission of data among one-third (37%) of grantees (though, many grantees also noted that these forms helped data collection and submission). Write-in responses further substantiated this claim; many grantees expressed discouragement by changing forms and systems mid-grant year. Staff resources and trainings each hindered approximately 20% of responding grantees as well.

[11] Only two write-in responses were provided, despite so many grantees indicating that "other" factors helped with data collection and submission.

The TASC inquired about grantees' current use of a data management system. Almost all (96%) of the grantees responding to the Annual Assessment indicated that they use a data management system for the collection and submission of client-level data. A diversity of systems was reported. Following "other" system, the most commonly use data management system was REDCap (15%), CAREWare (11%), Challenger Soft (8%) and Healthy Soft (1%). "Other" systems included: Avatar, CHART developed by SNJPC/FHI, DMCN, ECW, Efforts to Outcome (ETO), Go Beyond's Well Family System, Health & Hospital Corporation of Marion County's Corporate Information System (CIS) Core Services Tracking System (CSTS), In house data base, Maven Database, MicroMD, Microsoft Access system developed and maintained by our site, PeerPlace, Penelope (Athena), QuikenTool, RBase, Social Solutions/Apricot and SymServe.

Data management system(s) in use	% Grantees
Other	66.7%
REDCap	15.3%
CAREWare	11.1%
Challenger Soft	8.3%
Healthy Soft	1.4%

Percentages represent the proportion of grantees among respondents reporting these utilize a data management system to collect and submit client-level data (n=72); grantees could select more than one data management system and, therefore, the sum of the %s exceed 100%.

Strength of partnerships

HS grantees engage in partnerships with partner organizations to achieve their programmatic goals. The Assessment examined the number of partners reported by grantees and the level of partnership with these organizations, groups and other programs. Data revealed that 24% of grantees have fewer than 10 total partners, while 39% have greater than or equal to 10 but fewer than 20 partners. An additional 13% possess greater than or equal to 20 partners but fewer than 30 partners. The remaining 20% of grantees reported greater than or equal to 30 total partners. Although we cannot draw clear conclusions comparing the 2019 and 2020 data because different grantees responded to the Assessments, the cross-year data do reveal similar patterns, and majority of grantees reported having greater than or equal to 10 but fewer than 30 partners.

# Partners	% Grantees in 2019	% Grantees in 2020
<10	16.4%	24.0%
10≥ to <20	25.4%	38.7%
20≥ to <30	20.9%	13.3%
30≥ to <40	13.4%	5.3%
40≥ to <50	1.5%	2.7%
50+	7.5%	12.0%
Missing	14.9%	4.0%
Total	100%	100.0%

The Assessment inquired about the degree of partnership with three specific partners (provided by the site). Below we present data for the average level of partnership across these three partners. Nearly half (47%) of responding grantees report that they "collaborate" with these partners, whereas 12% "coordinate," and 27% are "integrated" with these partners. Looking at the 2019 data, we see similar patterns in which over two-thirds of grantees reported "collaborating" and "partnering" (a response category that was replaced by "integration" in this year's Assessment) across the three partners.

Current level of partnership	Average across 3 partners
No Interaction	0.9%
Networking (Sharing information and ideas)	4.4%
Cooperation (Helping distinct members accomplish their separate individual goals)	1.8%
Coordination (Shared goals but working separately)	11.6%
Collaboration (Working together toward a common goal but maintaining separate resources and responsibilities)	46.7%
Integration (Common goals, program alignment and leveraging and maximizing resources)	27.1%
I am a member of this organization	4.0%

Missing	3.6%

Progress towards sustainability

Grantees provided data related to the sustainability of their programs past the current funding cycle. Overall, we learned that grantees are excelling in the following areas related to sustainability: Planning for future resource needs; long-term financial planning; planning to sustain key project elements, such as strategies, services or interventions; ensuring goals are understood by all stakeholders; and establishing clear roles and responsibilities for all stakeholders. An area that appears to require additional support is the implementation of sustainability strategies, such as linking certifications and training curricula to reimbursable services. covered by Medicaid and/or Managed Care Organizations. In broad brushstrokes, looking at 2019 Assessment data, we note that greater proportions of grantees reported the highest levels of sustainability (responses 6 and 7) in all areas in 2020, suggesting improvements in these key elements of sustainability planning over time.

Levels of sustainability	The project plans for future resource needs.	The project has a long-term financial plan.	The project has a plan to sustain key project elements.	The project has been able to implement sustainability strategies.	The project goals are understood by all stakeholders.	The project clearly outlines roles and responsibilities for all stakeholders.
1: *To little or no extent*	0.0%	1.3%	2.7%	17.3%	0.0%	0.0%
2	0.0%	4.0%	1.3%	8.0%	1.3%	1.3%
3	2.7%	5.3%	2.7%	12.0%	2.7%	6.7%
4	10.7%	17.3%	14.7%	17.3%	12.0%	13.3%
5	21.3%	25.3%	25.3%	17.3%	20.0%	18.7%
6	26.7%	25.3%	24.0%	10.7%	26.7%	28.0%
7: *To a very great extent*	34.7%	20.0%	28.0%	9.3%	32.0%	26.7%
Not Applicable	0.0%	0.0%	0.0%	6.7%	4.0%	2.7%
Missing	4.0%	1.3%	1.3%	1.3%	1.3%	2.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

CONCLUSIONS

As part of our ongoing assessment of HS grantee' needs, NICHQ conducted an Annual Assessment to understand the various projects' organizational structures, satisfaction with the TASC, programmatic needs, progress toward benchmarks and key objectives, knowledge of the four HS approaches, data capacity, strength of partnerships and progress towards sustainability. Seventy-five HS grantees (76% of projects) provided invaluable data to aid the TASC's continuous efforts to refine and improve its CBA plan.

The findings from this Assessment reinforce the importance of capacity-building activities currently in place by the TASC and allows the TASC and HRSA to make data-driven decisions

about future activities.

Considering the 2020 Assessment data across all domains, it is evident that grantees continue to exhibit passion and tenacity as they work toward benchmarks and targets.

Key takeaways from the data

- The HS workforce is ever-expanding in numbers and services they provide to their clients.
- Project Directors report that staff are knowledgeable in the four HS approaches and many other relevant content areas.
- A majority of grantees reported meeting or making progress towards meeting their benchmarks, with the greatest percentage reporting meeting the benchmarks for establishing QI and performance process (77%) and increasing the proportion of HS women and children participants who have a usual source of medical care (76%).
- Grantees reported struggling to meet enrollment numbers for pregnant women, infants/children, and fathers/partners.
- HS grantees are actively engaging with partners and honing their sustainability plans.
- Fatherhood, recruitment and retention, and CANs remain salient programmatic areas of focus.
- Grantees enjoy participating in TASC learning events, particularly webinars and trainings.

Key areas of opportunities for the TASC

- Continue outreach to grantees that desire one-on-one virtual TA as well and those that expressed dissatisfaction with the TASC and/or are struggling to meet benchmarks but have not yet reached out to the TASC.
- Support grantees in their efforts to conduct local evaluations and develop clear programmatic objectives.
- Continue to support grantees in finding innovative solutions to meet their goals and reach target populations, especially in light of COVID-19.
- Support grantees in their efforts to implement changes in data collection protocol and forms.

PROGRESS TOWARDS BENCHMARKS

Overall, the majority of grantees reported either meeting or making progress towards all the benchmarks. However, they continue to struggle with the same benchmarks as last year, including postpartum visits, breastfeeding and father/partner involvement. Only half of grantees that reported struggling to meet benchmarks contacted the TASC for support, providing an important opportunity for targeted outreach by the TASC to determine how to best support those grantees. Additionally, nearly 9 out of 10 grantees reported that COVID-19 impacted their ability to meet these benchmarks. With these challenges, almost half of grantees reported that they may not meet target for enrolling 300 pregnant women, one third may not reach target of 300 infants/children, and nearly two thirds did not think they would meet the target of 100 fathers/male partners per year.

COMPARISONS TO 2019

As mentioned previously, for many Assessment domains, we cannot directly compare data from 2019 and 2020 due to changes made to the Assessment questions and response categories. There are, however, some broad conclusions we can make about trends over time.

- Staffing of behavioral and mental health personnel appears to have strengthened from 2019 to 2020.
- In 2020, the programmatic areas of highest priority revealed in the Assessment mirrored those shared in 2019, though new areas such as COVID-19 and behavioral and mental health emerged as salient this year.
- Across years, we also note similar trends in benchmark attainment (and challenges with the same benchmarks), continued evidence of collaboration with partners, and stronger sustainability planning over time.

ACTION AREAS FOR THE TA AND SUPPORT CENTER

In 2021, priorities for the TASC include three focus areas for TA and support: COVID-19, Targeted Technical Assistance, and Data Collection and Systems.

COVID-19

Summary: COVID-19 changed many facets of life in 2020, particularly for communities of color such as those represented by HS grantees. Assessment data clearly suggested that the pandemic negatively impacted HS grantees' ability to attain benchmarks and targets. Recruitment and retention efforts were challenged, and qualitative data suggests staff burnout as a result of the added workload related to these efforts.

TASC Priorities in 2021: The TASC will continue to provide COVID-19-related trainings and webinars throughout 2021. Additional forums and CBA should be offered by the TASC to aid in recruitment and retention of women, children, and families. In partnership with DHSPS, directed outreach should be made to grantees that are expressing challenges in meeting benchmarks and targets (due to COVID-19 and otherwise).

Targeted Technical Assistance

Summary: Areas that grantees will require support in the next year included: fatherhood; recruitment and outreach; retention; behavioral and mental health; CAN; COVID-19; and data collection, reporting and monitoring. Grantees also prioritized topics including quality improvement and assurance, as well as breastfeeding. When inquiring about staff knowledge, the Assessment also reveals that the topic of gentrification may be a priority area for the TASC. Grantees reported needing additional supports around attaining benchmarks as well.

TASC Priorities in 2021: The TASC has an opportunity to support grantees with strategies pertaining to recruitment, outreach, and retention, in the coming year. The TASC will work with DHSPS to further digest the results from this Assessment and to respond to the needs identified by grantees. The TASC will also engage directly with grantees, with a specific focus on:

- Grantees who expressed dissatisfaction with TA and Support offerings such as webinars and trainings.
- Grantees who did not respond to the survey.

- Groups of grantees who may have unique needs, including rural, tribal, and border grantees whose needs may not be fully represented here.

The purpose in this outreach will be to learn: How grantees engage with the TASC. Their experience and satisfaction with that engagement, and the best ways to provide meaningful and impactful TA.

Finally, as Year 3 of 5 of the Supporting Healthy Start Performance Project begins and with direction from DHSPS, the TASC may offer further support related to sustainability strategies.

Data Collection and Systems

Summary: Grantees generally expressed solid capacity for data collection. Most have planned or developed a local evaluation and have SMART objectives in place (though there remains an opportunity for support from the TASC around these objectives, as discussed previously). Staff knowledge around data collection and systems is strong, though the topic of evaluation may warrant additional support. Based on personnel data, not every site employs a data analyst and/or evaluator, although this staff role is one that many grantees plan to hire within the year. Most grantees utilize a data management system, such as REDCap, CAREWare or other system; however, across the 75 grantees that responded to the Assessment, there is great diversity in the systems employed. Qualitative data reveals that grantees data collection efforts were hindered by changing forms and systems mid-grant year. Furthermore, staff resources and trainings in the areas of data collection and submission were barriers to success.

TASC priorities in 2021: Given the diversity in the systems reported, the TASC has an opportunity to help consolidate the data management platforms being used by grantees and to continue offering support around the CAREWare system. The TASC will continue to support grantees' data capacity through Cohorts and Academies. If there is discordance among those grantees participating in the Cohort and those for which knowledge of evaluation is relatively low, the TASC can further target these grantees for additional support. Updated data collection forms in 2020 challenged grantees, and the TASC will work with DHSPS to support grantees throughout Year 3. ***In Year 3, the TASC will focus on moving beyond support for data collection towards encouraging and support for meaningful data utilization among the grantees.***

NEXT STEPS

The 2020 Annual Assessment sought to add to the TASC's understanding of HS grantee needs, and their satisfaction with the TASC, as well as capture their successes and challenges in several domains of their project work. The TASC will continue to seek out and collect information on the needs and experiences of grantees with the TASC. These continuous quality improvement activities include:

- In partnership with DHSPS, engage in active outreach to the grantees, as described above, that are not represented in this report. While three-quarters of grantees responded to the survey, there are 26 grantees that are not represented in the results provided in this report. As a TA and support center, we want to ensure that we are meeting the needs of all grantees.
- Satisfaction surveys conducted with all one-on-one TA, cohorts, webinars, and other TASC activities to ascertain real-time feedback and areas for improvement.

There are also key areas of HS programs where the TASC seeks to better understand the current status of HS grantees and the unique contribution that HS makes in these areas including:

1. Fatherhood involvement within the MCH framework,

2. Authentic community engagement through CANs,
3. The multi-faceted ways in which HS programs work to advance equity and address disparities in maternal and infant health outcomes.

In Year 3, the TASC will undertake activities to document and strategize ways to support and advance the programs' efforts in these areas.

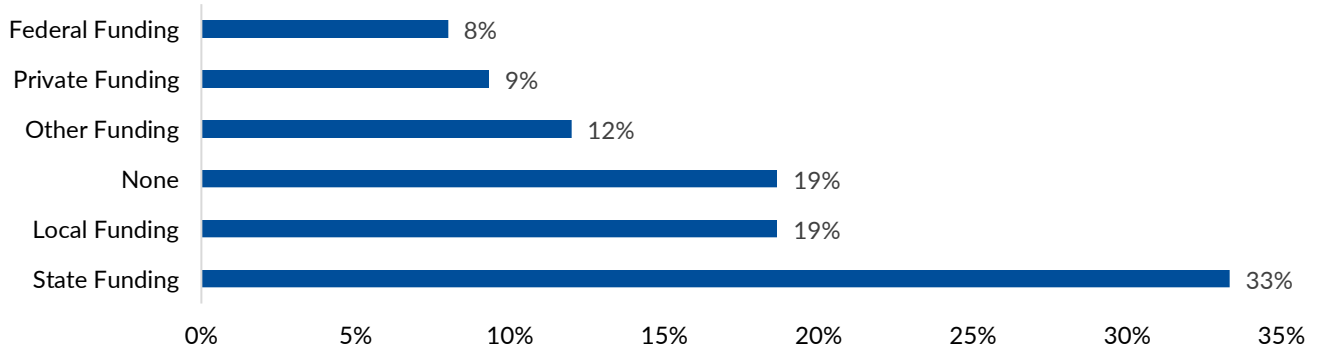
APPENDICES WITH ADDITIONAL TABLES AND DATA

APPENDIX X: PERSONNEL

Staff Category	% Grantees responding any staff paid with HS funds	% Grantees with 0 staff	% Grantees with 1-3 staff	% Grantees with 4+ staff	% Grantees responding intentions to hire
Program Director	78.7%	21.3%	78.7%	0.0%	4.0%
Program Manager	68.0%	32.0%	68.0%	0.0%	12.0%
Case Manager	62.7%	37.3%	24.0%	38.7%	8.0%
Community Health Worker	61.3%	38.7%	38.7%	22.7%	10.7%
Fatherhood Coordinator	61.3%	38.7%	61.3%	0.0%	10.7%
Evaluator / Data Analyst	46.7%	53.3%	45.3%	1.3%	10.7%
Nurse (LPN, RN, APN)	38.7%	61.3%	33.3%	5.3%	6.7%
Nurse Practitioner	30.7%	69.3%	30.7%	0.0%	5.3%
Care Coordinator	26.7%	73.3%	20.0%	6.7%	10.7%
Medical Doctor	9.3%	90.7%	9.3%	0.0%	1.3%

Staff role/services provided	Number of staff
Provide lactation support	232.25
Are licensed social workers/MSWs	96.00
Are CLCs or IBCLCs	108.00
Provide mental health counseling directly to HS participants	43.50
Are mental health consultants who provide support to HS workers (e.g., case consultation)	27.50
Provide substance use counseling directly to HS participants	24.00
Provide doula services	76.00
Are certified mental/behavioral health peer specialists or recovery support specialists/coaches	18.00
Total	**625.25**
**Staff role categories not mutually exclusive; grantees could select more than one staff role category*	

Please describe any additional funding resources that currently support your Healthy Start program beyond the federal Healthy Start grant - that help provide additional capacity and/or that allow for extended services?



Benchmarks	Met	Not met: Making positive progress	Not met: Struggling to meet	Not met: Not yet addressed	Missing	Total
i. Increase the proportion of HS women and child participants with health insurance to 90% (reduce uninsured to less than 10%)	70.7%	28.0%	1.3%	0.0%	0.0%	100.0%
ii. Increase the proportion of HS women participants who have a documented reproductive life plan to 90%	57.3%	33.3%	9.3%	0.0%	0.0%	100.0%
iii. Increase the proportion of HS women participants who receive a postpartum visit to 80%	24.0%	49.3%	25.3%	1.3%	0.0%	100.0%
iv. Increase the proportion of HS women and children participants who have a usual source of medical care to 80%	76.0%	21.3%	1.3%	1.3%	0.0%	100.0%
v. Increase the proportion of HS women participants who receive a well-woman visit to 80%	69.3%	24.0%	6.7%	0.0%	0.0%	100.0%
vi. Increase the proportion of HS women participants who engage in safe sleep practices to 80%	48.0%	44.0%	8.0%	0.0%	0.0%	100.0%
vii. 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%	40.0%	41.3%	16.0%	0.0%	2.7%	100.0%
viii. Increases the proportion of HS child participants whose parent/care giver reports they were breastfed or fed breast milk at 6 months to 61%	17.3%	45.3%	36.0%	0.0%	1.3%	100.0%
ix. Increase the proportion of pregnant HS participants who abstain from cigarette smoking to 90%	53.3%	36.0%	5.3%	0.0%	5.3%	100.0%
x. Reduce the proportion of HS women participants who conceive within 18 months of a previous birth to 30%	60.0%	28.0%	6.7%	5.3%	0.0%	100.0%
xi. Increase the proportion of HS child participants who receive the last age-appropriate recommended well child visit based on AAP schedule to 90%	54.7%	36.0%	8.0%	0.0%	1.3%	100.0%
xii. Increase the proportion of HS women participants who receive depression screening and referral to 100%	52.0%	42.7%	2.7%	0.0%	2.7%	100.0%
xiii. Increase the proportion of HS women participants who receive intimate partner violence screening to 100%	56.0%	40.0%	2.7%	0.0%	1.3%	100.0%
xiv. Increase the proportion of HS women participants who demonstrate father and/or partner involvement during pregnancy to 90%	22.7%	60.0%	17.3%	0.0%	0.0%	100.0%
xv. Increase the proportion of HS women participants who demonstrate father and/or partner involvement with their child participant to 80%	33.3%	54.7%	12.0%	0.0%	0.0%	100.0%

Benchmarks		Met	Not met: Making positive progress	Not met: Struggling to meet	Not met: Not yet addressed	Missing	Total
xvi.	Increase the proportion of HS child participants aged <24 months who are read to by a parent or family member 3 or more times a week to 50%	65.3%	29.3%	4.0%	1.3%	0.0%	100.0%
xvii.	Increase the proportion of HS programs with a fully implemented CAN to 100%	70.7%	20.0%	6.7%	2.7%	0.0%	100.0%
xviii.	Increase the proportion of HS programs with at least 25% community members and HS program participants serving as members of their CAN to 100%	53.3%	25.3%	16.0%	4.0%	1.3%	100.0%
xix.	Increase the proportion of HS programs who establish a QI and performance monitoring process to 100%	77.3%	17.3%	5.3%	0.0%	0.0%	100.0%