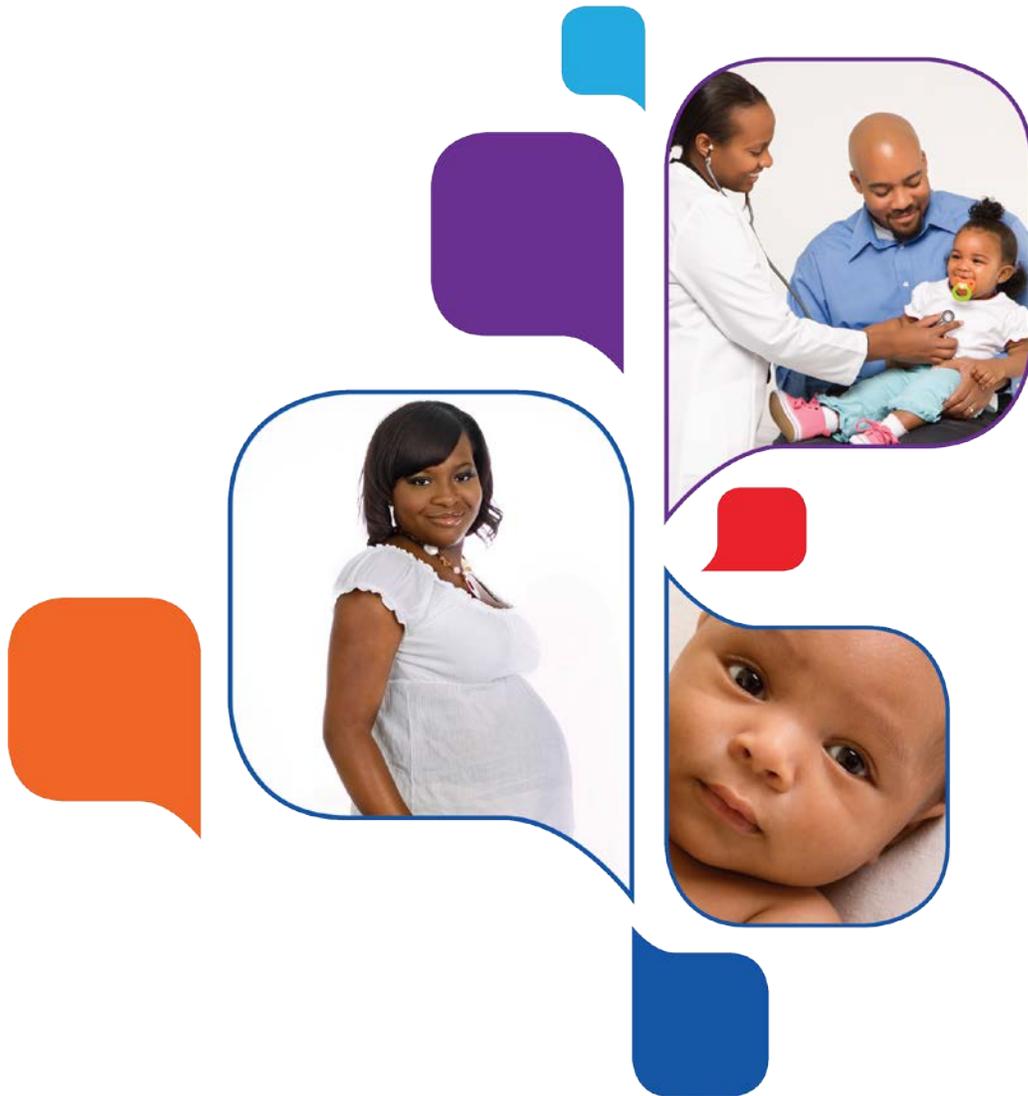


LESSONS LEARNED FROM THE FIELD:
**A Response to the Division of Healthy Start and Perinatal Services
Request to Inform Future Programming**



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Executive Summary

This summary provides the key points of the report. The remainder of the document provides detailed support for the recommendations outlined in this section.

Purpose

In March 2017, the Maternal and Child Health Bureau (MCHB) Division of Healthy Start and Perinatal Services (DHSPS) requested information from the Healthy Start Collaborative Improvement and Innovation Network (HS CoIIN) about the Healthy Start (HS) grantee experience in implementing the last round of funding for HS in 2014 (HS 3.0). HS 3.0, dedicated to eliminating disparities in perinatal health, adopted a Life Course Perspective^{1 2 3 4} and built on the long-standing program structure of focusing on individual/family health, adding greater emphasis to evidence-based practice, standardized approaches, quality improvement, and an increased role in driving community change, accountability, and collective impact.

HS 3.0 aims to reduce disparities in infant mortality and adverse perinatal outcomes by providing services through five approaches: 1) Improving Women's Health, 2) Promoting Quality Services, 3) Strengthening Family Resilience, 4) Achieving Collective Impact; and 5) Increasing Accountability through Quality Improvement, Performance Monitoring, and Evaluation.⁵

This report highlights findings from a survey of HS grantees, with specific focus on lessons learned that should be leveraged as well as challenges related to the five HS approaches; care coordination/case management; implementation of the HS screening tools; addressing the HS benchmarks, structure of HS CoIIN; Collective Impact; and characteristics that distinguish HS from other maternal and child health programs.

Process/Methodology

This mixed methods study reflects findings from a subset of responses from a survey conducted in May-June 2017 that included qualitative and quantitative data. Qualitative data analysis applied a two-step iterative process. First, the EPIC Center team identified themes which were then used to code the data. The themes were validated during a meeting of the HS CoIIN, and recommendations were developed based on the findings. Survey respondents (N=84, 84% response rate) represented grantees from each funding level, included a range of organizational settings, and incorporated perspectives from diverse community partners.

Lessons Learned and Challenges

Several recurring themes emerged that cut across sections of the survey.

- Healthy Start's commitment to providing community-responsive, participant-centered services that address social determinants of health through coordination with community connections.
- The importance of fostering participant empowerment through personal connection and promoting the health literacy of participants with complex needs.

- The value of data for performance monitoring and improvement, as well as the challenges of data collection.
- Male Inclusion/Fatherhood was raised as a challenge.
- The importance of and challenges related to participant engagement.
- The critical value and challenges of recruiting and retaining a strong, competent workforce through professional development.
- The importance of the client-case manager relationship.
- Structural flexibility as a core strength in Healthy Start's ability to be responsive to participants' needs.

Recommendations

Recommendations, derived through the HS CoIIN work group distillation and synthesis of findings, are organized below by discrete section. However, significant interplay and overlap exists between them.

Improve Women's Health

- Promoting a family-focused service provider model that effectively links HS with medical providers would enable service providers to meet the comprehensive needs of participants in a way that maximizes the skills and scopes of practice of medical and social service providers.
- Capitalize on the structural flexibility that sets it apart from other maternal child health programs, and position it to partner with other providers in the transforming healthcare landscape. Regardless of the direction health reform (or health care reform) takes, interventions or approaches that reduce costs and improve quality will increase in value. The benefits of HS should be widely messaged to a broad audience.
- This approach should center around the Life Course Perspective, reproductive health, and maternal mortality.
- Restructure the volume requirement so that it is based on a smaller number of participants in order to resource the high intensity of needed services to impact the HS participant population.

Promote Quality Services

- The participant volume recommendations should be reconsidered. That is, fathers and/or partners should be included as participants, and the required number of pregnant women served should be reduced.
- The grant cycle should incorporate a start-up/planning phase at the beginning.
- Refine criteria to include evidence-based curricula as a minimum requirement to ensure the comparative advantage of HS over other maternal child health programs.
- The data definitions and performance measures should be revisited and clarified, and the HS CoIIN should have a role in collaboration with the DHSPS in the clarification.
- In establishing funding to programs, consideration should be given to the actual costs of hiring, training and retaining staff with the requisite skills to address the unique needs of vulnerable HS participants. In addition, workforce development should take into account the job strain of HS staff in providing intensive services, and include development of skills around self-care.

Strengthen Family Resilience

- The support for involving fathers and/or partners in HS is growing but should be a core component of the program. Addressing the need for more father and/or partner -friendly approaches within HS is critical to promote involvement, communication and support from both parents and/or a support person.
- Levels of engaging and serving men's reproductive health needs vary across family planning clinics. HS could make a substantial contribution to providing men's preconception reproductive health services by leveraging its experience with engaging men via fatherhood initiatives.

Achieve Collective Impact

- Collective Action Network (CAN) requirements should be revisited and reconsidered. It should be clarified that the HS grantee is not required to serve as the backbone organization for Collective Impact (CI) but must be integrally involved in the CI process. CI/CAN requirements should be uniform for all levels and should include dedicated staff.
- Build in resources to support and incentivize participant membership (e.g., childcare, transportation, etc.)
- Clarify data requirements for the CAN that honor the community-driven intention of CI.

Increase Accountability through Quality Improvement (QI), Performance Monitoring, and Evaluation

- MCHB should provide a uniform database that can upload data for evaluation, and ensure that program-level data are available to drive improvement efforts.
- Although securing a program evaluator is not required by MCHB, adequately resourcing evaluation activities is essential to ensuring quality evaluation practices. Clarify evaluation responsibilities (e.g., nationally, state-level, local, etc.) and provide additional funding, or guidance regarding budgeting for monitoring and evaluation (such as recommended percentage of budget to be allocated to evaluation).
- Quality and continuous QI is a cross-cutting component of providing services that should be embedded in and inform all of HS in everything a program does. It should not be a separate approach.

Addressing Benchmarks

- Ensure adequate resources are in place to support staff capacity for data collection and utilization so programs can effectively address the performance measures and meet benchmarks.
- Any standardization (data system, definitions, etc.) should be done prior to the start of the next grant cycle to avoid frustration due to wasted time and effort for programs and their partners.
- The data definitions and performance measures should be revisited and clarified. Through its standard vetting processes with the larger HS community, the HS ColIN should have a role in collaboration with the DHSPS in the clarification.

HS Screening Tool Implementation

- The foundation and intent of the HS Screening tools should be maintained and used as a standard for data collection, while continuing to be improved upon based on need and opportunity.
- Continue to pursue opportunities to streamline data collection using the screening tools. A possible strategy is for the DHSPS to provide a centralized database with a portal that enables submission of data required for the evaluation, but also allows programs to access their own data for programmatic improvement purposes. This would enable the DHSPS to track progress of grantees toward benchmarks.
- Performance measures and screening tool questions should be mapped to the most utilized evidence-based intervention models to determine where overlap exists and data collection can be streamlined. Screening tool questions should align with existing evidence-informed/evidence-based models or interventions.

Care Coordination/Case Management

- Recognizing the breadth of participant needs and diverse approaches applied across programs, it may be beneficial to develop a conceptual model that maps the range of services provided, points of intervention, and relevant evidence-informed/evidence-based practices or curricula that apply. This is consistent with project management best practices.

Structure: Funding and HS CoIIN Membership

- Rather than structuring levels of funding around discrete criteria or activities, such as volume of participants served, and level of community engagement/leadership(as is currently in place), funding should be weighted for performance or particular contributions that individual applicants can make to the national HS program. For example, as noted in the Structure Section of the report, the top five capabilities in addressing community issues that grantees felt were important to consider in a funding criteria or model included the following:
 - Percentage of children under 18 years of age with family incomes below the Federal Poverty Level exceeded 25% for 2010
 - Number of preterm births
 - Low birth weight births
 - Infant mortality rate
 - Community partnerships
- Based on comprehensive qualitative responses, to ensure broader and more diverse representation on the HS CoIIN, an application process is recommended for HS CoIIN membership with a process that balances promoting continuity and increasing diversity.

Grant Application Process

- Eliminate redundant questions in the Funding Opportunity Announcement (FOA) and allow additional space for projects seeking higher levels of funding to provide more services.

Conclusion

In summary, this document was developed through an inclusive data-informed process in response to the DHSPS' request to articulate what distinguishes HS from other maternal and child health programs. While a range of programs exist to address the needs of women in pregnant and postpartum phases, HS provides services across the entire spectrum of perinatal phases. HS focuses on addressing social determinants that impact the health of women and their families. Structural flexibility is the defining factor that enables HS to address the unique needs of participants within the contexts of their families and community and must be preserved.

“Healthy Start is an affirmative public health program. We start with needs assessment and adapt to needs versus developing a program first and applying to population.”

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Introduction

The Maternal and Child Health Bureau (MCHB) is charged with promoting and improving the health of the nation's women and children by providing national leadership, and by working in partnership with states, communities, public-private partners, and families. In support of this mission, MCHB's Division of HS and Perinatal Services (DHSPS) provides administrative oversight of the federal HS program which makes available grants to communities to reduce infant mortality, reduce health disparities, and improve perinatal health outcomes.⁶

Each year in the United States, approximately four million women give birth, according to data from the National Center for Health Statistics. While most women have a safe pregnancy and deliver a healthy infant, that is not the experience for all women. Major and persistent racial and ethnic disparities exist for pregnancy-related maternal morbidity and mortality, infant mortality, and other adverse outcomes such as low birthweight and preterm birth.⁷ Following a plateau between 2000-2005, the infant mortality rate declined 12% overall and 16% for black infants between 2005-2011. However, the black infant mortality rate continues to be more than twice that for whites. Five leading causes account for more than half of all infant deaths; these are birth defects, short gestation and low birthweight, Sudden Infant Death Syndrome (SIDS), maternal complications, and unintentional injuries (accidental deaths).⁸ There is a potential for reducing each of these causes of death, particularly among low-income families and communities.

Differences in perinatal health indicators also are related to maternal education, age (being younger than 18 or older than 35 years), income,^{9,10} disability, stress, or living in isolated urban or rural areas.¹¹ These are among the range of socioeconomic factors that cluster as influencing social determinants.^{12,13} Emerging research indicates that environmental, biological, and behavioral stressors occurring over the lifespan of the mother from her earliest life experiences until she delivers her own child affect pregnancy outcome. While not all of the causes of preterm birth, birth defects, SIDS, and other causes of infant mortality are well understood, much is known about how to intervene. The HS program focuses on the factors which research shows influence the perinatal trends in high-risk communities.¹⁴ Over the past two decades, HS has evolved from a demonstration project in 15 communities to a national program of 100 grantees serving communities in 196 counties across 39 states, the District of Columbia and Puerto Rico.

HS grantees addressed high infant mortality rates (IMR) by assuring access to culturally competent, family-centered, and comprehensive health and social services to women, infants, and their families through a community-based participatory approach. Additionally, HS grantees fostered systems integration, coordination, and collaboration to advance community change and increase collective impact. HS grantees also coordinated and aligned with the state Title V Maternal and Child Health Block Grant programs to promote cooperation, integration, and dissemination of information with statewide systems and with other community services funded under Title V.

HS 3.0 adopts the Life Course Perspective, building on the long-standing program structure of focusing on individual/family health, adding greater emphasis to evidence-based practice, standardized approaches, and quality improvement. However, in the 2014 HS 3.0 funding announcement, grantees were also expected to have increasing roles in driving community change, accountability, and collective impact.

The HS program aims to reduce disparities in infant mortality and adverse perinatal outcomes by providing services through five approaches: 1) Improving Women's Health, 2) Promoting Quality Services, 3) Strengthening Family Resilience, 4) Achieving Collective Impact, and 5) Increasing Accountability Through Quality Improvement, Performance Monitoring, and Evaluation.¹⁵

In March 2017, at the request of the DHSPS to provide information about the HS grantee experience in implementing HS 3.0, the HS CoIIN initiated the planning process for the launch of the survey: *Capturing Lessons Learned from the Field: HS Comment Period (Appendix 1)*. The purpose of this survey was to provide HS programs the opportunity to provide perspectives from the field by sharing lessons learned from their experiences of implementing HS 3.0. The survey addressed two objectives:

- To document lessons learned from the implementation of current FOA; and
- To inform the next Notice of Funding Opportunity (NOFO).

The specific areas of interest to the lessons learned survey included: overarching themes related to challenges, successes, the five approaches; care coordination/case management; HS screening tools; addressing the HS benchmarks; structure of HS related to HS CoIIN; CAN; other recommendations related to the 2014 NOFO format, rationale for recommendations, what is different about HS, and a summary. The report will be shared with the DHSPS in order to shape future programming and will be available to the public and other stakeholders upon request. The information gathered with the survey was analyzed in aggregated form and reported in a summary format in the following sections.

Overview of Healthy Start

Structure of Grantees

Under the current 2014 FOA, 100 HS Grantees (HS) in 37 states received five-year funding to reduce disparities in maternal and infant health status in high risk communities. HS supports women before, during, and after pregnancy by addressing their health and social service needs, strengthening family resilience, and engaging community partners to enhance systems of care.



HS programs are funded at three different levels and are expected to impact the health of women, infants, children, and their families in different ways. However, all have a requirement to serve a minimum number of participants per year with at least of 50% of them needing to be pregnant.

Level 1: Community-Based HS (N=60)

- Intended to have an effect at the individual level
- Program awards up to \$750,000 annually to serve a minimum of 500 participants per year
- Support the implementation of essential HS program activities needed to achieve five approaches of the HS Model

Level 2: Enhanced Services HS (N=22)

- Intended to have an effect at the community level and thereby drive collective impact
- Program awards up to \$1.2 million per year to serve a minimum of 800 participants per year
- Support the implementation of the essential HS program activities needed to achieve the five approaches, and engage in additional services and activities, such as Fetal and Infant Mortality Review (FIMR), Perinatal Periods of Risk (PPOR), and/or Maternal Mortality and Morbidity Review (MMMR)

Level 3: Leadership and Mentoring HS (N=18)

- Intended to have an effect at the community level and thereby drive collective impact
- Program awards up to \$2 million per year to serve a minimum of 1,000 participants per year
- Support the implementation of the essential HS program activities needed to achieve the five approaches, and engage in additional services and activities, such as FIMR, PPOR, and/or MMMR.
- Support the provision of expanded maternal and women's health services and supports the development of a place-based initiative that will serve as the backbone or hub organization for achieving collective impact.
- Serve as a resource site for state, regional, and national action in support of other HS grantees and organizations working to improve perinatal outcomes through program and policy development
- Participate with other Level 3 Leadership and Mentoring HS grantees to support the HS EPIC and lead in the development and implementation of a HS CoIIN

Role and Uniqueness of HS CoIIN

In reviewing the themes from the lessons learned survey related to the HS CoIIN composition and membership (*see HS CoIIN Membership within the structure section*), the HS CoIIN felt it was important to clearly articulate what their role provides on behalf of the HS grantees as well as the uniqueness of the HS CoIIN in relation to the other MCHB CoIINs.

The MCHB adopted a collaborative approach to systems improvement by harnessing the collective expertise of front-line service providers and program managers through establishing CoIINs. The CoIINs to Reduce Infant Mortality (IM) and Home Visiting (HV) CoIIN were established in 2012 and 2013, respectively, while the HS (HS) CoIIN was established through a Funding Opportunity Announcement (FOA) in 2014. These three CoIINs are separate initiatives with a common aim to share lessons learned for improving MCH practice to improve birth outcomes and reduce perinatal health disparities. They differ distinctly in form, function, and process, each targeting improvements at different system levels and focus areas. The IM CoIIN convenes learning collaboratives of diverse state-level partners targeting state-level policy change. The HV CoIIN works at the program level to achieve breakthrough improvements in select measures, including benchmarks mandated for the Maternal, Infant, and Early

Childhood Home Visiting (MIECHV) program. The HS CoIIN works at the program level to advance program goals to reduce infant mortality and improve birth outcomes by strengthening HS services and systems.

The HS CoIIN, established in March 2015, is a partnership of HS grantees dedicated to strengthening HS services and systems in order to advance program goals to reduce infant mortality and improve birth outcomes. The HS CoIIN functions as an Expert Panel to the DHSPS and the HS EPIC Center, the training and technical assistance (TA) provider for the HS program. The HS CoIIN is a closed membership composed of representatives from twenty HS programs. The majority are Level 3 grantees (n=18); as membership in the CoIIN is a requirement of Level 3 grant funding. The HS CoIIN elected to expand its membership to include one grantee from Level 1 and one from Level 2 so that all levels would be represented.

The goal of the HS CoIIN is to strengthen HS (HS) services and systems by promoting implementation of standardized evidence-based approaches to core elements of the HS program. (*Program-level improvement and innovation*) The specific objectives of the HS CoIIN are to:

- Promote communication among/between grantees, DHSPS and HS EPIC Center to ensure all grantees have a voice in setting the direction for HS;
- Brainstorm and test opportunities to strengthen the program especially related to standardizing components of the HS model;
- Disseminate lessons learned to the HS community; and
- Promote HS as an effective and vital community-based resource in all communities to ensure the long-term success of HS.

The HS CoIIN has addressed their purpose and goals through establishing an operating structure which consists of CoIIN members actively participating with a consistent member representing their organization on monthly calls and bi-annual meetings and maintaining at least 80% participation rate. Additionally, the HS CoIIN meets monthly, including day-long, face-to-face sessions two times per year, with conference calls in the interim; and finally, two HS CoIIN members serve as Co-Chairs, for rotating six-month terms.

During the spring 2016 planning meeting, the HS CoIIN developed a communication strategy in collaboration with the DHSPS. The goals are to support HS CoIIN members' ability to:

- communicate key issues related to the role of the HS CoIIN , topics discussed and decisions made in a consistent manner; and
- solicit input and feedback from all HS programs and colleagues to inform the HS CoIIN discussions (see Appendix 2 for a more detailed overview of the structure and Appendix 3 for a description of the HS CoIIN accomplishments).

EPIC Center

The JSI Research and Training Institute, Inc. (JSI) operates the Healthy Start EPIC Center, funded by HRSA MCHB in 2016, to provide assistance to support HS grantees in achieving program goals. The HS EPIC Center helps to strengthen staff skills to implement evidence-based practices in maternal and child

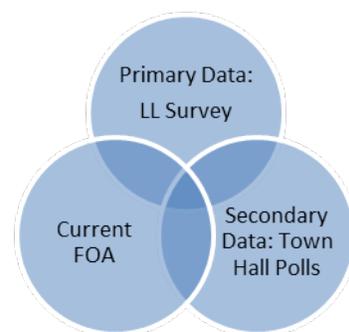
health, facilitates grantee-to-grantee sharing of expertise and lessons from the field, enables grantees to conduct ongoing evaluation of activities for effectiveness, and builds program capacity to work with community partners to improve health and social service systems for women, infants and families. Specific to the HS CoIIN, the HS EPIC Center was tasked with supporting a HS CoIIN. The EPIC Center CoIIN team provides logistical and facilitation support to the HS CoIIN to develop leadership, set objectives and facilitate peer sharing. The HS EPIC Center CoIIN team developed a schedule of planning calls with HS CoIIN Co-Chairs to provide an opportunity for them to set call objectives and establish an agenda and plan the implementation of the call. Following each call, the EPIC Center CoIIN Team disseminates the post-meeting packet and communicates findings to DHSPS and the larger HS grantee community.

Methodology

Overview

The methods for the survey were interdependent. The activities included quantitative and qualitative data collection across all HS grantees. Three primary sources of information were used to address the survey's purpose and objectives:

- Primary qualitative data collection via lessons learned survey which was primarily qualitative but had some quantitative questions as well
- Secondary quantitative data review (i.e. Town Hall polls)
- Literature review (i.e. current FOA)



The survey plan was designed to build upon HS' strong history of community cooperation, activism, and advocacy. The methodology described on the following pages was intended to spark systematic analytic thinking on the lessons learned that are important to leverage as well as challenges and recommended changes that can inform the next NOFO.

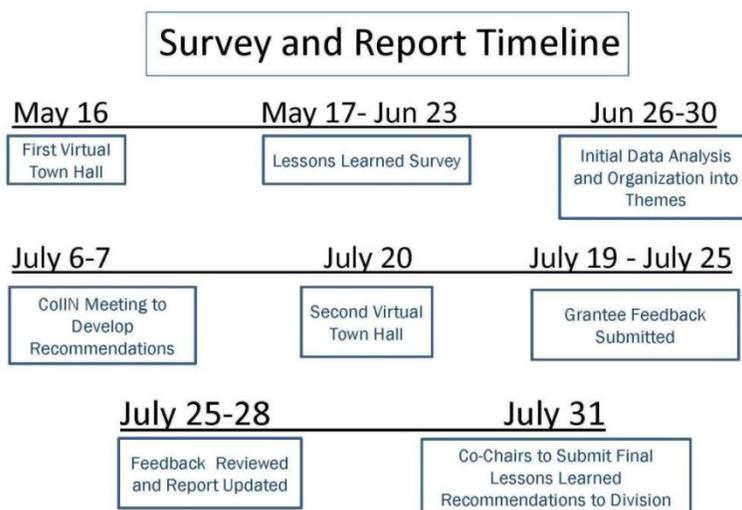
Steering Committee

The HS CoIIN served as the Steering Committee for the survey from the design, launch, analysis and reporting. The HS CoIIN monitored and evaluated the survey process, with the goal of ensuring quality completion of the scope of work. In order to promote the integrity and effectiveness of this steering process, as well as to protect the overall interests of HS grantees, each member was responsible for participating in monthly meetings as scheduled to collaborate with fellow committee members on establishing the working definitions for this project, as well as participating in the iterative process of developing tools and strategies.

Study Timeline

The survey was launched with a virtual Town Hall on May 16, 2017, and the survey was in the field from May 17 to June 23, 2017. The survey provided a key opportunity for HS grantees to provide feedback and input into the future of Healthy Start. The timeline is shown in Figure 1.

Figure 1: Survey and Report Timeline



Secondary Data Collection and Literature Review

The secondary data review using the polls from the two Town Halls - one held prior to launching the survey and a second one after the surveys were completed - were employed to enhance the validity of the primary qualitative data collection. The Town Hall polls were used to dis/confirm the findings related benchmarks and accountability approach. During each of the Town Halls, participants were asked the following questions, within each one, there were set responses from which the Town Hall participant could choose as appropriate to the question:

- Which of the five HS approaches did you find the most challenging to address?
- With regard to improving women's health, which benchmark did you have the most difficulty in addressing?
- With regard to promoting quality, which benchmark did you have the most difficulty in addressing?
- With regard to strengthening family resilience, which benchmark did you have the most difficulty in addressing?
- Does your program have a fully implemented Community Action Network (CAN)?
- Does your program have a QI and performance monitoring process in place?

The literature review consisted of reviewing the current 2014 FOA. The FOA provided information in terms of content and structure of program and addressed keys not addressed by themes from the primary data collection. The focus of the FOA review was on obtaining the appropriate breadth and depth, rigor and consistency, clarity and brevity, and effective analysis and synthesis. The concepts from the FOA were used to structure the analysis and report approach.

Data Management and Analysis

Simple frequency summaries were run on the quantitative survey questions within SurveyMonkey, and the qualitative survey questions were downloaded from SurveyMonkey and imported into NVIVO 9.11 for analysis.

The EPIC Center HS CoIIN team did the initial analysis and used NVIVO for the qualitative data questions. The team moved back and forth through the data in order to find, compare, and verify the patterns, concepts, categories, properties, and dimensions of the codes that we identified.¹⁶ A 'framework' technique developed by the National Centre for Social Research was used.¹⁷ The first four steps of this technique were employed primarily to order and manage the data: 1) familiarization; 2) identifying a thematic framework and developing a coding structure; 3) indexing (applying codes systematically to the data); and 4) charting (rearranging the data according to the thematic content).

The codes were derived from themes identified throughout the survey relating back to the survey's purpose, and other important points identified from the initial readings of the transcripts. The 84 surveys were then coded. The EPIC Center HS CoIIN team met to review the coded transcripts to reduce bias across the data. Finally, the HS CoIIN analyzed the text of survey responses according to the themes identified by the HS EPIC Center CoIIN team, and identified priorities which were then refined to recommendations.

The following strategies enhanced the validity of the primary qualitative data collection:

- The town hall polls were consistent with the findings related to benchmarks and accountability approach; and
- Overall findings were confirmed by soliciting further analysis from the HS CoIIN to the initial themes identified in the initial analysis:
 - During the day and a half HS CoIIN planning meeting (July 6-7) the HS CoIIN met in small groups and either each individual or as a group reviewed data output to pull out key information from the data in their assigned sections. Using a prioritization matrix template, small groups developed priorities related to lessons learned themes and key information they've pulled out of the detailed data.
 - Each small group reported their priorities back to the larger group and from the consensus of the group recommendations were developed for that focus area.

Demographics of Survey Respondents

A total of 84 grantees completed the survey. Levels 2 and 3 grantees were above 90% response rate at 95% and 100% respectively and Level 1 grantees reached a 75% response rate (see Table 1).

Table 1: Survey Response Rate by Grantee Levels

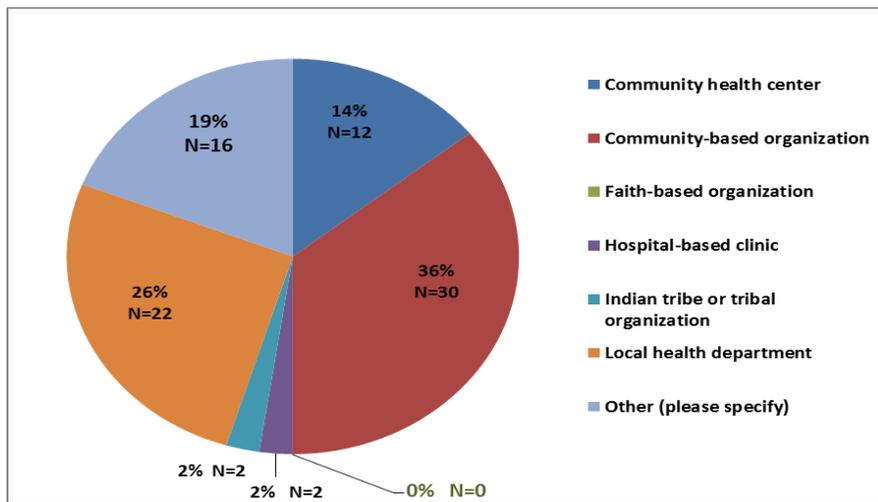
	Number of Responses	Percent Response Rate
Total Responses	N=84	84/100=84%
Level 1	N=45	45/60=75%
Level 2	N=21	21/22=95%
Level 3	N=18	18/18=100%

Organizational Types

Q3. How would you classify the entity that has direct responsibility over the HS Project? (N=84)

The majority of survey respondents were community-based organizations, followed by local health departments. The third most reported type of venue was “other”. No respondents reporting themselves as faith-based organization. Following in Graph 1 is a list of the types of organizations that comprised the “other” category.

Graph 1: Organizational Types



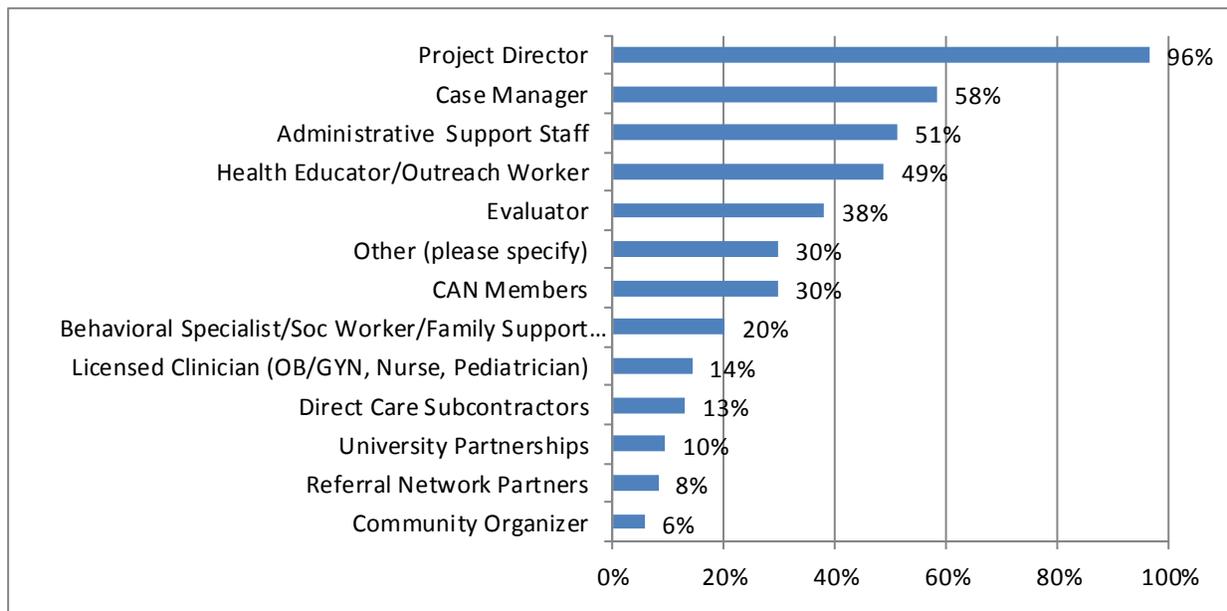
The types of organizations that comprised the “other” category are: Academic and University-Based; State Health Department; Pediatric and Children’s Hospital; Medical School; Community Foundation; Local Health Cooperative; Faith-Based; and Federally Qualified Health Center (FQHC).

Staff and Stakeholder Contributing to Survey

Q4. Please identify staff and stakeholders who contributed to your program’s feedback (Check all that apply): If one person serves multiple roles, please choose the primary role they play at your site. (N=84)

HS Grantees were asked to review the survey with all staff and key stakeholders from their HS site who serve participants. After reviewing the survey, the site worked as a team to summarize and submit their organization's feedback. Graph 2 shows the wide range of staff and stakeholders that contributed to grantees' surveys. Not surprisingly, Project Directors make up the most survey respondents with Case Managers, Administrative Support Staff, and Health Educators/Outreach Workers rounding out the top four staff. For community stakeholders, CAN members, University Partners and Referral Network Partners were the most referenced. The inclusion of diverse sectoral respondents in the process reflects broad community engagement, as well as diverse sectoral perspective in the responses.

Graph 2: Staff and Stakeholder Contributing to Survey

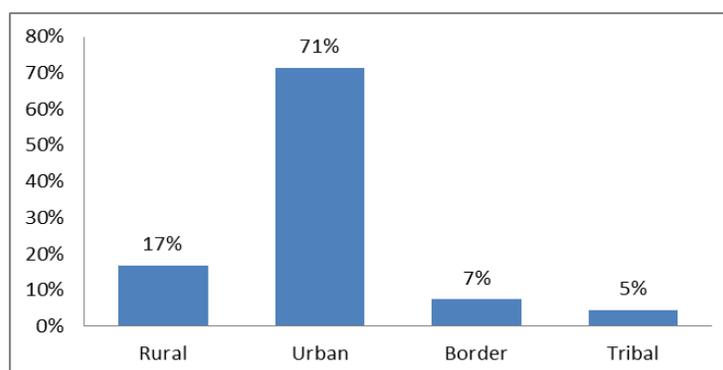


Geographic Reach

Q6. Indicate your geography (your reach). (N=84)

Graph 3 shows the geographic distribution of the survey respondents with the urban respondents having the most representation at 71%.

Graph 3: Geographic Reach



As noted, graph 3 displays the geographic distribution of survey respondents. To further put the survey responses within context, the geographic reach of the responses are related to the number of grantees funded within each project area type response rate: Border grantees 6/6=100%; Tribal grantees 4/4=100%; Urban grantees 60/71=85%; and Rural grantees 14/19=74%.

Survey Findings

The major survey findings are organized below to help inform future programming for the HS program and the next NOFO.

Cross-Cutting Themes

Across the key areas of the survey and Town Hall poll questions, the following consistent themes arose (these are highlighted in the following sections of the report):

- Community Connection
- Social Determinants, Social Disparities
- Coordinated Services
- Father and/or Partner Involvement
- Community Responsive Services/Culturally responsive services/Participant-centered services
- The value of personal connection
- Workforce/professional development of HS staff and other service providers
- Engagement – staff and participant
- Data – value, challenge of collection, utilization
- Education/Health Literacy

These themes, and more, are discussed in more detail on the following pages and are **enhanced by direct quotes** provided by survey respondents and Town Hall participants

Five Approaches

This section is organized around the five HS approaches. Each subsection begins with the survey question and number of associated responses, followed by a brief highlight of prevalent themes that emerged through analysis of the responses. This section is followed by descriptions of lessons learned that should be leveraged, as well as challenges and recommendations for changes that would improve the program. Recommendations, **which are noted in bold font**, were derived through the HS COIIN work group distillation and synthesis of the findings. It is important to note that although they are presented as discrete approaches, significant interplay and overlap exists between them.

Improve Women's Health

Improve Women's Health

The Life Course Perspective, MCH research and experience from the field all point to the importance of improving women's health before, during and after pregnancy as a means to improve perinatal outcomes and reduce infant mortality. To improve women's health HS programs assess participants' needs and work to ensure their access to comprehensive medical, social, behavioral, educational, and support services. HS also supports prevention and health promotion for women and families, including access to clinical preventive services, attention to pre/interconception health and reproductive life planning, and provision of health education.



Q16. What lessons have you learned about improving women's health in Healthy Start? (N= 69)

Most commonly cited themes for this approach included access to care, health literacy, the value of establishing personal connections with participants, and the importance of empowerment in promoting women's health. Performance measures that were explicitly cited in program comments regarding this approach included:

well-woman visits, postpartum visits, and initiation and sustainability rates for breastfeeding. Participant engagement is an important strategy, particularly engaging and retaining pregnant women at higher risk. The importance of programs adapting to the needs of changing populations was also cited. Although programs mentioned all perinatal phases, several programs specifically mentioned preconception as an important focus. Preventive care, reproductive life planning, and the importance of having a regular medical provider were also specified.

Lessons Learned that are Important to Leverage

Health literacy was closely linked to engagement, prevention and empowerment, countering the observation that women minimize their own health as a priority.

"Sometimes clients get correspondence from the state regarding their applications submitted and they don't respond due to lack of knowledge and the application gets cancelled."

"Hearing a common message from a range of sources, and in diverse settings (e.g., social settings, groups, and as a component of home visiting services) also has value. Case management can be particularly effective when delivered in the context of the patient-centered medical home/FQHC. Programs also cited the value of home visiting to provide services for women who might not otherwise access them. "The old saying ~It takes a village to raise a child~ is also true when it comes to some women, it takes numerous people all voicing the same message to get a message across and achieve follow-through."

"Follow up is extremely necessary because despite the case managers setting up medical appointments, some clients miss them for numerous reasons. They need to identify any other

barriers that are associated with missed appointments such as lack of transportation, lack of insurance, no child care, and fear of deportation to name a few. There also has to be follow up in regards to state benefit applications.”

“Experiential learning and community-based opportunities like group gatherings are more powerful than didactic teaching about ‘how to be healthier’.”

The importance of establishing personal relationships with participants was emphasized repeatedly, as a critical factor in engaging women in healthy decision-making and empowerment.

“We have found that much of this work is wrapped up in the relationship built between nurse and client, and it is within the safe context of that relationship that clients are able to accept referrals to other community resources, address their vulnerabilities and challenges, and move forward in the context of parenting.”

“It is the relationship that creates change. By creating a therapeutic relationship with a mother it supports her ability to be in a relationship with her baby.”

“Support for prevention, including attention to general health across the lifespan, positive health behaviors, and utilization of preventive health services is incorporated in the plan of care and reinforced during interactions with the [participant] and her family.”

“We have found ... that participants do not think that their health is important after childbirth. [They] understand and usually follow through with prenatal appointment. However, after the birth, the majority of participants report they are too busy or do not feel it is important.”

“The relationship between [our] staff and the participant, as well as between the participant and other health and social service providers, has a vital impact on her ability to act to improve her health and that of her baby and family.”

In addition to personal connections, programs identified the importance of establishing and maintaining community partnerships to expand breadth and depth to the resources that programs can access for participants. These connections include relationships with social service as well as clinical organizations. Addressing social determinants of health is critical, and benchmarks/performance measures provide a way to gauge progress.

“Without effective partnerships and collaboration among local programs, it will be difficult to make meaningful progress on these benchmarks.”

“The most important lesson that we've learned is the importance of a systems-based approach and ensuring all community partners are at the table. In a model like ours where women receive referrals to care, good relationships with all community clinicians is important.”

“Utilizing the Patient-Centered Medical Home (PCMH) model, which looks to support the needs of the patient beyond the walls of the health center, has also facilitated our ability to engage with communities and local organizations within which our patients reside. For example, we have been able to leverage already existing organizational efforts to conduct outreach to help educate the community about health insurance options and enrolling into a medical home.”

“Engaging community members and organizations to address the problem of infant mortality is a challenge and is complex. Maintaining the active participation of other organizations is more prevalent when there is a formal agreement such as a Memorandum of Understanding.”

Challenges and Recommended Changes

All of these factors point to the need for a workforce with the skills and resources needed to promote health literacy, access to care, and participant engagement, including the time needed to do so. Access to care was cited as an important factor to women's health. While some specifically identified the need for health insurance and promoting women's relationships with their primary care providers, it was also mentioned that having health insurance does not guarantee access to care. Some programs also distinguished between the need for access to medical care and a need for access to behavioral health services. The challenge of navigating the complex health care system was also identified as a barrier.

"Mental Health is an important part of overall health, however, there is a lack of quality access to care and some providers don't listen to the patients and brush off their concerns. Limited or no access to health coverage restricts women from continuing to access routine health care."

"Navigating the healthcare system is complicated to say the least. And many participants often become discouraged at the process and would prefer using the emergency room rather than establishing a medical home. Therefore, health needs and services for various populations have come to the forefront as states work to make their systems more efficient and inclusive."

"Women's health cannot be focused simply on the maternal child health issues associated with infant mortality but requires that projects understand that maternal child health is a subset of overall primary care health. By utilizing CAN partners and outreach resources, a HS project can create a "No Wrong Door" scenario. Thus, working on chronic disorders like LUPUS has the effect of exposing that population to the benefits associated with Healthy Start. Similarly, working on nutrition within WIC helps to create an environment for conveying the HS message."

Barriers to care include lack of insurance lack of access or utilization of services by immigrant population, and/or geographic consideration (including shortage of providers in some locations such as rural border areas). Programs also cited restricted Medicaid eligibility as a barrier (related to postpartum care, Medicaid expansion).

"Lack of OB providers in region can impact reproductive health planning."

"Lack of Medicaid after 60 days post-partum is a huge barrier."

"Losing insurance after six weeks postpartum is very hard and is a barrier to engaging in well woman visits with doctor after that point; home visiting (HV) helps women to access services they wouldn't have gotten on their own; it's difficult to maintain HV schedule based on tiering when some women who are high tier don't want frequent contact or refuse weekly visits (or no show chronically)."

However, even when women have access to medical services, providers often do not understand the needs of participants as they relate to social determinants of health, and further, do not know to explore these issues with their patients. Neglecting to address these issues is costly and ineffective. Further, forging stronger and deeper connections with primary care providers could promote their engagement and support in addressing community-centered needs that impact the health of their patients (e.g., social determinants of health, safety and equity). Lack of capacity and competing priorities

can pose barriers to effective partnering and collaboration. Strategies that promote engagement include outreach, offering a range of programs and providing incentives for participation.

“The most important lesson that we’ve learned is the importance of a systems-based approach and ensuring all community partners are at the table. In a model like ours where women receive referrals to care, good relationships with all community clinicians is important.”

Social determinants of health drive health care costs. Population-based approaches to health that target social determinants have the potential to improve health outcomes and lower costs by delivering holistic, participant- (or patient-) centered care. The rise of performance-based incentives for health care and value-based services presents a timely opportunity for HS to partner with health care providers and organizations.

Family planning services impact poverty, housing, environment, education, and many other social determinants of health by reducing unintended pregnancies, particularly among adolescents, improving educational and employment opportunities for women, which would in turn contribute to improving the status of women, increasing family savings, reducing poverty and spurring economic growth, and unintended pregnancies would decline by more than two-thirds with a doubled investment in family planning and maternal health services. This investment could potentially save taxpayers nearly \$6 for every \$1 spent on the investment.¹⁸

Recommendation: Promoting a family-focused service provider model that effectively links HS with medical providers would enable service providers to meet the comprehensive needs of participants in a way that maximizes the skills and scopes of practice of medical and social service providers.

The HS strength-based perspective that uses a systematic approach to determine individual needs, connect with participants to identify how to support and empower them, and make appropriate connections with community services, positions the program as a valuable partner to primary care providers.

Recommendation: Capitalize on the structural flexibility that sets it apart from other maternal child health programs, and positions it to partner with other providers in the transforming healthcare landscape. Regardless of the direction health reform (or health care reform) takes, interventions or approaches that reduce costs and improve quality will increase in value. The benefits of HS should be widely messaged to a broad audience.

“More emphasis should be placed on Maternal Mortality Case reviews of a women’s death as pregnancy related or pregnancy associated, tells the story of how that woman lived and how society cared for her. Maternal Mortality data is underutilized in Healthy Start.”

Recommendation: The Women’s Health approach should center around the Life Course Perspective, reproductive health, and maternal mortality.

Programs cited the challenge of balancing their capacity to provide intensive case management/care coordination needed to ensure high quality service for women and families with complex needs while maintaining the volume of participants required by the program. Providing services to this population requires increasing levels of knowledge and skill. Staff are committed to their work, but competitive pay,

training and support are necessary to ensure retention. The volume of participants that programs are required to serve and the levels of intensive support needed causes a strain on staff who can earn more doing similar work with less of a caseload elsewhere.

Recommendation: Restructure the volume requirement so that it is based on a smaller number of participants in order to resource the high intensity of needed services to impact the HS participant population.

Promote Quality Services

Promote Quality Services

HS works to ensure access to and delivery of high quality health and social services to women, infants and families by providing case management and care coordination to participants, and supporting systems integration on the community level. HS programs utilize evidence-based curricula and interventions to provide health education and health promotion in the required areas of breastfeeding, immunization, safe sleep, family planning and tobacco cessation, well-woman and well-child care.

Q20. What lessons have you learned about promoting Quality Services in the HS context? (N= 62)

Lessons Learned that are Important to Leverage

In general, programs identified quality with culturally-responsive/participant-centered services that are characterized by participant engagement and require HS staff to develop personal connections with participants. Several programs directly linked quality services with recruitment and retention, noting the positive reputation of HS as a program with structural flexibility to adapt approaches to the unique needs of participants. This includes a critical HS role with care coordination/case management as it relates to engaging participants in designing a plan for services, providing a wide range of wraparound services, and the option to use incentives as indicated. Including the participants' voices in developing services (e.g., through needs assessments and satisfaction surveys) is effective. The importance of distinguishing HS from home visiting programs is critical: home visiting programs provide home visiting services; HS may provide home visiting services as part of an array of other appropriate services.



"[The] array of comparable services and programs at multiple agencies is confusing for participants. We can play an important role in not only navigating but synthesizing/ translating complex array of resources."

"Using a culturally sensitive model that is delivered by paraprofessionals has facilitated strong relationships resulting in the retention of participants."

"Clinical partners providing similar screenings and education for our clients can see us as competition; it is helpful for us to make sure they understand we are an extension and

enhancement of their services, as we can spend more time and more quality time with participants than doctors can. In home visits we can take time to ensure that participants understand and prepare for interactions with their doctors and can help to ensure that they return for their appointments, identify other services they may need at the clinics, etc.”

Programs also acknowledged the value of collaboration and connection to community services, and the role of the CAN to promoting quality services by addressing social determinants. One strategy that was mentioned was establishing agreements with community clinics to give priority access to HS clients and their families.

“Change is inevitable. Continual communication with community partners [is needed]. As these partners update their focus, make sure that HS and the partners do not lose sight of collaborative opportunities, similar activities and importance of not duplicating services when avoidable.”

Programs that mentioned data and performance measures (specifically related to safe sleep, breastfeeding, pregnancy spacing, and tobacco abstinence) provided information on both the value and the challenges. Programs cited the use of data as it relates to demonstrating outcomes, staff understanding of how the data/measures tie to their work and the importance of regularly reviewing data with staff as well as community partners to ensure quality services.

“It is important to clearly reflect with all staff when engaging in continuous quality improvement (CQI) activities. Staff who are not familiar with CQI or who have not done it before may become frustrated when different approaches are abandoned because they did not work as intended, not realizing that the data do not support use of those approaches. Although we anticipated the need for continuous, clear communication across partners, this need cannot be emphasized enough.”

HS participants have complex needs. Providing training to and reinforcing learning of new staff as well as seasoned staff is essential and effects outcomes.

“By training staff to respond immediately to any breastfeeding questions or concerns we have increased our breastfeeding to six months rate 20% over the past three years. We have also documented a 16% increase in the number of participants who have initiated breastfeeding.”

Challenges and Recommended Changes:

“Professionals generally take pride in providing quality services. Their ability to do so is often affected by outside circumstances such as financial and time constraints, lack of rapid dissemination of best practices, and cultural and individual differences that affect their ability to communicate effectively with patients and change health behaviors.”

While many factors impacting a program’s capacity for providing quality services are not modifiable, some suggestions for addressing these limitations follow.

A major point to this approach is the need to balance quality and flexibility, recognizing that the participant volume requirement challenges the programs’ capacity for providing quality services.

Recommendation: The participant volume recommendations should be reconsidered. That is, fathers and/or partners should be included as participants, and the required number of pregnant women served should be reduced.

The challenge of balancing competing demands for limited resources between administrative requirements and service delivery was raised by several programs. Specifically, the development of data systems, transitioning to new screening tools, and the staff training required to implement them take staff away from addressing the care needs of participants.

Recommendation: The grant cycle should incorporate a start-up/planning phase at the beginning.

While it is important to build the program on evidence, it is not necessarily essential to require evidence-based programs, such as Nurse Family Partnership (NFP), that require inflexible eligibility and evaluation criteria. The program should use validated, scientific-based tools, and evidence-based curricula that allow flexibility in delivery of service as it relates to the unique needs of participants (e.g., setting, timing, etc.).

Recommendation: Refine criteria to include evidence-based curricula as a minimum requirement to ensure the comparative advantage of HS over other maternal child programs.

Comments related to specific performance measures mentioned challenges to collecting the data, and in some cases, questioned the value or validity of the data collected.

“Measuring pregnancy spacing between the current and previous pregnancy is not really giving any reflection of HS services. If we enroll a mom pregnant with her second child, there's no way we could have had any influence on the timing of the current pregnancy since it's already underway. It's good to have this info so we know our community's issues, but it's not fair to have a performance measure that we have no ability to influence on the individual level.”

Recommendation: The data definitions and performance measures should be revisited and clarified, and the HS CoIIN should have a role in collaboration with the DHSPS in the clarification.

“It has been difficult to understand definitions of the benchmarks. This often leads to long discussions about our CQI data and how we interpret that data.”

Finally, workforce/professional development is essential, time consuming and costly. HS is at a disadvantage to other programs in that the combination of high-need participants and lack of available resources to adequately train and retain staff places the program in competition with other programs, such as NFP, which has a more manageable staff:participant ratio and more lucrative pay scale. HS programs invest in training their staff all too often to lose them to other programs which have more to offer them as employees.

Recommendation: In establishing funding to programs, consideration should be given to the actual costs of hiring, training and retaining staff with the requisite skills to address the unique needs of vulnerable HS participants. In addition, workforce development should take into account the job strain of HS staff in providing intensive services, and include development of skills around self-care.

Strengthen Family Resilience

Strengthen Family Resilience

A focus on engaging both parents in the future of their child and on strengthening family resilience helps address, to some degree, the toxic stress that underlies many disparities in birth outcomes. HS programs promote father involvement both before and after the baby is born, provide parenting support and education, utilize a trauma-informed approach to care, and strive to support the mental and behavioral health of mothers and families.

Q24. What lessons have you learned about strengthening family resilience in the HS context? (N=62)



The most common themes that emerged related to family resilience included father and/or partner engagement, taking a strength-based approach, culturally-responsive/participant-centered services, personal connection, empowerment, community connections and workforce development. Programs referenced behavioral health and substance misuse, as well as intimate partner violence as prevalent issues impacting family resilience.

Lessons Learned that are Important to Leverage

Resilience refers to a dynamic process encompassing positive adaptation in the context of significant adversity, the ability of an individual, family, organization, or community to cope with adversity and adapt to challenges or change. HS will support the ability of an individual, family, or community to cope with adversity and make positive adaptations. Reducing risks and advancing positive opportunities are key to fostering resilience. A hallmark of HS is empowering individuals, families, and communities through education, skills building, and building a community voice.

Programs emphasized the importance of community connections and broad community support as critical to strengthening family resilience. Capacity to address a range of issues that impact women's health and family resilience through care coordination and case management (CC/CM), positions HS in a leadership role within the community. Community health and family resilience are interdependent.

"Families need additional resources to maintain a health family. They need additional assistance with job training, continuing education etc. Those additional resources are stressed and embedded within the HS model."

"The community plays an integral role in building and strengthening family resilience."

"Strengthening family resilience helps take stressors off families that are at risk, helps support the communities they live in, and helps minimize infant deaths on a local, state and national level. [It] gives families a better quality of life."

Healthy Start's structural flexibility sets it apart from other programs and enables HS to be a community leader in this area. For example, as it relates to male inclusion/fatherhood engagement:

“The limited inclusion of fathers by healthcare providers and prenatal organizations was very eye-opening. Prior to our work with HS we had not looked at prenatal care from a fatherhood lens and did not realize how mother centric it was. By looking at things differently, we have been able to make substantial changes in the community to make fathers feel important from conception on.”

Strategies that help improve fatherhood engagement include enlisting fathers and/or partners in advising on strategies for father and/or partner engagement, educating mothers on the importance of father and/or partner engagement, providing support in a group setting, and flexibility in the timing of groups and access to services.

“Engaging male partners can be very challenging. We have found that engaging this population using a peer group support model, rather than a one-on-one approach is leading to increased willingness to participate.”

In addition, in developing relationships with participants, HS programs can tailor services to unique family needs through CC/CM.

“The relationship between [HS staff and participant] serves as the foundation for the program to be successful. Supporting family resilience is best done in the context of relationships. That building resiliency is an ongoing process. Every time we see or talk to a participants we are encouraging. We also support the family through whatever they are going through (domestic violence, legal issues, child protection, and chemical use).”

“Every [participant]/family presents with own set of skills, needs. There is not a recipe for success that can be applied to everyone. Working with families to identify personal strengths, resources within their circle and community is essential. Reinforcement of positive, forward moving behaviors.”

“There is so much value in “being with” the family, listening to the family and allowing them the opportunity to reflect on their situation and build their resiliency. Often times we cannot solve the problems that are burdening the families that we serve. We can teach them skills to cope with their concerns, we can demonstrate that their voice is being heard and validate them, we can help connect them to community resources and natural support systems.”

Challenges and Recommended Changes:

Establishing the quality of relationships between staff, participants, and their families is resource-intensive. The complex needs of participants and their families require knowledge and skill, which requires an investment in workforce/professional development; building relationships takes time. All of these issues are impacted by staff turnover.

“Additionally, education is still needed with staff, families, partners, and in the community how important engaging fathers are to the family dynamic.”

“It takes time to build and nurture a relationship with a family and it takes the right staff. Those who go the extra mile to keep a family engaged are critical to forging those relationships that will assist in long-term change.”

“The project has developed several program initiatives with collaborative partners to support family resilience to incorporate father/male involvement these efforts continue to be challenging without adequate staffing.”

Although women’s health, resilience and self-efficacy are critical to family resilience, as an approach, family resilience is treated as a discrete area, and often translates into “father involvement”. However, many participants are not in a relationship with the baby’s father, and not all families are interested in involving or engaging fathers or partners. In many cases, women lack models for healthy relationships that include father support or involvement. In other cases, fathers reach out for support separate from their relationships with the mothers of their children. The issue of male inclusion/fatherhood engagement also raises the largely unaddressed issue of how to honor partners in same sex relationships, and the unanswered questions about how male inclusion/fatherhood engagement applies in those situations.

A tension often exists between honoring the mom and engaging fathers and/or partners, especially when intimate partner violence, substance use, or other social issues are involved.

“[We] often have to address social issues/crisis before we can address health issues; client wants the best for their family but not all know how to advocate for themselves; father engagement is very hard to do – many clients have relationship issues and do not want father involved and have no personal history of father support/involvement themselves, thus no models on how healthy relationships should work; clients don’t know how to co-parent outside of a relationship and often don’t want to try; only want father involved in paying child support or financially.”

Recognizing the importance of father and/or partner involvement, the challenge lies in balancing the needs of the father and/or partner, inclusion of male role models for children, respecting preferences of women, and engaging fathers and/or partners in a meaningful way that may require some flexibility and creativity.

Recommendation: The support for involving fathers and/or partners in HS is growing but should be a core component of the program. Addressing the need for more father and/or partner-friendly approaches within HS is critical to promote involvement, communication and support from both parents and/or support person.

Engaging young men in sexual and reproductive health education and health care services is critical to preventing premature fatherhood, which can have serious consequences for the young men, their partners, and their children. The 2004-2008 Pregnancy Risk Assessment Monitoring System (PRAMS) data indicated that approximately 25% of female adolescents (15-19 years old) reported the reason for not using contraception as “their partner did not want to use contraception”. Young men are also more likely to exhibit pregnancy ambivalence, which is associated with a lowered likelihood of using contraceptives.¹⁹ Approximately 25% of male adolescents reported receiving Sexual Reproductive Health (SRH) services compared to approximately 50% of females, and preconception care for men is important for improving family planning and pregnancy outcomes, enhancing the reproductive health and health behaviors of their female partners, and preparing men for fatherhood.²⁰ However, both male and female adolescents report an interest in receiving sexual health information from health care providers.²¹ The challenge, however, has been translating this objective and research into a pragmatic application of increased gender equality in the field.²²

Recommendation: Levels of engaging and serving men's reproductive health needs vary across family planning clinics. HS could make a substantial contribution to providing men’s preconception

reproductive health services by leveraging its experience with engaging men via fatherhood initiatives.

Achieve Collective Impact

Achieve Collective Impact

HS programs lead and participate in community collaboration, information sharing and advocacy through Community Action Networks (CAN) which involve HS participants, community-based organizations, providers and community leaders in efforts to strengthen community service systems and address social determinants of health. The Collective Impact framework is used to facilitate community collaboration to address specific social problems.

This section includes responses for two survey questions:

Q28. What lessons have you learned about achieving collective impact in the HS context? (N=63)

Q42. What lessons have you learned about engaging your CAN in the HS context? (N=58)

Most common emerging themes included community responsive services, engagement, resources needed, data and shared measurement systems, common agenda, and the importance of relationships.



Lessons Learned that are Important to Leverage

Programs identified CI and the CAN as rewarding and important to the HS goals, if challenging to implement. Community-level systems improvements related to social determinants of health are achieved through this approach. Specific elements that promote success include diverse membership that includes community members, regular and meaningful meetings, and a discrete focus.

The requirement to engage in the CAN sets HS apart from other maternal child programs, and should continue.

“...Frequency and quality of contact is pivotal in ensuring engaged partners. Quarterly meetings were insufficient for buy-in, and the group was engaged to come up with new solutions that fit all stakeholders (e.g. set meeting times, adapting meeting times, hosting off-month phone calls as needed, every other month).”

“Community members need to be included in the CAN as they have the best understanding of the social issue being addressed.”

“We have seen improvements in our work with thoughtful inclusion of local and state government agency leadership. By ensuring government representation, we are better able to align our CAN work with ongoing high-level policy conversations, thus leading to more effective outcomes.”

“A CAN requires significant effort to establish, grow, and change with changing needs and resources. Make attendance worthwhile. It should provide not only a chance to acquire new information and nurture partnerships, but a chance to showcase the services provided by other programs that foster the goals of the five HS approaches.”

“Not everyone is comfortable with the emergent / adaptive process where roles and measures aren't clearly defined. We had the catch 22 of trouble defining measures until the stats people started coming, but getting the stats people to engage regularly was a challenge until we had measures defined.”

Many programs mentioned the benefit of leveraging group structures already in place to strengthen existing efforts by making a unique contribution to an unaddressed issue.

“It is important to identify a unique topic to be addressed. There are many consortia and collaboratives addressing MCH issues in [our region], so it was important that the members of our CAN felt they were contributing to a specific purpose that was not already being addressed by another group.”

“We found that many home visiting or other service programs in the area needed an advisory group, so we have gotten all of the home visiting programs or services that needed an advisory group to join together as a CAN and at each meeting report on their programs progress.”

“Due to the number of CI groups in the city, we have come to realize that very few work with the community. Most of the groups are working with professional organizations. We have decided to take it to the neighborhood level first and slowly bring in the organizations as we figure out our needs.”

“The CAN partners have expressed that CAN meetings are very different from the typical advisory board meetings that everyone attends because ... there is an honest attempt to create that shared agenda and developing vehicles for establishing joint outcomes that benefit all involved.”

“The use of the CI framework was helpful in identifying one of the social determinants of health that continues to present as a challenge. Additionally, [our] CAN members learned that working collaboratively helps to minimize the burden of the decision making process on any one person. In that, everyone has an invested interest in bringing about social change.”

“...It takes time to fully engage the community in the work of CAN, but having a transparent and slower process has helped us realize the true value of collective impact and community engagement.”

“As we have gained momentum with working groups and generated more attention for our work, we have to work hard to ensure that all partners are recognized adequately and prevent perceptions that our work is only about Healthy Start.”

Engagement in the CAN provides a mechanism or venue for professional and personal growth of members, and promotion of member organizations.

“[Provides an] opportunity to share information about resources in the community, and also is a good Public Relations opportunity for the program in the community.”

“It is important to provide opportunities for individuals to bring both their personal and professional selves to the CAN. Over time it will be their personal connection to CAN goals that sustains their engagement.”

“We celebrate the early adopters who engage on faith and work to truly listen to the ideas of those who may be skeptical or need more time so that we can learn from them. Some energy and momentum is lost the more structured and established we become; we try to alternate the focus of meetings between updates on CAN "business" and exercises to break new ground. Working groups can be the most effective and 'nimble' when they are smaller - no more than 5-6 people.”

Challenges and Recommended Changes

Many programs mentioned the challenge of garnering the resources required to effectively contribute to and/or lead a collective effort, specifically, the time required of individual members for engagement in the process, as well as the time required for the group at large to make progress.

“Need a strong backbone to lead/facilitate the effort. Hire a dedicated staff person to organize and maintain the CAN – which will be more helpful than a person with various duties.”

“Achieving the kind of collective impact that decreases then eliminates disparities may demand more resources than are available in some communities, yet the process of striving for that goal improves the collective impact of those resources.”

“The expectation of leadership in this area would be unrealistic for Level 1 projects because of limited financial resources - could not serve as a 'backbone' organization. It would be wonderful to have a person solely devoted to the cultivation and maintenance of CI initiatives.”

“We needed to find a different route to get participants and common stakeholders together. We initially started with participants and their input but found it difficult to get other stakeholders to the table because of busy schedules and involvement with similar meetings.”

Recommendation: CAN requirements should be revisited and reconsidered. It should be clarified that the HS grantee is not required to serve as the backbone organization for CI, but must be integrally involved in the CI process. CI/CAN requirements should be uniform for all levels, and should include dedicated staff.

The challenge of meeting the benchmark was also identified. Recruitment and retention of 25% HS community participants can be a challenge.

“The advisory board is a rather large group of organizations, so meeting the 25% benchmark is an issue.”

Recommendation: Build in resources to support and incentivize participant membership (e.g., childcare, transportation, etc.)

Challenges related to membership issues were multifaceted, and included instability of membership and the likelihood that a CAN without dedicated staff may find its priorities shifted in light of other pressing issues:

“In terms of our CAN, we've found it challenging to create and sustain work groups over an extended period of time, because there are always new members. In addition, even CAN members who attend our monthly meetings as part of their job, are often "volunteering" their time for anything extra, and CAN projects may have to be pushed aside if the person has a pressing obligation at work.”

“The work of the CAN has been very rich. Three out of the four work groups have produced tangible results and/or are in the process of doing so. One group has not flourished as well as the others but I think that is due to the broadness of the category (Community, Families and Parenting). This group has had difficulty maintaining membership most likely due to a lack of focus and the homogeneity of the group. A lesson learned is that a specific and narrower focus helps.”

Another commonly raised challenge relates to data collection and sharing:

“It is easier to share a theoretical agenda than it is to share metrics that determine whether the agenda has been met. Shared metrics often overlaps with the sharing of proprietary information. Thus, it is incumbent upon a project wishing to advance collective impact to identify those metrics that are consistent with the self-interests of each organization and does not reveal competitive proprietary information.”

“A shared data system is extremely important but also a very heavy lift. Individual partner staff may be resistant to a new system. They have data entry burdens already. Data systems are expensive and time is required to identify the right system, get partner buy-in on using the system, and get enough data into the system to make it worthwhile as a tool for quality improvement.”

“Data are not easily available for baselines for some of our population results, so as an interim success measure we are working with local systems and to better collect relevant data by subgroups; this is a key collective impact product for our CAN.”

Even when the CAN comes together, it can be very difficult to get agencies to work together. Competing interests related to agency priorities, territorial issues, and uneven commitment levels across agencies, as well as lack of adequate funding present barriers.

“Human nature is the biggest barrier to strengthening collaboration. Organizational histories, personalities, politics and turf all serve as barriers to progress.”

“Community members may differ on what the specifics of the collective impact should be and which elements are most important. It is a responsibility of those who seek collective impact to refuse to let this cause stagnation. Common ground can be found.”

“[CAN] members may not actually have the same agenda as Healthy Start, and they may not want to explore areas of similarity. Do not assume that the partners you thought would want to engage in activities related to MCH will be willing to participate. Recognize that when a community assessment indicates that there is not a problem with MCH and there are no needs for change identified, the HS program must shift gears and identify how HS can work with the goals identified by other programs. Make the net of inclusion wider than first anticipated.”

Recommendation: Clarify data requirements for the CAN that honor the community-driven intention of collective impact.

Increase Accountability through Quality Improvement, Performance Monitoring, & Evaluation

Increase Accountability through Quality Improvement (QI), Performance Monitoring, & Evaluation

HS programs work to enhance their services and increase their impact on participant health outcomes by systematically monitoring their performance and engaging in QI efforts informed by participant-level, program-level and community-level data.

Q32. What lessons have you learned about addressing accountability via QI, PM, or evaluation in the HS context? (N= 56)

The most common themes that emerged for this approach included staff engagement, resources required to address accountability, data and data systems, continuous process, evaluation, leadership, partner engagement and workforce/professional development. Themes were rarely identified in isolation, but were highly inter-related.

Lessons Learned that are Important to Leverage



The importance of staff engagement in the QI process was by far the strongest theme, and it was an underpinning theme for many of the others. The continuous nature of QI was embedded in many of the comments, as well.

“Regular communication with staff is important so that they understand not only what they need to do, but why they need to do it. Regular structured education for QI staff is needed.”

“We learned the importance of continuous monitoring and communication during the Plan, Do, Study, Act (PDSA) cycle across the program. We also learned that it may take several

tries before we see results.”

“Engagement of home visitors and other staff is critical. We always try to foster shared expertise, shared decision making, and shared leadership across all staff.”

“Team meetings are held weekly and administrative days for each staff member is assigned to ensure daily data entry to make sure that progress is notated.”

“The importance of ongoing monitoring utilization and quality assurance through client procedures and program participant surveys, focus groups, CAN surveys and abstraction of information from the current database.”

Data collection, storage and reporting are absolutely essential for reporting purposes, and impact workflow and staffing.

“A well-tuned data system is critical to having access to the kind of continual data needed to monitor quality. We underestimated the level of resources - in both time and money - needed for the data support aspects of quality. CQI that involves any additional client-level data collection is going to overwhelm staff - best to figure out how to do it just using the data you already have to collect or can access.”

“The HS context presents additional complexities due to the comprehensive nature of the program, including the need to track outcomes at both the mother- and child-levels. A major lesson learned since the roll-out of the new HS screening tools, is that the volume of data collections required rethinking staffing structures and processes. In collaboration with a local business organization that funds small-term projects, a part-time volunteer was placed with us to help at a time of the highest need for data entry assistance (i.e. as the first assessments were being rolled out and deployed to all active HS participants). Additionally, our agency made deeper investments in our data system and staff training to ensure we meet reporting needs.”

Programs identified the value of data in informing an understanding of how a program is doing through evaluation, and providing a basis for decision making.

“Data is key to successful sustainability of Healthy Start.”

“Having staff with an eye on data and understanding the program activities is an asset to identifying gaps in services or tasks in need of attention. All staff are accountable for participating in QI activities and facilitating change as needed.”

“[Our] staff engaged in the QI Peer Learning Network aimed at improving the benchmark for reproductive life planning. All QI at the program level is based on ongoing performance monitoring, client satisfaction survey results, emerging data, and direction from the CAN and from the National HS Program. [We] provide ongoing training to all of [our] staff and work in collaboration with local and state experts to continue to grow and learn as a program.”

“It is valuable to have all grantees using the same tools and collecting the same data, even with different program models.”

Leadership engagement and endorsement is important for accountability.

“We also receive monthly reports from sites and have ongoing communication with them as needed. [Our] staff conducted in-depth site visits with the Executive Leadership at the contracted ... sites. Successes and opportunities for improvement on a site by site basis were discussed. We have worked closely with staff at subcontracted sites to make improvements to our case management/data collection tools in order to strengthen our case management and evaluation process.”

“Monthly reports show the performance level by county for the past three months on all MCHB performance measures and additional measures defined by leadership and staff. Problem areas are reviewed with CMs at case conferences. As needed, action steps are determined at the leadership meeting and explained in project-wide meetings and at case conferences. Other ad hoc queries are run to address specific or new data-driven concerns.”

“A written plan, reflective of program needs takes dedicated time and specific intentions/skills from staff needs leadership buy-in and staff training/communication.”

“... our increased presence at leadership events in our agency has brought us much needed attention and awareness of our important work. This increases our attention to detail and program performance which holds us more accountable as a program.”

A diverse set of data sources that include vital records, participant focus groups and satisfaction surveys, screening tools and community assessments are helpful to provide comprehensive feedback that reflects the complexity of HS reach and performance.

“In our analysis of fetal and infant mortality data, gathering data from multiple sources has been essential. Just analyzing data from vital records only gives us one view of risk factors associated with fetal-infant mortality. We’ve also interviewed key informants whose personal accounting of risk and protective factors has shed light on many aspects on local, pregnant women’s lives. A survey of social services in the county has provided information on the network of organizations and on the sectors in which there are gaps and surpluses of services.”

“In the past few years there has been a proliferation of outcome measures and instruments for QI/QA. We believe many of HS grantees have taken on the challenge of developing systematic ways to address accountability because there is universal agreement that addressing

accountability is an essential part of better evaluation systems. Until recently, each grantee has approached the issue a little differently, and this multiplicity of approaches may have been helpful for the early stages of the process; however, we realized that eventually some standardization is necessary in order to fully assess the quality and value of the services we provide to our clients.”

Challenges and Recommended Changes

As with Collective Impact, accountability is an issue that essentially cuts across, or underpins each of the other approaches.

Conducting meaningful evaluation and ensuring program accountability requires significant resources. Reliable data are needed, which requires establishing and maintaining accessible data systems. Performance monitoring and QI activities require unique knowledge and skills, and the inclusion of staff at all levels is critical to success. Workforce development is essential, time consuming and costly. Staff turnover is a significant barrier to ensuring that staff have the knowledge and skills needed for accountability.

“It is important that all staff are formally trained on QI and are aware of QI projects as they happen. When staff are not familiar with processes, they may become frustrated when something they liked is discontinued because the data shows it doesn’t work.”

“Trainings are not enough; ample time needs to be included for post-training follow up and individual support to help guide staff through new data collection tools and processes. Database creation took significantly longer than anticipated; delays should be expected and accounted for in contract language. Data checking and cleaning is instrumental to identifying potential trouble areas in the use of the screening tools. For example, data checks of the Pregnancy History Screening Tool revealed many/most staff misunderstood some of the questions. This required us to do additional follow-up trainings for staff and make edits to some of the participant responses. The amount of staff time dedicated to Quality Improvement, Performance Monitoring, and Evaluation should not be underestimated.”

“Staff needs education on the importance of developing and following processes, data integrity and quality improvement. Staff input must be involved from the beginning of any quality project and sufficient time must be allocated for them to participate in QI work.”

“Hard data with numbers is vital to determining effectiveness and remaining accountable, but [we] are also accountable for the less easily quantified quality of case management provision. Case in point: A computer system may show that a woman received a needed referral and completed that referral, but the woman and case manager have vital information on whether the need has been met or persists.”

Recommendation: MCHB should provide a uniform database that can upload data for evaluation, and ensure that program-level data are available to drive improvement efforts.

Lack of clarity regarding the evaluation plan, and changing the program model make it challenging to track program improvements, or plan for needed program-level evaluation capacity and costs.

“How do we balance service delivery with data collection, evaluation, etc. – don’t know how to budget, especially when requirements are trickled out after the fact.”

“It is critical to have final evaluation protocols to ensure that data systems are set up correctly for the required needs for the program.”

Recommendation: Although securing a program evaluator is not required by HRSA, adequately resourcing evaluation activities is essential to ensuring quality evaluation practices. Clarify evaluation responsibilities (e.g., nationally, state-level, local, etc.) and provide additional funding, or guidance regarding budgeting for monitoring and evaluation (such as recommended percentage of budget to be allocated to evaluation).

“It helps programs/projects assess impact and the quality of services provided.”

“QI should be continuous. There is always room for improvement. It is always helpful to re-examine individual performance measures or benchmarks with program staff to identify potential issues from multiple perspectives. Internal program processes and linkages to other programs and referral processes are always changing and need to be assessed for continual optimization.”

Recommendation: Quality and continuous QI is a cross-cutting component of providing services that should be embedded in and inform all of HS in everything a program does. It should not be a separate approach.

Addressing Benchmarks

Q46. What lessons have you learned about addressing the HS benchmarks? (N=50)

Specific themes emerging from responses to this question included accountability, quality, data and data systems, and evaluation. While many comments reflected barriers and challenges, programs also provided some practices that are working well with regard to addressing benchmarks. Benchmarks most mentioned were related to well woman visits, abstinence from tobacco, postpartum visits, initiating and sustaining breastfeeding, safe sleep, reading, pregnancy spacing, and CAN membership. These were raised in the context of difficulty in meeting them.

Lessons Learned that are Important to Leverage

Some programs responded that fully implementing the screening tools will result in better collection of benchmark data, but that meeting all the standards and parameters requires careful planning and a sustained effort.

“The project has come to embrace the benchmarks as “goalposts” for both staff and management accountability. By using benchmarks as yardsticks, the project is able to clearly see progress over time.”

“Addressing the HS benchmarks are pivotal to describing the impact of the project on women's health, pregnancy outcomes, and infant mortality. When all grantees address the same measures, the results are powerful. Our project learned that our data system could not conform to the data mapping and if the EPIC center did not have the Gizmo as an option we would have failed to comply with the data collection requirements of the grant. Some of the HS benchmarks align with the HRSA Performance Measures.”

“The HS Benchmarks continue to provide a standard way of looking at our participants and reaching our program goals. The benchmarks allow for a standard flow of case management based services on how our participants enter our program: Prenatal, Postpartum or Interconception. Each screening tool used establishes a standard format to better evaluate our

program. The benchmarks also help the program demonstrate its strengths and identify areas which need improvements. These benchmarks also help our program identify staff training needs, growth and improvements, which all leads to better program outcomes. Review of benchmarks with staff has improved the way they look at their individual work plans and how they approach each issue.”

Many of the comments focused on the team effort that is required to effectively address and improve performance measures.

“We identify key benchmarks for improvement and review as a team on a quarterly basis to track progress and areas of improvement. We also break down our benchmark data by site to identify areas of problem and/or best practices that can be applied across the whole project. Discussing benchmarks with the case management staff is critical for ensuring accurate and standardized documentation. The provision of a data dictionary from the start is critical for ensuring that we can do this.”

Issues specific to data management were raised by several programs.

“Because we use a shared data system with real-time client entry, the data is constantly changing. While we have observed stabilization in benchmarks, it took a few months for this to occur.”

“The implementation of an electronic database caused staff and evaluators to use a variety of sources to accurately count and report numbers. Although these barriers have not drastically altered overall outcomes, we have taken the necessary steps to overcome them.”

“If the data doesn’t make sense, investigate. There may be a service provision or data collection problem that needs to be addressed or there may be a data entry, storage, or retrieval issue. Look at trends in the benchmarks at intervals throughout the year. Adjustments in case management or corrections of data errors can be made as needed. Use the Benchmarks, Performance Measures, other HRSA EHBs information, and community-wide statistics to plan and implement collaborative as well as [program] interventions and activities.”

Some specific tips were shared:

“Data checking and cleaning at regular intervals is instrumental to identifying potential trouble areas. For example, by identifying early in the year that our Reproductive Life Plan completion rate was low, we were able to conduct additional staff training and new strategies for participant engagement early enough to more than double our completion rate before the end of reporting year.”

“We have developed a tool to track the benchmark on a monthly or more basis. Our staff reviews benchmarks on every home visit and they address those that are not being accomplished.”

“Participating in our organization's Women's Health Quality Committee has provided us with a forum to address issues beyond the program's control. For example, standardizing the definition and documentation required for a well woman visit within the organization.”

Challenges and Recommended Changes

Specific challenges to addressing the benchmarks were tied to a lack of clarity in benchmark definitions, cultural influences, and systemic barriers on healthy behaviors.

“We needed a clear definition for all the benchmarks before our evaluator started.”

“The HS Benchmarks are a good starting point but are not sufficient to discuss or address the multitudinous and varied needs of participants. The full impact of case management and life course improvement is difficult to quantitatively measure.”

“There are multiple cultural influences that determine enrollee behaviors related to safe sleep, breastfeeding and pregnancy spacing. Family and community need to be educated and engaged to change historical beliefs about safe sleep, breastfeeding and pregnancy spacing. In addition, there needs to be a concerted effort to bring fathers into all aspects of pregnancy and parenting.”

“Some benchmarks reflect systematic barriers that are very difficult to change. For example, insurance status is largely determined by the laws of a given state, and successful completion of a mental health/depression referral is dependent to a large degree on the availability of accessible and culturally relevant mental health services. There is still room for HS programs to help individuals achieve these benchmarks and also to advocate for systems-level changes that help address these barriers, but they are not likely to change in the course of one or many grant cycles.”

Consistent with findings related to other issues, the importance of staff education and workforce/professional development were critical to addressing the benchmarks.

“Staff don't understand the difference between performance measures and benchmarks.”

“Many interventions need to be coordinated in order to achieve progress in the many benchmarks and it is very dependent upon staff knowledge, skills and abilities. We have learned the hard way that lower pay, temporary staff are not adept at doing this work. It is crucial to have professional, full-time staff to work with our moderate to high risk community.”

“Ensure that all staff are trained on the importance of data collection and meeting benchmarks as it relates to the quality of care rendered to the client as part of their orientation.”

“There are many facets to each benchmark – need to be very specific in defining who should be included in numerator and denominator. Ongoing training is needed about the importance of collecting data.”

“...all staff including seasoned and new always need to maintain current knowledge on topics that affect our community such as domestic violence, substance and mental abuse, etc.”

Recommendation: Ensure adequate resources are in place to support staff capacity for data collection and utilization so programs can effectively address the performance measures and meet benchmarks.

Some comments identified a tension between the use of data for CC/CM as opposed to the use of data for evaluation.

“Imperative for forms to capture the data in the database system. [O]ur existing data collection was not capturing all of our activities. The benchmarks and performance measures are heavily based on case management services. HS incorporates more elements, which don't seem to get equal attention. We are able to provide summations in the Progress Report narrative, but it still feels as though the bulk of the information is about case management.”

“A significant challenge was identified terms of the implementation process.”

“Primary discussions on common agenda included recommendations from all partners. These recommendations fell in line with the HS policy/practice requirements in screening, counseling, and father engagement. The time allotted for discussion of the common agenda could have been decreased by providing the HS benchmarks up front and then expanding on these evidence-based

practices. The delay and/or change of benchmark definitions until June 2016 caused us to backtrack. Although data collection was emphasized within the first six months of development, using the HS benchmarks up front would have provided partners a better picture of the data pieces to be collected.”

“Updates to benchmark definitions lead to issues when looking at trends over time.”

Recommendation: Any standardization (data system, definitions, etc.) should be done prior to the start of the next grant cycle to avoid frustration due to wasted time and effort for programs and their partners.

Table 2: Issues around Specific Performance Measures/Benchmarks

<p>Well Woman Visit Increase proportion of HS women participants that receive a well-woman visit to 80%.</p>	<p><i>“Most difficult to get women to well-woman visits; they often put off their own health care to ensure their kids get care.”</i></p>
<p>Abstinence from Tobacco Increase abstinence from cigarette smoking among HS pregnant women to 90%.</p>	<p><i>“Participants need motivation and encouragement to continue with services. More support and local resources are needed to increase abstinence from tobacco.”</i></p>
<p>Postpartum Visits Increase the proportion of HS women participants who receive a postpartum visit to 80%.</p>	<p><i>“Goal of 80% is high. We need to think about what we can do about this, look at best practices. Local Medicaid MCOs ... are less concerned about women completing postpartum visit within the HRSA-specified four to six weeks, and are satisfied with a longer time frame.”</i></p> <p><i>“Many women miss well woman and postpartum exam visits even after receiving reminders and having HS show up at their home to transport them to the appointment.”</i></p>
<p>Breastfeeding Initiation Increase proportion of HS women participants who ever breastfeed or pumped breast milk to feed their new baby to 82%.</p>	<p><i>“Too aggressive in progress expectations during the five-year grant cycle i.e. improvement in breastfeeding rates among African American women.”</i></p> <p><i>“Initiation and sustainability rates for breastfeeding were low for African American women. A breastfeeding support group was establishing specifically for African American women. It is well received and attended. “</i></p> <p><i>“Third trimester visits are a critical time for ensuring breastfeeding initiation at birth.”</i></p>
<p>Breastfeeding at Six</p>	<p><i>“Some benchmarks are more difficult to address than others. For</i></p>

<p>months Increase proportion of HS child participants whose parent reports they were breastfed or fed breast milk at six months to 61%.</p>	<p><i>example, breastfeeding initiation is going well, but maintaining breastfeeding for six months is much more of a challenge.”</i> <i>“Some of the benchmarks are a bit unrealistic (the target for duration of breastfeeding is high) and sometimes despite the best efforts of all-progress is minimal at best.”</i> <i>“By training staff to respond immediately to any breastfeeding questions or concerns we have increased our breastfeeding to six months rate 20% over the past three years. We have also documented a 16% increase in the number of participants who have initiated breastfeeding.”</i></p>
<p>Safe Sleep Increase proportion of HS women participants who engage in safe sleep practices to 80%.</p>	<p><i>“Safe sleep practices continue to be an ongoing concern. The HS team identified the need to have more intentional conversations with clients regarding safe sleep and infant mortality.”</i></p>
<p>Reading to Child Increase the proportion of HS child participants aged 0-24 months who are read to five or more times per week to 50%</p>	<p><i>“Some such as Reading to Your Child Weekly is difficult to measure because it is self-reporting.”</i></p>
<p>CAN Membership Increase the proportion of HS grantees with at least 25% community members and HS program participants serving as members of their CAN to 100%.</p>	<p><i>“Achieving the 25% HS participant-based requirement ... is daunting and is counter to creating a truly community-based network - the overall percentage should be reduced, and it should be open to consumers of the collective members organizations, not just HS participants.”</i></p>
<p>Pregnancy Spacing Reduce the proportion of HS women participants who conceive within 18 months of a previous birth to 30%.</p>	<p><i>“Measuring pregnancy spacing between the current and previous pregnancy is not a reflection of HS services, because we may not have any influence on timing of the current pregnancy.”</i> <i>“We have also found that there are some areas that are harder than others to make an impact in (such as birth spacing and use of LARC), and that the pulse of the community has a direct impact on these areas.”</i></p>

Recommendation: The data definitions and performance measures should be revisited and clarified. Through its standard vetting processes with the larger HS community, the HS CoIIN should have a role in collaboration with the DHSPS in the clarification.

Standardized Curriculum, Interventions, and Screening Tools

Evidence-based practices include specific actions, activities, strategies, or rigorously evaluated approaches that improve the health of women, before, during, and after pregnancy in order to improve birth outcomes and give infants up to age two years a healthy start. Evidence-informed practices are also guided by research and evaluation but may offer a more flexible approach in various service delivery settings. As part of the promoting quality services approach, HS grantees were asked to identify and justify other evidence-based models and evidence-informed approaches as well as implement standardized assessment tools in the local context.

To understand the landscape of evidence-informed/evidence-based practices being implemented and standardized assessment tools being implemented across the HS grantees, grantees were asked to indicate which curricula, interventions or models and standardized tools they are utilizing within their programs. The list provided in the survey was not exhaustive, and respondents were encouraged to add models that were not listed.

Q7. What evidence-based models or evidenced-informed models does your program use?(Check all that apply*) (N=84)

The top seven evidence-informed/evidence-based practices being utilized are shown in Table 3.

Partners for Healthy Baby being the number one listed and Parents as Teachers and Community Health Workers/Promotora coming in at number two.

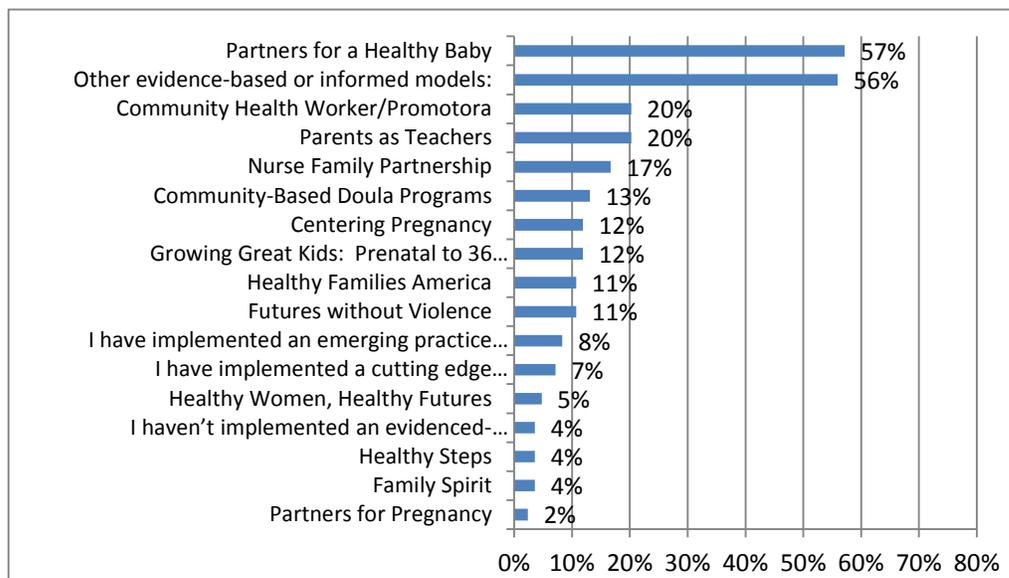


Table 3: Top Identified Evidenced-Informed/Evidenced-Based Practices

Model/Intervention	# of Grantees Using	% of Grantees Using
Partners for Healthy Baby	48	57.1%
Parents as Teachers	17	20.2%
Community Health Workers / Promotora	17	20.2%
Nurse Family Partnership	14	16.7%
Community-Based Doula	11	13.1%
Growing Great Kids	10	11.9%
Centering Pregnancy	10	11.9%

Graph 4 shows the full range of interventions and models that HS grantees are implementing within their program.

Graph 4: Evidence-Informed/Evidence-Based Practices Implemented Across HS Grantees



In addition to the list of evidence-informed/evidence-based practices, HS grantees identified a wealth of other types of evidence-based or informed practices that comprised the other category, with the three most frequently mentioned being: DANCE, GAD-7, and Danger Assessment. For additional practices mentioned in this section, please see Appendix 4.

Q11. What validated or standardized tools does your program use? (Check all that apply*) (N=84)

To help respondents determine if their tools are validated, definitions of the various levels of practice were provided:

- A validated tool is an instrument that has been tested for reliability (the ability of the instrument to produce consistent results), validity (the ability of the instrument to produce true results), and sensitivity (the probability of correctly identifying a patient with the condition).
- A non-validated tool is one that has not undergone testing as noted above and might be a home-grown tool that a program has put together.

The top six standardized and validated screening tools being utilized are shown in Table 4. EPDS was the number one listed, Ages and Stages, and Ages and Stages Social came in at numbers two and three.

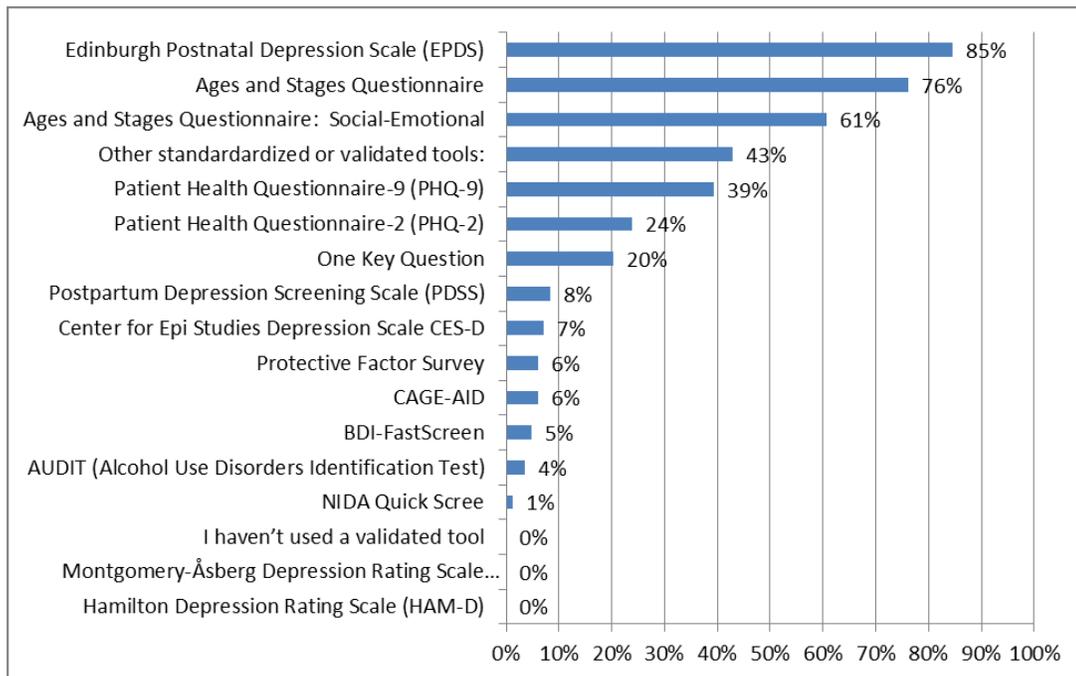
Table 4: Top Identified Standardized and Validated Screening Tools

Standardize Screening Tool	# of Grantees Using	% of Grantees Using
Edinburgh Postnatal Depression Scale	71	84.5%
Ages and Stages	64	76.2%
Ages and Stages Social	51	39.3%

Standardize Screening Tool	# of Grantees Using	% of Grantees Using
PHQ-9	33	39.3%
PHQ-2	20	23.8%
One Key Question	17	20.2%

Graph 5 shows the full range of standardized and validated screening tools that HS grantees are implementing within their program. It's important to note that no grantee reported that they haven't or don't use validated screening tools.

Graph 5: Standardized and Validated Screening Tools Implemented Across HS Grantees

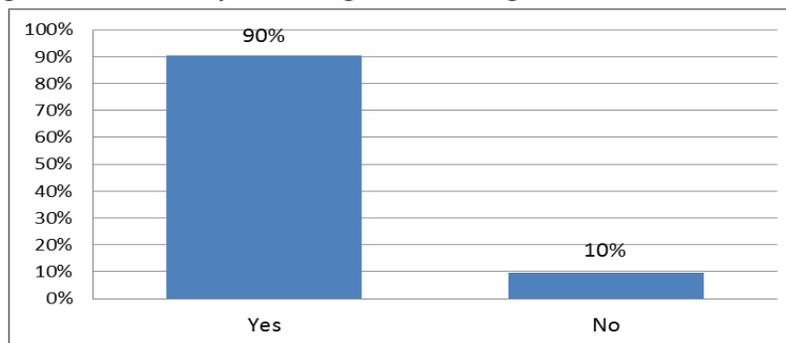


HS Screening Tool Implementation

Q49. Did your program implement the screening tools? (N=73)

As shown in Graph 6, 90% of respondents have implemented the HS screening tools.

Graph 6: Percentage of Grantees Implementing HS Screening Tools



Programs that implemented the HS screening tools were asked to share lessons learned through the implementation.

Q52. What lessons have you learned during the implementation of the screening tools? (N=53)

Programs provided responses that reflected both participant and staff perspectives with regard to the screening tools and their implementation. Key themes that emerged through analysis of this section include staff and participant burden, recommendations related to administering the tools, data and data systems, alignment with existing evidence-based interventions, and workforce/professional development.

Lessons Learned that are Important to Leverage

Several programs reported that their staff were surprised at the amount of information they gleaned from participants through the use of the screening tools, and reported that participants willingly answered the questions asked.

“Clients are not resistant to responding to the questions. Participants for the most part answer the questions willingly.”

“The Designated Care Coordinators are surprised at how much new information they are gaining from completing the screening tools.”

“Staff like that there is a question about community involvement on the tools.”

“Through the use of the screening tools the program is able to collect data on the client at each perinatal phase. Collecting this data assists the program in addressing the client’s needs during each perinatal phase. Through the questions on the HRSA screening tools the program was able to assess and learn how the client felt about the environment in which they live.”

Programs also felt that implementation of the tools facilitates collection of the data useful to CC/CM and evaluation.

“Fully implementing the screening tools will result in better collection of benchmark data.”

“Standardized, extensive screening tools reveal some risks and needs sooner after enrollment.”

“The screening tools will be valuable in gathering beneficial data to help evaluate program.”

Specific screening tool administration tips included:

“Environment in some households due to domestic violence, etc., staff has to create different methods of communication to answers.”

“It is important to have the option [of] break[ing] the screening tool implementation into multiple home visits, but also to answer the most important questions first (usually benchmark related). Need to prep before asking the [sensitive] questions – decide in advance which can be completed beforehand, and which she wants to ask at that visit. Sometimes [staff] have to finish asking the questions over the phone.”

“Communication with staff about the many changes at the grantor level was key to them understanding the dynamics surrounding the transformation of case management and data collection. Training was critical so that they understood the instruments and the “art of collection”, making tool delivery seamless with case management workflows.”

“...some colonias have issues connecting with wifi, therefore, we conduct the surveys at the community centers that have wifi capability.”

“Expect change. It’s important to make sure staff members understand the importance of the screening tools when it comes to not only the HS National Evaluation, but the case management process.”

“The screening tools can interfere with Patient Navigator-client relationship if not conducted at the pace of the participant.”

“...the screening tools needed to be incorporated into the participant's initial home visit after the enrollment process in the office because of the additional time required and privacy needed to complete the forms. Case managers need to allow for the appropriate amount of time to complete screening and prepare participant ahead of time. Preparing participants for what could appear to be invasive questions. Ensuring participants that their information is kept confidential.”

“Reminding employees about the importance of completing each question of the tool and interacting with clients while completing the tools, not just giving the tools to the clients.”

“Including case management staff early in the screening tool process was both helpful [but] caused some unnecessary concern as the multiple versions of screening tools were implemented. Having flexibility to respond to multiple versions of tools was helpful.”

Programs also identified the importance of securing a good database vendor to ensure smooth implementation.

“Consistency in assessment and data collection is important and this can be a challenge with multiple users.”

“We should have started looking at the capabilities of our previous vendor much sooner in the process in order to avoid some of the delay we are experiencing now.”

Challenges and Recommended Changes

Various challenges faced by programs in implementing the screening tools are outlined below. However, the overriding recommendation is that the screening tools are important to standardization.

Recommendation: The foundation and intent of the HS Screening tools should be maintained and used as a standard for data collection, while continuing to be improved upon based on need and opportunity.

The majority of comments identified barriers and challenges posed by implementing the tools. A common issue was the burden to staff and participants due to the length of the tools and time required to administer them, especially when language translation was a factor. This was raised in the context of balancing administrative activities with providing direct services.

“Majority of enrollments are completed after the participant has had a WIC appointment and, therefore, has been on the premises for at least 1-2 hours and do not want to stay for an additional two hours to do the enrollment process and screening tools.”

“The implementation of all of the screening tools places a major burden on our staff. We have noticed that by asking the additional questions in the tools (especially those unrelated to the benchmarks) families are often offended or become fatigued from answering so many questions

and it takes longer to build a trusting relationship. In some instances the participant will then refuse to answer any additional questions and this has caused issues with completing screenings and other direct services. Often staff have had to make the difficult decision between reporting and providing care for our families.”

“There isn’t enough time to conduct tools and address a participant’s needs. This requires additional coordination between participant and home visitor which is already difficult to do. These questions at times would lead to other conversations that would then steer us from the questions from the screening tools. It was difficult to then find a way to get back to the tool. Clients are skeptical in answering questions.”

“The average time for completing the postpartum screening tool was close to 70 minutes. On the screenings tools that were received the main question we had were if the participants were provided referrals, education and assistance in response to their answers to the screening tool questions (i.e. housing assistance, mental health/depression screenings, substance abuse, domestic violence, etc.). Other concerns were if the questions that were not answered were actually a participant’s refusal to answer, misunderstanding of the question or the screening tools administrator’s failure to record the participant’s response.”

“We have addressed this by providing gift cards but have had to reduce already tight budget categories to support this effort.”

“Translating and administering the screening at the same time was challenging and time consuming. Screening took double the time to complete when in another language that wasn’t English.”

Recommendation: Continue to pursue opportunities to streamline data collection using the screening tools. A possible strategy is for the DHSPS to provide a centralized database with a portal that enables submission of data required for the evaluation, but also allows programs to access their own data for programmatic improvement purposes. This would enable the DHSPS to track progress of grantees toward benchmarks.

Another issue was the impact of including questions perceived as personal, unnecessary or invasive, as related to the challenge of establishing trusting relationships between staff and participants.

“They are redundant, unnecessary, and violate a lot of intimate information regarding the client.”

“Administering these tools affects the relationship between the Family Service Worker (FSW) and participant because they lose trust in the FSW. They feel that they are only being sought after to complete some form/document and not to address their needs. In some instances after administering the tool the participant will no longer answer calls and will not be available for the home visitor to engage with them.”

“We believe that there are many items on the screening tools that are not critical for helping the participant achieve healthy outcomes for herself and her family.”

Programs identified specific sensitive topics or questions that are difficult to raise with participants. In some cases, the environment was not conducive to administering the tools (e.g., when there is no private space available).

“Participants felt that the questions were too personal (i.e., feeling safe in the community, weight, medical history, etc.) and were uncomfortable supplying responses to the questions.”

“Some of the questions made the participants relive traumatic experiences (i.e., child loss.). Once encountering such a question the participant needed to take a break or speak at length about the experience.”

“Neighborhood/Community and Domestic Violence questions were uncomfortable to ask. When discussing domestic violence, participants are reluctant to talk or will not talk at all. Domestic violence is difficult to address when the abuser is in the home.”

“Father Involvement questions were uncomfortable.”

“Would not be able to ask these questions until after a few months of relationship building. Cannot implement with new clients.”

“When discussing immigration status participants questioned how honest they had to be in their responses, why is immigration status/country of origin important? The current political climate has made the participants cautious of sharing such information even with the staff’s assurance that it will not affect their ability to receive HS services nor will the information be used to determine any other services they receive. Though they are reassured this fear ultimately hinders the relationship that has been built between the participant and the home visitor.”

“Clearly not developed by home visitors or practitioners but by administrators, researchers and non-direct service staff. They are not validated. Hard to prove usefulness. Must tell staff they are required which does not promote buy in.”

Challenges were also identified related to the tools’ lack of fit with existing program models, a particular challenge for programs currently implementing evidence-based models that require their own data collection process for evaluation and to ensure fidelity.

“Some screening tools elements collected are duplicative of existing program models - but must ask twice as the questions are worded different and adherence to model fidelity.”

“It is hard to change/adjust from forms...specifically designed to assess your participant population and collect specific data to a more universal screening tool which may not assess in the best way for your program. It takes a while to ensure each member using the tool has the same understanding of the questions asked. Consistency in assessment and data collection is important and this can be a challenge with multiple users.”

Recommendation: Performance measures and screening tool questions should be mapped to the most utilized evidence-based intervention models to determine where overlap exists and data collection can be streamlined. Screening tool questions should align with existing evidence-informed/evidence-based models or interventions.

The roll-out process for the tools presented challenges, such as the ongoing identification of problems that required revision to the tools that were identified through implementation.

“There were and are still many changes that have occurred and should occur since implementation across all programs – which involves confusion and is time-consuming to adjust screening on various levels (paper forms, electronic data collection, training staff, non-comparability of data across time).”

“It is difficult to change courses in the middle of project period. And that many adjustments had to be made by case managers to implement more screenings.”

“Even though standardization is the goal, the tools leave many items open to interpretation. It is likely that different sites will interpret the questions in different ways.”

“It might have been better if the implementation of the tools was first and much later begin the National Evaluation.”

“Changing program workflows and data collection processes is very disruptive to service delivery and subcontractor relationships.”

“The challenge has been incorporating the new processes while implementing an electronic database amidst the internal challenges.”

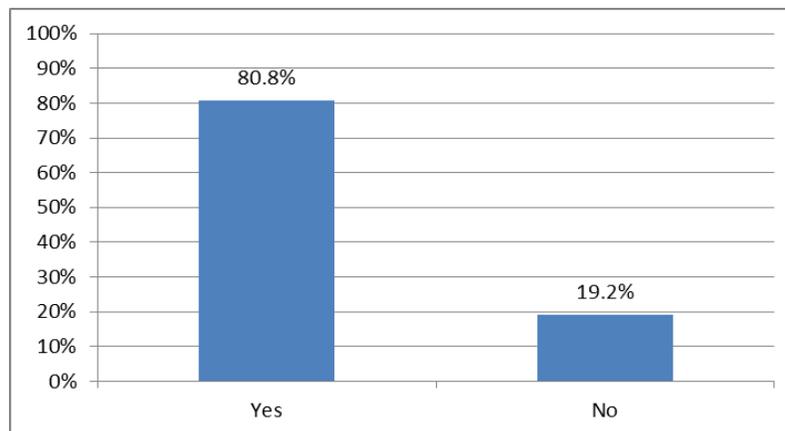
Care Coordination/Case Management (CC/CM)

Q50. Does your program have one or more standardized care coordination/case management systems in place? (N= 73)



Most programs have a standardized CC/CM system in place (Please see Graph 7).

Graph 7: Does your program have one or more standardized care coordination/case management system in place?



Programs with a CC/CM system in place were asked a follow-up question.

Q57. What lessons have you learned with your standardized care coordination/case management system? (N=42)

The most common themes emerging from this section included staffing and workforce/professional development, importance of guidelines and protocols, flexibility, engagement, accountability and partnering.

Lessons Learned that are Important to Leverage

Having structure and systems in place is important not only for staff but also for participants. Programs specifically identified approaches to CC/CM that included one-on-one as well as group case conferencing and team-based approaches.

“One-on-one case conferencing is very effective in identifying boundary violation issues and case management approaches that are anecdotal and not based upon best evidence practices. Over a period of time, one-on-one case conferencing also reveals systemic issues that need to be addressed either through more training or imposition of a protocol.”

“Group case conferencing allows for lessons to be learned based upon the experience of one-on-one conferencing and file review.”

“Team huddles/case conferencing to agree a team approach to next steps in care.”

With regard to settings, programs provided some lessons that articulated the value of having care coordinators at multiple sites throughout the system, utilizing shared care plans, and also specifically mentioned the value of working with a care team anchored in a Patient Centered Medical Home (PCMH) model and the value of warm hand-offs for referrals. Additional mentions included the increased efficiency of assigning clients to case managers by territory to decrease travel time, and a team approach that enables support of a lead case manager for high risk cases and other issues. Programs also mentioned a need to establish standards and models of intervention based on unique family needs, and to have written protocols in place, although also mentioned that complex or lengthy documents/toolkits are not used by staff or participants.

“Must decide on standards of quality and models for services. Do you want to invest in long-term intervention, moderate or short term? This depends on acuity and need of family.”

“Be flexible. One system does not fit all.”

“Having written procedures from the beginning and each/every time they are adjusted/updated is important. It can be a challenge for a new program, with team members of various experiences, to have the foresight to “get it right the first time” as the process takes time.”

“Standardized practices and expectations contribute to staff's better understanding of roles and responsibilities as case coordinators and case managers.”

“The importance of a multi-level system to ensure qualitative case management services for program participants by reducing staff burnout due to high acuity levels and creating an environment of effective time management and responsiveness to clients' individualized case needs. [In our program, they] consist of three categories Level One (low risk), Level two (moderate risk), and Level three (high risk).”

Suggestions for addressing accountability included continuous assessment of processes and intervening for improvement as needed. The importance of continuity of staffing was also mentioned.

“System changes and implementation needs need to be addressed periodically.”

“The best results occur when staff are employees of the agency and not subcontracted.”

“Over a period of time, one-on-one case conferencing also reveals systemic issues that need to be addressed either through more training or imposition of a protocol.”

“It is an intensive process and requires intentionality at all levels with a focus on trends and meeting benchmarks as well as impacting the five approaches.”

“The sooner data is entered, the more accurate it is.”

Engagement of staff, partners, and participants is also important for successful CC/CM: engagement of staff in the planning for programming and sharing of ideas; engagement of partners to address complex needs of participants, and engagement of participants to foster empowerment.

“Care coordination/case management involves coordinating different service providers which include medical, behavioral health specialists, social workers, insurance plans, and community-based organizations, to address the complex multiple needs of the client.”

“The participant must be an equal partner in the case management relationship and is treated with respect and dignity. Throughout the program involvement, it is important to nurture and develop the participant and family ability to problem solve. This will enable and empower to navigate future situations as they arise.”

“Have a clear vision of what you would like the partnership to look like before you go into a contract with a new partner.”

“Finding areas of mutual benefit can increase buy-in to partnerships. For example, when we learned that a clinic partner was struggling with their postpartum visit rate, we were able to explain how our program could help fill that gap and increase their interest in working with us.”

Challenges and Recommended Changes

Challenges centered on systems issues and the complex needs of HS participants. For example, from the systems perspective, programs identified difficulty in implementing structured curriculum within the context of the complex situations that characterize participants’ lives and the lives of their families.

“Structured curriculum is difficult to use due to the transient nature of our women, constant crises and time constraints.”

Challenges specific to data systems were also identified:

“Having a stand-alone database limits the ability to incorporate forms developed by the funder.”

“...It is difficult to capture our complex clients. We have needed continual modification as we develop this system. Starting care coordination and helping mothers connect with other providers early is important. Both Case Management Systems require time to input and we also understand that all documentation should be recorded in a timely fashion.”

“Difficult to track whether referrals are completed.”

Partner-related CC/CM issues included the challenges of working with medical providers, which has been identified already within the five approaches.

“Many of the medical providers comment that it is time-consuming to refer all women that need [services] due to time constraints of the medical practice. Social service agencies are much more engaged with the participant's needs and more willing to work with [us] to share information on behalf of the client enabling [us] to address participant's immediate needs.”

Finally, workforce-related issues again highlighted the need for staff retention, training, and ongoing support.

“Having staff vacancies can really impact the efficiency and ability to complete the standard case management process appropriately.”

“Staff need to be well trained and need lots of on-going technical support.”

Ensuring a quality standard for care coordination would require a basic package of services available for each participant (based on criteria, such as age, acuity, parenting skills, diagnoses, modality of service delivery, etc.) with flexibility to tailor services to client needs.

Recommendation: Recognizing the breadth of participant needs, and diverse approaches applied across programs, it may be beneficial to develop a conceptual model that maps the range of services provided, points of intervention, and relevant evidence-informed/evidence-based practices or curricula that apply. This is consistent with project management best practices.

Structure

There were two areas that grantees were asked to provide input to related to the structure of the HS program. These included the funding criteria for the program and the HS CoIIN composition.

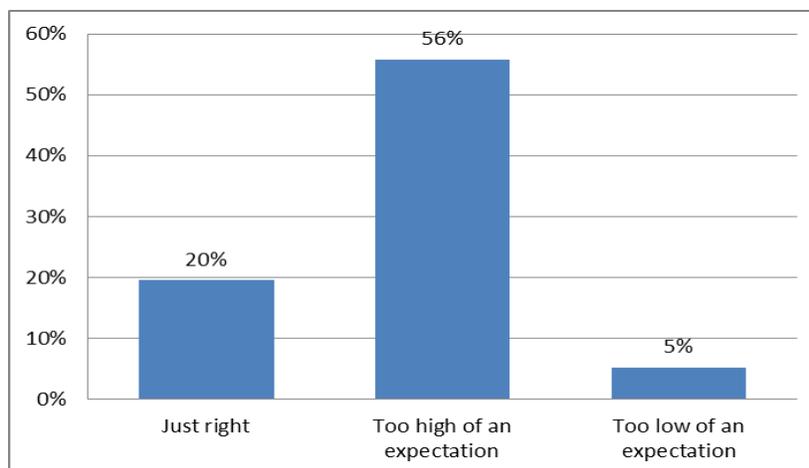
Funding

There were three questions asking the grantees to provide their thoughts on how the criteria for future funding opportunities might be changed.

Q35. Please indicate whether the service delivery requirements/numbers of pregnant women, interconception women and children you are required to serve given the funding amount you receive is. (N=77)

The vast majority of the survey respondents indicated they felt the service delivery requirements compared to the funding amount provided was too high of an expectation. Graph 8 shows the full range of how grantees responded to the service delivery requirements as compared to the funding amount.

Graph 8: Service Delivery Requirements in Comparison to Funding Amount



Themes that emerged in addition to the set responses on the funding criteria question included the challenge in balancing service delivery and administration costs were: programs should be able to count men, the challenge with reaching service delivery numbers and changing pregnancy status, and the requirements for reaching pregnant women being too high.

“Too high for pregnant women. It’s mathematically impossible to meet the target if one also keeps women in the program for two years after their child’s birth.”

“Hard to get the number of pregnant women required if you are in a rural area.”

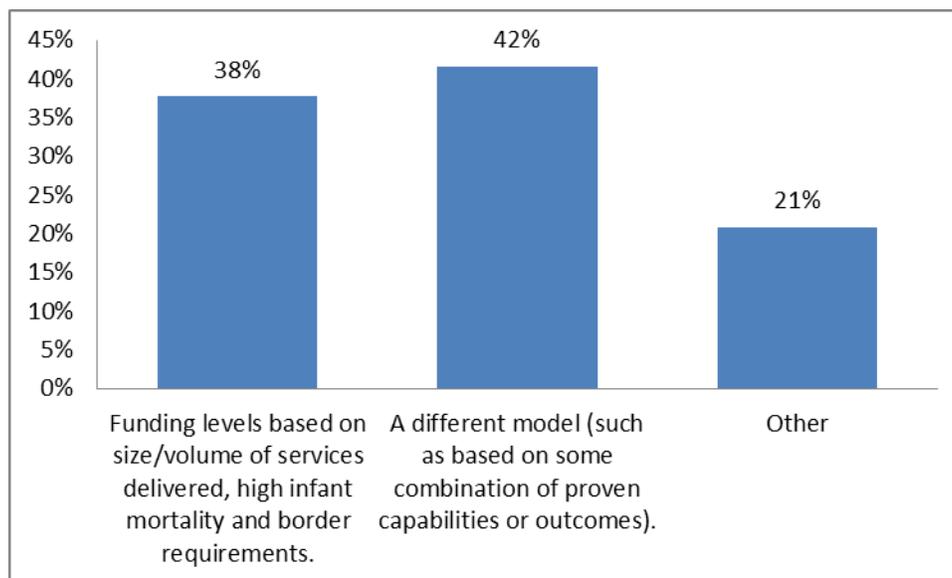
“The number of pregnant women is way too high and fathers need to be counted as participants.”

“Too much of our funding has to be allocated to the administrative/evaluation portion for us to be able to meet our service delivery requirements.”

Q36. Should funding be based on any of the following? (N=77)

As Graph 9 shows, the response to the funding model that should guide funding allocations in the next program period were almost equally divided between funding levels based on size and volume delivered and high infant mortality or a completely different model such as a combination of outcomes and proven grantee leadership and capabilities.

Graph 9: Funding Model



Themes that emerged in addition to the set responses to potential funding model included volume, providing community responsive services, sustainability, setting in which services are provided, providing quality services, and HS CoIIN membership.

“Yes, size/volume of service, but also “add-ons” for things such as mentoring and HS CoIIN membership. Level 1 and 2 grantees that have deep experience with HS should be able to fill the

“mentoring and leadership” roles, and receive funding to do so. The program would be better served by having programs of various sizes in these roles.”

“The numbers should have reasonable service delivery numbers. Grantees should set their own service targets based on data and justify.”

“Not based on sustainability as program can't sustain without funding; biggest issue isn't infant mortality but rather lack of prenatal care access in first trimester and throughout pregnancy; outcomes should be based on how the mom does with the NEXT pregnancy as often we get them too late for the current one or after birth.”

If respondents indicated that funding should be based on another model, a follow-up question asked what other outcomes or capabilities should be factored into the criteria.

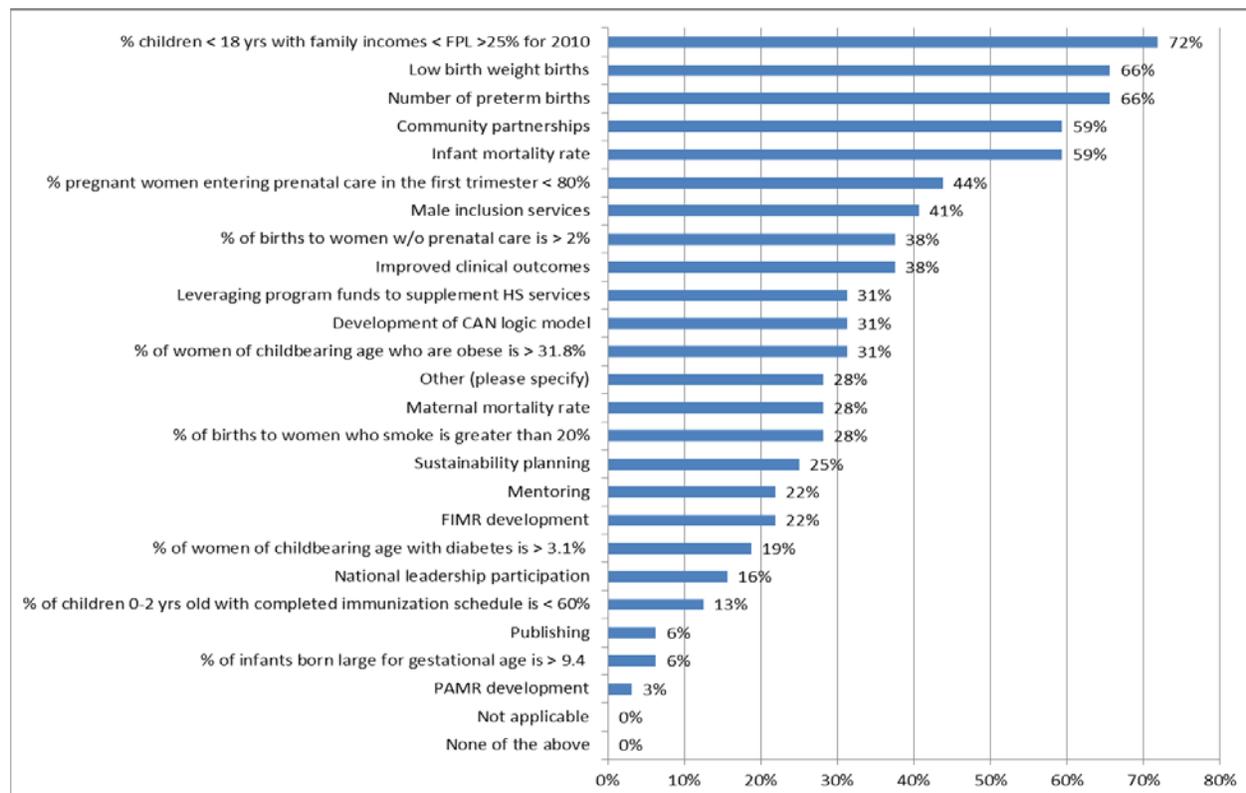
Q37. Follow-up from question 36: If you chose another model, which outcomes or capabilities should be considered? (N=32)

The top five grantee outcomes and capabilities respondents felt were important to consider in a funding criteria or model included the following:

- Percentage of children under 18 years of age with family incomes below the Federal Poverty Level exceeded 25% for 2010
- Number of preterm births
- Low birth weight births
- Infant mortality rate
- Community partnerships

Graph 10 shows the full range of capabilities that grantees identified as important.

Graph 10: Grantee Capacities to Consider in Revised Funding Model



Themes that emerged regarding outcomes and capacities to consider in a revised funding model included balancing service delivery and administration costs, addressing equity, social determinant of health, and disparities, addressing geography diversity, addressing substance use and mental health.

“Decrease requirements for the number of participants to be served but address TRUE community needs (community acuity of need and cost per participant).”

“Community risk factors/ social determinants. We are all improving outcomes within our communities, but it's critical we keep these services available to continue to mitigate risk. We shouldn't be choosing sites based on IMR or other MCH outcomes, but on things like poor housing, unemployment, violence, low graduation rates, etc.”

“Analysis on number of other HS programs in the state. Focus on tribal communities and maintaining programs in states with two or less HS programs.”

“History of work related to health equity, anti-racism efforts, and/or racial equity. History of working to address social determinants of health such as housing, food security and employment. Evidence of ability to conduct rigorous evaluation and CQI. Ability to address mental health issues (depression, stress, PTSD, ACE, and trauma) and provide direct mental health services rather than simply referring. Funding should be based on number of families served in addition to all the other factors mentioned here, e.g., projects that provide long-term case management home visiting services to male clients should receive higher funding, as well as projects that contract

mental health therapists, offer parenting courses, child development programs, or provide other levels of intense services.”

There was consensus around the notion of having the funding standardized if the program is to be standardized.

“If you want to standardize the program, funding has to be standardized.”

It is a hardship for grantees to meet deliverables and outcomes that are not aligned with the level of effort required (e.g., number of clients served, scope of services provided and level of collaborative engagement – local, state, regional, national).

Recommendation: Rather than structuring levels of funding around discrete criteria or activities, such as volume of participants served, and level of community engagement/leadership (as is currently in place), funding should be weighted for performance or particular contributions that individual applicants can make to the national HS program. For example, the top five capabilities in addressing community issues that grantees felt were important to consider in a funding criteria or model included the following:

- Percentage of children under 18 years of age with family incomes below the Federal Poverty Level exceeded 25% for 2010
- Number of preterm births
- Low birth weight births
- Infant mortality rate
- Community partnerships

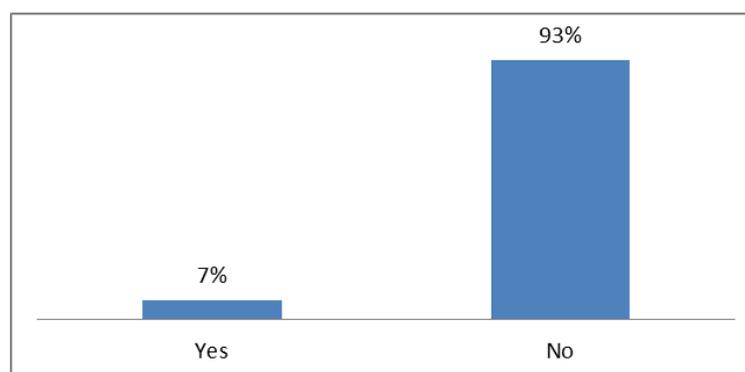
HS CoIIN Membership

There were three questions asking the grantees to provide their thoughts on the HS CoIIN membership composition, what is working for the HS CoIIN and what could be improved.

Q38. HS CoIIN Composition/Membership: Should there be a different composition? (N=44)

As the graph 11 shows, overwhelmingly the survey respondents did not feel there should be a different composition to the HS CoIIN membership; however, there were many suggestions to the open-ended question about suggestions to a different composition.

Graph 11: Recommended Different HS CoIIN Composition



Themes that emerged related to suggested changes to the HS CoIIN composition centered around diversity: diversity of grantee levels, gender, racial, and geography, National Healthy Start Association (NHSA) membership, and program participants. A final theme was a lack of understanding about the HS CoIIN membership.

“It shouldn’t just be based on a level 3, but should include more representation from the other levels, especially among grantees from other levels with 20 years or above experience with the HS initiative, and should be funded accordingly.”

“It should be inclusive - it is heavily level 3 represented, some of the level 1 and 2 are quite HS experienced and are underrepresented.”

“Membership should be based on the expertise of the participants and not on the level of funding which, in turn, is currently based on the number of clients served. An experienced Level 1 HS project director or staff, who knows HS first-hand, would be more valuable than a brand new level 3 project director. Other factors to consider are geographic, racial and gender representation. I think it is critical that the National HS Association be represented as well due to its long history of serving HS, the extensive work it has done with HS (leadership training, mentoring, evaluation and standards, tool-kit development, fatherhood programs, conferences, etc.) and in-depth knowledge of HS.”

“Any HS should be allowed to be a member. I am not sure how the composition of the HS CoIIN is currently determined.”

Q39. What is working about the current HS CoIIN composition? (N=49)

Themes that emerged in relation to what is working about the current HS CoIIN composition were structure and process, responsiveness, on-going communication, outputs of the HS CoIIN, JSI/EPIC Center support, and expertise and knowledge base of the members.

“The consistency and group size. While there hasn’t been complete consistency, there have been a core set of members who have learned to trust each other’s opinions and experience. The shared experience of working together has increased our investment in the HS model and expanded our network of expertise beyond our regional colleagues. If the HS CoIIN is too large, I doubt we would be able to develop the rapport needed to move projects forward.”

“It seems the members are trying their hardest to represent us all but are also given directives on what should be addressed and what the anticipated outcomes need to be.”

“Participants are knowledgeable about maternal and child health. The roles of members differ in their respective programs, i.e., project directors, evaluators, administrators, state-level personnel, etc. EPIC is a great support for meeting preparations including: mentoring and guiding co-chairs, keeping members on track of tasks, and communicating with HS CoIIN members outside of meetings. The size of the group at 20 seems to move forward with tasks at a steady pace.”

Q40. What could be improved with the current HS CoIIN composition? (N=50)

Themes that emerged in relation to what could be improved with the current HS CoIIN composition were better dissemination of information on HS CoIIN activities, better feedback mechanisms, structure and process of the HS CoIIN, and a more diverse composition of members.

“It should be more diverse, with a cross-section of grantees based on size, geography, age of HS program (number of years receiving HS funding), rural/urban/tribal/border, etc. This would ensure that all perspectives are represented.”

“The size of the group can make discussions difficult and decision-making processes unwieldy. Additionally, some discussions may be improved by ensuring that there is a balance between members with deep experience with newer grantees/directors in novel/diverse contexts that can bring fresh perspectives.”

“We are hopeful that there is some planned process for rotation of members.”

“More formalized process of communicating efforts.”

“Offer a training on what HS CoIIN's purpose is for the entire HS population.”

During the past four years, the HS CoIIN has formalized its membership, role and operations. The HS CoIIN members have been dedicated and highly productive, so continuity in membership is strongly encouraged. At the same time, there continues to be concerns raised by the broader HS community that membership should be expanded based on experience and knowledge of the HS program rather than solely on volume of participants served.

Recommendation: Based on comprehensive qualitative responses, to ensure broader and more diverse representation on the HS CoIIN, an application process is recommended for HS CoIIN membership with a process that balances promoting continuity and increasing diversity.

Grant Application Process

In addition to the recommendations regarding structure and content of the program, further recommendations focus on revising the grant application process. The past FOA structured the application and funding requirements around volume of participants served, and level of community engagement/leadership.

“The way the funding application was set up, it forced well-positioned grantees to down-select to apply as Level 1 grantees because of the burdensome process of writing a cumulative proposal that included all points for each level.”

The funding application structure required some applicants to complete redundant sections of the application. For example, a program applying for Level 2 was required to respond to Level 1 and Level 2 questions. Likewise, applicants for Level 3 needed to respond to Level 1, 2 and 3 questions, resulting in the loss of programs that might have provided strong skills and talents to a higher level of involvement.

Recommendation: Eliminate redundant questions in the FOA and allow additional space for projects seeking higher levels of funding to provide more services.

What Sets HS Apart from other Maternal and Child Health Programs?

Q62. What sets your HS Program apart from other Maternal and Child Health Programs within your community? (N=73)

Themes that emerged in describing the unique characteristics of HS programs included the ability to provide a range of wraparound services, establish community connections, focus on disparities, focus on a range of perinatal phases that includes preconception, provide services in varied settings, and focus on male inclusion and fatherhood involvement. All of these qualities centered on a strong reputation, and having the capacity for structural flexibility to meet the needs of the unique communities they serve.



HS provides a focus on disparities through a range of initiatives:

“[Ours] is the only grant-funded program with the purpose to improve perinatal health outcomes and reduce racial and ethnic disparities in perinatal health outcomes by using community-based approaches to service delivery, and to facilitate access to comprehensive health and social services for women, infants and their families.”

“Our program is a Culturally Specific Model that addresses health disparities and infant mortality and poor birth outcomes for African American Women only.”

“Our program addresses the social determinants of health on an individual-, community-, and systems-level through our CAN.”

“We are the only MCH program to carry out intentional and extensive racial equity / anti-racism work.”

“[Our program]: works to increase health equity literacy via serving as a partner in implementation of an Community Organizing for Undoing Racism® Workshop, increases investments in high risk communities to address poverty and building community capacity by hiring indigenous workers, increases opportunities and resources to build the community’s efforts to promote and protect the health and well-being of its citizens, especially mothers, infants, and young children and their families, and provides an environment in which university researchers can conduct community-based participatory research.”

The HS program service delivery model encompasses the whole family (i.e., women, infants and their families) in order to achieve better health outcomes. The assumption is if the family is being provided the salient quality services, the health, behavioral health outcomes etc., will show improvements. Each family enrolled in HS is required to receive a comprehensive screening that considers health and behavioral health, employment, housing, and domestic violence risks, etc. Understanding all aspects of family needs helps provide targeted and needed services. Because HS expands the scope from individual to family, (i.e., women, infants, males and/or partners), the service array also expands, to be comprehensive. Several programs identified their approaches to promote father and/or partner involvement as a factor that sets their programs apart from others in their communities.

“Fathers/male partners of [our] program participants receive case management and participate in education/support groups (using evidenced-based fatherhood curriculums) and father-child enrichment sessions conducted by trained Fatherhood Educators. This is a much needed initiative

because males/fathers are often times not thought of in the complete family unit. There are many households where the father is the sole caretaker/caregiver of the child, many of whom are grateful to have the opportunity to improve their parental skills.”

“Involvement of fathers and discussion of pre/inter-conception care.”

“We offer six-week discussion groups for men, open to anyone in the community, arrange father-child activities, and train barbers in health topics they can then discuss with their clientele. We hold monthly Friend of the Court days when men can have legal issues cleared. No other MCH program provides services for men.”

“Through our Fatherhood initiative we are able to offer similar case management services to male partners of our clients and to men raising children under two or whose partners do not want to be in HS through home visits by a male CHW.”

The longevity of the HS program and its resilience in enduring structural changes while maintaining a reputation of trust and leadership sets it apart from other agencies.

“Our staff have over 25 years of experience and one of the original HS Demonstration Projects that has endured many structural changes and service delivery models.”

“Our longevity. We are known as the ‘go to’ agency.”

“[We] have a proven track record of excellence and dependability in the communities served for [over 20 years].”

HS is distinctive among other maternal child health programs in its structural flexibility to adapt approaches to the distinctive needs of participants.

“The flexibility of fit. Although we have a basic program structure we are able to individualize the program based on the stated needs of the participant in real time.”

“[Our program] services women from all stages of the perinatal period unlike NFP who services only first-time pregnant women.”

“[Our program] uses an incentive program to reward patients for healthy behaviors and make them feel like they are a part of helping the community improve outcomes.”

“The design of HS has always been one that is not strictly standardized, allowing for well-designed and applied case management and community education services that are based on identified needs, not only standards of care.”

This characteristic flexibility includes the range of settings where services are provided, depending upon the community.

“It provides evidence-based services, delivered by paraprofessionals in home-based settings. Other similar programs are center based.”

“Services are not clinic-based but are provided at community sites and in homes throughout the project area, reaching a broader population.”

“[Our] program is housed within a Federally Qualified Health Center, allowing for patients to receive comprehensive health care and management.”

“We are housed in a local health department which gives us great credibility and lots of built in partnerships.”

Several programs specifically named their staffing as a component that sets them apart from other maternal child health programs within their community. Examples included the incorporation of Community Health Workers (CHWs), health educators, fatherhood facilitators, fatherhood educators, Certified Lactation Counselors (CLCs), and in-home therapists trained in many evidence-based models. Many programs provide only one evidence-based model, whereas HS provides a range of services that may include various evidence-based models.

“Comprehensive case management services by licensed, paraprofessionals, and male involvement staff.”

“Pregnancy Care Managers (OBCM) and Family Care Coordinators (FCC) integrate strengths based screening, assessment and care plan development strategies that recognize and promote protective factors that families present with at the time of enrollment in program services.”

“Bilingual, bi-cultural CHW staff that can connect with our community on a different level than a nurse or clinic staff member can. Consideration of the life course and a woman's needs beyond child-bearing and raising. Involvement of fathers and discussion of pre/interconception care.”

“All of our Care Coordinators are degree professionals with Bachelor- or Master-level degrees.”

Additionally, the HS enrolls women and their families at various stages of need such as pre-, inter- and post-conception care.

“[Our program] is known throughout [our region], and though we have changed from our direct service approach to partnering with Federally Qualified Health Centers (FQHCs) and [others] to implement HS Services for preconception, pregnant, postpartum and interconception women and their families. With this we have the potential to have the greatest reach and partner with other programs and services to improve the lives of women, infants, children and their families.”

“We are one of the few case management programs that accept moms who have existing children.”

“One stop shop for access to care, family resiliency services and case management before, during and beyond pregnancy.”

Implementation of the Life Course perspective builds on the understanding in regards to family risk and protective factors.^{23, 24, 25,26} This proactive framework provides an opportunity to establish and/or develop a bank of preventative services for participants. A socio-ecological approach²⁷ helps consider other factors about the family, environment, social service systems, etc. In conjunction, both assure an accurate picture of the population.

“We administer a local coordinated intake process with other programs in our community (MCH, NFP, Healthy Families America). We have 37 interpreters/outreach workers on staff, who speak a total of 26 different languages and dialects, and 80% of our participants don't speak English (they spoke a total of nearly 40 different languages last year). There is no capacity in the community to meet the needs of our population outside of Healthy Start.”

HS grantees provide care management services in collaboration with agencies/entities on the community-, local- and state-level to ascertain needed services for program participants. HS programs support coordination, integration, and mutually reinforcing activities among health, social services, and other providers and key leaders in the community to maximize opportunities for community action to address social determinants of health and achieve collective impact. Programs provide a wide array of

wraparound services that include transportation, breastfeeding/lactation support, cribs, car seats, behavioral health services, blood pressure screening, doula services, programs addressing domestic violence, and outreach, as well as other services.

“Unlike other MCH programs we are able to assist with transportation immediately for anything the supervisors deem appropriate with no limit (e.g., to get to breastfeeding support group or a job interview). We are able to offer client assistance items such as Pac ‘N Plays, car seats, and baby books when needed.”

“We have a mobile medical unit that travels to different colonias and eliminates barriers such as lack of transportation or lack of health care coverage.”

“[Our] assessments and care plans include risk reduction to decrease unhealthy behaviors and facilitate linkage to resources and providers to address ongoing health issues. The care managers assist parents with becoming economically self-sufficient by connecting them with continuing education and employment opportunities.”

“Grantees are required to establish formal agreements and linkages with community, local and state service providers/partners. The formal agreements may include the number of slots, time-frame for receiving services when referred, status reports on the outcomes of the service provision for program participants, etc., ... formal agreements may be expanded to other providers during the course of the grant to align with the needs of the program participants/population.”

Lastly, grantees are responsible for developing systems around verifying data, and addressing measures that provide insight regarding program effectiveness, service provision, and outcomes, as well as, building a system of QI (i.e., develop activities to data to improve processes) to inform practice, policy, quality service, service delivery, research and overall system changes.

“[Our] Program has influenced & impacted practice and policy locally and statewide with its involvement in multiple level activities [which target] building and strengthening the bridges between communities, families and clinical care to reduce the unacceptable health disparities between Black and White mothers and infants.”

“Extensively demonstrated support from local and state leadership (e.g., elected officials, hospital systems and local colleges and universities, partnering university, etc.)”

“The formal capacity to support enrollment and implementation of coverage under the Affordable Care Act which is enhanced by a part-time Navigator position. [We] have demonstrated strong, meaningful, and ongoing collaboration with other community organizations and MCH programs.”

“Strategically and deliberately placed ourselves [over the past 18 years] at the center of service delivery in the most vulnerable and marginalized community in the county. We strive to effectively and efficiently leverage existing resources and knowledge to reduce the infant mortality rate of our nation.”

“The capacity to serve as a resource, trainer, mentor, adviser, and consultant to other HS grantees and perinatal projects.”

Summary

In summary, this document was developed through an inclusive data-informed process, in response to the DHSPS’s request to articulate what distinguishes HS from other maternal and child health programs.

While a range of programs exist to address the needs of women in pregnant and postpartum phases, HS provides services across the entire spectrum of perinatal phases. HS focuses on addressing social determinants that impact the health of women and their families.

The current funding cycle has afforded the opportunity and means to begin to build a foundation that advances the key Healthy Start principle of promoting equity through a standardized system of care. Structural flexibility is the defining factor that enables HS to address the unique needs of participants within the contexts of their families and community, and must be preserved.

“Healthy Start is an affirmative public health program. We start with needs assessment and adapt to needs versus developing a program first and applying to population.”

Endnotes and References

¹ Braveman, Paula, and Colleen Barclay. "Health disparities beginning in childhood: a life-course perspective." *Pediatrics* 124.Supplement 3 (2009): S163-S175.

² Cheng, Erika R., et al. "Examining the link between women's exposure to stressful life events prior to conception and infant and toddler health: the role of birth weight." *J Epidemiol Community Health* 70.3 (2016): 245-252.

³ Salinas-Miranda, Abraham, et al. "Exploring the Life Course Perspective in Maternal and Child Health through Community-Based Participatory Focus Groups: Social Risks Assessment." *Journal of Health Disparities Research and Practice* 10.1 (2017): 9.

⁴ Pies, Cheri, et al. "Growing a Best Babies Zone: Lessons Learned from the Pilot Phase of a Multi-Sector, Place-Based Initiative to Reduce Infant Mortality." *Maternal and child health journal* 20.5 (2016): 968-973.

⁵ U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Health Resources and Services Administration. Maternal and Child Health Bureau, Division of HS and Perinatal Services. *HS Initiative: Eliminating Disparities in Perinatal Health: Announcement Numbers: HRSA-14-121, HRSA-14-120, HRSA-14-122.*

⁶ *Ibid*

⁷ *Ibid*

⁸ MacDorman M, Hoyert DL, Mathews TJ. Recent Declines in Infant Mortality in the United States, 2005-2011. *NCHS Data Brief*. No 120. Hyattsville, MD: National Center for Health Statistics. 2013. <http://www.cdc.gov/nchs/data/databriefs/db120.pdf>

⁹ Olson ME, Diekema D, Elliott BA, Renier CM. Impact of income and income inequality on infant health outcomes in the United States. *Pediatrics*. 2010 Dec; 126(6):1165-73.

¹⁰ Smith LK, Manktelow BN, Draper ES, Springett A, Field DJ. Nature of socioeconomic inequalities in neonatal mortality: population based study. *BMJ*. 2010 Dec 2; 341:c6654.

¹¹ Sparks PJ, McLaughlin DK, Stokes CS. Differential neonatal and postneonatal infant mortality rates across US counties: the role of socioeconomic conditions and rurality. *J Rural Health*. 2009 Fall; 25(4):332-41.

¹² Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic disparities in health in the United States: what the patterns tell us. *Am J Public Health*. 2010 Apr 1; 100 Suppl 1:S186-96.

¹³ Livingood WC, Brady C, Pierce K, Atrash H, Hou T, Bryant T 3rd. Impact of preconception health care: evaluation of a social determinants focused intervention. *Maternal Child Health J*. 2010 May; 14(3):382-91.

- ¹⁴ U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Health Resources and Services Administration. Maternal and Child Health Bureau, Division of HS and Perinatal Services. *HS Initiative: Eliminating Disparities in Perinatal Health*: Announcement Numbers: HRSA-14-121, HRSA-14-120, HRSA-14-122.
- ¹⁵ *Ibid*
- ¹⁶ Strauss, A., & Corbin, J. (1998). Basics of Qualitative Research: Grounded Theory, Procedures and Techniques. Newbury Park, CA: Sage.
- ¹⁷ Ritchie, J. & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman, & R. Burgess (Eds.). Analyzing Qualitative Data. London: Routledge.
- ¹⁸ Dr. Sami L. Gottlieb, from the Division of Sexually Transmitted Disease Prevention at the U.S. Centers for Disease and Prevention, 9.10.2010
- ¹⁹ Higgins, J., Popkin, R., & Santelli, J. (2012). Pregnancy Ambivalence and Contraceptive Use Among Young Adults in the United States. *Prospectives on Sexual Reproductive Health*, 44(4), 236-243. doi: 10.1363/4423612
- ²⁰ Frey, K., Navarro, S., Kotelchuck, M., Lu, M. (2008). *The Clinical Content of Preconception Care: Preconception Care for Men*. American Journal of Obstetrics & Gynecology, supplement s389-s395.
- ²¹ Marcell, et al. Male Adolescent and Sexual and Reproductive Health Care. *Pediatrics* 2011-2384
- ²² A long-running QI project with Title X Family Planning clinics explored factors associated with choosing birth control methods and unintended pregnancy. Two key messages came out of these studies: The first is that young women (and men) want information about making healthy choices if they decide to become sexually active; and secondly, their parents and health care providers are their most trusted sources of information. Participants in the JSI studies underscored the value of providers in providing this information. This is an area that HS it could excel in given their stellar ability to connect to participants. Available at: <http://www.jsi.com/JSIInternet/USHealth/project/display.cfm?ctid=na&cid=na&tid=40&id=2621>
- ²³ Braveman, Paula, and Colleen Barclay. "Health disparities beginning in childhood: a life-course perspective." *Pediatrics* 124.Supplement 3 (2009): S163-S175.
- ²⁴ Cheng, Erika R., et al. "Examining the link between women's exposure to stressful life events prior to conception and infant and toddler health: the role of birth weight." *J Epidemiol Community Health* 70.3 (2016): 245-252.
- ²⁵ Salinas-Miranda, Abraham, et al. "Exploring the Life Course Perspective in Maternal and Child Health through Community-Based Participatory Focus Groups: Social Risks Assessment." *Journal of Health Disparities Research and Practice* 10.1 (2017): 9.
- ²⁶ Pies, Cheri, et al. "Growing a Best Babies Zone: Lessons Learned from the Pilot Phase of a Multi-Sector, Place-Based Initiative to Reduce Infant Mortality." *Maternal and child health journal* 20.5 (2016): 968-973.
- ²⁷ Traverso-Yepez, Martha, Leslie Rourke, and Sandra Luscombe. "Connecting the Dots: An Ecological Lens to Preventive Measures for Adverse Childhood Experiences." *Social Work in Public Health* (2017): 1-16.

Appendices

The following pages provide the appendices in the following order:

Appendix 1

Capturing Lessons Learned from the Field: Healthy Start Comment Period: May 16 to June 16, 2017

Appendix 2

Healthy Start Collaborative Innovation and Improvement Network (HS CoIIN) Structure Overview

Appendix 3

Healthy Start Collaborative Innovation and Improvement Network - HS CoIIN Priorities, 2015-2019 Overview

Appendix 4

Types of Evidence-Based or Evidence-Informed Models and Practices

Appendix 1

Capturing Lessons Learned from the Field: Healthy Start Comment Period: May 16 to June 16, 2017

Introduction and Purpose

The purpose of this survey is to provide Healthy Start programs the opportunity to provide perspectives from the field by sharing promising and best practices they used to implement Healthy Start 3.0 and lessons learned from those experiences.

This information will be shared with the Division of Healthy Start and Perinatal Services in order to shape future programming. The information you provide to the survey will not be aligned in any way to you individually or to your Healthy Start program; a summary of the survey data will be developed in order to eliminate the potential for specific responses to be linked to any particular individual HS program. Your information will be analyzed in aggregated form and reported in a summary format.

Process for Feedback Submission

Please review the pdf version of the Feedback Summary Form that includes specific areas to provide feedback with all staff and key stakeholders from your HS site who serves participants. After reviewing the Feedback Summary Form, your site should work as a team to summarize and submit your organization's feedback. We will be accepting one feedback form per Healthy Start program.

If you need to return to a previous page that you have already completed, please use the Prev button at the bottom of each page (rather than the internet back arrow at the top of the screen).

Thank you in advance for your thoughtful input.

Part 1. Information for Grantee Submitting Feedback

These questions help us get a clearer idea of who is completing and submitting lessons learned feedback. We appreciate you taking the time to complete this next set of required questions.

* 1. Name and title of contact person submitting comment form:

This will not be used in the analysis of information or shared as part of the report. We will only use this information if we need to follow-up to clarify any of your program's responses.

* 2. Name of Agency/HS Grantee:

We are hoping to reach a 90% response rate, so this information will only be used to track response rate to the survey.

* 3. How would you classify the entity that has direct responsibility over the Healthy Start Project?

- Community health center
- Community-based organization
- Faith-based organization
- Hospital-based clinic
- Indian tribe or tribal organization
- Local health department
- Other (please specify)

* 4. Please identify staff and stakeholders who contributed to your program's feedback (Check all that apply):

If one person serves multiple roles, please choose the primary role they play at your site.

- Project Director
- Administrative Support Staff
- Case Manager
- Health Educator/Outreach Worker
- Licensed Clinician (OB/GYN, Nurse, Pediatrician)
- Behavioral Specialist/Social Worker/Family Support Specialist
- Direct Care Subcontractors
- Evaluator
- CAN Members
- Referral Network Partners
- University Partnerships
- Community Organizer
- Other (please specify)

* 5. Indicate your level of funding

- 1
- 2
- 3

* 6. Indicate your geography (your reach)

- Rural
- Urban
- Border
- Tribal

Part 2: Types of Models or Interventions and Tools Used

The following questions ask you to share what types of models and tools you have used in your programs. You will have space to share your top 2 best practices and challenges with implementing a particular model or tool within your Healthy Start program, if you would like to share.

* 7. What evidence-based models or evidenced-informed models does your program use? (check all that apply)

This is not an exhaustive list. There is space for you to add a model that you are using that is not listed here. We encourage you to please do share your models that are not listed.

Evidence-Based or Informed Models: To help you determine what type of model you are using, please see the definitions of the various levels of practice:

Cutting Edge Practice/Innovation:

- Innovative solution to an evolving public health issue
- Aligns with experiential evidence inside and outside of public health
- Perceived benefit to MCH populations
- Early signs of success and commitment to ongoing evaluation.

Emerging Practice:

- Incorporates the philosophy, values, characteristics, and indicators of other positive/effective public health interventions.
- Is based on guidelines, protocols, standards, or preferred practice patterns that have been proven to lead to effective public health outcomes.

Evidence-Informed:

- An evidence-informed practice, in addition to fulfilling the criteria above, has been, or is being evaluated and:
- Has strong quantitative and qualitative data showing positive outcomes, but does not yet have enough research or replication to support generalizable positive public health outcomes.

Evidence-Based:¹

- An evidence-based practice results from a rigorous process of peer review and evaluation that indicates effectiveness in improving public health outcomes for a target population:
- Has been reviewed and substantiated by experts in the public health field according to predetermined standards of empirical research;
- Is replicable, and produces desirable results in a variety of settings.
- Clearly links positive effects to the program/practice being evaluated and not to other external factors.

<http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/Pages/Best-Practices-Program.aspx>

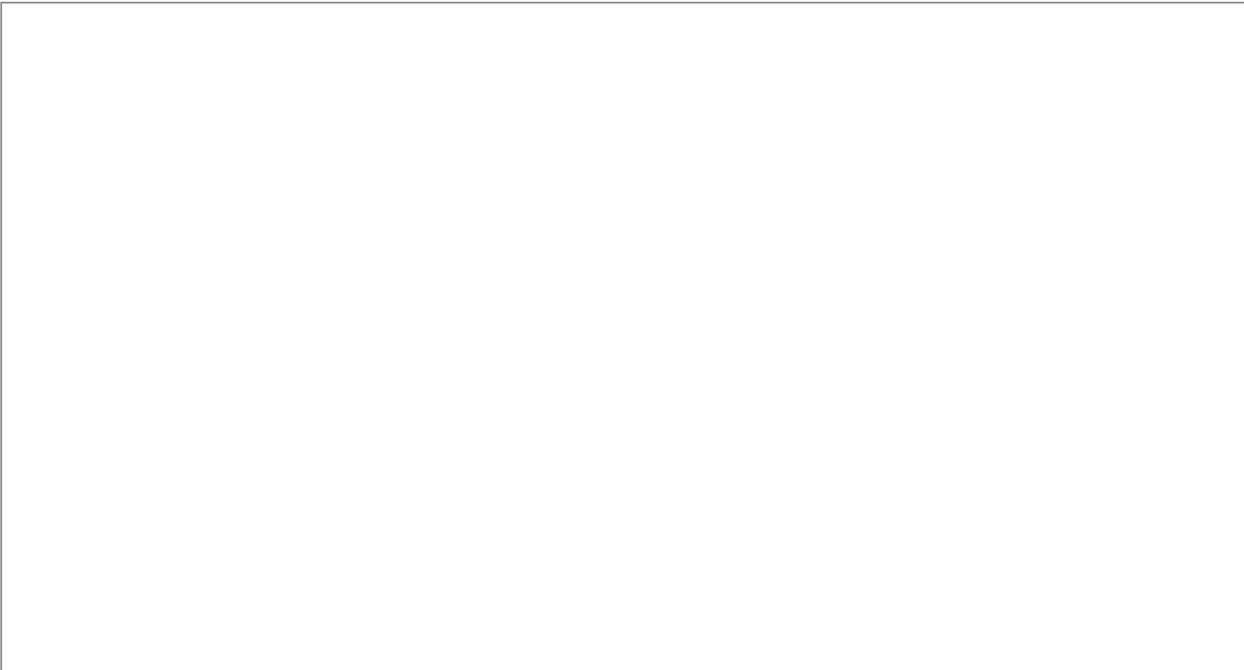
What evidence-based models or evidenced-informed models does your program use? (check all that apply)

- Nurse Family Partnership
- Growing Great Kids: Prenatal to 36 Months Curriculum
- Partners for a Healthy Baby
- Centering Pregnancy
- Healthy Women, Healthy Futures
- Futures without Violence
- Birth Centering
- Partners for Pregnancy
- Prenatal Plus Program
- Healthy Families America
- Parent Child Assistance Program
- Pathways Model
- Family Spirit
- Parents as Teachers
- Community-Based Doula Programs
- Healthy Steps
- Community Health Worker/Promotora
- None of the Above. I haven't implemented an evidenced-based or informed model.
- I have implemented an emerging practice model.
- I have implemented a cutting edge practice/innovation model.
- Other evidence-based or informed models:

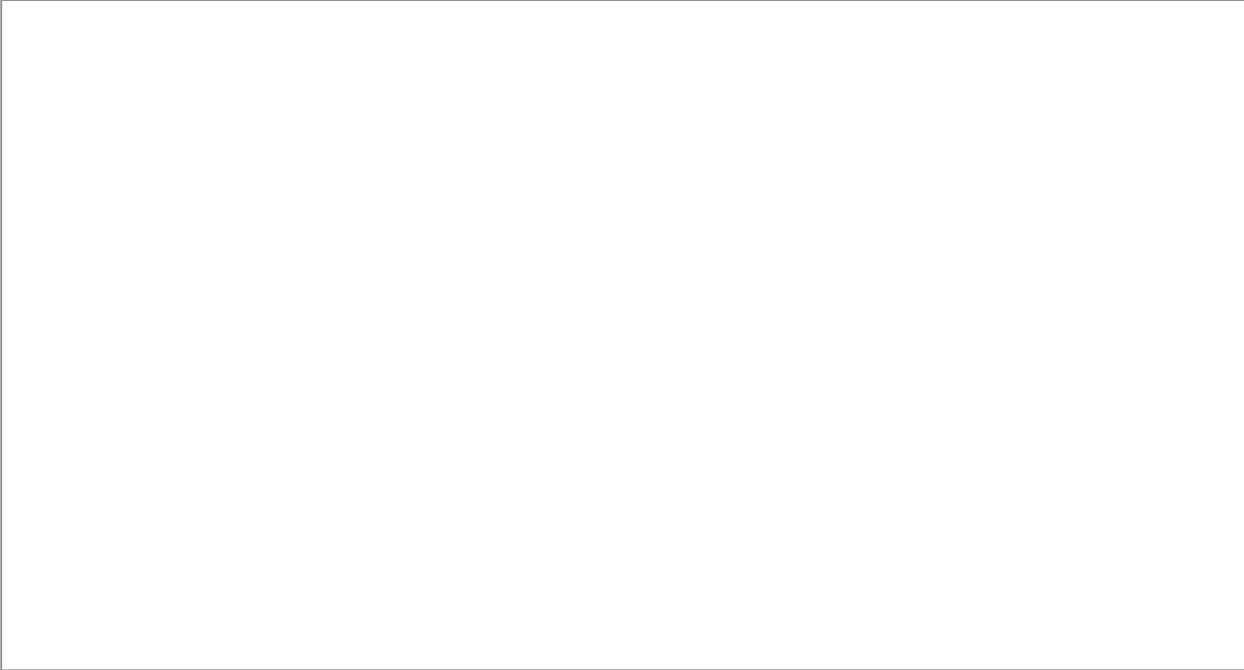
8. What lessons have you learned related to implementing the models you identified in question 7?



9. What are your top 2 best practices related to implementing the models you identified in question 7?



10. What are your top 2 challenges related to implementing the models you identified in question 7?



* 11. What validated or standardized tools does your program use? (check all that apply)

Validated tools: To help you determine if your tools are validated, please see the definitions of the various levels of practice:

A validated tool is an instrument that has been tested for reliability (the ability of the instrument to produce consistent results), validity (the ability of the instrument to produce true results), and sensitivity (the probability of correctly identifying a patient with the condition). A non-validated tool is one that has not undergone testing as noted above and might be a home-grown tool that a program has put together themselves.¹

¹<https://manual.jointcommission.org/Manual/Questions/UserQuestionId03Sub0015>

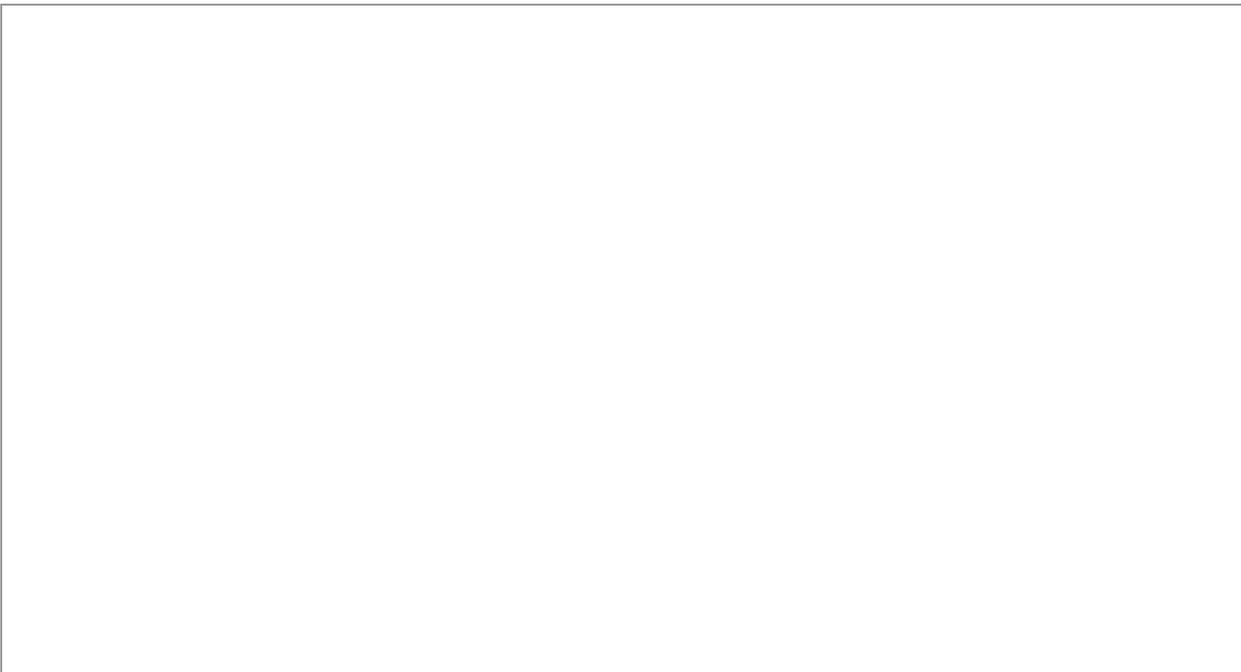
What validated or standardized tools does your program use? (check all that apply)

- Patient Health Questionnaire-2 (PHQ-2)
- Patient Health Questionnaire-9 (PHQ-9)
- Edinburgh Postnatal Depression Scale (EPDS)
- NIDA Quick Scree
- Postpartum Depression Screening Scale (PDSS)
- CAGE-AID
- BDI-FastScreen
- AUDIT (Alcohol Use Disorders Identification Test)
- Center for Epidemiologic Studies Depression Scale CES-D
- Hamilton Depression Rating Scale (HAM-D)
- Montgomery-Åsberg Depression Rating Scale (MADRS)
- Protective Factor Survey
- Ages and Stages Questionnaire
- Ages and Stages Questionnaire: Social-Emotional
- One Key Question
- None of the Above. I haven't used a validated tool.
- Other standardized or validated tools:

12. What lessons have you learned related to implementing the tools you identified in question 11?



13. What are your top 2 best practices related to implementing the tools you identified in question 11?



14. What are your top 2 challenges related to implementing the tools you identified in question11?



Part 2: Input Based on the 5 HS Approaches

The following questions ask you to share how you addressed the 5 approaches. You will have space to provide a description of what and how you implemented services and programs to address each of the approaches. These questions are required, and then you will have space to share your top 2 best practices and challenges with addressing each approach if you would like to share.

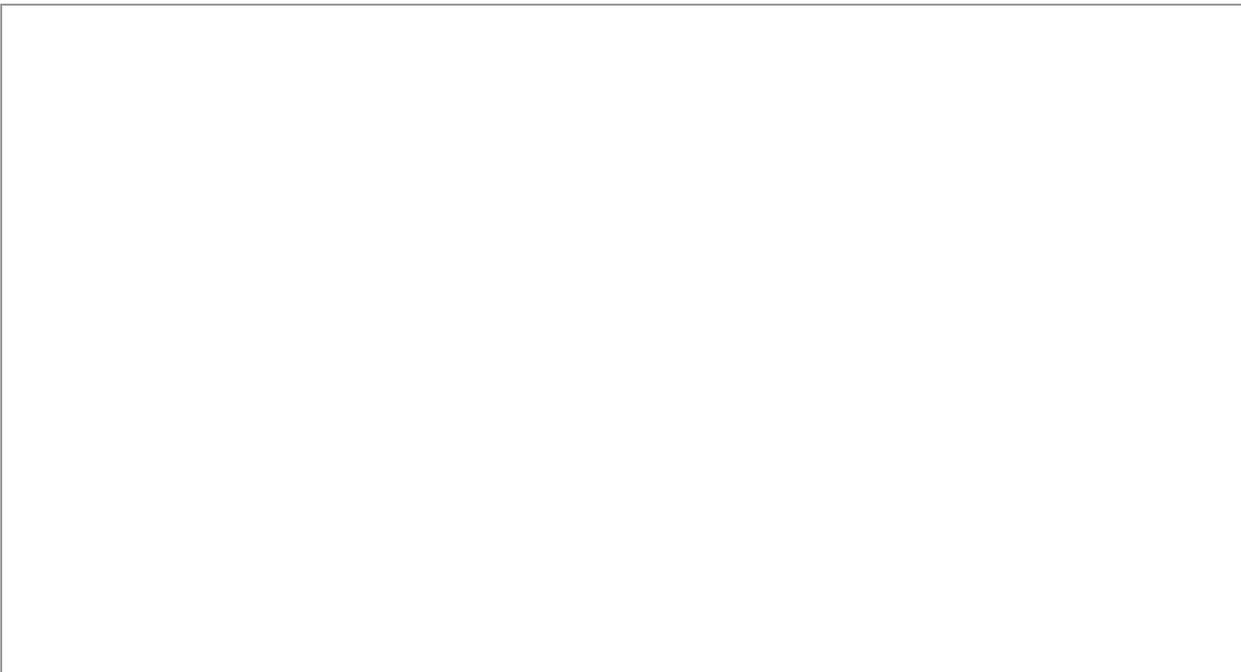
* 15. Improve Women's Health:

Describe how your project addressed women's health.

16. What lessons have you learned about improving Women's Health in the Healthy Start context?



17. Describe two best practices that succeeded in your project related to improving women's health.

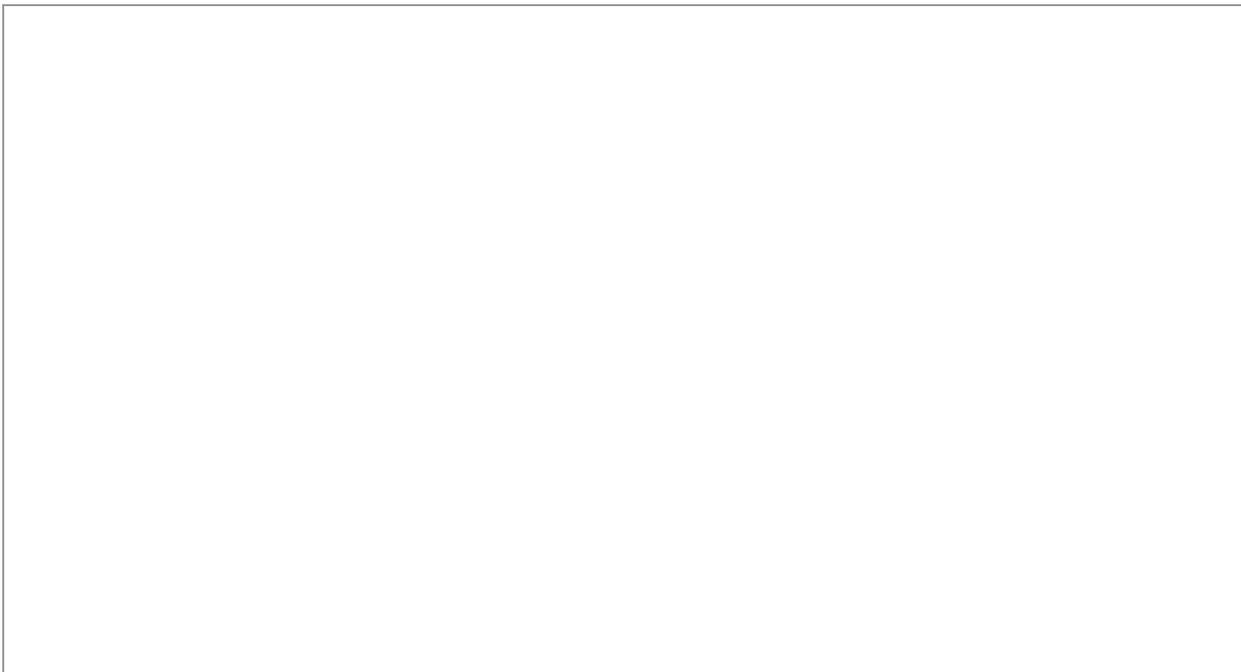


18. Describe your project's two greatest challenges related to improving Women's Health.
What did you do to minimize the impact of each challenge on your project outcomes?



* 19. Promote Quality Services:

Describe how your project addressed promoting quality services.



20. What lessons have you learned about promoting Quality Services in the Healthy Start context?



21. Describe two best practices that succeeded in your project related to promoting quality services.

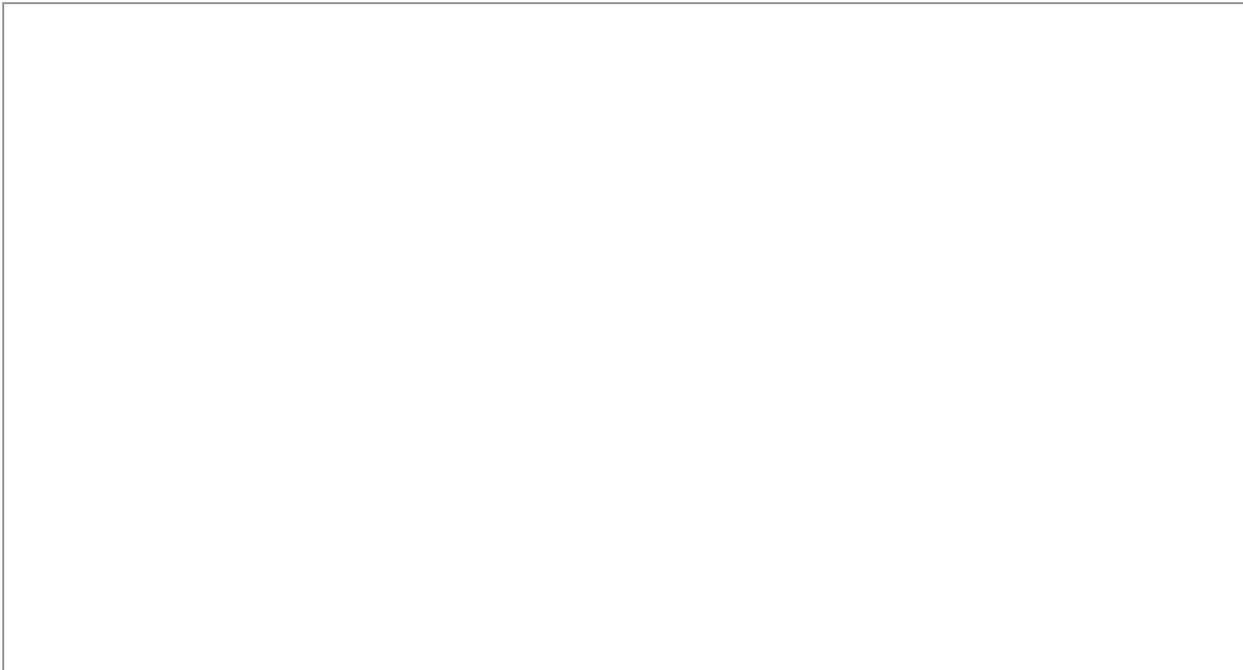


22. Describe your project's two greatest challenges related to promoting quality services.
What did you do to minimize the impact of each challenge on your project outcomes?



* 23. Strengthen Family Resilience:

Describe how your project addressed strengthening family resilience.



24. What lessons have you learned about strengthening family resilience in the Healthy Start context?



25. Describe two best practices that succeeded in your project related to strengthening family resilience.

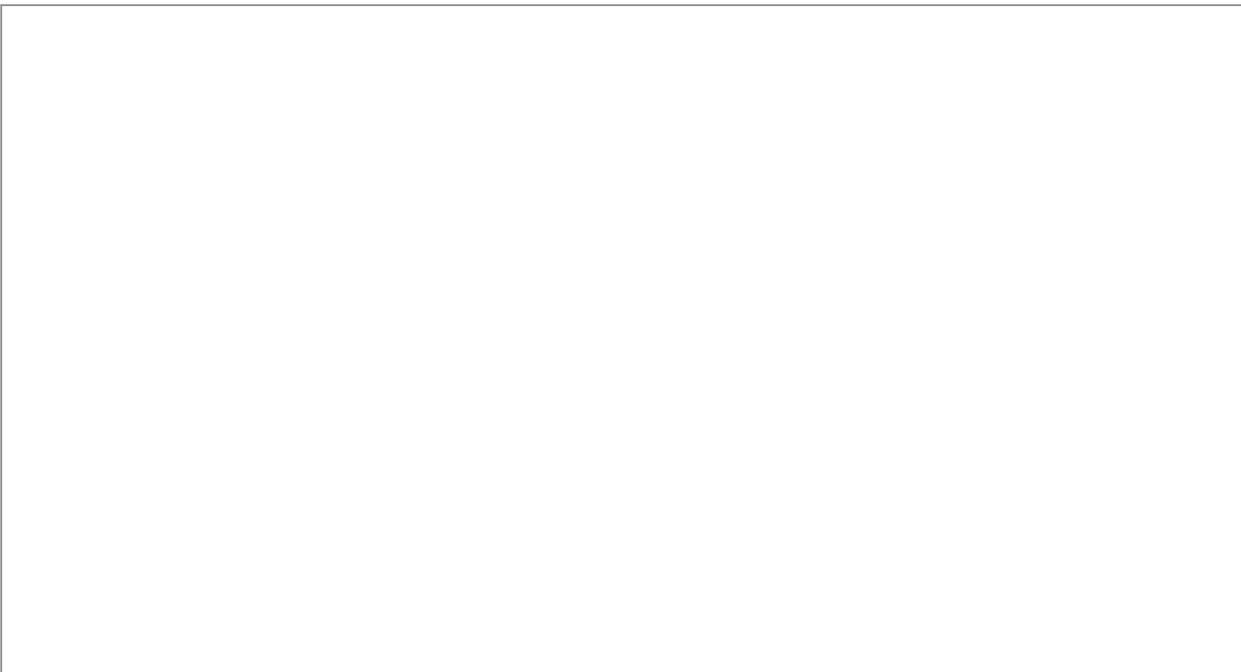


26. Describe your project's two greatest challenges related to strengthening family resilience.
What did you do to minimize the impact of each challenge on your project outcomes?



* 27. Achieve Collective Impact:

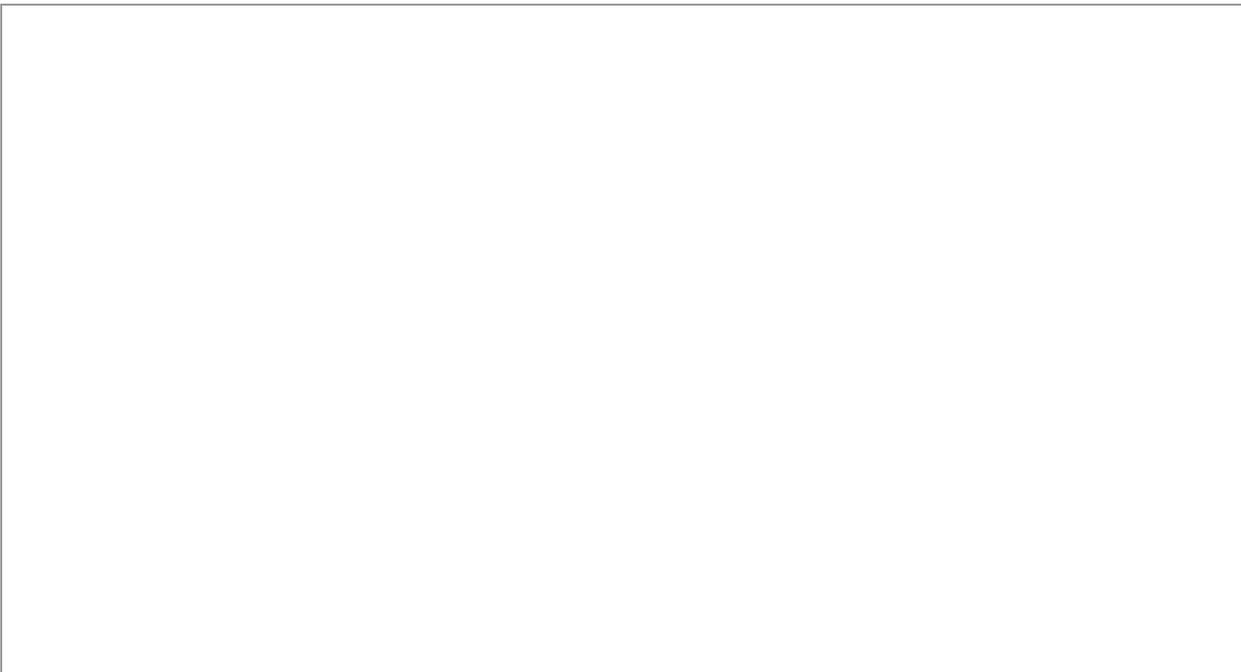
Describe how your project addressed achieving collective impact.



28. What lessons have you learned about achieving collective impact in the Healthy Start context?



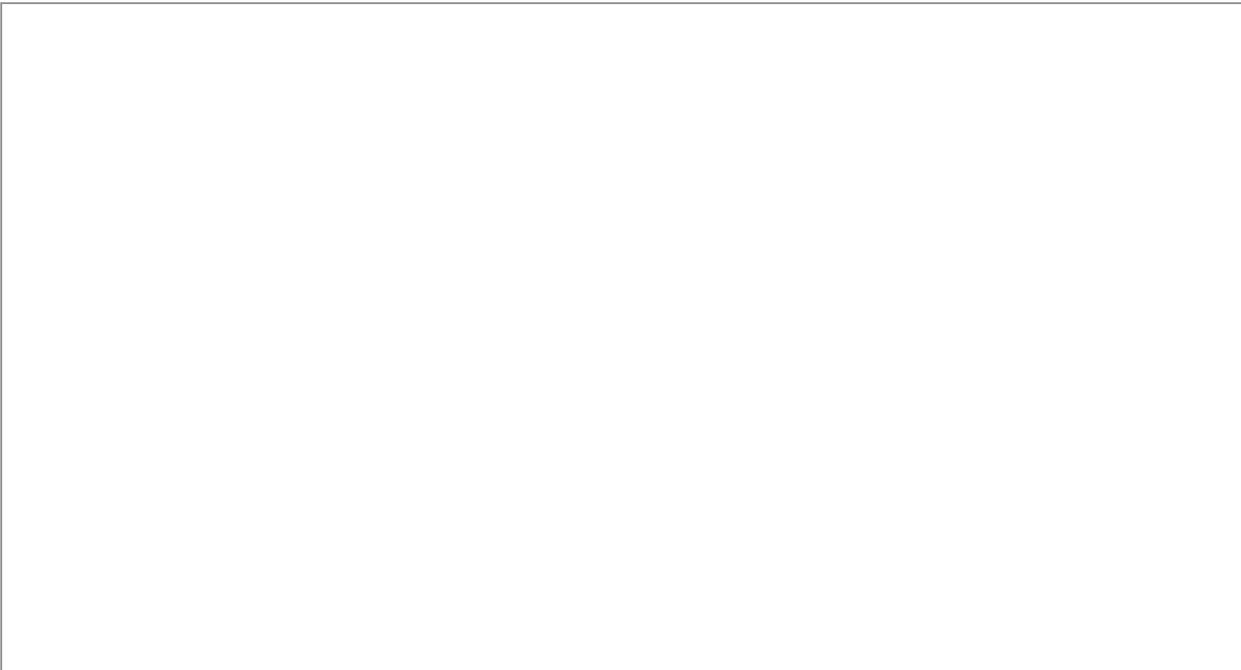
29. Describe two best practices that succeeded in your project related to achieving collective impact.



30. Describe your project's two greatest challenges related to achieving collective impact.
What did you do to minimize the impact of each challenge on your project outcomes?



* 31. Accountability through Quality Improvement, Performance Measures and Evaluation:
Describe how your project addressed accountability.



32. What lessons have you learned about addressing accountability via QI, PM, or evaluation in the Healthy Start context?



33. Describe two best practices that succeeded in your project related to accountability.



34. Describe your project's two greatest challenges related to accountability.

What did you do to minimize the impact of each challenge on your project outcomes?



Part 4: Criteria for Funding Application

The following questions ask you to share your thoughts about how the criteria for future funding opportunities might be changed.

* 35. Please indicate whether the service delivery requirements/numbers of pregnant women, interconception women and children you are required to serve given the funding amount you receive is: (please select one)

- Just right
- Too high of an expectation
- Too low of an expectation
- Other (please specify)

* 36. Should funding be based on any of the following? (please select one)

- Funding levels based on size/volume of services delivered, high infant mortality and border requirements.
- A different model (such as based on some combination of proven capabilities or outcomes). See next question to select possible options.
- Other (please specify)

Part 4a: Criteria for Funding Application

* 37. Follow-up from question 36, if you chose another model, which capabilities should be considered?

- Improved clinical outcomes
- Infant mortality rate
- Number of preterm births
- Low birth weight births
- Percentage of women of childbearing age with diabetes is 3.1% or more
- Percentage of women of childbearing age who are obese is 31.8% or more
- Percentage of pregnant women entering prenatal care in the first trimester is less than 80%
- Percentage of births to women who had no prenatal care is greater than 2%
- Percentage of births to women who smoke is greater than 20%
- Percentage of children 0-2 years old with a completed schedule of immunization is less than 60%
- Percentage of children under 18 years of age with family incomes below the Federal Poverty Level exceeded 25% for 2010
- Percent of infants born large for gestational age (LGA) is 9.4 or greater
- Maternal mortality rate
- PAMR development
- FIMR development
- Male inclusion services
- Publishing
- Mentoring
- National leadership participation
- Community partnerships
- Development of CAN logic model
- Leveraging program funds to supplement HS services
- Sustainability planning
- None of the above
- Not applicable
- Other (please specify)

Part 5: Input Based on Other Areas

The following questions ask you to share your thoughts about other areas of the current funding guidance and Healthy Start model. Some of them are short answer or open-ended responses and others ask you to share how you addressed the area and share your top 2 best practices and challenges with addressing each approach if you would like to share.

* 38. Healthy Start CollIN Composition/Membership:

Should there be a different composition?

Yes

No

If yes, what would it look like?

39. What is working about the current HS CollIN composition?

40. What could be improved with the current HS CoIIN composition?



* 41. Documenting Activity Level of the CAN:

Please describe your approach for engaging your CAN.



42. What lessons have you learned about engaging your CAN in the Healthy Start context?



43. Describe two best practices that succeeded in engaging your CAN.



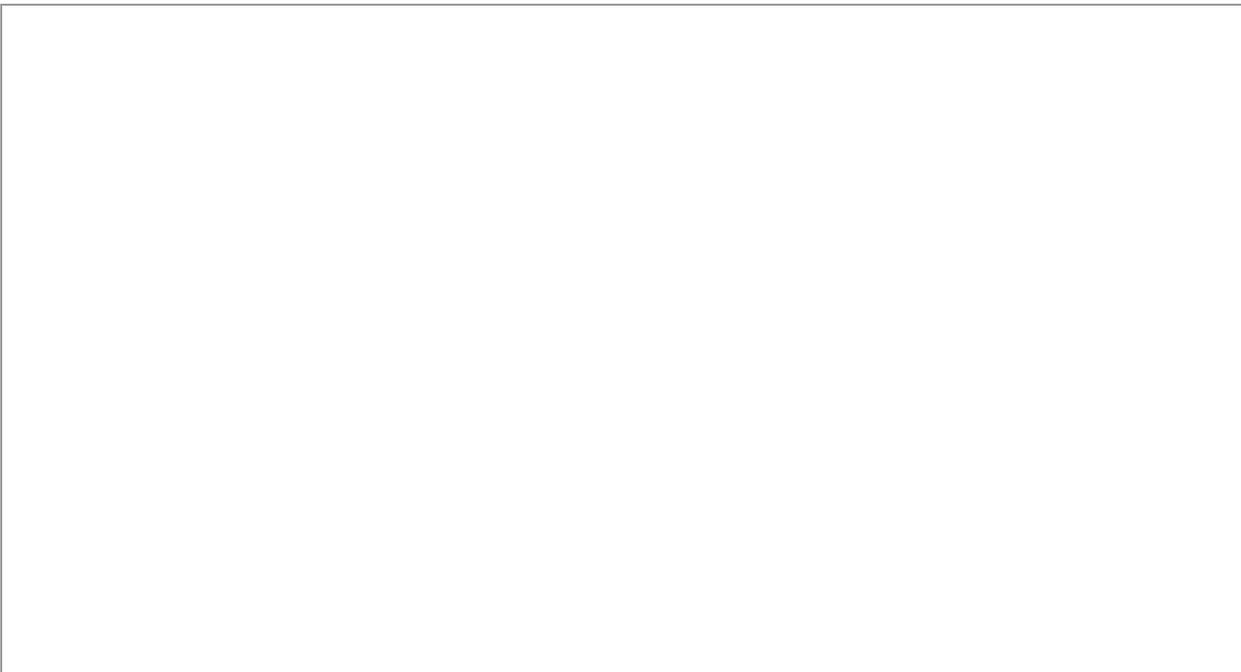
44. Describe your project's two greatest challenges related to engaging your CAN.



* 45. Benchmarks:

Please describe your approach for documenting and addressing the HS Benchmarks.

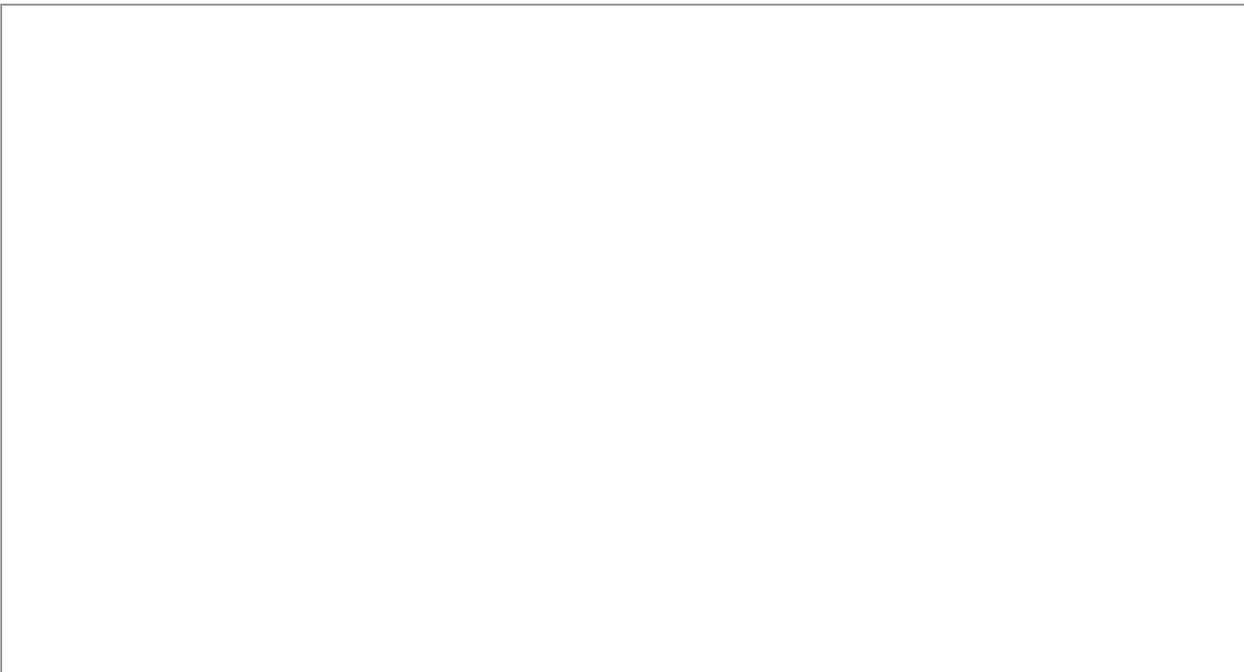
For example, if you have a software program how have you ensured that it captures the required elements or how have used the data to improve your services?



46. What lessons have you learned about addressing the HS benchmarks?



47. Describe two best practices that succeeded in addressing the HS benchmarks.



48. Describe your project's two greatest challenges related to addressing the HS benchmarks.



Part 5: Input Based on Other Areas

49. Screening Tool Implementation:

Did your program implement the screening tools?

- Yes, if yes, you will be asked to describe your implementation process.
- No, if no, you will be asked to describe how you are capturing data for the evaluation.

Part 5: Input Based on Other Areas

50. Care Coordination/Case Management Processes and Systems

Does your program have one or more standardized care coordination/case management systems in place?

- Yes, if yes, you will be asked to describe your process and/or system
- No, if no, you will be asked to describe your process

Part 5a. Input Based on Other Areas

* 51. Please describe your implementation process for the screening tools.

52. What lessons have you learned during the implementation of the screening tools?

53. Describe two best practices that succeeded during the implementation of the screening tools.

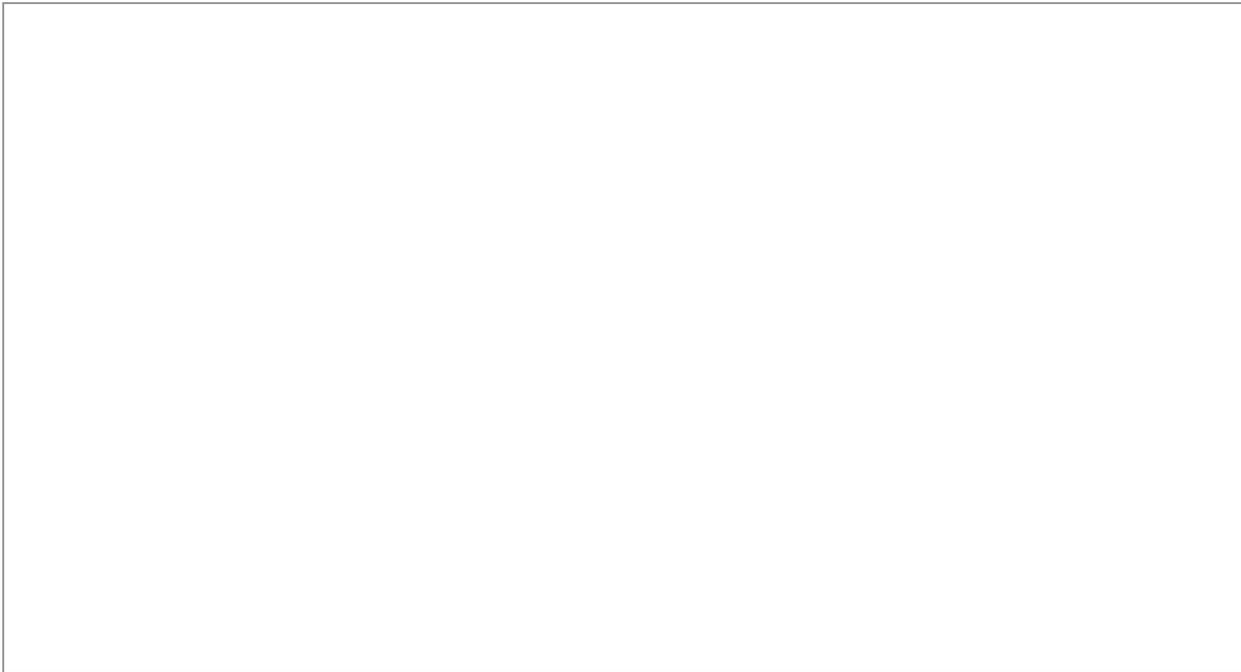


54. Describe your project's two greatest challenges related to the implementation of the screening tools.



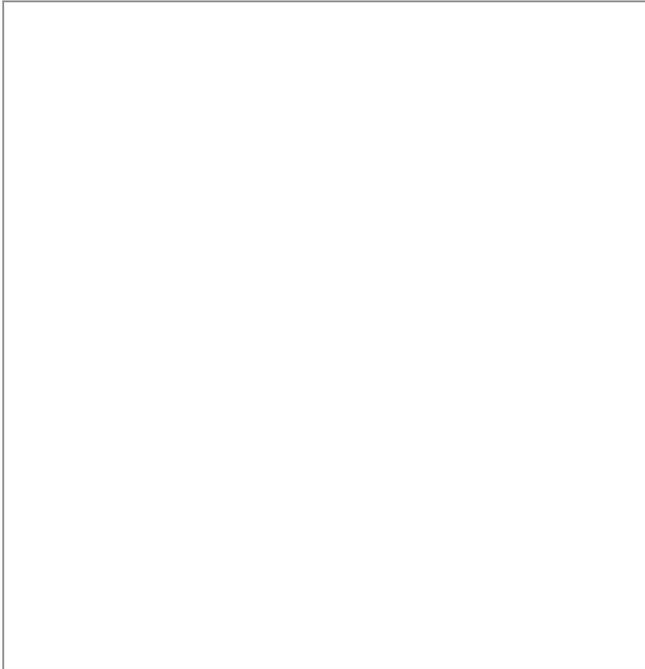
Part 5b: Input Based on Other Areas

* 55. Please describe how you are capturing data for the evaluation, if you chose to not use the screening tools.

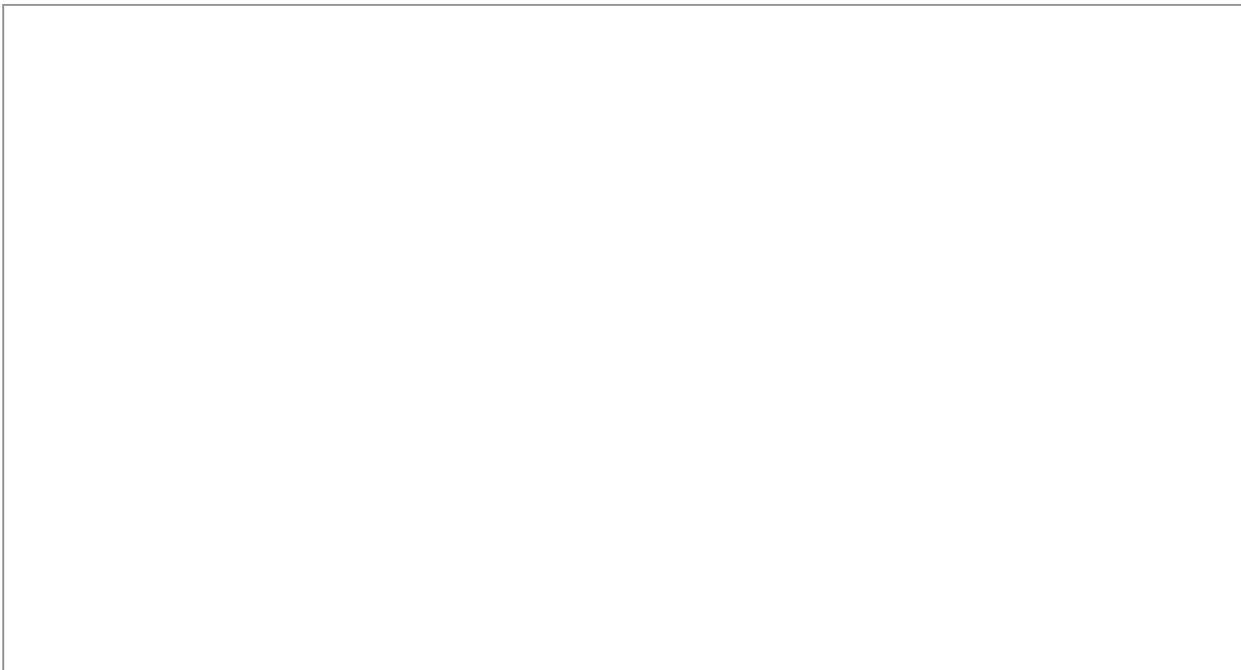
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Part 5c: Input Based on Other Areas

* 56. Please describe your standardized care coordination/case management system



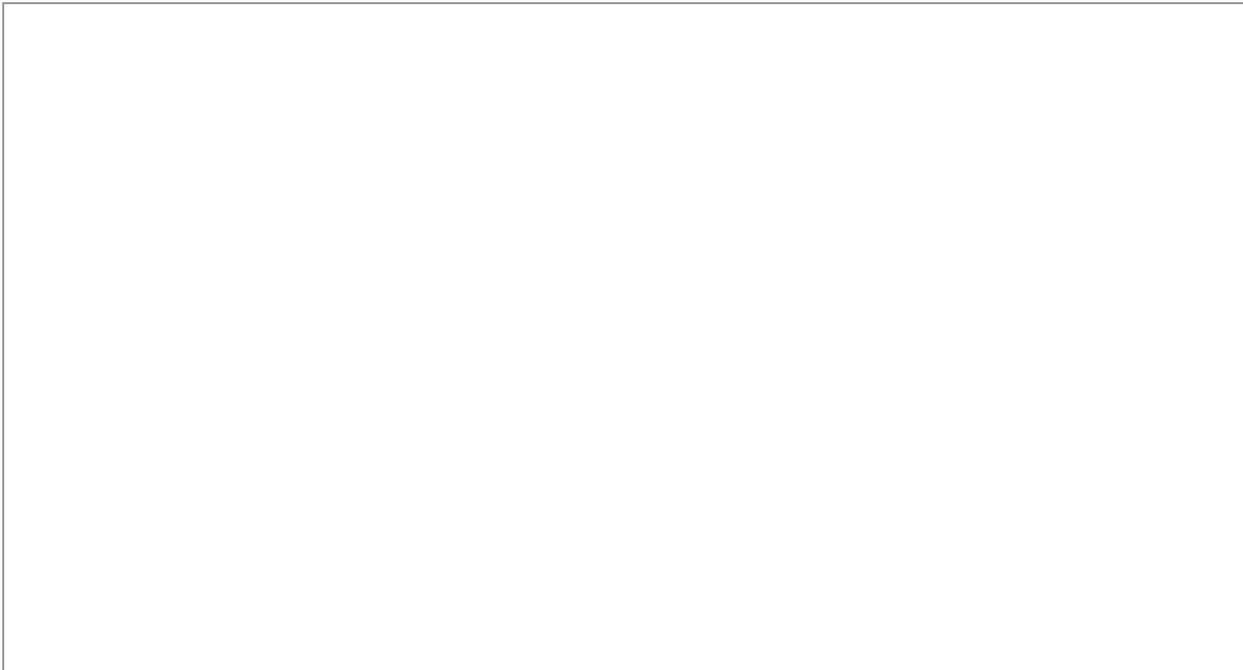
57. What lessons have you learned with your standardized care coordination/case management system?



58. Describe two best practices that succeeded with your standardized care coordination/case management system.



59. Describe your project's two greatest challenges related to your standardized care coordination/case management system.



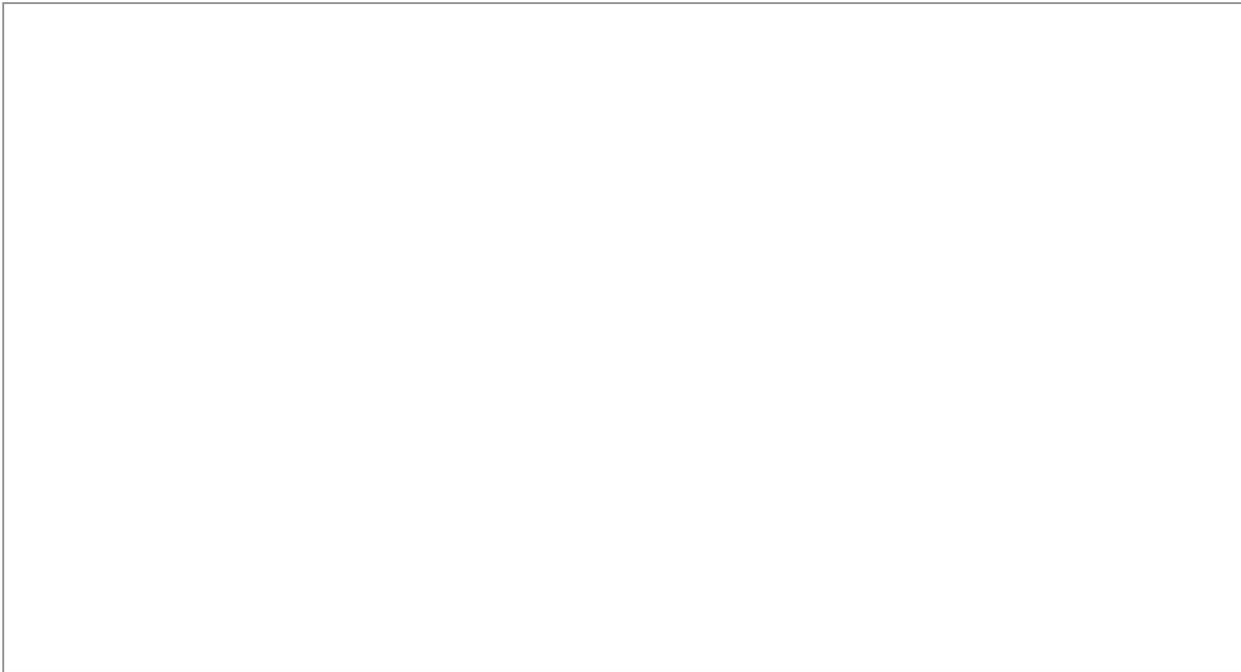
Part 5d: Input Based on Other Areas

* 60. Please describe your care coordination/case management process.

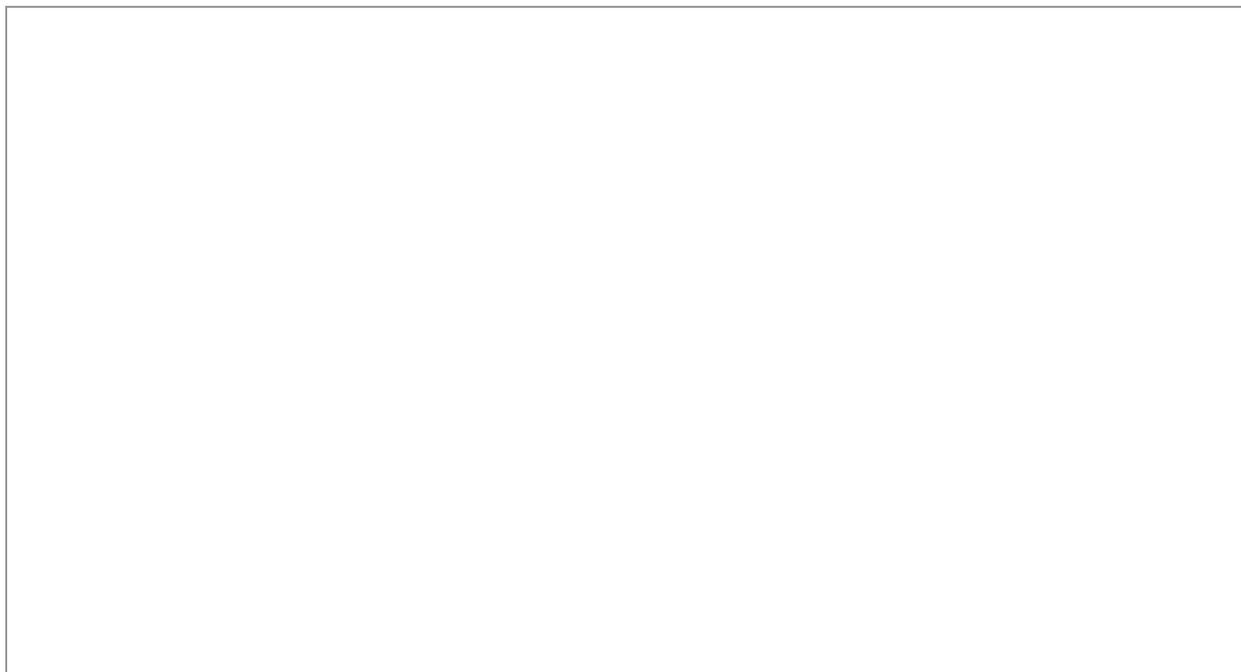
A large, empty rectangular box with a thin black border, intended for the user to describe their care coordination/case management process.

Part 5e: Input Based on Other Areas

61. How does your Healthy Start program showcase its cost savings (Return on Investment (ROI) / Cost Benefit Analysis)?

A large, empty rectangular box with a thin black border, intended for the user to provide their response to question 61. The box is currently blank.

* 62. What sets your Healthy Start Program apart from other Maternal and Child Health programs within your community?



Final Questions

Thank you so much for taking the time to complete this feedback form. Your insight is invaluable in ensuring the success of the Healthy Start Program and learning what worked during this funding period. We have a couple final questions before the survey is complete.

63. What else would you like use to take into account about your program as we develop recommendations for improving Healthy Start?

* 64. Would you be interested in participating in a discussion or learning group to discuss what it means to implement the HS screening tools and evaluation as part of an evidence-based model?

You would be grouped with other Healthy Start programs that are using the same model. This would provide an opportunity to share your successes and problem-solve your challenges in implementing the HS screening tools and other evaluation components in your specific model.

- Yes
- No
- Not sure

Appendix 2

Healthy Start Collaborative Innovation and Improvement Network (HS CoIIN) Structure Overview

Healthy Start Collaborative Innovation and Improvement Network



The Healthy Start CoIIN is a partnership of Healthy Start grantees dedicated to strengthening Healthy Start services and systems, in order to advance program goals to reduce infant mortality and improve birth outcomes. The HS CoIIN functions as an Expert Panel to the Division of Healthy Start and Perinatal Services (DHSPS) and the HS EPIC Center, the training and technical assistance provider for the program.

HS CoIIN Goals and Objectives

Through a structured process of best practices review and discussion, the HS CoIIN seeks to identify and promote implementation of standardized evidence-based and field-tested approaches to essential HS components such as perinatal risk assessment, care coordination, participant engagement and empowerment, and fostering Collective Impact and local systems integration through Community Action Networks (CAN).

The goal of the HS CoIIN is to strengthen Healthy Start (HS) services and systems, by promoting implementation of standardized evidence-informed/based approaches to core elements of the HS program (*Program level* improvement and innovation).

The specific objectives of the HS CoIIN are to:

- Promote communication among/between grantees, DHSPS and HS EPIC Center to ensure all grantees have a voice in setting the direction for HS
- Brainstorm and test opportunities to strengthen the program especially related to standardizing components of the HS model
- Disseminate lessons learned to the HS community
- Promote HS as an effective and vital community based resource in all communities to ensure the long-term success of HS.

Collaborative Learning: From HS Grantees to the HS CoIIN and Back

The HS CoIIN will articulate best practices and quality improvement guidance based on state-of-science and rooted in grantee experience serving HS participants. Through a series of ongoing discussion forums on priority topics HS grantees across the country will share elements for success and implementation challenges with each other, and feed their findings to the HS CoIIN. The CoIIN in turn will review, distill and integrate these findings to make



recommendations for standards of practice for HS programs. Once approved by DHSPS, these recommendations will be disseminated by the HS CoIIN to all HS grantees.

Operating Structure of the HS CoIIN

- The HS CoIIN meets monthly, including day-long face-to-face sessions 2 times per year, with conference calls in the interim.
- Two CoIIN members serve as Co-Chairs, for rotating six-month terms.
- The HS EPIC Center provides support to plan and facilitate meetings, identify issues and information needs, and communicate findings to the larger HS grantee community.
- CoIIN members actively participate with a consistent member representing their organization on monthly calls and bi-annual meetings, maintaining at least 80% participation rate.

Decision Making Process

- One vote per site.
- Decision requires a 90% quorum (n=18)
- Consensus requires an 80% agreement (n=14)

HS CoIIN Communication Strategy

Goals developed in collaboration with the Division are to support HS CoIIN members' ability to:

- communicate key issues related to the role of the CoIIN, topics discussed and decisions made in a consistent manner; and
- solicit input and feedback from all Healthy Start programs and colleagues to inform the CoIIN discussions.

...with the intended outcome of enhancing communication with Bureau, Division, and Grantees.



CoIIN Primary Member List

NAME	PROGRAM NAME	LOCATION
Anna Gruver	Alameda County Healthy Start Initiative	Leandro, CA
Maxine Vance	Baltimore City Healthy Start	Baltimore, MD
Rickey Green ¹	Birmingham Healthy Start Plus	Birmingham, AL
Deborah Allen ¹	Boston Healthy Start Initiative	Boston, MA
Maria Lourdes Reyes ⁵	California Boarder Health y Start	National City, CA
Dianne Browne	Camden Healthy Start	Pennsauken, NJ
Lo Berry ³	Central Hillsborough Healthy Start	Tampa, FLA
JoAnn Smith	DC Healthy Start	Washington, DC
Gwendolyn Daniels ²	Detroit Healthy Start	Detroit, MI
Delores Passmore	Greater Harlem Healthy Start	New York, NY
Mary-Powel Thomas	Healthy Start Brooklyn	Brooklyn, NY
Mary Alexander ⁵	Healthy Start of New Orleans	New Orleans, LA
Andrea Kimple ⁴	Healthy Start Inc. Pittsburgh	Pittsburgh, PA
Anna Colaner	Midwest Healthy Start Initiative	Chicago, IL
Lisa Matthews	MomsFirst	Cleveland, OH
Lakeisha Johnson	NC Baby Love Plus	Raleigh, NC
Risë L. Ratney ³	Northwest Indiana Healthy Start	Hammond, IN
Sara Kinsman ²	PDPH Healthy Start	Philadelphia, PA
Kori Eberle ⁴	San Antonio Healthy Start	San Antonio, TX
Meloney Baty	South Phoenix Healthy Start	Phoenix, AZ

¹Cohort of Co-Chairs

²Cohort of Co-Chairs

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⁵Cohort of Co-Chairs

CoIIN please contact the HS EPIC Center: healthystartepic@jsi.com or go to healthystartepic.org.

Appendix 3

Healthy Start Collaborative Innovation and Improvement Network - HS CoIIN Priorities, 2015-2019
Overview

Healthy Start Collaborative Innovation and Improvement Network (HS CoIIN)

HS CoIIN Priorities, 2015-2019
Overview



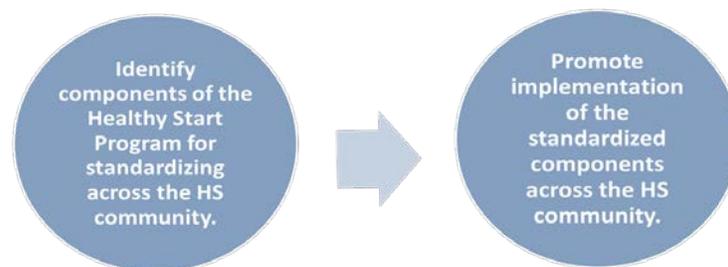
Top 5 Things to Remember

1. **Expert Panel to the Division of Healthy Start and Perinatal Services**
2. **CoIIN Structure and Process**
 - A. 6-month Rotation of Co-Chairs
 - B. Decision Making Process
3. **Standardization of HS Program Approach**
4. **Communication**
 - A. Coordinate with Division
 - B. Elicit Feedback from Larger HS Community
5. **The Focus of the HS CoIIN Is Working Toward:**
 - A. Healthy Start as promoting equity;
 - B. Healthy Start as a standardized system of care; and
 - C. Standardization as a strategy for sustainability.

Initial Standardization Priorities

Building a Stronger Healthy Start Program through Standardization, Adopted March 2015

The CoIIN recognizes the importance of honoring the diversity of approaches of Healthy Start programs and reinforcing the need for standardizing certain components while honoring the uniqueness of each program.



Why standardize Healthy Start?

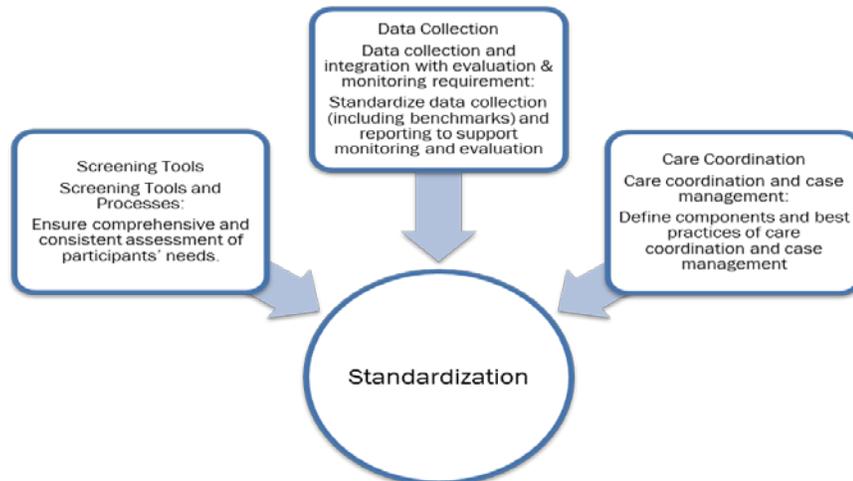
Provides a consistent, predictable, and replicable experience for Healthy Start participants designed to achieve positive health outcomes.

Overview of CoIIN Priorities, Adopted March 2015

An initial day long planning meeting was conducted with CoIIN members on March 25, 2015. The HS CoIIN members recognized the importance of articulating a conceptual framework and science base for the long-term sustainability of the Healthy Start program. In response, HS CoIIN members expressed a majority interest in focusing HS CoIIN efforts on identifying opportunities for standardizing elements of the program.

The goal of the HS CoIIN is to strengthen Healthy Start (HS) services and systems, by promoting implementation of standardized evidence-informed/based approaches to core elements of the HS program (*Program level* improvement and innovation).

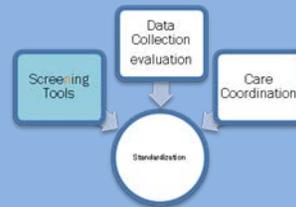
These initial standardization priorities were chosen as the focus for the CoIIN’s initial focus as they have substantial synergy and overlap to inform program level improvement and innovation.



HS Program Elements to Demonstrate Impact

- The HS screening tools allow HS programs to document care coordination such as information or education, specific services, or referral for ongoing services beyond the program.
- Alignment with other MCH Bureau measurements allowed the process of standardizing the HS program to demonstrate collaboration across the HS Division, and the MCH Bureau.
- HS screening tools informed the development of the screening and assessment module as part of the HS Community Health Worker curriculum.
- Training is the initial step to implementing the Screening Tools.

First Initiative of the HS CoIIN: Developing Standardized Screening Approach



Overview of Initiative #1: Screening Tools

During Year 2, the CoIIN engaged in an inclusive process to develop a comprehensive screening process for Healthy Start participants. Screening has always been a fundamental component of Healthy Start services, and serves as the starting point for Healthy Start’s case management approach with participants. This initiative was prioritized because a common, standardized screening approach will help to ensure comprehensive and consistent assessment of participants’ needs across all Healthy Start programs.

Drafting the Screening Tools

The HS CoIIN used a consensus process to select the risks to be included in a portfolio of standardized screening tools to use with participants at intake and throughout their involvement with their Healthy Start program. Risks designated by 80% or more of HS CoIIN members as “priority” were incorporated. In developing the screening tools the HS CoIIN adhered to the following principles:

Screening vs. Assessment

Screening is an initial step to gauge whether a participant may have a particular risk or risks. Screening indicates whether further assessment is necessary to clarify the nature of a risk and which services or referrals may be most appropriate. Assessment may include the use of additional evidence-based checklists or tests to confirm a participant’s needs.

Guiding Principles

The following principles informed the development of the screening tools:

- The screening tools serve as the foundation and starting point for Healthy Start’s care coordination/case management approach with participants.
- The screening tools address evidence-based risks associated with maternal and infant health outcomes for each perinatal period.
- The screening tools were designed to include questions addressing comprehensive risks and strengths for each perinatal period, to capture the HS benchmarks, and to align with the national evaluation.
- Sources for Healthy Start screening tool questions included a range of standardized surveys, practice guidelines and tested valid and reliable instruments, including One Key Question[®][1], the NIDA Quick Screen, the Patient Health Questionnaire-2 (PHQ-2), the Everyday Discrimination Scale (Short Version), and the Social Support Survey Instrument-modified.



- Questions were selected through a participatory process that included incorporating feedback from Healthy Start programs and other stakeholders through a public commenting period and lessons learned through pilot testing.
- The screening tools are comprehensive and may include risks that a program (or even a community) has no current capacity to address. Detection of risks for which no services currently exist will help inform grantees' Community Action Network initiatives.
- Local HS programs may opt to include additional risks beyond those covered in the standardized screening tools, as appropriate to their community.

In April the opportunity for the HS CoIIN to align the screening tools with other evaluation and reporting data collection emerged. A working group composed of members of the HS CoIIN was convened to review and provide recommendations for the screening tools, ensuring that the current tools are **fully aligned with all reporting requirements**:

- Healthy Start Benchmark Reporting (20+1)
- Federal Healthy Start Monitoring + Evaluation (3Ps)
- DGIS Performance Measures

Some structural changes included integrating questions from the SDH tool into the relevant perinatal tool, and integrating the relevant interconception questions from preconception/interconception tool into the postpartum and parenting tools. Final drafts of the screening tools were rolled out for review to all grantees in January. Feedback received from 81% of grantees during the comment period was incorporated into the final six screening tools which were submitted for OMB approval in June 2016:

1. Demographic Tool
2. Past Pregnancy History Tool
3. Preconception
4. Prenatal
5. Postpartum
6. Parenting/Interconception

Piloting the Screening Tools

The tools were pilot tested with 12 CoIIN and non-CoIIN grantees volunteers between July 11-22, 2106. The goals of the pilot were to:

- Gauge usefulness of the screening tools to HS programs and participants.
- Assess program participants' understanding of the questions on the tools.
- Understand feasibility of using the screening tools.
- Identify any questions that could be deleted or revised to improve clarity.
- Determine the average time it takes to administer the tools.
- Identify training needs for implementation of the screening tools.



Each pilot site was asked to pilot the screening tools with up to 9 participants. Pre pilot-training:

- Provided background and overview of the tools
- Provided guidance for piloting programs in administering screening tools and completion of the pilot program evaluation form
- Established follow-up check-in meeting times

During the week of the pilot, four 1-hour office hours were provided for sites to ask questions if they ran into any challenges during the pilot process. Results of the pilot test were summarized in a report titled Healthy Start Screening Tools Pilot Report.

OMB Approval

The results of the pilot and revised tools were submitted to OER for approval and OMB submission in September. Approval was granted in November 2016: OMB Number: 0915-0338, expiration 11/30/2019.

Launching

Upon OMB approval, the CoIIN worked with the Training and TA team to facilitate a smooth implementation including translation into Spanish and continue to provide consultation to individual grantees, helpline, and Training and TA team. The CoIIN team has facilitated the integration of the screening tools into monitoring and evaluation process. Communication with the grantees are ongoing in form of FAQs and the CoIIN team is establishing a process to capture ongoing feedback from the field regarding future improvements to the tools that will require OMB approval.

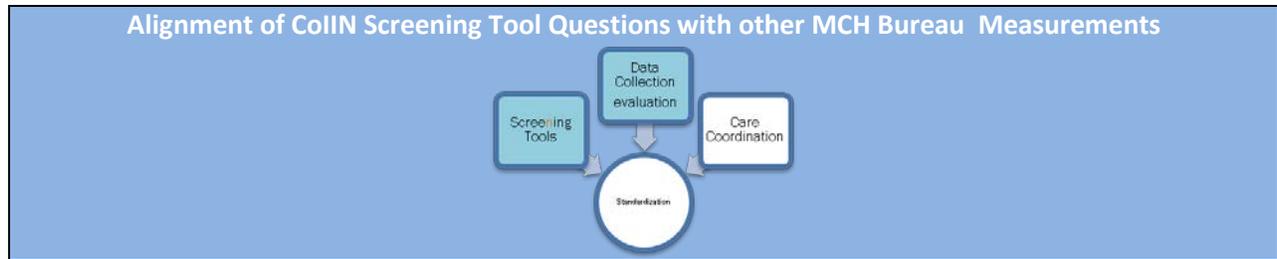
On-Going Support

Lessons learned through the initial implementation process highlight the complexity of this systems change. The CoIIN has recognized the need to continue to address emerging issues and support a successful transition at the program level.

Lessons Learned from Screening Tool Development

The HS CoIIN has reflected on a few lessons learned from the development and implementation of first standardization will build these lessons learned into our processes as move forward to address the care coordination/case management priority.

- Shift the core work from the large CoIIN group to small work group model to more efficiently address initiatives.
- Build in more frequent feedback opportunities from all grantees to manage workflow of each CoIIN work group.
- Recognize the diversity of approaches of Healthy Start programs and reinforcing the need for standardizing certain components while honoring the uniqueness of each program.



Overview of Initiative #2: Data Collection and Reporting

The Data Collection and Reporting initiative has involved 1) drafting concise definitions for the Healthy Start benchmarks; 2) aligning data collection with the national evaluation; and 3) developing an electronic reporting tool to support grantees in collecting and reporting data.

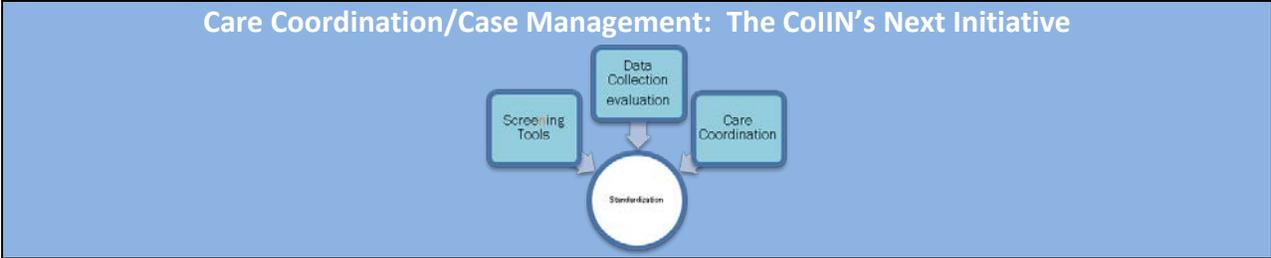
A work group of CoIIN members and volunteer grantees was convened virtually 3 times during January to develop draft definitions. These definitions were aligned with an MCH initiative to revise the performance measures. A reconciled Data Dictionary was approved by MCHB and HS in June and disseminated to grantees. Data definitions were submitted to OMB for final approval as part of the MCH revised performance measures OMB package. Approval was formally received in December. Grantees are advised to begin reporting using the new definitions in 2017. EPIC is working with grantees and the Division to facilitate data collection of the benchmarks.

EPIC provided assistance to grantees with ChallengerSoft and ETO to support group negotiation to:

- Reduce cost of integrating screening tools into existing software programs that can generate data submission for evaluation to DSFederal.
- Improve efficiency as tools are modified over time.
- The initial phase of negotiation focuses on existing users
 - 24 for ChallengerSoft and 12 for ETO

The negotiations have concluded, and contracts are available to other grantees upon request.

In addition, EPIC developed a Survey Gizmo application as an alternative to the paper screening tools. The online tool was tested in the pilot phase of the screening tools and received positive feedback. To date, 37 grantees are using the tool to collect and report screening tool data to the national evaluation. EPIC will be producing the xml export for participating grantees.

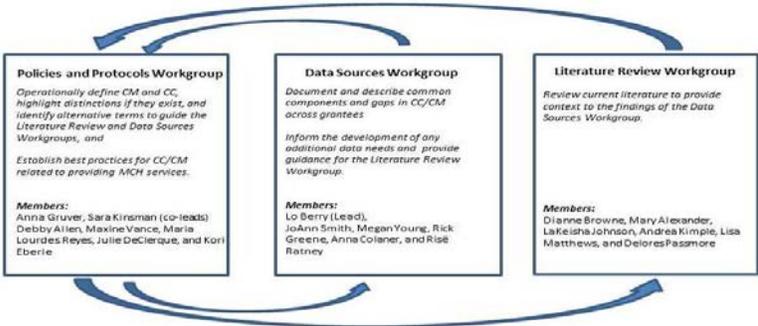


Overview Initiative #3: Care Coordination/Case Management

The July 2016 ColIN call began initial planning for Care Coordination and Case Management standardization. In September we established our guiding principles that would serve as our touchstone during the development of our standardization approach to care coordination:

- The initial step toward standardization is establishing a shared understanding of care coordination/case management across the Healthy Start ColIN.
- Establish common definitions of care coordination and case management as a foundation for any other steps in standardization.
- Care Coordination/Case Management is the foundation of re-framing Healthy Start as a system of care:
 - To ensure sustainability of the program in order to mobilize more communities to create more equity for our families in need.
 - Ensure care coordination and case management are rooted in the community, are multidisciplinary: address linkages and referrals; include a family centered approach; incorporate advocacy and a cultural focus.

The ColIN established the following work groups to establish the focus and provide expertise for standardizing care coordination/case management for Healthy Start programs.



Define terms	What is current HS practice ?	What does the literature tell us?
Informs actions of Data Sources and Literature Review Workgroups (components, terms, etc.)	Based on adopted definition, identify existing functions in Healthy Start programs	How does the literature support current HS practice?
Informed by findings of Data Sources and Literature Review Workgroups	Identify Gaps	How can the literature address identified gaps
Establish best practices for recommendation to Healthy Start	Inform the establishment of best practices by the policy group	Inform the establishment of best practices by the policy group



As of March 2017, the CoIIN shifted its near-term focus. Recognizing screening tool implementation challenges experienced by programs, the CoIIN determined the need to table their third standardization initiative, Care Coordination-Case Management. Per the Division request, their efforts for the time being will focus on 1) ensuring readiness of programs to fully engage in the national evaluation and 2) focus on capturing timely feedback from the field to inform planning for the future of the Healthy Start program.

Overview Initiative #4: Capturing Lessons Learned from the Field

The purpose of this survey is to provide Healthy Start programs the opportunity to provide perspectives from the field by sharing promising and best practices they used to implement Healthy Start 3.0 and lessons learned from those experiences.

This information will be shared with the Division of Healthy Start and Perinatal Services in order to shape future programming. The information you provide to the survey will not be aligned in any way to you individually or to your Healthy Start program; a summary of the data will be developed in order to eliminate the potential for specific responses to be linked to any particular HS program. Your information will be analyzed in aggregated form and reported in a summary format. Below is the timeline for lessons learned process:

Healthy Start: Capturing Lessons Learned from the Field Timeline and Process Overview

Activity	Timeline
Step One: First Virtual Town Hall	May 16, 3-4:30 ET
Gather CoIIN and Grantees input: lessons learned qualitative format	May17 to June 17
Step Two: CoIIN to prioritize issues from Practical Vision session at Spring meeting and build into NOFO feedback	May 20-30
Present preliminary results to CoIIN	June 6
EPIC CoIIN Team to organize results into themes and priorities	June 17-30
Step Three: CoIIN Face to Face Meeting: NOLA	July 6-7
Final virtual Town Hall with all HS grantees to present final recommendations	July 20, 3-4:30 ET
Provide final draft to CoIIN and grantees before it is submitted	July 28
Co-Chairs submit final recommendations	July 31

Appendix 4

Types of Evidence-Based or Evidence-Informed Models and Practices

Other types of evidence-based or evidence- informed models and practices that comprised the other category in the survey.

- DANCE
- GAD-7
- Danger Assessment
- Excellence Baby Academy, based on the AVANCE Parent-Child Education Program
- Trauma focused cognitive behavioral therapy
- Dialectical behavior therapy
- Circle of Security
- Injoy
- Period of Purple Crying
- Becoming a Mom from March of Dimes
- ReMerge
- Effective Black Parenting
- STEPS program
- LAMAZE program
- Bavolek Parenting
- Growing Birth to Three
- 24-7 Dad
- Teenagers and Their Babies
- Responsible Fatherhood
- Healthy Families Jacksonville
- Early Head Start
- Magnolia Project Standardized Health Education Curriculum
- Make a Noise! Make a Difference Lay Health Advocate Curriculum
- Strengthening Families
- Mom as Gateway
- Foundations for Success in Parenting
- Comprehensive Case Management / Care Coordination System developed by the State Medicaid Prenatal Care Coordination and Social Work Practice. The project is utilizing evidence-based curriculum such as the Beginning Prenatal and Parenting Guides and the CDC's "Learn the Signs, Act Early" Developmental Milestone Checklist. All materials are culturally competent to the population served.
- Anger Management for Substance Abuse and Mental Health Clients: A Cognitive Behavioral Therapy