Conversations with the Division – November 2024 Frequently Asked Questions (FAQ)

Alumni Peer Navigator

1. **Q:** Will all Healthy Start sites eventually receive funding to implement Alumni Peer Navigator services?
   A: Some grantees may have the opportunity to apply for additional funding to support the use of Alumni Peer Navigators. However, this depends on the Fiscal Year (FY) 2025 Healthy Start appropriations.

Clinical Funds

2. **Q:** It is required that 12 percent of each Healthy Start award is dedicated to hiring maternal-child advanced practice providers. My program would like an exception to hire a non-advanced practice provider. When will I find out if we are able to budget a non-advanced practice provider under the 12 percent for clinical funds?
   A: It is required that 12 percent of each Healthy Start award is dedicated to hiring maternal-child advanced practice providers. If you have proposed to hire a non-advanced practice provider, your Project Officer will work with you to develop a plan to hire an advanced practice clinician.

3. **Q:** All Healthy Start grantees are expected to dedicate at least 12 percent of their annual budget to hiring maternal-child health advanced practice providers, can we include supplies that the advanced-practice provider will use within the 12 percent?
   A: Yes, you may include supplies that the advanced-practice provider will use within the 12 percent.

Community Consortia

4. **Q:** Healthy Start grantees are expected to participate in a Community Consortium community of practice. Do you have any additional information on the community of practice?
   A: The Healthy Start Technical Assistance and Support Center (HS TASC) will host a ***Consortium Basics 101 Training*** in mid-late January. This training is open to all grant recipients. In February, the HS TASC will use an application process to identify and create staggered community of practice cohorts. The communities of practice will provide grantees/Consortium leadership with the opportunity to immerse themselves in group learning to identify consortium frameworks, conceptualize sustainability plans and strategize evaluating your Community Consortium's work.

5. **Q:** Is there a required template for the Community Consortium plan?
   A: Please use the Community Consortium Planning Overview & Support Materials to complete your Community Consortium plan. These materials include the requirements for the Community Consortium plan, a community consortium planning tool, a workplan template, and relevant resources.

6. **Q:** Does my program need to wait for the Division of Healthy Start and Perinatal Services to approve our Community Consortium plan before beginning to implement?
   A: No, you do not need to wait to begin to implement your plan. However, your Project Officer may request or suggest changes to your Community Consortium Plan based upon their review.

Enrolling Participants Outside of the Project Area

7. **Q:** Page 12 of the HRSA-24-033 Notice of Funding Opportunity (NOFO) indicates that out of the 700 participants served, a minimum of 50 percent should be from the target population (group with the highest infant mortality rate in your project area…) Does this mean my program can serve and count participants outside of the project area?
   A: In most cases, no, your program cannot serve and count participants living outside of the project area. In your application you identified a target population which is the group with the highest rates of infant mortality (or low birthweight or preterm birth) living in your project area. Per the guidance in the NOFO, 50 percent of the participants you serve should be from the target population. The other 50 percent can be from groups with lower rates of infant mortality, low birthweight or preterm birth **living in your project area**. For example, if the target population in your application was black women, at least 50 percent of your participants served should be black women who live within your project area. The other 50 percent can be individuals of the same or other demographics who also live within the project area. Please note that Healthy Start is intended to support improved birth outcomes in communities and populations experiencing the greatest disparities in maternal and infant health outcomes. Therefore, you should focus your outreach and recruitment efforts on the population with the highest rates of adverse perinatal health outcomes (that is, your target population).

8. **Q:** My program is working with an enrolled participant and infant/child who lives in the project area, the co-parent would also like to enroll in Healthy Start but they live outside of the project area. Can my program enroll a co-parent who lives outside of the project area?
   A: Yes, if your program is providing case management/care coordination and/or group-based health and parenting education to an enrolled participant/child living in the project area you may enroll a co-parent living outside of the project area in either case management/care coordination and/or group-based health and parenting education.

Group-Based Health and Parenting Education

9. **Q:** For group-based health and parenting education participants, the Demographic Form must be administered one-on-one by a trained Healthy Start staff member. Can programs allow group-based health and parenting education participants to self-administer the Demographic Form if there are concerns about participant privacy and/or staff capacity in the group-based setting?
   A: Yes, if your program encounters challenges administering the Demographic Form in a group-based education setting as recommended in the Data Collection Forms Training, you may use the modified method for participant self-administration. The full revised Group-Based Data Collection Protocol can be found here on the Healthy Start TASC Hub. **Please note that self-administration is only permitted for the Demographic Form in group-based health and parenting education sessions. All data collection forms completed for**

case managed/care coordinated participants must be administered by a trained Healthy Start staff member.

Division of Healthy Start and Perinatal Services/Healthy Start Grantee Communication

10. **Q:** How can grantees get information on HRSA updates such as upcoming conferences, reporting deadlines, etc. Are all communications supposed to come through Project Officers?
A: Your HRSA Project Officer is a great resource for information on upcoming conferences, meetings and reporting deadlines. They may provide you with this information via email or verbally during your monitoring calls. It is also important for grantees to monitor EHB for reporting deadlines and stay up to date with communication from the Healthy Start Technical Assistance and Support Center and the National Healthy Start Association.

11. **Q:** What should grantees do if they feel they are not receiving effective communication from their Project Officer?
A: As a first step please discuss your concerns directly with your Project Officer. If you feel that your Project Officer is unresponsive or the concern warrants a conversation with Division of Healthy Start and Perinatal Services (DHSPS) leadership please email MCHBHealthyStart@hrsa.gov with a description of your concern and/or a request for a meeting with DHSPS leadership.

Data and Evaluation

12. **Q:** Page 21 of the HRSA-24-033 Notice of Funding Opportunity states, *"A final program evaluation and performance monitoring plan will be required 12 months after the award is made. A description of progress to implement the program evaluation and performance monitoring plan will be due annually, when submitting your annual non-competing progress report."* When will the performance monitoring plan be due?
A: Please expect to submit your performance monitoring plan in May 2026. The Division of Healthy Start and Perinatal Services will send guidance within the coming months.

13. **Q:** How do you count an infant death that occurs before the infant is officially enrolled in the program. For example, if the infant dies shortly after birth?
A: Infant deaths that occur within the first 27 days after birth (i.e., neonatal deaths) are recorded on the birthing parent's Prenatal Form, in the Post-Pregnancy Follow-up section. The Post-Pregnancy Follow-up section is completed as an update to the Prenatal Form after an enrolled pregnant participant gives birth or their pregnancy otherwise ends.

    To record a neonatal death, staff must:
    1) Select "live birth" in Q1 ("Birth Outcomes") of the Post-Pregnancy Follow-up section,
    2) Indicate the number of live births that resulted from the pregnancy,
    3) Respond "Yes" to Q5 ("Neonatal Death"), and
    4) Indicate the number of neonatal deaths that occurred from 0-27 days after delivery.

*The number of neonatal deaths recorded cannot be greater than the number of live births that resulted from the pregnancy.

Please note that the denominator for infant mortality and neonatal death only includes live births. Stillbirths are calculated as a separate indicator and are not considered neonatal loss/infant loss. To record a stillbirth, staff must select "stillbirth" in Q1 ("Birth Outcomes") in the Post-Pregnancy Follow-up section. The HSMED data validations will not allow a Prenatal form to be uploaded where only "stillbirth" is indicated as the birth outcome of the pregnancy and "neonatal loss" is selected, as this contradicts the definition for neonatal death (the loss of a live born infant within 0-27 days after delivery).

14. **Q**: For Year 1 of this grant cycle, the target for number served will be pro-rated because it was an 11-month project period. Which report will reflect the pro-rated target?
A: Data collection and reporting in Healthy Start serves two main purposes: 1) to monitor the performance of grant recipients against their stated objectives, workplan goals, and the goals of the Healthy Start program overall, and 2) to demonstrate the impact of the Healthy Start program in reducing disparities in infant mortality and other adverse perinatal outcomes. To meet each purpose, the DHSPS Data, Analysis and Planning Branch (DAPB) employs separate approaches to data analysis.

Calendar Year Reporting
The annual Discretionary Grants Information System (DGIS) Performance Reports collect participant numbers and benchmark outcomes by calendar year (CY), so that key program indicators are comparable to other national public health data and information sources. The DGIS Performance Report completed at the end of Budget Year 1 (opens 4/1/2025) will collect participant numbers and benchmark outcomes for the calendar year 5/1/2024 - 12/31/2024 (CY1), as the FY24 grant cohort began May 1, 2024. To calculate an entire year of Healthy Start outcomes, the DAPB will include the last four months of the FY19 cohort participant numbers and benchmark data (1/1/2024 - 4/30/2024) to create a 12-month reporting period for 2024. When these figures are reported by the DAPB, detailed information is provided about the two separate cohorts, any changes in Notice of Funding Opportunity (NOFO) requirements during the period, and potential limitations.

Budget Year Reporting
To monitor the performance of grant recipients against the required number of participants served, the Healthy Start Monitoring and Evaluation Data System (HSMED) provides a client-level breakdown of service delivery. The DAPB develops reports for Project Officers (PO) using HSMED data to indicate the number of participants served over each budget year of the grant cycle. Project Officers are able to use these reports, along with regular monitoring calls with grant recipients, to determine whether projects met the pro-rated number of participants served for Budget Year 1 (5/1/2024 - 3/31/2025), and if any technical assistance is required to assist projects in reaching enrollment requirements.

15. **Q:** For Year 1 of this grant cycle, the target for number served will be pro-rated because it was an 11-month project period. What are the pro-rated targets Year 1 (5/1/2024 – 3/31/2024)?
    A: The pro-rated required number of participants served for Budget Year 1 (5/1/2024 - 3/31/2025) are: A total of 641 **<u>unduplicated</u> participants**

    - 412 participants served through Case Management/Care Coordination
        - A minimum of 229 pregnant women
        - A minimum of 23 fathers/partners
        - 160 may be any combination of:
            - Pregnant women, preconception women, interconception women of reproductive age, infants/children from birth through 18 months of age, fathers/partners*
    - 229 participants served through Group-based Health Education
    -

16. **Q:** Where can I find training and resources on Healthy Start data reporting requirements?
    A: All Healthy Start data reporting webinars, slides, manuals, and resources are available on the HealthyStart-tasc.org website. To navigate to the resources, select "Implement" from the home page, scroll down to "Data Collection and Reporting" and select the topic of your choice. The "Data Collection Forms" topic will include all resources relevant to the Healthy Start Data Collection Forms. The "Reporting" topic will include all resources relevant to the HSMED, and annual performance and progress reports.

    If you have a question regarding the HSMED, please reach out to HealthyStartData@hrsa.gov and copy your Project Officer. For questions regarding your annual performance report or progress report, please contact your Project Officer directly.

17. **Q:** Is a woman who is pregnant from January-April and delivers in May counted as pregnant for the entire year?
    A: If a participant was pregnant at any point starting May 1, 2024, they will be counted as a "pregnant participant" for the entirety of the calendar year for Fiscal Year (FY) 2024 grant recipient reporting, regardless of if they also gave birth that month or were no longer pregnant for any reason. Please note, only participants actively receiving services in the FY 2024 grant reporting period (5/1/2024 - 12/31/2024) should be counted in your numbers of participants served. Do not "roll over" participants from one grant cohort to the next. In other words, if a participant was enrolled December 2023 but never returned for services in calendar year 2024, they cannot be counted as a participant in CY2024 reporting.

    Starting January 1, 2025, if the participant is no longer pregnant and still receiving services, they will be counted in a non-pregnant reproductive status (e.g., interconception) for the remainder of the CY2025 reporting (1/1/2025 - 12/31/2025), unless they become pregnant again.

18. **Q:** If someone was pregnant during the last grant cycle but delivered in May 2024, can we count them as pregnant in our Year 1 report?

A: Yes, they may be counted as pregnant in the Year 1 report if they received services in this grant period (May 2024 through December 2024).

If a participant was enrolled in the Fiscal Year (FY) 2019 grant period (or earlier) and continued to participate in the FY 2024 grant period, they can be counted in the FY 2024 numbers when they received services in the new grant cycle. For example, if a participant was enrolled December 2023 and received their first FY 2024 home visit in June 2024, they can be counted as a participant in the FY 2024 numbers starting June 2024.

19. **Q:** When will the CAREWare system be updated and available for use?
    A: The Healthy Start Data Collection Forms were updated in CAREWare on 12/6/2024. The HSMED compliant file export will be available before the end of December 2024.

20. **Q:** What are the dates for the Year 1 reporting period?
    A: The DGIS Performance Report (opens 4/1/2025) will collect data for calendar year 1 (CY1) - 5/1/2024 - 12/31/2024. Additional instructions will be provided to all grantees via the HealthyStartData@hrsa.gov mailbox when the report opens. Please note that participant counts will include both case management/care coordination participants and those enrolled in group-based health education. The benchmark outcomes should only include individuals receiving case management/care coordination; those exclusively receiving group-based education are not included in the benchmark outcomes because they do not complete the forms that collect the outcomes (Background, Prenatal and Parent/Child forms).

21. **Q:** When will data from Fiscal Year 2023 be shared?
    A: Data from Fiscal Year 2023 will be shared at the Healthy Start All Grantee Meeting in May 2025. The Data Analysis and Planning Branch will also provide data updates at future Conversation with the Division webinars.