Healthy Start Benchmarks

Data Dictionary

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Healthy Start Benchmarks - Data Dictionary

This manual includes a brief introduction to the Healthy Start (HS) Program Measures, definitions and terms, and instructions for accurately capturing Healthy Start Benchmark Measures.

Healthy Start works to improve maternal and child health outcomes by strengthening the foundations at the community, state, and national levels to help women, infants, and families reach their fullest potential. Healthy Start is an initiative of the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), and the US Department of Health and Human Services (HHS). Healthy Start programs serve communities with infant mortality rates at least 1.5 times the national average, and high rates of low birth weight, preterm birth, and maternal mortality.[1]

The Healthy Start program has established benchmarks and goals for performance. These benchmarks are also the performance measures for DGIS performance reporting for Healthy Start programs.

1. Increase the proportion of HS women and child participants with health insurance to 90 percent (reduce uninsured to less than 10 percent).
2. Increase the proportion of HS women participants who have a documented reproductive life plan to 90 percent.
3. Increase the proportion of HS women participants who receive a postpartum visit to 80 percent.
4. Increase the proportion HS women and child participants who have a usual source of medical care to 80 percent.
5. Increase the proportion of HS women participants that receive a well-woman visit to 80 percent.
6. Increase the proportion of HS women participants who engage in safe sleep practices to 80 percent.
7. Increase the proportion of HS child participants whose parent/ caregiver reports they were ever breastfed or pumped breast milk to 82 percent.
8. Increase the proportion of HS child participants whose parent/ caregiver reports they were breastfed or fed breast milk at 6 months to 61 percent.
9. Increase the proportion of pregnant HS participants that abstain from cigarette smoking to 90 percent.
10. Reduce the proportion of HS women participants who conceive within 18 months of a previous birth to 30 percent.
11. Increase the proportion of HS child participants who receive the last age-appropriate recommended well child visit based on the AAP schedule to 90 percent.
12. Increase the proportion of HS women participants who receive depression screening and referral to 100 percent.
13. Increase the proportion of HS women participants who receive intimate partner violence (IPV) screening to 100 percent.
14. Increase the proportion of HS women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, etc.) during pregnancy to 90 percent.
15. Increase the proportion of HS women participants that demonstrate father and/or partner involvement (e.g. attend appointments, classes, infant/child care) with their child participant to 80 percent.

16. Increase the proportion of HS child participants aged <24 months who are read to by a parent or family member 3 or more times per week to 50 percent.
17. Increase the proportion of HS programs with a fully implemented Community Action Network (CAN) to 100 percent.
18. Increase the proportion of HS programs with at least 25 percent community members and HS program participants serving as members of their CAN to 100 percent.
19. Increase the proportion of HS programs who establish a QI and performance monitoring process to 100 percent.

[1] Healthy Start NOFO

As outlined in the Notice of Funding Opportunity and the Notice of Award, all Healthy Start grantees are expected to collect data and report performance on all 19 benchmarks, annually. In general, Healthy Start benchmarks are aligned with national performance measures to enable comparisons between the U.S. population at large and those served by Healthy Start program grantees.

Definitions

This section provides definitions which are critical for consistent reporting of Healthy Start data across grantees.

Healthy Start (HS) Program Participant

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

A program participant is an individual having direct contact with HS staff or subcontractors and receiving HS case management/care coordination services on an ongoing, systematic basis to improve perinatal and infant health.[1] Specifically, Healthy Start participants are pregnant women and women of reproductive age, infants, and children up to18 months. Participants also include fathers/male partners who are affiliated with women and/or children who receive services from Healthy Start.

- **Woman Participant:** A woman is counted as a Healthy Start woman participant for the purposes of benchmark reporting if she 1) is of reproductive age, 2) has completed the enrollment process including all applicable HS Data Collection Forms, and 3) has one or more contacts with the Healthy Start program during the reporting period.

- **Child Participant:** A child is counted as a Healthy Start child participant if the child 1) is aged <18 months during the reporting period, 2) has a completed/updated HS Parent/Child Form documented, and 3) has one or more contacts with the Healthy Start program during the reporting period.

- **Male Participant:** A father/male partner is counted as a Healthy Start male participant for the purposes of benchmark reporting if he 1) is affiliated with an enrolled woman and/or child, 2) has completed the enrollment process including all applicable HS Data Collection Forms, and 3) has one or more contacts with the Healthy Start program during the reporting period.

"Other Adults"

- Other adults who have primary responsibility for/custody of an enrolled child must complete the Healthy Start Background Information Form and Parent/Child Form, but are not enrolled into the Healthy Start program and are not counted in the benchmark measures. "Other adults" are individuals who do not meet the Healthy Start participant requirements outlined above.

[1] Healthy Start NOFO

Enrollment

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

Reporting Period

January 1 – December 31 (though may differ the initial reporting period)

All benchmarks are to be reported as of the last available data for each participant in a reporting year.

1. PERFORMANCE MEASURE Approach: Improve Women's Health Related DGIS Measure: LC 1	The percent of Healthy Start women and child participants with health insurance.
GOAL	Increase the proportion of HS women and child participants with health insurance to 90 percent (reduce uninsured to less than 10 percent).
MEASURE	The percent of Healthy Start (HS) women and child participants with health insurance.
DEFINITION	**1a.** **Numerator:** Number of HS women participants with health insurance as of last assessment in the reporting period. **Denominator:** Number of total women HS participants in the reporting period. **1b.** **Numerator:** Number of Healthy Start (HS) child participants whose parent/ caregiver reports that the child has health insurance as of the last assessment in the reporting period. **Denominator:** Number of total child HS participants in the reporting period. Participants are identified as uninsured if they report not having any of the following: private health insurance, Medicare, Medicaid, State Children's Health Insurance Program (CHIP), State-sponsored or other government-sponsored health plan, or military plan at the time of the interview. A participant is also defined as uninsured if he or she reported having only Indian Health Service coverage, or only a private plan that paid for one type of service such as family planning, accidents, or dental care. For more information regarding health insurance questions please refer to Section VII (page 35) of the 2014 National Health Interview Survey (NHIS) Survey Description.
BENCHMARK DATA SOURCES	National Survey of Children's Health (Children's Average 94.5%, 2011/2012),[2] National Health Interview Survey[3]
GRANTEE DATA SOURCES	**1. HS Data Collection Forms** (1a) Background Information Form – Q9 Numerator – Include women participants with "currently have" checked for any response(s) a-g. **Note:** Exclude participants with only "Don't know"/"Declined to answer" responses from the numerator and denominator.

(1b) Parent/Child Form – Q13

Numerator – Include child participants with "currently have" checked for any response(s) a-g.

Note: Exclude children with only "Don't know"/ "Declined to answer" responses from the numerator and denominator.

2. Grantee data systems

SIGNIFICANCE

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

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

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

2. PERFORMANCE MEASURE Approach: Improve Women's Health Related DGIS Measure: HS 01	The percent of Healthy Start women participants that have a documented reproductive life plan.
GOAL	Increase the proportion of HS women participants who have a documented reproductive life plan to 90 percent.
MEASURE	The percent of Healthy Start (HS) women participants that have a documented reproductive life plan.
DEFINITION	**Numerator:** Number of HS women participants with a documented reproductive life plan in the reporting period. **Denominator:** Number of HS women participants in the reporting period. There is no formal written format for a reproductive life plan. A participant is considered to have a reproductive life plan and included in the numerator if there is documentation in the participant's record of an annually updated statement to include: 1) goals for having or not having children; and 2) plans for how to achieve those goals. Participants with permanent birth control are included in both the denominator and numerator. If a participant completes the Reproductive Life Plan questions within the Healthy Start Data Collection Forms during the reporting period, then they are considered to have a documented Reproductive Life Plan. See "Grantee Data Sources" below.
BENCHMARK DATA SOURCES	Pregnancy Risk Assessment Monitoring System (PRAMS) Phase 8, Question 14
GRANTEE DATA SOURCES	**1. HS Data Collection Forms** Background Information Form – Q21, Q22 (if applicable), Q23 (if applicable), Q24 (if applicable), Q25. Numerator – Include all women participants who responded to items Q21-Q25 (as applicable). **Note:** Exclude participants who indicated only "Don't know"/"Declined to answer" for all reproductive life questions (Q21-25) from the numerator and denominator. **2. Grantee data systems**

SIGNIFICANCE

A reproductive life plan reduces the risk of unintended pregnancy, identifies unmet reproductive health care needs, and increases the number of women who plan their pregnancies and engage in healthy behaviors *before* becoming pregnant.[4]

[4] http://www.cdc.gov/preconception/documents/reproductivelifeplan-worksheet.pdf

3. PERFORMANCE MEASURE Approach: Improve Women's Health Related DGIS Measure: WMH 2	The percent of Healthy Start women participants who receive a postpartum visit.
GOAL	Increase the proportion of HS women participants who receive a postpartum visit to 80 percent.
MEASURE	The percent of Healthy Start women participants who receive a postpartum visit.
DEFINITION	**Numerator:** Number of Healthy Start women participants who enrolled prenatally or within 30 days after delivery and received a postpartum visit between 4-6 weeks after delivery.[5] **Denominator:** Number of Healthy Start women participants who enrolled prenatally or within 30 days after delivery during the reporting period. ACOG recommends that the postpartum visit occur between 4-6 weeks after delivery. ACOG suggests a 7-14 day postpartum visit for high-risk women.[6] A participant who has a visit prior to 4-6 weeks must still have a visit between 4-6 weeks to meet the standard and be included in the numerator.
BENCHMARK DATA SOURCES	Pregnancy Risk Assessment Monitoring System (PRAMS) (91% in 14 states with no timing restriction, 2011); Healthcare Effectiveness Data and Information Set (HEDIS) – (61.8% Medicaid HMO, 2014)
GRANTEE DATA SOURCES	**1. HS Data Collection Forms** Parent/Child Form – Q23 Numerator – Include all women participants with "Yes, between 4 weeks and 6 weeks following delivery" selected in response to Q23. **Note:** Exclude participants who selected only "Don't know" or "Declined to answer" from the numerator and denominator. **2. Grantee data systems**

SIGNIFICANCE

Since the period immediately following birth is a time of many physical and emotional adjustments, the postpartum visit is important for educating new mothers on what to expect during this period and address any concerns which may arise. Additional issues include any health complications the mother may have and the health benefits of breastfeeding for the mother and baby. [7]

[5] PRAMS measures 4-6 weeks, a visit between 28-42 days of delivery.
[6] Note: ACOG suggests a 7-14 day postpartum visit for high-risk women.
[7] http://www.aafp.org/afp/2005/1215/p2491.html

4. PERFORMANCE MEASURE Approach: Improve Women's Health Related DGIS Measure: HS 02	The percent of Healthy Start women and child participants that have a usual source of medical care.
GOAL	Increase the proportion HS women and child participants who have a usual source of medical care to 80 percent.
MEASURE	The percent of Healthy Start (HS) women and child participants who have a usual source of medical care.
DEFINITION	**4a.** **Numerator:** Total number of HS women participants that report having a usual source of care as of the last assessment in the reporting period. **Denominator:** Total number of women HS participants in the reporting period. **4b.** **Numerator:** Total number of Healthy Start (HS) child participants whose parent/caregiver reports that they have a usual source of care as of the last assessment in the reporting period. **Denominator:** Total number of child HS participants in the reporting period. A participant is considered to have a usual source of care and included in the numerator if the participant identifies a regular place where they can go for routine and sick care other than an emergency room. A participant receiving regular prenatal care from a prenatal provider is considered to have a usual source of care.
BENCHMARK DATA SOURCES	National Survey of Children's Health (Children 0-5 with a Usual Source of Care 91.7%, 2011-2012); National Health Interview Survey (Children 0-4 with a Usual Source of Care: 97.5%, 2012-2014; Women 18-44 with a Usual Source of Care 81.8%, 2012-2014)
GRANTEE DATA SOURCES	**1. HS Data Collection Forms.** (4a) Background Information – Q6 & Q7 Numerator – Include all women participants who respond "yes" to Q6, and select a response to Q7 other than "Hospital Emergency Room", "Don't know", or "Declined to answer". Participants who respond "no" to Q6 should be included in the denominator, but not the numerator.

Note: Exclude participants from the numerator and denominator who indicate "Don't know" or "Declined to answer" to either Q6 or Q7.

(4b) Parent/Child Form – Q10 & Q11

Numerator – Include all children whose parent or caregiver indicated "yes" to Q10, and selected a response to Q11 other than "Hospital Emergency Room", "Don't know", or "Declined to answer". Children with a "no" response to Q10 should be included in the denominator, but not the numerator.

Note: Exclude children from the numerator and denominator whose parent or caregiver indicated "Don't know" or "Declined to answer" to either Q10 or Q11.

2. Grantee data systems

SIGNIFICANCE

Having a usual source of medical care has been shown to improve care quality as well as access to and receipt of preventative services.[8] Further, patients having a usual source of care reduce overall costs to patients, employers, and health plans by reducing emergency department visits, hospital readmissions, and inpatient visits. [9]

[8] Blewett LA, Johnson PJ, Lee B, Scal PB. When a usual source of care and usual provider matter: adult prevention and screening services. J Gen Intern Med. September 2008 [Epub Ahead of Print May 28, 2008];23(9):1354-60.

[9] https://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home

5. PERFORMANCE MEASURE Approach: Improve Women's Health Related DGIS Measure: WMH 3	The percent of Healthy Start women participants who have a well-woman visit.
GOAL	Increase the proportion of HS women participants that receive a well-woman visit to 80 percent.
MEASURE	The percent of Healthy Start women participants who have a well-woman visit.
DEFINITION	**Numerator:** Number of Healthy Start (HS) women participants who received a well-woman or preventive (including prenatal or postpartum) visit in the 12 months prior to last assessment within the reporting period. **Denominator:** Total number of HS women participants during the reporting period. A participant is considered to have a well-woman or preventive visit and included in the numerator if she has a documented health assessment visit where she obtained recommended preventive services that are age and developmentally appropriate within twelve months of her last contact with the Healthy Start Program in the reporting period.[10] For purposes of reporting, a prenatal visit or postpartum visit during the twelve month period meets the standard.
BENCHMARK DATA SOURCES	BRFSS (Women 18-44 with a past-year preventive visit: 65.2%, 2013); Vital Statistics (any prenatal care: 98.4%, 2014); PRAMS (postpartum visit: 91%, 2011)
GRANTEE DATA SOURCES	**1. HS Data Collection Forms** (1) Non-pregnant women - Background Information Form – Q10 Numerator – Include all women participants who indicate "Yes" to Q10. **Note:** Exclude women participants who respond "Don't know" or "Declined to answer" from the numerator and denominator. (2) Pregnant women - Prenatal Form – Q5 Numerator – Include all pregnant women who indicate the number of months pregnant they were when they had their first visit for prenatal care. **Note:** For pregnant women who have not received prenatal care yet, or responded "Don't know"/ "Declined to answer", defer to Q10 from the Background Information Form.

(3) Postpartum women –Parent/Child Form – Q23

Numerator – Include all postpartum women who select any "Yes" response to Q23.

Note: For postpartum women who indicate "Not yet", "No…", "Don't know", or "Declined to answer", defer first to Q5 on the Prenatal Form, then Q10 on the Background Information Form.

2. Grantee data systems

SIGNIFICANCE

A number of illnesses that affect women can be prevented when proper well-woman care is a priority and even illnesses that can't be prevented have a much better prognosis when detected early during a regular well-woman care exam. ACOG recommends annual assessments to counsel patients about preventive care and to provide or refer for recommended services. These assessments should include screening, evaluation and counseling, and immunizations based on age and risk factors.[11]

[10] http://www.hrsa.gov/womensguidelines/

[11] http://www.acog.org/About-ACOG/ACOG-Departments/Annual-Womens-Health-Care/Well-Woman-Recommendations

6. PERFORMANCE MEASURE Approach: Improve Family Health and Wellness Related DGIS Measure: PIH 1	The percent of Healthy Start child participants who are placed to sleep following safe sleep behaviors.
GOAL	Increase the proportion of HS women participants who engage in safe sleep practices to 80 percent.
MEASURE	The percent of Healthy Start child participants who are placed to sleep following safe sleep practices (i.e., place infant on their back on a firm sleep surface without loose bedding and no bed sharing).
DEFINITION	**Numerator:** Number of Healthy Start (HS) child participants (aged <12 months) whose parent/caregiver reports that they are placed to sleep following all three AAP recommended safe sleep practices .[12] **Denominator:** Total number of HS child participants aged <12 months. A participant is considered to engage in safe sleep practices and included in the numerator if it is reported that the baby is 'always' or 'most often' 1) placed to sleep on their back, 2) always or often sleeps alone in his or her own crib or bed with no bed sharing, and 3) sleeps on a firm sleep surface (crib, bassinet, pack and play, etc.) with no soft objects or loose bedding. [13] The requirement is that the baby is placed on their back to sleep. If they roll over onto their stomach after being placed to sleep, the standard is met. Although safe sleep behaviors are self-reported, programs are encouraged to observe safe sleep practices during home visits, as possible.
BENCHMARK DATA SOURCES	Pregnancy Risk Assessment Monitoring System (PRAMS) Phase 7, Question 48 (Sleep Position) and F1 (Bed Sharing).[14]
GRANTEE DATA SOURCES	**1. HS Data Collection Forms** Parent/Child Form – Q19, Q20, & Q20a Numerator – Include all children whose parent/caregiver responded "on his or her back" for Q19, "Always" or "Often" for Q20, and "Yes" for Q20a; children with the response "On his or her side"/"On his or her stomach" for Q19, "Sometimes"/"Rarely"/"Never" for Q20, or "No" for Q20a should be included in the denominator but not the numerator. **Note:** Exclude children with "Not applicable", "Don't know", or "Declined to answer" responses from the numerator and denominator.

2. Grantee data systems

SIGNIFICANCE

It is estimated that 14% of infant deaths—those categorized as Sudden Unexpected Infant Death (SUID)—may be prevented by changing the ways babies are put down to sleep.[15]

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

[13] https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/aap-expands-guidelines-for-infant-sleep-safety-and-sids-risk-reduction.aspx#sthash.1nnEJQwk.dpuf

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

[15] http://nappss.org/plan/background.php

7. PERFORMANCE MEASURE Approach: Improve Family Health and Wellness Related DGIS Measure: PIH 2	The percent of Healthy Start child participants whose parent reports they were ever breastfed or fed pumped breast milk, even for a short period of time.
GOAL	Increase the proportion of HS child participants whose parent/ caregiver reports they were ever breastfed or pumped breast milk to feed their baby to 82 percent.
MEASURE	The percent of Healthy Start child participants that are ever breastfed or fed pumped breast milk, even for a short period of time.
DEFINITION	**Numerator:** Total number of HS child participants aged <12 months whose parent was enrolled prenatally or at the time of delivery who were ever breastfed or fed pumped breast milk. **Denominator:** Total number of HS child participants aged <12 months whose parent was enrolled prenatally or at the time of delivery. A participant is considered to have ever breastfed and included in the numerator if the child received breast milk direct from the breast or expressed at any time in any amount.
BENCHMARK DATA SOURCES	Pregnancy Risk Assessment Monitoring System (83.9%, 2011); Vital Statistics (81%, 2014); National Immunization Survey (80%, 2012)
GRANTEE DATA SOURCES	**1. HS Data Collection Forms** Parent/Child Form – Q15 Numerator – Include all children whose parent or caregiver responded "Yes" to Q15. **Note:** Exclude children whose parent/caregiver responded "Don't know" or "Declined to answer" from the numerator and denominator. **2. Grantee data systems**
SIGNIFICANCE	Breastmilk contains vitamins and nutrients babies need for good health and to protect the baby from disease. Research shows that any amount of breastfeeding is beneficial for the baby and that skin-to-skin contact of breastfeeding has physical and emotional benefits. Some studies have found that breastfeeding may reduce risk for certain diseases while also increasing cognitive development.[16]

[16] http://www.nichd.nih.gov/health/topics/breastfeeding/conditioninfo/Pages/benefits.aspx

8. PERFORMANCE MEASURE Approach: Improve Family Health and Wellness Related DGIS Measure: PIH 2	The percent of Healthy Start child participants whose parent reports they were breastfeed or fed breast milk at 6 months.
GOAL	Increase the proportion of HS child participants whose parent/ caregiver reports they were breastfed or fed breast milk at 6 months to 61 percent.
MEASURE	The percent of Healthy Start participants that breastfeed or pumped breast milk to feed their new baby at 6 months.
DEFINITION	**Numerator:** Total number of HS child participants age 6 through 11 months whose parent was enrolled prenatally or at the time of delivery that were breastfed or were fed pumped breast milk in any amount at 6 months of age. **Denominator:** Total number of HS child participants age 6 through 11 months whose parent was enrolled prenatally or at the time of delivery.
BENCHMARK DATA SOURCES	CDC National Immunization Survey (51.4%, 2012)
GRANTEE DATA SOURCES	**1. HS Data Collection Forms** Parent/Child Form – Q18 Numerator – Include all children age 6 through 11 months (Question G10) with "Yes" selected for Q18. **Note:** Exclude children from the numerator and denominator with "Don't know", or "Unable to determine" selected for Q18. **2. Grantee data systems**
SIGNIFICANCE	The American Academy of Pediatrics recommends breastfeeding for the first six months because scientific studies have shown that breastfeeding is good for both the baby's and mother's health.[17] Breastmilk contains vitamins and nutrients babies need for good health and to protect the baby from disease. Research shows that any amount of breastfeeding is beneficial for the baby and that skin-to-skin contact of breastfeeding has physical and emotional benefits. Some studies have found that breastfeeding may reduce risk for certain diseases while also increasing cognitive development.[16]

[16] http://www.nichd.nih.gov/health/topics/breastfeeding/conditioninfo/Pages/benefits.aspx

[17] http://www.babycenter.com/0_how-breastfeeding-benefits-you-and-your-baby_8910.bc

9. PERFORMANCE MEASURE Approach: Improve Women's Health Related DGIS Measure: LC 2	The percent of Healthy Start prenatal participants that abstain from smoking cigarettes in their third trimester.
GOAL	Increase the proportion of pregnant HS participants that abstain from cigarette smoking to 90 percent.
MEASURE	The percent of Healthy Start prenatal participants that abstain from smoking cigarettes.
DEFINITION	**Numerator:** Number of Healthy Start prenatal women participants who abstained from using any tobacco products during the last 3 months of pregnancy. **Denominator:** Total number of Healthy Start prenatal women participants who were enrolled at least 90 days before delivery. Smoking includes all tobacco products and e-cigarettes.
BENCHMARK DATA SOURCES	Healthy People 2020 (Baseline 89.6%, 2007), Pregnancy Risk Assessment Monitoring System (PRAMS) (89.8%, 2011); Vital Statistics (94.4%, 2014)
GRANTEE DATA SOURCES	**1. HS Data Collection Forms** Parent/Child Form – Q24 & Q25 Numerator – Include all women participants who indicated "I didn't smoke then" to Q24, and "Not at all" for all tobacco/nicotine products (a-d) in response to Q25. Participants who indicate any cigarette/tobacco/nicotine use in response to Q24 and/or Q25 should be included in the denominator but not the numerator. **Note:** Exclude women participants who indicated "Don't know" or "Declined to answer" to Q24 and/or Q25. **2. Grantee data systems**
SIGNIFICANCE	Research shows that smoking in pregnancy is directly linked to problems including premature birth, certain birth defects, sudden infant death syndrome (SIDS), and separation of the placenta from the womb prematurely. Women who smoke may have a harder time getting pregnant and have increased risk of miscarriage.[18]

[18] http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/TobaccoUsePregnancy/index.htm

10. PERFORMANCE MEASURE Approach: Improve Women's Health Related DGIS Measure: HS 03	The percent of Healthy Start women participants who conceive within 18 months of a previous birth.
GOAL	Reduce the proportion of HS women participants who conceive within 18 months of a previous birth to 30 percent.
MEASURE	The percent of Healthy Start women participants who conceive within 18 months of a previous birth.
DEFINITION	**Numerator**: Number of Healthy Start (HS) women participants whose pregnancy during the reporting period was conceived within 18 months of the previous live birth. **Denominator:** Total number of HS women participants enrolled before the current pregnancy in the reporting period who had a prior pregnancy that ended in live birth. The interval between the most recent pregnancy and previous birth is derived from the delivery date of the birth and the date of conception for the most recent pregnancy.
BENCHMARK DATA SOURCES	CDC National Survey of Family Growth, Healthy People 2020 Family Planning Goal 5; Vital Statistics[19]
GRANTEE DATA SOURCES	**1. HS Data Collection Forms** Prenatal Form – Q8 Numerator – Include all women participants who indicated "0 to 12 months" and "13 to 18 months" in response to Q8. **Note:** Exclude any participant who indicated "This is my first pregnancy", "Don't know", or "Declined to answer" from the numerator and denominator. Additionally, exclude any participants from the denominator who have not had a previous live birth as indicated in Q28 of the Background Information Form. **2. Grantee data systems**
SIGNIFICANCE	Family planning is important to ensure spacing pregnancies at least 18 months apart to reduce health risks for both mother and baby. Pregnancy within 18 months of giving birth is associated with increased risk for the baby including low birth weight, small size for gestational age, and preterm birth. Additionally, the mother needs time to fully recovering from the previous birth.[20]

[19] http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_03.pdf

[20] http://www.mayoclinic.org/healthy-lifestyle/getting-pregnant/in-depth/family-planning/art-20044072

11. PERFORMANCE MEASURE Approach: Improve Family Health and Wellness Related DGIS Measure: CH 1	The percent of Healthy Start child participants who receive well child visits.
GOAL	Increase the proportion of HS child participants who receive the last age-appropriate recommended well child visit based on the AAP schedule to 90 percent
MEASURE	The percent of Healthy Start child participants who receive well child visits.
DEFINITION	**Numerator**: Number of Healthy Start (HS) child participants whose parent/ caregiver reports that they received the last recommended well child visit based on the AAP schedule well child visit as of the last assessment within the reporting period. **Denominator:** Total number of HS child participants in the reporting period. A participant is considered to have received the last recommended well child visit based on the AAP schedule when they have been seen by a healthcare provider for preventive care, generally to include age-appropriate developmental screenings and milestones, and immunizations, in the month recommended by AAP. The AAP recommends children be seen by a healthcare provider for preventive care at each of the following ages: by 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 24 months/ 2 years, 30 months, 3 years, and then annually thereafter.[21]
BENCHMARK DATA SOURCES	National Survey of Children's Health K4Q20
GRANTEE DATA SOURCES	**1. HS Data Collection Forms** Parent/Child Form – Q14a Numerator – Include all children whose parent/caregiver indicated "Yes" in response to Q14a. **Note:** Exclude any children with "Unable to determine" selected from the numerator and denominator. **2. Grantee data systems**
SIGNIFICANCE	Childhood is a time of rapid growth and change. Regular preventive care visits are intended to assess if the child is meeting developmental milestones around hearing, vision, nutrition, safety, sleep, diseases, and growth as well as reduce the risk of serious disease and injury.[22]

[21] https://www.aap.org/en-us/Documents/periodicity_schedule.pdf
[22] https://www.nlm.nih.gov/medlineplus/ency/article/001928.htm

12. PERFORMANCE MEASURE Approach: Improve Women's Health Related DGIS Measure: WMH 4	The percent of Healthy Start women participants who receive depression screening and referral.
GOAL	Increase the proportion of HS women participants who receive depression screening and referral to 100 percent.
MEASURE	The percent of Healthy Start women participants screened for clinical depression using an age appropriate standardized tool and, if screened positive for depression, received a referral for follow-up services.
DEFINITION	**Two benchmarks are calculated to capture screening rates and referral rates:** **12a.** **Numerator:** Number of Healthy Start (HS) women participants who were screened for depression with a validated tool during the reporting period. **Denominator:** Number of HS women participants in the reporting period. A participant is considered to have been screened and included in the numerator if a standardized screening tool which is appropriately validated for her circumstances is used. Several screening instruments have been validated for use to assist with systematically identifying patients with depression.[23] **12b.** **Numerator:** Number of women participants who screened positive for depression during the reporting period and received a subsequent referral for follow-up services. **Denominator:** Number of HS women participants who screened positive for depression during the reporting period. A participant is considered to have been referred for follow-up services and included in the numerator if she is referred to a qualified practitioner for further assessment for depression. Referral can be to either an internal or external provider depending on availability and staffing model.
BENCHMARK DATA SOURCES	PRAMS (screening)

GRANTEE DATA SOURCES

1. HS Data Collection Forms

(12a) Background Information Form – Q16

Numerator – Include all women participants with "Yes, both items" selected in response to Q16.

Note: Exclude women participants with "No, was not able to administer this" selected in response to Q16 from the numerator and denominator.

(12b) Background Information Form – Q17

Numerator – Include all women participants with "Participant's total score of 3 or more indicates that additional screening and referral is needed and referral WAS PROVIDED" selected in response to Q17.

Note: Exclude all women participants from the numerator and denominator with "No was not able to administer this" in response to Q16, and "Participant's total score was less than 3 and so did not indicate a need for referral" in response to Q17.

2. Grantee data systems

SIGNIFICANCE

Perinatal depression is one of the most common medical complications during pregnancy and may include major and minor depressive episodes. It is important to identify women with depression because when untreated, mood disorders can have adverse effects on women, infants, and families. Often, perinatal depression goes unrecognized because the changes are often attributed to normal pregnancy, such as changes in sleep and appetite. Therefore, it is important and recommended that clinicians screen patients at least once during the perinatal period for depression. Although screening is important for detecting perinatal depression, screening by itself is insufficient to improve clinical outcomes and must be paired with appropriate follow-up and treatment when indicated.[23]

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

13. PERFORMANCE MEASURE Approach: Improve Family Health and Wellness Related DGIS Measure: HS 04	The percent of HS women participants who receive intimate partner violence screening.
GOAL	Increase the proportion of HS women participants who receive intimate partner violence (IPV) screening to 100 percent.
MEASURE	The percent of Healthy Start women participants who receive intimate partner violence screening.
DEFINITION	**Numerator**: Number of Healthy Start (HS) women participants who received intimate partner violence screening using a standardized screening tool during the reporting period. **Denominator:** Total number of HS women participants in the reporting period. A participant is considered to have been screened and included in the denominator if a standardized screening tool which is appropriately validated for her circumstances is used. A number of screening tools have been validated for IPV screening. Intimate Partner Violence is a pattern of assaultive behavior and coercive behavior that may include physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and reproductive coercion. These behaviors are committed by someone who is, was, or wishes to be involved in an intimate relationship with the participant.[24]
BENCHMARK DATA SOURCES	PRAMS
GRANTEE DATA SOURCES	**1. HS Data Collection Forms** Background Information Form – Q20 Numerator – Include all women participants with "Screening completed (all questions answered)" selected in response to Q20. **2. Grantee data systems**
SIGNIFICANCE	Intimate Partner Violence is a substantial yet preventable public health problem that affects women across the world. Research shows that intimate partner violence screening differs among health care specialties and is overall relatively low. The U.S. Department of Health and Human Services recommends that IPV screening and counseling to be a core part of a women's well visit. [25]

[24] http://mchb.hrsa.gov/whusa09/hstat/hi/pages/226ipv.html

[25] http://aspe.hhs.gov/report/screening-domestic-violence-health-care-settings/prevalence-screening

14. PERFORMANCE MEASURE Approach: Improve Family Health and Wellness Related DGIS Measure: HS 05	The percent of Healthy Start women participants that demonstrate father and/or partner involvement during pregnancy.
GOAL	Increase the proportion of HS women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, etc.) during pregnancy to 90 percent.
MEASURE	The percent of Healthy Start women participants that demonstrate father and/or partner involvement during pregnancy.
DEFINITION	**Numerator:** Number of Healthy Start (HS) prenatal participants who report supportive father and/or partner involvement (e.g., attend appointments, classes, etc.) in the reporting period **Denominator:** Total number HS prenatal participants in the reporting period. A participant is considered to have support and included in the numerator if she self- reports a partner who has a significant and positive role in the participant's pregnancy. Involvement during pregnancy may include, but is not limited to: • Attending prenatal appointments • Attending prenatal classes • Assisting in preparing the home for the baby e.g., putting together a crib • Providing economic support • Provide other meaningful support
BENCHMARK DATA SOURCES	Child Trend Research Brief, CDC National Health Statistics Report
GRANTEE DATA SOURCES	**1. HS Data Collection Forms** Prenatal Form – Q10 Numerator – Include all prenatal participants who indicate "Involved in my pregnancy and supportive of me and the child I'm carrying", "Involved with the child I'm carrying but not support of me", or "Involved and supportive of me but not the child I'm carrying" in response to Q10. **Note:** Exclude prenatal participants with "Declined to answer" selected in response to Q10 from the numerator and denominator. **2. Grantee data systems**

SIGNIFICANCE

Research suggests that paternal involvement has been recognized to have an impact on both pregnancy and infant outcomes. Father involvement during pregnancy has shown to reduce negative maternal health behaviors, risk of preterm birth, low birth weight, and fetal growth restrictions. [26]

[26] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3606253/

15. PERFORMANCE MEASURE Approach: Improve Family Health and Wellness Related DGIS Measure: HS 06	The percent of Healthy Start child participants <24 months whose mother reports supportive father and/or partner involvement.
GOAL	Increase the proportion of HS women participants that demonstrate father and/or partner involvement (e.g. attend appointments, classes, infant/child care) with their child participant to 80 percent.
MEASURE	The percent of Healthy Start child participants <24 months whose mother reports supportive father and/or partner involvement.
DEFINITION	**Numerator:** Number of Healthy Start (HS) child participants whose mother reports supportive father and/or partner involvement (e.g., attend appointments, classes, child care, etc.) during the reporting period **Denominator:** Total number of Healthy Start child participants <2 years of age. A participant is considered to have support and included in the numerator if the mother reports a partner who has a significant and positive role for the child. Involvement includes, but is not limited to:[27] • Engagement or direct interaction with the child, including taking care of, playing with, or teaching the child • Accessibility or availability, which includes monitoring behavior from the next room or nearby and allowing direct interaction if necessary • Responsibility for the care of the child, which includes making plans and arrangements for care • Economic support • Attending postpartum and well child visits • Other meaningful support
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	**1. HS Data Collection Forms** Parent/Child Form – Q22 Numerator – Include all women participants who complete the Parent/Child Form and indicate "Involved and supportive of me and the child", or "Involved with the child but not supportive of me" in response to Q22. **Note:** Exclude from the numerator and denominator all women participants who do not complete the Parent/Child Form, or who indicate "There is no second parent", "Don't know", or "Declined to

answer" in response to Q22.

2. Grantee data systems

SIGNIFICANCE

Father and/or partner involvement should consider participation in areas of medical appointments for infants, children and/or mother, attending HS sponsored classes, prenatal care, care for infant or child, etc.

[27] http://www.cdc.gov/nchs/data/nhsr/nhsr071.pdf

16. PERFORMANCE MEASURE Approach: Improve Family Health and Wellness Related DGIS Measure: HS 07	The percent of Healthy Start child participants age 6 through 23 months who are read to 3 or more times per week, on average.
GOAL	Increase the proportion of HS child participants aged <24 months who are read to by a parent or family member 3 or more times per week to 50 percent.
MEASURE	The percent of Healthy Start child participants age 6 through 23 months who are read to by a family member 3 or more times per week, on average.
DEFINITION	**Numerator:** Number of Healthy Start children participants whose parent/ caregiver reports that they were read to by a family member on 3 or more days during the past week during the reporting period. **Denominator:** Total number of Healthy Start child participants 6 through 23 months of age during the reporting period. Reading by a family member may include reading books, picture books, or telling stories.
BENCHMARK DATA SOURCES	National Survey of Children's Health (2011-2012)
GRANTEE DATA SOURCES	**1. HS Data Collection Forms** Parent/Child Form – Q21 Numerator – Include all children participants between 6-23 months of age (as identified in question G10) whose parent/caregiver indicated "3 days in the past week" or "4-7 days in the past week" in response to Q21. **Note:** Exclude children participants from the numerator and denominator whose parent/caregiver indicated "Don't know" or "Declined to answer" in response to Q21, and children younger than 6 months of age as indicated in question G10. **2. Grantee data systems**

SIGNIFICANCE

Reading to a child teaches them about communication, introduces concepts such as numbers, letters, colors, and shapes, builds listening, memory, and vocabulary skills, and gives them information about the world around them.[28] The American Academy of Pediatrics (AAP) promotes reading aloud as a daily fun family activity to promote early literacy development as an important evidence-based intervention beginning in infancy and continuing at least until the age of school entry.[29]

[28] http://kidshealth.org/parent/positive/all_reading/reading_babies.html
[29] http://pediatrics.aappublications.org/content/pediatrics/134/2/404.full.pdf

17. PERFORMANCE MEASURE Approach: Promote Systems Change Related DGIS Measure: HS 08	The percent of Healthy Start grantees with a fully implemented Community Action Network (CAN).
GOAL	Increase the proportion of HS programs with a fully implemented Community Action Network (CAN) to 100 percent.
MEASURE	The percent of Healthy Start grantees with a fully implemented Community Action Network (CAN).
DEFINITION	**Two benchmarks are calculated to capture Community Action Network (CAN) implementation and progress towards achieving collective impact:** **Numerator**: Number of related CAN measure components implemented by the CAN in which the Healthy Start grantee participates. **Denominator**: 3 (representing total of CAN components) This is a scaled measure which reports progress towards full implementation of a CAN. A "yes" answer is scored 1 point; a "no" answer receives no point. To meet the standard of "fully implemented" for this measure, the HS grantee must answer "yes" to all three core elements listed below: 1. Does your CAN have regularly scheduled meetings? Regular scheduled is minimally defined as? (i.e., once a month, every quarter during the reporting period). This can be documented by using sign in sheets. Yes = 1 No = 0 2. Does your CAN have members from three or more community sectors? (e.g., individuals with lived experience, Healthy Start consumer, faith based, hospital, school setting, community based organizations, government, business, medical provider(s), child care provider(s)). Yes = 1 No = 0 3. Does your CAN have a twelve month work plan? This work plan should outline the CAN's goals, objectives, activities, entities responsible for completing, and timelines. Yes = 1 No = 0

Numerator: Number of related Collective Impact (CI) measure components implemented by the CAN in which the Healthy Start grantee participates.

Denominator: 10 (representing total points for 5 CI measure components)

1. Does your CAN have a common agenda developed? All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions. This can be documented by using a theory of change, logic model, work plan template that captures this information, and/or a charter.
Yes = 2 In Process = 1 Not started = 0

2. Does your CAN have Shared Measurement Systems? The CAN has identified a common set of indicators that tracks progress/action related to the common agenda, collects data across partners, presents data on a consistent basis, and uses data to make informed decisions and to hold each other accountable.
Yes = 2 In Process = 1 Not started = 0

3. Does your CAN engage in Mutually Reinforcing Activities? Participant activities are differentiated while still being coordinated through a mutually reinforcing plan of action. This plan of action can be included on the work plan noted above and should include at least two to three activities, a description of how it is believed that the activities will impact the common agenda, how the activities will be measured, who/what organization will take the lead, and the timeline for implementation.
Yes = 2 In Process = 1 Not started = 0

4. Does your CAN have Continuous Communication? Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and appreciate common motivation. A communication plan agreed upon by stakeholders should be included as a part of the work plan noted above.
Yes = 2 In Process = 1 Not started = 0

5. Does your CAN have a backbone infrastructure in place? Creating and managing collective impact requires a dedicated staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies. Documentation is shared with CAN members describing roles and responsibilities, and skills required for staff of the entity(ies) supporting the backbone infrastructure.
Yes = 2 In Process = 1 Not started = 0

BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	A Community Action Network, or CAN, is an existing, formally organized partnership of organizations and individuals. The CAN represents consumers and appropriate agencies which unite in an effort to collectively apply their resources to the implementation of one or more commons strategies to achieve a common goal within that project area.

18. PERFORMANCE MEASURE Approach: Promote Systems Change Related DGIS Measure: HS 09	The percent of Healthy Start grantees with at least 25% community members and Healthy Start program participants serving as members of their Community Action Network (CAN).
GOAL	Increase the proportion of HS programs with at least 25 percent community members and HS program participants serving as members of their CAN to 100 percent.
MEASURE	The percent of Healthy Start grantees with at least 25% community members and Healthy Start program participants serving as members of their CAN.
DEFINITION	**Numerator:** Number of community members and Healthy Start (HS) program participants serving as members of the CAN. **Denominator:** Total number of individual members serving on the CAN. Community Member: an individual who has lived experience that is representative of the project's Healthy Start target population. Community members may include former Healthy Start participants, fathers and/or partners of Healthy Start participants, males and family members. Program Participant: an individual having direct contact with Healthy Start staff or subcontractors and receiving Healthy Start services on an ongoing systematic basis to improve perinatal and infant health. Specifically, program participants are pregnant women and women of reproductive age and children up to 18 months of age. A Community Action Network, or CAN, is an existing, formally organized partnership of organizations and individuals. The CAN represents consumers and appropriate agencies which unite in an effort to collectively apply their resources to the implementation of one or more commons strategies to achieve a common goal within that project area.
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Consumer involvement in setting the community agenda and informing efforts to effectively meet the community's needs is critical to the effectiveness of the CAN.

19. PERFORMANCE MEASURE Approach: Assure Impact and Effectiveness Related DGIS Measure: Core 2	The percent of Healthy Start grantees who establish a quality improvement and performance monitoring process.
GOAL	Increase the proportion of HS programs who establish a QI and performance monitoring process to 100 percent.
MEASURE	The percent of Healthy Start grantees who establish a quality improvement and performance monitoring process.
DEFINITION	**Numerator:** Number of related QI measure components implemented by the HS Grantee. **Denominator:** 7 (representing the four QI components) This is a scaled measure which reports progress towards full implementation of a quality improvement and performance monitoring process which consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted populations.[30] A "yes" answer is scored 1 points; a "no" answer receives no point. To meet the standard of "fully implemented" for this measure, the HS grantee must answer "yes" to all seven questions: 1. Has the organization established a culture that encourages continuous improvement of services and programs? Yes = 1 No = 0 2. Does the organization have a structure to assess and improve quality of care? Yes = 1 No = 0 3. Do providers and staff have a basic understanding of QI tools and techniques? Yes = 1 No = 0 4. Do providers and staff understand their roles, responsibilities, and expectations regarding QI activities? Yes = 1 No = 0 5. Does the organization routinely and systematically collect and analyze data to assess quality of care including HS benchmarks? Yes = 1 No = 0 6. Does the organization have resources dedicated to QI activities? Yes = 1 No = 0 7. In the previous 12 months, has your Healthy Start project conducted at least one QI project? Yes = 1 No = 0
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Grantee data systems

SIGNIFICANCE

Quality improvement and performance monitoring processes provide a mechanism for assessing the degree to which program goals are met and the effectiveness of corrective actions to ensure the best health outcomes for participants.

[30] http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/part2.html