Healthy Start Benchmarks

Data Dictionary

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Healthy Start Benchmarks - Data Dictionary

This manual includes a brief introduction to the Healthy Start Benchmarks for Healthy Start Enhanced (HRSA-23-130) and FY24-FY29 Healthy Start (HRSA-24-033) grant recipients, detailed performance measure definitions, and instructions for calculating annual performance measure outcomes using the Healthy Start Data Collection Forms.

Program Background

Healthy Start (HS) is an initiative of the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), and the U.S. Department of Health and Human Services (HHS). HS uses a community-based approach to delivering direct and enabling services that facilitates access to health care and community services. The program focuses on addressing factors that contribute to infant mortality, such as low birthweight, preterm birth, and social determinants of health. The purpose of HS is to reduce infant mortality rates and improve perinatal outcomes by focusing on project areas with high or above the national average annual rates of infant mortality. Since its start as a demonstration project in 1991, the HS program has provided awards to communities with infant mortality rates at 1.5 times the U.S. national average and high rates of other adverse perinatal outcomes.[1]

[1] Healthy Start FY24 NOFO (HRSA-24-033)

Healthy Start Benchmarks

The HS program established 10 benchmarks and goals for grant recipient performance. In general, Healthy Start benchmarks are aligned with national performance measures to enable comparisons between the U.S. population at large and participants served by the HS program:

1. Increase the proportion of HS women and child participants with health insurance to 90 percent (reduce uninsured to less than 10 percent).
2. Increase the proportion of pregnant HS participants who receive prenatal care in the first trimester to 80 percent.
3. Increase the proportion of HS women participants who receive a postpartum visit to 80 percent.
4. Increase the proportion of HS women participants who receive a well-woman/preventive visit in the past year to 80 percent.
5. Increase the proportion of HS infants placed to sleep following safe sleep practices to 80 percent.
6. Increase the proportion of HS infant participants who were:
   A. ever breastfed or fed breast milk to 82 percent.
   B. breastfed or fed pumped breast milk at 6 months to 50 percent.
7. Increase the proportion of pregnant HS participants that abstain from cigarette smoking, or using any tobacco products, to 90 percent.
8. Increase the proportion of HS child participants who receive the last age-appropriate recommended well-child visit based on the AAP schedule to 90 percent.
9. Increase the proportion of HS women participants who receive depression screening to 90 percent; of those who screen positive for depression, increase the proportion who receive referral to 95 percent.
10. Increase the proportion of HS women participants who receive interpersonal violence (IPV) screening to 90 percent; of those who screen positive for IPV, increase the proportion who receive referral to 95 percent.[1]

[1] Healthy Start FY24 NOFO (HRSA-24-033)

HS Data Collection Forms and Annual Performance Reporting

As outlined in the Notice of Funding Opportunity and the Notice of Award, all HS grant recipients are expected to collect benchmark data using the HS Data Collection Forms (Demographic, Background, Prenatal, and Parent/Child Forms). Grant recipients report benchmark outcomes (performance measures) annually in the Discretionary Grants Information System (DGIS) Performance Report. This manual serves as a crosswalk between the data collected using the HS Data Collection Forms, and the calculations for the DGIS performance measures.

Definitions

This section provides definitions which are critical for consistent reporting of data across grant recipients.

Healthy Start (HS) Program Participant

Every HS program is required to report the total unduplicated count of participants receiving HS services during each reporting period (calendar year). An unduplicated count refers to the fact that a participant counts only once towards the total count regardless of the number and type of contacts they have with the HS program.

A program participant is an individual receiving HS case management/care coordination services, or group-based prenatal and parenting education, on an ongoing, systematic basis to improve perinatal and infant health. Specifically, HS participants are pregnant women and women of reproductive age, infants, and children up to 18 months of age. Participants also include fathers/male partners who have an infant or child from newborn to 18 months of age and/or are the current or former partner of an enrolled participant.

- **Case Management/Care Coordination (CM/CC):** Helps participants to access medical care, community resources and health/parenting information by encouraging, guiding, and coordinating services and supports. It is a family-centered, strength-based partnership between the HS/HSE participant, HS/HSE staff/team and other affiliated providers. Services are flexible, culturally responsive, and linguistically appropriate.[1]
    - **CM/CC Participant:** An individual who is enrolled in the HS program for case management/care coordination services.
- **Group-Based Prenatal and Parenting Education (GBE):** A structured and highly collaborative form of learning aimed at improving prenatal health and wellness while providing critical social support for women and increasing empowerment and resiliency. Activities such as health fairs do not constitute group-based education.[1]

- **GBE participant:** An individual who is only attending group-based health education and is *not* enrolled in case management/care coordination services.

Other Adult

An individual who is not enrolled in the HS program but has primary responsibility for/custody of an enrolled child is considered an "Other adult". "Other adults" are individuals who do not meet the Healthy Start participant requirements for enrollment, and do not participate in group-based prenatal and parenting education. Other adults are not program participants and are not counted in the performance measure outcomes, though their enrolled children are counted toward the infant/child outcomes.

Enrollment

A participant is considered "enrolled" in the HS program after completing all applicable HS Data Collection Forms and grant recipient site-specific enrollment requirements. The participant continues to be considered enrolled in the program during any reporting period that the participant has one or more contacts with the Healthy Start program. Therefore, the term "enrolled" encompasses initial enrollment and subsequent periods of participation.

Reporting Period

The reporting period for annual HS performance measures is always by calendar year.

Performance Measure Calculations

Instructions for calculating numerators and denominators for each performance measure are outlined below in the "**Grantee Data Sources**" section of the Performance Measure Detail Sheets on pages 7-36. All performance measures are to be reported as of the last available data for each participant in a reporting period, unless noted otherwise in the detail sheets. All performance measures must include unduplicated counts of participants meeting the numerator and denominator criteria.

For participants who have more than one pregnancy in a reporting period (calendar year), each pregnancy is counted toward the pregnancy-related outcome measures (please refer to the notation in the "Grantee Data Sources" section for instructions on where this guidance applies). For participants who give birth once during a reporting period resulting in multiple babies ("birth to multiples"), the pregnancy is counted once toward the pregnancy-related outcomes and each child is counted individually toward the infant-/child-related measures (please refer to the notation in the "Grantee Data Sources" section for instructions on where this guidance applies).

[1] Healthy Start FY24 NOFO (HRSA-24-033)

HS Performance Measure

Detail Sheets

1. PERFORMANCE MEASURE **Goal:** Interpersonal Violence Screening and Referral **DGIS Measure:** HS 04	The percent of HS women participants who receive interpersonal violence screening and referral.
GOAL	To increase the proportion of Healthy Start women participants who receive interpersonal violence (IPV) screening to 90%; of those who screen positive for IPV, increase proportion who receive referrals to 95%.
MEASURE	The percent of Healthy Start women participants who receive interpersonal violence screening and referral.
DEFINITION	**% of Healthy Start (HS) women participants screened for IPV using a standardized screening tool** **Numerator:** Number of HS women participants who received interpersonal violence screening using a standardized screening tool during the reporting period. **Denominator:** Total number of HS women participants in the reporting period. **Definition:** A participant is considered to have been screened and included in the denominator if a standardized screening tool which is appropriately validated for her circumstances is used. A number of screening tools have been validated for IPV screening. **% of HS women participants who screened positive for IPV who received a referral for services** **Numerator:** Number of HS women participants who screened positive for IPV during the reporting period and received a subsequent referral for follow-up services. **Denominator:** Number of HS women participants who screened positive for IPV during the reporting period. **Definition:** A participant is considered to have been referred for follow-up services and included in the numerator if she is referred to a qualified practitioner for further assessment for IPV. Referral can be to either an internal or external provider depending on availability and staffing model.[2] Interpersonal Violence is a pattern of assaultive behavior and coercive behavior that may include physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and reproductive coercion. These behaviors are committed by someone who is, was, or wishes to be involved in an intimate relationship with the participant.[3]

BENCHMARK DATA SOURCES	PRAMS
GRANTEE DATA SOURCES	**Healthy Start Data Collection Forms** **% of Healthy Start (HS) women participants screened for IPV using a standardized screening tool** **Numerator:** # of HS women participants who meet the denominator criteria, **AND** responded "Current or Former Intimate Partner", "Other Family Member", "Someone Else", **and/or** "No-one" to *any* question in **Q16a-Q16e on the Background Form**. **Denominator:** Total # of HS women participants served in the reporting period who identified "Female" for **Q4 on the Demographic Form**. **Note:** Exclude participants who declined *all* Healthy Start Data Collection Form screening **% of HS women participants who screened positive for IPV who received a referral for services** **Numerator:** # of HS women participants who meet the denominator criteria, **AND** who staff indicated, "Yes, referral for follow-up services was provided or the participant is already receiving appropriate services" in **Q17 of the Background Form**. **Denominator:** Total # of HS women participants served in the reporting period who: - identified "Female" for **Q4 on the Demographic Form**, **AND** - responded, "Current or Former Intimate Partner", "Other Family Member", **and/or** "Someone Else" to *any* question in **Q16a-Q16e on the Background Form**.

Note: Exclude participants who declined *all* Healthy Start Data Collection Form screening.

SIGNIFICANCE

Interpersonal Violence is a substantial yet preventable public health problem that affects women across the world. Research shows that interpersonal violence screening differs among health care specialties and is overall relatively low. The U.S. Department of Health and Human Services recommends IPV screening and counseling be a core part of a women's well visit.[4]

[2] https://www.ahrq.gov/ncepcr/tools/healthier-pregnancy/fact-sheets/partner-violence.html
[3] http://mchb.hrsa.gov/whusa09/hstat/hi/pages/226ipv.html
[4] http://aspe.hhs.gov/report/screening-domestic-violence-health-care-settings/prevalence-screening

2. PERFORMANCE MEASURE **Goal:** Prenatal Care **DGIS Measure:** HS 10	The percent of pregnant HS participants who receive prenatal care beginning in the first trimester.
GOAL	To increase the proportion of pregnant HS participants who receive prenatal care in the first trimester to 80 percent.
MEASURE	The percent of pregnant HS participants who receive prenatal care beginning in the first trimester.
DEFINITION	**During the reporting period:** **Numerator:** Number* of pregnant HS participants who began prenatal care in the first trimester of pregnancy. *The number of pregnant participants is unduplicated. Pregnant HS participants should be counted only once during a calendar year unless they have experienced more than one pregnancy in that calendar year. (If pregnant participant is counted more than once in the numerator, they should be counted more than once in the denominator.) **During the reporting period:** **Denominator:** Number of pregnant HS participants who had enrolled prenatally, prior to their second trimester of pregnancy.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objective MICH08: Increase the proportion of pregnant women who receive early and adequate prenatal care. (Baseline: 76.4% in 2018, Target: 80.5%)[5]
GRANTEE DATA SOURCES	**Healthy Start Data Collection Forms** **<u>Numerator:</u>** # of HS participants who meet the denominator criteria, **AND** responded, "0-13 weeks," to **Q4 of the Prenatal Form**. **<u>Denominator:</u>** Total # of HS participants served who: - completed a **Prenatal Form** in the reporting period, **AND** - indicated "I enrolled before this pregnancy" or "0-13 weeks" in **Q3 of the "Pregnancy and Health" section of the Prenatal Form**.

Note: The number of pregnant participants is unduplicated. Pregnant HS participants should be counted only once during a calendar year unless they have experienced more than one pregnancy in that calendar year. Exclude participants who declined *all* Healthy Start Data Collection Form screening.

SIGNIFICANCE

Early and continuous prenatal care is essential for identification of maternal disease and risks for complications of pregnancy or birth. This can help ensure that women with complex problems, chronic illness, or other risks are seen by specialists. Prenatal care can also provide important education and counseling on modifiable risks in pregnancy, including smoking, drinking, and inadequate or excessive weight gain.

[5] https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/increaseproportion-pregnant-women-who-receive-early-and-adequate-prenatal-care-mich-08 (accessed on 5/25/22)

3. PERFORMANCE MEASURE **Goal:** Perinatal/Postpartum Care **DGIS Measure:** HS 11	The percent of pregnant/newly postpartum HS participants who received a postpartum visit within 12 weeks of delivery.
GOAL	To increase the proportion of HS women participants who receive a postpartum visit to 80 percent.
MEASURE	The percent of pregnant/newly postpartum HS participants with a postpartum visit within 12 weeks of delivery.
DEFINITION	**During the reporting period:** **Numerator:** The number* of pregnant/newly postpartum HS participants, who had enrolled prenatally or within 30 days after delivery, and received a comprehensive postpartum visit within 12 weeks after delivery. *The number of pregnant/newly postpartum participants with a postpartum visit within 12 weeks of delivery is unduplicated. Pregnant/newly postpartum HS participants should be counted only once during a calendar year unless they have experienced more than one pregnancy in that calendar year. **During the reporting period:** **Denominator:** The number of HS participants who enrolled prenatally or within 30 days after delivery. **Definition:** ACOG recommends that postpartum care would ideally include an initial assessment, either in person or by phone, within the first 3 weeks postpartum to address acute postpartum issues. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive well-woman visit no later than 12 weeks after birth.[6, 7]
BENCHMARK DATA SOURCES	PRAMS (postpartum visit: 88%, 2020)
GRANTEE DATA SOURCES	**Healthy Start Data Collection Forms** **<u>Numerator:</u>** # of HS participants who meet the denominator criteria, **AND** responded, "Yes, within the first 3 weeks...", "Yes, between 4 weeks and 6 weeks...", "Yes, between 7 weeks and 8 weeks...", **and/or** "Yes, between 9 and 12 weeks...", to **Q20 on the Parent/Child Form** linked to the participant's pregnancy/delivery in the reporting period.

Denominator:

Total # of HS participants who:

- gave birth in the reporting period,

AND

- completed a **Parent/Child Form**,

AND

- responded, "Part of a family enrolled for HS services before the child's birth", **or** "Part of a family enrolled for HS services within 30 days following the child's birth" to **Q1 of the Parent/Child Form**.

Note: The number of pregnant/newly postpartum participants with a postpartum visit within 12 weeks of delivery is unduplicated. For a participant whose pregnancy resulted in multiple live births, only count their postpartum visit outcome once. Exclude participants who declined *all* Healthy Start Data Collection Form screening.

SIGNIFICANCE

Since the period immediately following birth is a time of many physical and emotional adjustments, the postpartum visit is important for educating new mothers on what to expect during this period and address any concerns which may arise. Additional issues include any health complications the mother may have and the health benefits of breastfeeding for the mother and baby.[8]

[6] https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care (accessed 5/25/22)

[7] https://www.marchofdimes.org/pregnancy/your-postpartum-checkups.aspx (accessed 5/25/22)

[8] http://www.aafp.org/afp/2005/1215/p2491.html

4. PERFORMANCE MEASURE **Goal:** Well Woman Visit/Preventive Health **DGIS Measure:** HS 12	The percent of HS women participants with a well-woman/ preventive visit in the past year.
GOAL	To increase the proportion of HS women participants that receive a well-woman/ preventive visit in the past year to 80 percent.
MEASURE	The percent of HS women participants with a well-woman/ preventive visit in the past year.
DEFINITION	**Numerator:** Number of HS women participants within the reporting period who received a well-woman or preventive visit (including prenatal or postpartum visit) in the past 12 months prior to last assessment. **Denominator:** Total number of HS women participants during the reporting period. **Definition:** A participant is considered to have a well-woman or preventive visit and included in the numerator if she has a documented health assessment visit where she obtained recommended preventive services that are age and developmentally appropriate within twelve months of her last contact with the Program in the reporting year. For purposes of reporting, a prenatal visit or postpartum visit during the twelve month period would meet the standard.
BENCHMARK DATA SOURCES	BRFSS (Women 18-44 with a past-year preventive visit: 72%, 2019-2020); PRAMS (early prenatal care: 87%, 2020); PRAMS (postpartum visit: 88%, 2020)
GRANTEE DATA SOURCES	**Healthy Start Data Collection Forms** **<u>Numerator:</u>** # of HS women participants who meet the denominator criteria, **AND** responded, "Yes" to **Q3 on the Background Form**. **<u>Denominator:</u>** Total # of HS women participants served in the reporting period who identified "Female" for **Q4 on the Demographic Form**.

Note: Prenatal and postpartum care visits should be counted as preventive visits in Q3 on the Background Form. Exclude participants who declined *all* Healthy Start Data Collection Form screening.

SIGNIFICANCE

An annual well-woman visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. The American College of Obstetrics and Gynecologists (ACOG) recommends an annual well-woman visit beginning in adolescence and continuing across the lifespan with any health care provider offering preventive well-woman care.

5. PERFORMANCE MEASURE **Goal:** Depression Screening and Referral **DGIS Measure:** HS 13	The percent of HS women participants who receive depression screening and referral.
GOAL	To increase the proportion of HS women participants who receive depression screening to 90%; of those who screen positive for depression, increase the proportion who receive a referral to 95% .
MEASURE	The percent of HS women participants who receive depression screening and referral.
DEFINITION	**Percent of women screened for depression using a validated tool** **Numerator:** Number of HS women participants who were screened for depression with a validated tool during the reporting period. **Denominator:** Number of HS women participants in the reporting period. **Definition:** A participant is considered to have been screened and included in the numerator if a standardized screening tool which is appropriately validated for her circumstances is used. Several screening instruments have been validated for use to assist with systematically identifying patients with depression.[9] **Percent of women who screened positive for depression who receive a referral for services** **Numerator:** Number of women participants who screened positive for depression during the reporting period and received a subsequent referral for follow-up services. **Denominator:** Number of HS women participants who screened positive for depression during the reporting period. **Definitions:** A participant is considered to have been referred for follow-up services and included in the numerator if she is referred to a qualified practitioner for further assessment for depression. Referral can be to either an internal or external provider depending on availability and staffing model.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objective MICH-D01: (Developmental) Increase the proportion of women who are screened for postpartum depression at their postpartum checkup. PRAMS (depression screening)
GRANTEE DATA SOURCES	**Healthy Start Data Collection Forms**

Percent of women screened for depression using a validated tool

Numerator:

# of HS women participants who meet the denominator criteria,

AND

responded, "Not at all", "Several days", "More than half the days", **and/or** "Nearly every day" to **both Q12a and Q12b on the Background Form**. Exclude participants who "Declined to answer" both Q12a and Q12b.

Denominator:

Total # of HS women participants served in the reporting period who identified "Female" for **Q4 on the Demographic Form**.

Note: Exclude participants who declined *all* Healthy Start Data Collection Form screening.

Percent of women who screened positive for depression who receive a referral for services

Numerator:

# of HS women participants who meet the denominator criteria,

AND

who staff indicated, "Yes, a referral for follow-up services was provided or the participant is already receiving services for depression or possible depression," on **Q13 of the Background Form**.

Denominator:

Total # of HS women participants served in the reporting period who:

- identified "Female" for **Q4 on the Demographic Form**,

AND

- had a total score of 3 or more for **Q12 on the Background Form** during the reporting period. Exclude participants who "Declined to answer" both Q12a and Q12b.

Note: Only include participants who were screened during the reporting period and had a total score of 3 or more (positive). Exclude participants who declined *all* Healthy Start Data Collection Form

screening.

SIGNIFICANCE

Postpartum depression (PPD) is common, affecting as many as 1 in 7 mothers. Symptoms may include depressed mood, loss of interest or pleasure in activities, sleep disturbance, appetite disturbance, loss of energy, feelings of worthlessness or guilt, diminished concentration, irritability, anxiety, and thoughts of suicide.[10] PPD is associated with negative maternal physical and psychological health, relationship problems, and risky behaviors.[11] PPD is also associated with poor maternal and infant bonding and may negatively influence child development. Infant consequences of PPD include less infant weight gain and stunting, problems with sleep, poor social, emotional, behavioral, cognitive, and language development.[7] Universal screening and treatment for pregnant and postpartum women is recommended by the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), and the U.S. Preventive Services Task Force.[12]

[9] http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-forPerinatal-Depression

[10] Pearlstein T, Howard M, Salisbury A, Zlotnick C. Postpartum depression. American Journal of Obstetrics & Gynecology. 2009; 200(4): 357-364

[11] Slomian J, Honvo G, Emonts P, Reginster JY, Bruyere O. Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. Women's Health. 2019; 15:1-55. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6492376/pdf/10.1177_1745506519844044.pdf

[12] http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-forPerinatal-Depression

6. PERFORMANCE MEASURE **Goal:** Safe Sleep **DGIS Measure:** HS 14	Percent of HS infants placed to sleep following safe sleep practices.
GOAL	To increase the proportion of HS infants placed to sleep following safe sleep practices to 80%.
MEASURE	The percent of HS infants placed to sleep following safe sleep practices.
DEFINITION	**Numerator:** Number of HS infant participants aged <12 months whose parent/caregiver reports that they are always or most often placed to sleep following all three AAP recommended safe sleep practices.[13] **Denominator:** Total number of HS infant participants aged <12 months. A participant is considered to engage in safe sleep practices and included in the numerator if it is reported that the baby is 'always' or 'most often' 1) placed to sleep on their back, 2) always or often sleeps alone in his or her own crib or bed with no bed sharing, and 3) sleeps on a firm sleep surface (crib, bassinet, pack and play, etc.) with no soft objects or loose bedding.[14] The requirement is that the baby is placed on their back to sleep. If they roll over onto their stomach after being placed to sleep, the standard is met. Although safe sleep behaviors are self-reported, programs are encouraged to observe safe sleep practices during home visits, as possible.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objective MICH-14: Increase the proportion of infants placed to sleep on their backs (Baseline: 78.7% in 2016; Target: 88.9%); Healthy People 2030 Objective MICH-D03: Increase the proportion of infants who are put to sleep in a safe sleep environment. (Developmental) Pregnancy Risk Assessment Monitoring System (PRAMS) Phase 7, Question 48 (Sleep Position) and F1 (Bed Sharing).[15]
GRANTEE DATA SOURCES	**Healthy Start Data Collection Forms** **<u>Numerator:</u>** # of HS infant participants who meet the denominator criteria, **AND** whose parent/caregiver indicated:

- "On his or her back," to **Q17 and**
- "Always" or "Often" to **Q18 and**
- "Yes" to **Q19**

on the infant's **Parent/Child Form**.

Denominator:

Total # of HS infant participants with a completed **Parent/Child Form** who indicated 1-11 months **or** "Child is less than 1 month of age" on **Q9** during the reporting period.

Note: Report numerator responses as of last assessment in the reporting period. Exclude participants who declined *all* Healthy Start Data Collection Form screening.

SIGNIFICANCE

Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep inside (lateral) or stomach (prone) sleep positions, the American Academy of Pediatrics (AAP) has long recommended the back (supine) sleep position. In 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding.[16]

[13] https://www.aap.org/en/patient-care/safe-sleep/ (accessed 5/26/22)

[14] Pediatrics (2016) 138 (5): e20162938. https://doi.org/10.1542/peds.2016-2938

[15] http://nccd.cdc.gov/PRAMStat/rdPage.aspx?rdReport=DRH_PRAMS.ExploreByTopic&islClassId=CLA8&islTopicId=TOP23&go=GO

[16] American Academy of Pediatrics (AAP). Task Force on Sudden Infant Death Syndrome. SIDS and other sleep-related infant deaths: Updated 2016 recommendations for a safe infant sleeping environment. Pediatrics 2016. 138 (5):e20162938.

7. PERFORMANCE MEASURE **Goal:** Breastfeeding **DGIS Measure:** HS 15	The percent of HS infant participants who were ever breastfed or fed pumped breast milk, and/ or were fed breast milk at 6 months of age.
GOAL	To increase the proportion of HS infant participants who were: • ever breastfed or fed pumped breast milk to 82 percent. • breastfed or fed pumped breast milk at 6 months to 50 percent.
MEASURE	The percent of HS infant participants who were ever breastfed or fed pumped breast milk, and/ or were fed breast milk at 6 months of age.
DEFINITION	**Percent of HS infant participants ever breastfed or fed pumped breast milk** **Numerator:** Total number of HS infant participants aged <12 months who were ever breastfed or fed pumped breast milk, and whose parent was enrolled prenatally. **Denominator:** Total number of HS infant participants aged <12 months whose parent was enrolled prenatally. **Definition:** A participant is considered to have ever breastfed and included in the numerator if the infant received breast milk directly from the breast or that was pumped/expressed; this includes breast milk received at any time in any amount. **Percent of HS infant participants breastfed or fed pumped breast milk at 6 months.** **Numerator:** Total number of HS infant participants ages 6 through 11 months who were breastfed or were fed pumped breast milk in any amount at 6 months of age, and whose parent was enrolled prenatally. **Denominator:** Total number of HS infant participants ages 6 through 11 months whose parent was enrolled prenatally. **Definition:** A participant is considered to have ever breastfed at 6 months and included in the numerator if the infant received breast milk directly from the breast or That was pumped/expressed; this includes breast milk received in any amount during the sixth month.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objective MICH-15: Increase the proportion of infants who are breastfed exclusively through 6 months (Baseline: 24.9% in 2015, Target: 42.4%); Related to Healthy People 2030 MICH-16: Increase the proportion of infants who are breastfed at 1 year (Baseline: 35.9% in 2015, Target: 54.1%)

GRANTEE DATA SOURCES

Healthy Start Data Collection Forms

Percent of HS infant participants ever breastfed or fed pumped breast milk

Numerator:

# of HS infant participants who meet the denominator criteria,

AND

whose parent/caregiver indicated, "Yes" to **Q13** on the infant's **Parent/Child Form**.

Denominator:

Total # of HS infant participants with a completed **Parent/Child Form** who indicated 1-11 months or "Child is less than 1 month of age" on **Q9** during the reporting period,

AND

indicated "Part of a family enrolled for HS services before the child's birth" on **Q1 of the Parent/Child Form**.

Note: Exclude participants who declined *all* Healthy Start Data Collection Form screening.

Percent of HS infant participants breastfed or fed pumped breast milk at 6 months.

Numerator:

# of HS infant participants who meet the denominator criteria,

AND

who staff indicated, "Yes" to **Q16** on the infant's **Parent/Child Form**.

Denominator:

Total # of HS infant participants with a completed **Parent/Child Form** who were 6-11 months at any time during the reporting period,

AND

indicated "Part of a family enrolled for HS services before the child's birth" on **Q1**.

Note: Include any children who were 6-11 months in the reporting period, even if they don't have a Parent/Child form that indicates 6-

11 months in Q9. For example, if a child only has a form that indicates "12 months" in Q9, they would still be included in the denominator if they were 6-11 months of age at some point during the reporting period. Exclude participants who declined *all* Healthy Start Data Collection Form screening.

SIGNIFICANCE

The American Academy of Pediatrics (AAP) recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months, followed by continued breastfeeding as complementary foods are introduced for 1 year or longer. Exclusive breastfeeding for six months supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, reduces respiratory infections, gastrointestinal illness, and SIDS, and promotes neurodevelopment. Breastfed children may also be less likely to develop diabetes, childhood obesity, and asthma. Maternal benefits include reduced postpartum blood loss due to oxytocin release and possible protective effects against breast and ovarian cancer, diabetes, hypertension, and heart disease.

8. PERFORMANCE MEASURE Goal: Well Child Visit DGIS Measure: HS 16	The percent of HS child participants who received well-child visits.
GOAL	To increase the proportion of HS child participants who received the last age-appropriate recommended well-child visit based on AAP schedule to 90 percent.
MEASURE	The percent of HS child participants who received recommended well-child visits.
DEFINITION	**Numerator:** Number of HS child participants whose parent/ caregiver reports that they received the last recommended well-child visit based on the AAP schedule well-child visit as of the last assessment within the reporting period. **Denominator:** Total number of HS child participants in the reporting period. **Definition:** A participant is considered to have received the last recommended a well-child visit based on the AAP schedule when they have been seen by a healthcare provider for preventive care, generally to include age-appropriate developmental screenings and milestones, and immunizations, in the month recommended by AAP. The AAP recommends children be seen by a healthcare provider for preventive care at each of the following ages: by 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 24 months/ 2 years, 30 months, 3 years, and then annually thereafter.[17]
BENCHMARK DATA SOURCES	National Survey of Children's Health K4Q20
GRANTEE DATA SOURCES	**Healthy Start Data Collection Tools** **<u>Numerator:</u>** # of HS child participants who meet the denominator criteria, **AND** who staff indicated, "Yes" to **Q12a** on the child's **Parent/Child Form**. **<u>Denominator:</u>** Total # of HS child participants with a completed **Parent/Child Form** in the reporting period. **Note:** Exclude participants who declined *all* Healthy Start Data Collection Form screening.

SIGNIFICANCE

Routine pediatrician visits are important to (1) prevent illness and injury through immunizations and anticipatory guidance, (2) track growth and development and refer for interventions as needed, (3) address parent concerns (e.g., behavior, sleep, eating, milestones), and (4) build trusting parent-provider relationships to support optimal physical, mental, and social health of a child.[18]

[17] https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

[18] https://www.aappublications.org/news/aapnewsmag/2015/12/15/WellChild121515.full.pdf

9. PERFORMANCE MEASURE **Goal:** Health Insurance Coverage **DGIS Measure:** HS 17	The percent of HS women and child participants with health insurance coverage.
GOAL	To increase the proportion of HS women and child participants with health insurance to 90 percent (reduce uninsured to less than 10 percent).
MEASURE	The percent of HS women and child participants who had health insurance as of the last assessment during the reporting period.
DEFINITION	**% of HS women participants with health insurance** **Numerator:** Number of HS women participants with health insurance as of the last assessment during the reporting period**.** **Denominator:** Total number of HS women participants during the reporting period**.** **% of HS child participants with health insurance** **Numerator:** Number of HS child participants with health insurance as of the last assessment during the reporting period. **Denominator:** Total number of HS child participants during the reporting period. Participants are identified as not insured if they report not having any of the following: private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), State-sponsored or other government-sponsored health plan, or military plan at the time of the interview. A participant is also defined as uninsured if he or she reported having only Indian Health Service coverage, or only a private plan that paid for one type of service such as family planning, accidents, or dental care. For more information regarding health insurance questions please refer to Section VII (page 35) of the 2014 National Health Interview Survey (NHIS) Survey Description.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objective AHS-01: Increase the proportion of people with health insurance (Baseline: 89.0% of persons under 65 years had medical insurance in 2018; Target: 92.1%); National Survey of Children's Health (Children's Average 94.5%, 2011/2012),[19] National Health Interview Survey[20]

GRANTEE DATA SOURCES

Healthy Start Data Collection Forms

% of HS women participants with health insurance

Numerator:

# of HS women participants who meet the denominator criteria,

AND

have any insurance type a-k selected in **Q5** of their most recently screened **Background Form** in the reporting period. Exclude participants with only "j. Indian Health Service or tribal" selected.

Denominator:

Total # of HS women participants served in the reporting period who identified "Female" for **Q4 on the Demographic Form**.

Note: Exclude participants who declined *all* Healthy Start Data Collection Form screening.

% of HS child participants with health insurance

Numerator:

# of HS child participants who meet the denominator criteria,

AND

have any insurance type a-j selected in **Q11** of their most recently screened **Parent/Child Form** in the reporting period. Exclude participants with only "i. Indian Health Service or tribal" selected.

Denominator:

Total # of HS child participants who were 18 months or less during the reporting period with a completed **Parent/Child Form**.

Note: Exclude participants who declined *all* Healthy Start Data Collection Form screening.

SIGNIFICANCE

Individuals who acquire health insurance are more likely to have access to a usual source of care, receive well child care and immunizations, to have developmental milestones monitored, and receive prescription drugs, appropriate care for asthma and basic dental services. Insured children not only receive more timely diagnosis of serious health care conditions but experience fewer avoidable hospitalizations, improved asthma outcomes and fewer missed school days.

[19] http://childhealthdata.org/browse/survey/results?q=2197&r=1

[20] http://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201406.pdf

10. PERFORMANCE MEASURE **Goal:** Prenatal Tobacco and eCigarette Use **DGIS Measure:** HS 18	The percent of prenatal HS participants who abstain from smoking cigarettes, or using any tobacco products, in their third trimester.
GOAL	To increase the proportion of pregnant HS participants that abstain from cigarette smoking, or using any tobacco products, to 90 percent.
MEASURE	The percent of prenatal HS participants who abstain from smoking cigarettes, or using any tobacco products, in their third trimester.
DEFINITION	**Numerator:** Number of prenatal Healthy Start participants who abstained from using any tobacco products during their third trimester (i.e., last 3 months of pregnancy). **Denominator:** Total number of prenatal Healthy Start participants who were enrolled at least 90 days before delivery. Smoking includes all tobacco products and e-cigarettes
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objective MICH-10: Increase abstinence from cigarette smoking among pregnant women. (Baseline: 93.5% in 2018, Target: 95.7%). Related to HP2030 TU-15: Increase smoking cessation success during pregnancy among females. (Baseline: 20.2% in 2018, Target 24.4%)
GRANTEE DATA SOURCES	**Healthy Start Data Collection Forms** **<u>Numerator:</u>** # of HS prenatal participants who meet the denominator criteria, **AND** responded, "Never" to **Q21** on the **Parent/Child Form** linked to their child born during the reporting period. **<u>Denominator:</u>** Total # of HS prenatal participants who completed a **Prenatal Form**, responded "I enrolled before this pregnancy", "0-13 weeks", **or** "14-27 weeks" to Q3, **AND** who responded to **Q21 on the Parent/Child Form** linked to their

child born during the reporting period.

Note: The number of prenatal HS participants who abstained from using any tobacco products during their 3rd trimester is unduplicated. For a participant whose pregnancy resulted in multiple live births, only count their outcome once. Exclude participants who declined *all* Healthy Start Data Collection Form screening.

SIGNIFICANCE

Research shows that smoking in pregnancy is directly linked to problems including premature birth, certain birth defects, sudden infant death syndrome (SIDS), and separation of the placenta from the womb prematurely. Women who smoke may have a harder time getting pregnant and have increased risk of miscarriage.

11. PERFORMANCE MEASURE **Goal:** Low Birthweight **DGIS Measure:** HS 19	Percent of low birthweight infants among all singleton live births to Healthy Start participants.
GOAL	To reduce the proportion of low birthweight infants among all singleton live births to HS participants.[21]
MEASURE	The percent of low birthweight infants among all live births to Healthy Start participants.
DEFINITION	**Numerator:** Number of singleton live births with birth weight less than 2,500 grams in the calendar year among HS participants. **Denominator:** Total number of singleton live births in the calendar year among HS participants. Count only participants who gave birth while enrolled in Healthy Start**.**
BENCHMARK DATA SOURCES	CDC, NCHS (2020 data: 8.24%)[22] HS Budget Justification (Targets: 2023=9.6%; 2024=10.3%)[23]
GRANTEE DATA SOURCES	**Healthy Start Data Collection Forms** **<u>Numerator:</u>** # of live births who meet the denominator criteria, **AND** responded less than 2,500 grams (or less than 5 lbs 8 oz) **to Q6 of Parent/Child Form**. **<u>Denominator:</u>** Total # of enrolled children with a completed Parent/Child Form who: - had a Birth Year in the reporting period as indicated in **Q1a**, **AND** - responded "Part of a family enrolled for HS services before the child's birth " to **Q1**, **AND** - were a singleton birth as indicated in **Q7**. **ALSO include** children without a completed Parent/Child Form who: - were a singleton live birth in the reporting period as indicated in **Q1** (LiveBirthNumber = 1 and no other BirthOutcomes) on the **Post-**

Pregnancy Section of Prenatal Form,

AND

- had a birth year in the reporting period as indicated in **Q2a** on the **Post-Pregnancy Section of Prenatal Form**.

Note: Count only participants who gave birth while enrolled in HS.

To calculate a singleton birth on the Post-Pregnancy Section of the Prenatal Form, count only responses where live birth = "1", and no other birth outcomes are indicated in Q1 (such as, "Fetal Death").

If a child has a Parent/Child Form, do not count their information from the Prenatal form. Only include children born as indicated on the Prenatal form if they do not have a completed Parent/Child Form. This count is unduplicated.

SIGNIFICANCE

Low birthweight (LBW) is among the leading causes of infant death in the United States. LBW infants are also more likely to have health problems. After reaching its highest level in four decades, the LBW rate among all births declined from 2006 to 2014, but the trend reversed in 2015 and 2016 when the LBW rate increased, moving further away from the Healthy People 2020 goal of reducing LBW rates to 7.8% of live births.[24] Black infants (14.0%) were about 2 times as likely as white infants (6.9%) to be born low birthweight during 2018-2020 (average).[25]

[21] https://www.cdc.gov/nchs/products/databriefs/db306.htm

[22] https://www.cdc.gov/nchs/fastats/birthweight.htm (accessed on 5/26/2022)

[23] https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2023.pdf (FY2024 target included in HRSA's not-yet-published FY2024 Budget Justification)

[24] https://www.cdc.gov/nchs/products/databriefs/db306.htm (accessed on 5/26/2022)

[25] https://www.marchofdimes.org/peristats/data?reg=99&top=4&stop=45&lev=1&slev=1&obj=125

12. PERFORMANCE MEASURE **Goal:** Preterm Birth **DGIS Measure:** HS 20	Percent of infants born preterm (delivery prior to 37 completed weeks of gestation) among all singleton live births to Healthy Start participants.
GOAL	To reduce the proportion of infants born preterm among all singleton live births to HS participants.
MEASURE	Percent of infants born preterm (delivery prior to 37 completed weeks of gestation) among all singleton live births to Healthy Start participants.
DEFINITION	**Numerator:** Number of singleton infants born preterm (delivery prior to 37 completed weeks of gestation) in the calendar year among HS participants. **Denominator:** Total number of singleton live births in the calendar year among HS participants. Count only participants who gave birth while enrolled in Healthy Start.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objective MICH-07: Reduce preterm births (Baseline 10.0%, 2018; Target 9.4%)[26] CDC, NCHS (2019 data: 10.2%)[27] [HS Data for 2020 (singleton): 9.4%]
GRANTEE DATA SOURCES	**Healthy Start Data Collection Forms** **<u>Numerator:</u>** # of live births who meet the denominator criteria, **AND** responded less than 37 weeks to **Q5 of Parent/Child Form**. **<u>Denominator:</u>** Total # of enrolled children with a completed **Parent/Child Form** who: - had a Birth Year in the reporting period as indicated in **Q1a**, **AND** - responded "Part of a family enrolled for HS services before the child's birth " to **Q1**, **AND**

- were a singleton birth as indicated in **Q7**.

ALSO include children without a completed Parent/Child Form who:

- were a singleton live birth in the reporting period as indicated in **Q1** (LiveBirthNumber = 1 and no other BirthOutcomes) on the **Post-Pregnancy Section of Prenatal Form**,

AND

- had a birth year in the reporting period as indicated in **Q2a** on the **Post-Pregnancy Section of Prenatal Form**.

Note: Count only participants who gave birth while enrolled in HS.

To calculate a singleton birth on the Post-Pregnancy Section of the Prenatal Form, count only responses where live birth = "1", and no other birth outcomes are indicated in Q1 (such as, Fetal Death).

If a child has a Parent/Child Form, do not count their information from the Prenatal form. Only include children born as indicated on the Prenatal form if they do not have a completed Parent/Child Form. This count is unduplicated.

SIGNIFICANCE

Infants born before 37 weeks of gestation have a higher risk of infections, developmental problems, breathing problems, and even death. Preterm births are more common in some racial/ethnic groups. Strategies to reduce preterm births include promoting adequate birth spacing, helping women quit smoking, and providing high-quality medical care for women during pregnancy.[28] Following increases from 2014 to 2019, the singleton preterm birth rate declined by less than 1% from 2019 (8.47%) to 2020 (8.42%).[29]

[26] https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-pretermbirths-mich-07 (accessed on 5/26/22)

[27] https://www.cdc.gov/nchs/fastats/birthweight.htm (accessed on 5/26/22)

[28] https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-pretermbirths-mich-07 (accessed on 5/26/22)

[29] https://www.cdc.gov/nchs/data/databriefs/db430.pdf

13. PERFORMANCE MEASURE **Goal:** Infant Mortality **DGIS Measure:** HS 21	The infant mortality rate (per 1,000 live births) of enrolled Healthy Start (HS) infants.
GOAL	To reduce infant death among enrolled Healthy Start participants.
MEASURE	The infant mortality rate (per 1,000 live births) of enrolled Healthy Start (HS) infants.
DEFINITION	**Numerator:** Number of deaths of enrolled HS infants (from birth through 364 days of age to HS participants in the calendar year). **Definition:** Count deaths that occurred in both infants "born into the program" to enrolled participants (regardless of infant enrollment status) AND infants enrolled at some point after their birth and before their first birthday (less than one year in age/through 364 days of age). "Born into the program" refers to infants born to participants who were enrolled prenatally.[30] **Denominator:** Total number of live births in the calendar year among HS participants.
BENCHMARK DATA SOURCES	Note: All IMR data below reported in the format of "number of infant deaths per 1,000 live births." Related to Healthy People 2030 Objective MICH-02: Reduce the rate of infant deaths (Baseline 5.8, 2017; Target 5.0)[31] CDC, NCHS (2020 data: 5.42)[32] [HS IMR Data: 2020: 7.04, 2019: 8.05, 2018: 6.26]
GRANTEE DATA SOURCES	**Healthy Start Data Collection Forms** **<u>Numerator:</u>** # of infant deaths who meet the denominator criteria, **AND** responded to **Q22 of Parent/Child Form**. **ALSO include** the number of infant deaths of children without a completed **Parent/Child Form** as indicated in **Q5** on the **Post-Pregnancy Section of the Prenatal Form**.

Denominator:

Total # of enrolled children with a completed **Parent/Child Form** who:

- had a Birth Year in the reporting period as indicated in **Q1a**,

AND

- responded "Part of a family enrolled for HS services before the child's birth" to **Q1**.

ALSO include the number of live births of children without a completed **Parent/Child Form** as indicated in **Q1 on the Post-Pregnancy Section of the Prenatal Form**.

AND

who had a Birth Year in the reporting period as indicated in **Q2a** on the **Post-Pregnancy Section of the Prenatal Form**.

Note: Count deaths that occurred in both infants "born into the program" to enrolled participants and infants enrolled at some point after their birth before their 1st birthday (i.e., less than 12 months of age).

This count includes births of multiples. If using the Post-Pregnancy section of the Prenatal Form because a Parent/Child form was not completed, include the total number of live births as indicated in Q1 (for example, if Q1 indicates a participant had "4" live births on the Post-Pregnancy Section, include all 4 in the denominator).

SIGNIFICANCE

Every year in the United States, thousands of infants die from causes like preterm birth, low birth weight, and sudden infant death syndrome. Although the rate of infant deaths has fallen over the past decade, there are disparities by race/ethnicity, income, and geographic location. Equitable, high-quality care for moms and babies and community-based interventions can help reduce the rate of infant deaths.

[30] Healthy Start Aggregate Template User Guide and Data Dictionary (2021): https://www.healthystartepic.org/healthy-start-implementation/monitoring-data-and-evaluation/

[31] https://health.gov/healthypeople/objectives-and-data/browse-objectives/infants/reduce-rate-infant-deaths-mich-02 (accessed on 5/26/22)

[32] US DHHS, CDC, NCHS, Division of Vital Statistics, Natality public-use data 2016-2020, on CDC WONDER Online Database, October 2021.