NICHQ
National Institute for Children's Health Quality

Supporting Healthy Start Performance Project Needs Assessment

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Contents

Introduction 4
Methods 5
  Focus Group Methods 5
  Project Officer Discussion Methods 5
  Project Director Survey Methods 6
Results 6
  Focus Group Findings 6
  HRSA/MCHB Project Officer Findings 9
  Project Director Survey Findings 10
Discussion 17
  Summary of Results 17
  Cross-Cutting Themes 17
  Next steps 19

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Introduction

Launched in 1991, as a response to the nation's high infant mortality, the federal Healthy Start (HS) program has created partnerships and linkages to services, and improved systems of community care to address disparities in perinatal outcomes for communities "with the greatest risk of losing their babies" in the first year of life. The HS program grantees[1] currently represent 101 distinct communities exhibiting higher than average rates of infant mortality and consist of three Tribal Nations, at least one Appalachian community, and a mix of urban, border and rural communities across the country serving populations of predominantly African American and Latino/a families. HS communities' common thread is poverty, lack of resources, and a need to address a constellation of social determinants of health, including housing, education, economic inequality, transportation, poor access to high quality food, high crime, racism and racial bias that are contributing to poor maternal and infant health outcomes.

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

During the current funding cycle (2019-2024), the National Institute for Children's Health Quality (NICHQ) leads the Supporting Healthy Start Performance Project (SHSPP) to foster improved service delivery by HS program grantees across the country. In order to meet the diverse needs of grantees, NICHQ will deliver capacity-building assistance (CBA) to grantees focused on HS's four approaches to reduce disparities in infant mortality and perinatal outcomes: 1) improve women's health, 2) improve family health and wellness, 3) promote systems change, and 4) assure impact and effectiveness through ongoing HS workforce development, data collection, QI, performance monitoring and program evaluation.

To this end, **NICHQ has conducted a needs assessment to identify CBA needs of HS programs and develop a responsive CBA curriculum and plan.** Additionally, the needs assessment seeks to enable NICHQ to categorize grantees into cohorts. Between August 2019 and November 2019, HS staff from NICHQ's Department of Applied Research and Evaluation (DARE) led and/or participated in three (3) needs assessment activities: 1) discussions with Project Officers (POs) in the Division of Healthy Start and Perinatal Services (DHSPS) at the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB), 2) in-person focus groups with key stakeholders at the National Healthy Start Association (NHSA) meeting, and 3) a survey sent to all Project Directors (PDs) of HS programs. In this report, we describe the methods and results related to these activities synthesize findings and describe next steps for the Healthy Start Technical Assistance (TA) Center.

[1] Note that, in this report, we refer to Healthy Start grantees also as "project", "programs" and "sites."

Methods

Focus Group Methods

NICHQ hosted four focus groups at the October 2019 NHSA Annual Conference to better understand the needs of the HS sites from the perspectives of three key audiences: one group represented HS fatherhood coordinators, two groups represented HS staff, and one group represented HS consumers. Below, we summarize the date, number of participants and purpose of the focus groups.

Audience	Date of Focus Group	Number of Participants	Purpose
Fatherhood Coordinators	October 19, 2019	29	To understand how these coordinators are connected with other HS staff, the trainings they received, the support available to them, as well as how these staff recruit and retain male partners.
Staff	October 22, 2019	35 (across two groups)	To understand their intake processes, challenges with making referrals and connections to services, and experiences with recruitment and retention.
Consumers	October 22, 2019	9	To hear directly from HS consumers and to discuss their engagement with local HS programs as well as the barriers and challenges they face in receiving necessary services.

Prior to the focus groups, three staff from DARE developed interview guides for each audience with input from the Senior Project Director, Kenn Harris. These guides were utilized by NICHQ staff during the focus group sessions, which were one-hour each in duration. Two NICHQ staff facilitated and supported each focus group; the supporting staff took notes during the discussions, and sessions were recorded using the Zoom platform. After the focus groups, DARE staff reviewed the notes and recordings, organized themes from each focus group and discussed any inconsistencies noted internally across NICHQ staff.

Project Officer Discussion Methods

Beginning in August 2019, NICHQ staff conducted calls with POs to ascertain the needs of the HS grantees they represent. As of December 2019, calls have been held with five of the 15 HS POs (33%). NICHQ is continuing to reach out to POs and will update this document to reflect additional calls when they occur. With guidance and historical experience surveying HS grantees from the Senior Project Director, staff from DARE developed a standard set of questions to ask POs on the following topics: areas for and methods of delivering technical assistance (TA), mentoring needs of grantees, the ability to serve as a mentor to other grantees, and specific subject-matter expertise of grantees. Either two or three NICHQ staff participated in the PO calls, typically the Senior Project Director, the Senior Analyst from the DARE team and the Project Specialist. The Senior Project Director and Senior Analyst facilitated the calls, and the Project Specialist took notes. Notes were reviewed and themes across calls were synthesized by DARE staff.

Project Director Survey Methods

In October 2019, a needs assessment survey was distributed to all Healthy Start PDs (n=101). With leadership and guidance from the Senior Project Director, DARE staff developed draft questions aimed at understanding the following topics at the grantee-level: personnel/staffing, progress toward benchmarks, programmatic needs, data collection and reporting capacity, quality improvement capacity, partnerships and sustainability. Where appropriate, staff incorporated standardized questionnaires into the survey. Leadership at HRSA and NHSA reviewed and offered feedback on the survey, and NICHQ implemented this input with attention to the survey's overall length. The survey was programmed into and administered through an online survey platform, SurveyGizmo. NICHQ staff utilized email, the HS newsletter, webinars and personal phone calls as methods for engaging PDs and increasing response rates. By mid-November, responses were received from 67 (response rate=66.3%), with 57 complete and 10 partial responses. Raw data was downloaded and stored on a secure drive only accessible to DARE staff. Results were analyzed by DARE staff using SurveyGizmo analytics and reporting as well as Microsoft Excel.

Results

Focus Group Findings

Common elements of programmatic success emerged in all three audiences. These included actively engaging the community, providing/receiving help with needs beyond services (transportation and housing, for example), and providing incentives when participants become involved in meetings outside of their regular services. Common barriers to programmatic success included difficulties engaging with participants due to large caseloads, lack of funding resources for participant incentives, and difficulties providing resources for competing needs that participants may have (housing, immigration concerns, mental health, etc.).

Fatherhood Coordinators Focus Group Themes

The Fatherhood Coordinators focus group had 29 participants from 14 Healthy Start (HS) sites and was held to better understand how these coordinators are connected with other HS staff, the trainings they received, the support available to them, as well as how these staff recruit and retain male partners. Approximately two-thirds of the coordinators in this focus group reported being the only person assigned to their site's fatherhood program, while one-third of coordinators report ed having two or more staff dedicated to their program's fatherhood initiative on site.

Coordinators reported that recruitment of fathers was easier if both parents lived in the same household and if coordinators were able to do outreach in the community. Coordinators also had success getting referrals if there was a case manager on site, if fatherhood coordinators went with case managers to do site visits, and if coordinators attended community events.

Most coordinators shared that they received referrals to fathers from their HS program.

"Lots of success with engaging fathers in households with two parents in the same household – we can do screening and enrollment of fathers during same home visit with mom," A Fatherhood Coordinator focus group participant

Fatherhood coordinators reported several successes related to connecting fathers to local CANs.

Coordinators mentioned connecting fathers with other community organizations, particularly those that support fathers with employment, legal aid, housing and education as well as involving them in community events. Fatherhood coordinators reported sustained engagement with a father when communication was nurtured, events involved groups of fathers, and fathers were provided the same resources as the mother. Coordinators mentioned a need for additional funding, staff, visibility, and respect. They also expressed interest in a mentorship program in which newer coordinators could learn from more seasoned coordinators.

Coordinators referenced challenges with engaging with fathers and external partners to sustain a fatherhood program, including a lack of structure for their programs, an ambitious caseload of 100 men, and not knowing how much of the HS budget is going to fatherhood. Focus group participants also mentioned the difficulty of figuring out how to effectively engage fathers, waiting for referrals from community health workers, and hesitation for some moms to involve their children's fathers for fear of police intervention.

Frontline Staff Focus Group Themes

Two focus groups with HS Frontline staff were conducted in order to understand their intake processes, challenges with making referrals and connections to services, and experiences with recruitment and retention, among other topics. This group had approximately 35 participants and represented home visitors, PDs, CAN outreach coordinators, community health workers, doula coordinators, data managers, and others.

Most staff have had success recruiting new HS participants from the same sources, namely through obstetricians and gynecologists, other healthcare providers, hospital referrals, WIC referrals and participation in community events. Barriers to recruitment included staff turnover and challenges with outreach to clients who are homeless and/or undocumented. Furthermore, limitations on the use of federal funding for incentives serves as another barrier, which staff shared as impacting participant involvement.

To retain existing participants, staff from some HS programs reported leveraging donations, educational opportunities, and their personal connections with participants to keep them involved after enrollment. Some barriers staff reported post-enrollment included transportation, stigma and immigration/government concerns. One staff participant mentioned that consumers often have competing needs that preclude their participation in the HS program; for instance, if participants are worried about other issues such as housing, they may not want to come to classes or, if they only go for the incentives, they may not fully absorb the information and/or engage in the HS program.

"At the core of this, are the issues of resources, poverty, and need. Incentives can be married with the important education and support that HS gives them. But if women are hungry, they don't want to hear about your birthing class. No matter what you do;

as we talk about trouble with retention, we have to face that. People want stuff that they need. They're not going to come to classes without their real/more immediate needs being met. It's hard for them to concentrate on other things if they can't meet their needs," A Frontline Staff focus group participant

Several staff shared that they devote meaningful time to referrals to other services such as mental health, housing, and domestic violence agencies as well as to classes and support groups. Staff noted success with these services when they had strong and trusting relationship with participants. Barriers to referring participants to other services consisted of an inability to cover the costs for services.

Many staff mentioned access to health insurance as a barrier for women and families. Language served as an additional constraint due to the paperwork required to enroll participants in health insurance. Many staff had concerns regarding the fatherhood program – they wanted more information from HRSA about collection of data, and also had concerns about the bandwidth needed to support 100 fathers. One staff mentioned confidentiality issues; for example, in the case of domestic dispute and one party is served with an order of protection, do both parties remain clients? Staff also mentioned a need for more support and resources to devote toward their CANs and the implementation of HS screening tools.

Consumers Focus Group Themes

*HS participants repeatedly shared that **incentives**, such as stipends, childcare, and food, motivated them to attend meetings outside of HS services. They also mentioned these incentives as important because it was a form of being valued for their time*

The Consumer focus group included 9 current and former HS consumers, such as mothers and fathers. This focus group was conducted to hear directly from HS consumers and to discuss their engagement with local HS programs as well as the barriers and challenges they face in receiving necessary services, among other topics. Participants reported that they engage in meetings outside of regular HS services depending on the topic of the meeting and what they personally need at the time. Some participants mentioned attending these events to be social and meet other moms, which helped foster a familial feeling for the program, while others mentioned not attending if the meeting did not seem pertinent to them.

"Before I became employed with Healthy Start, I went to everything. Incentives… sometimes that was my best part of my day. Food was enough sometimes to go to meetings. When you're trying to get your bearings about yourself… [a] stipend or gift card, it was always nice to be valued for my time, something that was provided always kept me coming. If it was like a $20 gift card, I would take [that] back to the caretaker of my babies. Incentives are a form of value for time," A Consumer focus group participant

Highlights from Consumers group

- Incentives helped engagement
- Consumers challenged by competing priorities
- Consumers prefer one-on -one meetings with HS staff
- Transportation encouraged participation
- Importance of trusting relationships between consumers and staff

Competing priorities was another topic discussed in this group. Consumers would miss meetings if they were focused on other priorities, such as housing and employment. Consumers also felt staff could increase participation by publicizing these meetings, educating communities and by engaging in one-on-one meetings with consumers. Support with transportation also motivated participants to attend meetings outside of services. Consumers also spoke of the importance of trusting relationships with staff and how that helped them be more open to learning about services. Consumers expressed discouragement that so few fathers participated in meetings.

In terms of services, consumers discussed being more aware of community opportunities than they were of services offered through Healthy Start. One participant mentioned having a good experience after researching and finding a black doctor that was also a mother she could trust and shared that this was able to happen because she was educated. Most consumers shared negative experiences – such as being called "*ghetto*" or "*someone with mental health issues*" – and reported feeling distrustful of medical professionals and the health care industry, which leads to avoidance. Consumers mentioned the importance of having advocates and feeling a sense of empowerment of knowing your personal rights related to accessing care.

HRSA/MCHB Project Officer Findings

Technical Assistance Topic Areas and Delivery Methods

Areas for TA raised by POs:

1. *Fatherhood*
2. *Breastfeeeding*
3. *Recruitment and outreach*
4. *Data Collection and screening tools*
5. *Mentorship*
6. *Maternal mortality supplemental funding*
7. *CAN development*
8. *Staffing*
9. *Urban revitalization*
10. *Training for staff*

Ten areas for TA support emerged during these calls. Notably, the need for support on grantees' Fatherhood Initiatives was raised by all POs. Grantees will benefit from immediate support for outreach and recruitment strategies for fathers, as well as dedicated time and space for fatherhood coordinators to share learnings and challenges. POs also mentioned the need to consider "parenting penalties," or tax incentives for remaining a single parent, and the impact on father involvement. The importance of arriving at a shared definition for fatherhood across all grantees was raised as well. Another frequently discussed topic on these calls

was how the TA Center could best support breastfeeding initiatives and the recommendation for dedicated time and space for International Board-Certified Lactation Consultants (IBCLCs) across grantees to share learnings and challenges. POs raised general challenges related to recruitment and outreach as well, particularly for rural grantees, and dedicated time needed for projects with supplemental maternal mortality funding to share resources and experiences. Finally, several POs discussed challenges related to data collection and the concerns of their grantees related to the expiration of the current screening tools.

Mentoring and Subject Matter Experts

As part of the discussions with POs, NICHQ has generated a list of grantees who are experts in the areas of fatherhood, data collection and evaluation, and maternal mortality/morbidity, as well as grantees who may need support from more advanced projects. For example, sites may be poised to mentor other grantees on the subjects of fatherhood and data collection. POs recommended that the TA Center establish opportunities for sub-groups to discuss their experiences and challenges (i.e., fatherhood coordinators, rural grantees), highlight a successful/veteran grantee on a webinar, and ensure that grantees know the process for requesting TA through the EPIC website.

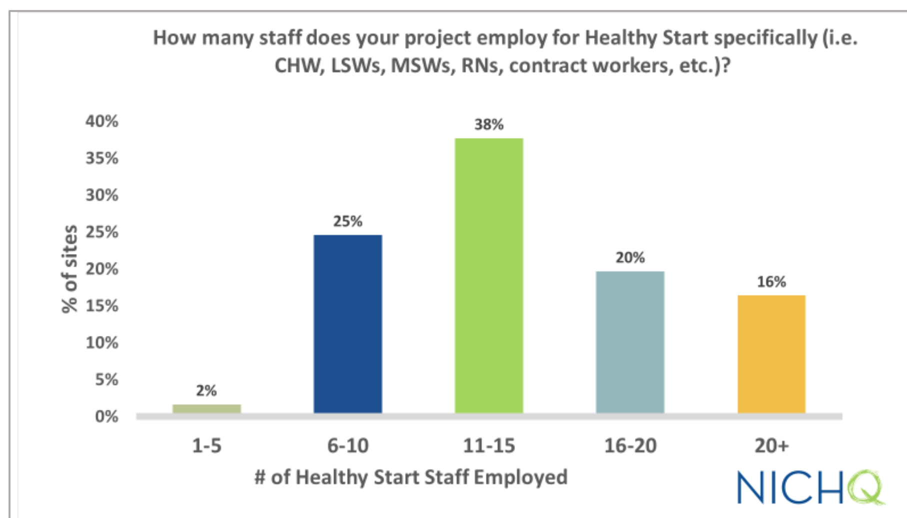
Project Director Survey Findings

Below we present the overall results of the PD survey – which reflects overall findings from quantitative and qualitative analyses – as well as survey results among sub-groups for which TA needs may differ. For example, we present survey findings by grantee tenure (new and never funded, new to this grant cycle but previously funded, continuing grantee the last funding cycle).

Overall survey findings

Personnel/Staffing

Among the PDs that responded to the survey (n=67), 38% of sites employed 11-15 Healthy Start staff (CHWs, LSWs, MSWs, RNs, contract workers, etc.), 25% employed 6-10 staff, 20% employed 16-20 staff, and 16% employed 20 or more staff. Only one site responded that there were fewer than six



Healthy Start staff employed at their site. Among the PDs that responded to the questions about staff supporting breastfeeding, 26% reported that the Healthy Start site had no Certified Lactation Counselors (CLCs), 34% had one CLC, 29% had 2-4 CLCs, and 11% had five or more. While 78% had no IBCLCs, 15% reported that they had one and 6% had two or more IBCLCs.

When asked about **additional staffing**, 44% of PDs responded that they have staff members that provide mental health counseling directly to HS participants, 32% have staff members that provide substance use counseling, and 21% have staff who are certified mental/behavioral health peer specialists or recovery support specialists/coaches.

Benchmarks

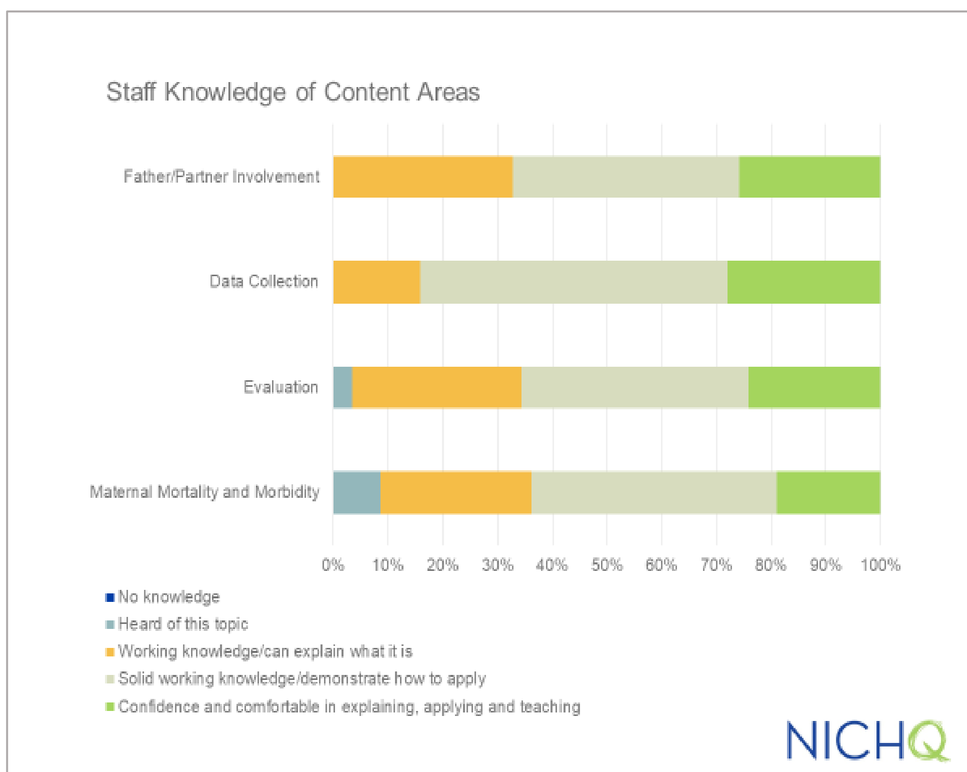
PDs from grantees that were previously funded (n=11) and continuing grantees (n=50) were asked to indicate which benchmarks their projects have successfully met and those which their projects have struggled to meet. (Newly-funded grantees were not asked these survey questions.) The responses are shown in the table below, with the percentages in ***red*** indicating those where less than 50% of PDs responded that their program has successfully met the benchmark and percentages in ***purple*** where more than 50% of PDs reported that they struggled to meet the benchmark. This is being used to highlight potential problem areas where grantees need assistance. This table reveals that grantees are particularly successful with benchmarks related to health insurance enrollment, participants with usual medical care, and CAN implementation (over 85% of grantees have met benchmarks i, iv, and xvii).

Benchmark	Percentage responding successfully met	Percentage responding struggled to meet
i. Increase the proportion of HS women and child participants with **health insurance** to 90% (reduce uninsured to less than 10%)	88.7%	7.7%
ii. Increase the proportion of HS women participants who have a **documented reproductive life plan** to 90%.	79.2%	13.5%
iii. Increase the proportion of HS women participants who receive a **postpartum visit** to 80%.	***47.2%***	40.4%
iv. Increase the proportion of HS women and children participants who have a **usual source of medical care** to 80%.	86.8%	7.7%
v. Increase the proportion of HS women participants who receive a **well-woman visit** to 80%.	71.7%	21.2%
vi. Increase the proportion of HS women participants who engage in **safe sleep practices** to 80%.	71.7%	19.2%
vii. Increase the proportion of HS child participants whose parent/caregiver reports they were **ever breastfed or pumped breast milk** to feed their baby to 82%.	***41.5%***	***53.8%***
viii. Increases the proportion of HS child participants whose parent/care giver reports they were **breastfed or fed breast milk at 6 months** to 61%.	***22.6%***	***78.8%***
ix. Increase the proportion of pregnant HS participants who **abstain from cigarette smoking** to 90%.	67.9%	25.0%
x. Reduce the proportion of HS women participants who **conceive within 18 months of a previous birth** to 30%.	69.8%	26.9%
xi. Increase the proportion of HS child participants who receive the **last age-appropriate recommended well child visit based on AAP schedule** to 90%.	69.8%	25.0%
xii. Increase the proportion of HS women participants who receive **depression screening and referral** to 100%.	67.9%	19.2%
xiii. Increase the proportion of HS women participants who receive **intimate partner violence screening** to 100%.	64.2%	26.9%

xiv. Increase the proportion of HS women participants who demonstrate **father and/or partner involvement during pregnancy** to 90%.	***35.8%***	***53.8%***
xv. Increase the proportion of HS women participants who demonstrate **father and/or partner involvement with their child participant** to 80%.	***43.4%***	***50.0%***
xvi. Increase the proportion of HS **child participants aged <24 months who are read to by a parent or family member 3 or more times a week** to 50%.	73.6%	17.3%
xvii. Increase the proportion of HS programs with a **fully implemented CAN** to 100%.	90.6%	5.8%
xviii. Increase the proportion of HS programs with **at least 25% community members and HS program participants serving as members of their CAN** to 100%.	60.4%	28.8%
xix. increase the proportion of HS programs who establish a **QI and performance monitoring process** to 100%.	84.9%	3.8%

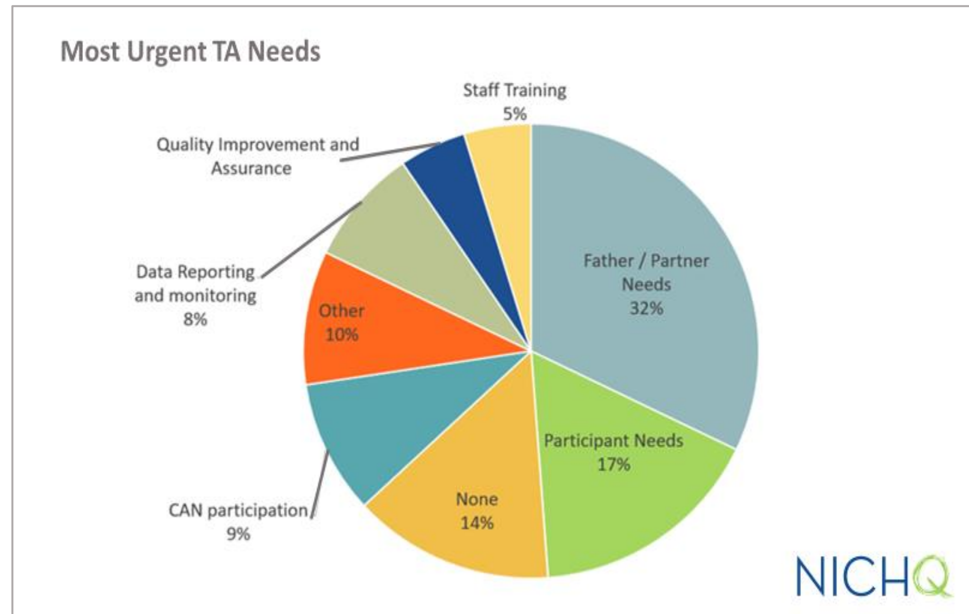
Programmatic Needs

Almost half of the PD survey questions focused on understanding a wide range of grantees' programmatic needs, which reveal numerous areas of achievement as well as areas requiring additional support from the TA Center. Survey data indicates that nearly all projects have a CAN in place (95.2%), have obtained supplemental HRSA funding to hire clinical service providers (82.4%), have hired a fatherhood coordinator (77.9%), screen for social needs (91.9%) and connect participants with community resources (98.4%). Similarly, roughly two-thirds of PDs responded that they have project staff members who are considered subject matter experts (69.7%) and responded that they would be willing to serve as a mentoring project to new projects (64.8%). When asked to select the staff's knowledge of specific content areas, such as father/partner involvement, data collection, evaluation and maternal mortality and morbidity, the majority of PDs responded that they had at least a "solid working knowledge of this topic and could demonstrate how to apply it to daily work," although only half (55.6%) have developed SMART aims for their work.



Several open-ended survey questions were fielded to determine grantees' technical assistance needs. The most frequently reported priority area for support over ***the next two years*** was the fatherhood initiative

(28% of PDs). PDs mentioned fatherhood as an area for support due to the new requirement to serve 100 fathers in Healthy Start as well as challenges related to the recruitment, retention and engagement of fathers. Additionally, one-fifth of PDs referenced data collection and reporting as a priority area for support, and topics related to improving women's health (including increasing breastfeeding rates and sustaining breastfeeding up to and past 6 months) were reported by 15% of respondents. Other areas mentioned as priority areas included: the implementation of new screening tools (15%), support for services (such as prenatal care, postpartum, behavioral health, and referral management) (7%), and promoting systems change (6%).



The most urgent TA need PDs mentioned for ***the next 3-6 months*** was support related to fathers and partners (32%), including recruiting fathers, engaging fathers, and supporting fatherhood staff. Similarly, 17% of PDs identified the needs of female participants as an area for urgent TA, specifically in the areas of prenatal recruitment, outreach, enrollment, retention, adherence to referrals, engagement post-delivery, and breastfeeding (including past 6 months). Other respondents also mentioned CAN participation (10%), data reporting and monitoring (8%), quality improvement and assurance (5%), and staff trainings (5%) as areas for immediate TA. Ten percent of PDs mentioned "other" topics, including family engagement, fetal infant mortality review, standardized tools, screening tools, maternal mortality/morbidity expansion, and marketing plans. Fourteen percent of PDs did not list any areas for immediate TA.

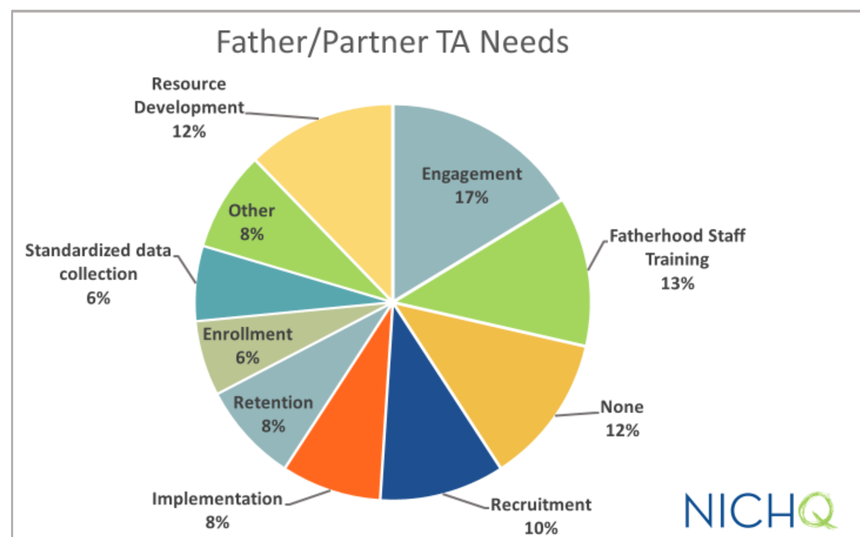
PD were also asked what supports they needed to ***achieve the targets*** of serving 300 pregnant women, 300 infants/children and 100 fathers/male partners each year. The most frequently mentioned need to achieve the target of serving at least 300 women was supports for participants (46%), such as retention, enrollment, recruitment, engagement, outreach, keeping appointments, and referrals. Other PDs noted a need for best practices for serving this population (10%), additional staff (6%), marketing materials (6%) and additional resources such as funding, training, transportation, support from providers, and screening tools (2%). Nearly one-quarter of PDs reported that they did not need additional supports to achieve this target.

To reach the target for infants and children, most PDs (70%) responded that they did not face challenges achieving this target. Other PDs reported the need for additional staff (7%), additional funding (4%),

successful strategies and best practices (4%), outreach (4%), marketing (4%), training opportunities (4%), and support of providers and CAN members (4%) in order to meet this target.

Finally, to achieve targets for serving fathers and male partners, 44% of respondents mentioned that they needed support related to engaging fathers/male partners, including recruitment, enrollment, retention, and referrals. PDs also requested support with defining criteria for fathers (10%), specifically regarding guidelines for who counts as a male participant/father, whether a father and child can be in program without a mother, and better understanding the grant requirements related to fatherhood. Other TA areas mentioned to achieve the fatherhood targets were additional funding for dedicated male staff positions (7%), standardized marketing materials for fatherhood (5%), screening tools that help support standardized data collection and incorporate presence of a father (5%) and training opportunities on and/or best practices for fatherhood programming (5%). Nearly one-quarter of PDs reported that they did not need additional supports to achieve this target.

PDs offered insights into the TA and training needs to support specific programmatic elements as well, including fatherhood, breastfeeding and data review processes to inform programing. Related to fatherhood, 16% of PDs respondents mentioned father engagement as an area of TA need, including, support related to community education in the parent/fatherhood curriculum.



PDs also raised the need for TA on recruitment (10%), specifically in encouraging women to refer male partners to father involvement services, as well as retention (8%), and enrollment (6%). Additionally, PDs requested trainings for fatherhood staff (12%), best practices with fatherhood implementation (8%), standardized data collection (6%), resource development (including marketing and social media strategies for a national campaign) (6%), including but limited to program and curriculum development. To support breastfeeding initiatives, 20% of PDs raised the need for support for the initiation and continuation of breastfeeding, specifically addressing breastfeeding misconceptions and stigma and encouraging African American women to breastfeed. Roughly the same proportion (18%) requested more funding to train and hire Certified Lactation Consultants (CLCs), as well as more TA for lactation training and certification. Other topics raised by PDs included TA for breastfeeding 6 months or longer (16%), webinars on different breastfeeding topics (9%) such as going back to work and breastfeeding, engaging partners (2%), materials in other languages such as Spanish (2%), and breastfeeding while on other medications (including medications used by people who use drugs) (2%). Over a quarter of PDs that responded to this question did not specify any specific TA needs related to breastfeeding. Finally, more than half of PDs responded that they needed support with Fetal and Infant Mortality Review (65.5%), Maternal Mortality Review (51.7%) and Perinatal Periods of Risk (55.2%).

Data Collection and Reporting

More than 90% of PDs responded that their project has a performance monitoring plan in place, including process and outcomes metrics to assess performance (91%) and a data collection system, including case management, process and outcome data (93%). PDs were asked about facilitators and barriers to their project's data collection and submission of client-/ participant-level data. The top three things that helped were access to technology (79.6%), data management systems (75.9%), and standardized screening tools (72.2%), while the top three challenges were data management systems (53.2%), patient privacy concerns/regulations (31.9%), and staff resources dedicated to data collection/submission (31.9%). More than 50% of PDs wrote in additional challenges, including legal issues (IRB issues, Data Use Agreements, etc.), resource issues (lack of funding, staff capacity), availability of data, and issues with the reporting requirements.

Other areas of TA requested included: helping case managers on the most effective ways to include fathers/partners in home visits, fundraising, CoIIN Tools, HRSA reporting requirements for fathers, and what to do with single dads with no female partner enrolled in HS.

Findings from sub-group analyses

In order to determine the needs of particular grantees, we examined survey responses by grantee tenure (new and never funded, new to this grant cycle but previously funded (prior to 2014), continuing grantee the last funding cycle) and present data most salient to TA planning and for which variability was apparent. (Note: data was also examined by grantee location (urban, rural, border and tribal community. Location appears to impact grantees' ability to meet some benchmarks, however, to ensure that data remains deidentified, this analysis is not presented here.)

Of the 67 respondents to the PD survey, 74.6% (50) responded that they were continuing grantees from last funding cycle, 16.4% (11) responded new and never funded by HS, and 8.9% (6) responded new to this grant cycle but previously funded by HS.

Although we did not conduct formal tests to determine statistically significant differences across groups, tenure appears to impact grantees' ability to meet some benchmarks. (Note: new and never funded grantees were not asked questions about benchmarks, therefore, data for these grantees is not presented below.) Continuing grantees from the last funding cycle reported more success with benchmarks overall compared to grantees new to this cycle but previously funded, especially for benchmarks iii, v, xv, xvii and xix, which focus on female participant and community engagement as well as QI.

Benchmark successfully met	New to this grant cycle but previously funded by Healthy Start (before 2014)	Continuing grantee from last finding cycle
iii. Increase the proportion of HS women participants who receive a postpartum visit to 80 percent.	20%	50%
v. Increase the proportion of HS women participants who receive a well-woman visit to 80 percent.	40%	75%
xv. Increase the proportion of HS women participants who demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) with their child participant to 80 percent.	20%	45.8%
xvii. Increase the proportion of HS programs with a fully implemented Community Action Network (CAN) to 100 percent.	80%	91.7%
xix. Increase the proportion of HS programs who establish a QI and performance monitoring process to 100 percent.	60%	87.5%

A greater proportion of new-to-this-cycle grantees reported being unsuccessful in meeting benchmarks iii, v, xiii and xiii, which pertain to supporting and engaging female participants and CANs, compared to continuing grantees, although more continuing grantees struggled with benchmarks vi, x and xi which all relate to engaging participants in the early months of their child's life.

Benchmark unsuccessfully met	New to this grant cycle but previously funded by Healthy Start (before 2014)	Continuing grantee from last funding cycle
iii. Increase the proportion of HS women participants who receive a postpartum visit to 80 percent.	80%	36.2%
v. Increase the proportion of HS women participants who receive a well-woman visit to 80 percent.	60%	17%
vi. Increase the proportion of HS women participants who engage in safe sleep practices to 80 percent.	0%	21.3%
x. Reduce the proportion of HS women participants who conceive within 18 months of a previous birth to 30 percent.	0%	29.8%
xi. Increase the proportion of HS child participants who receive the last age-appropriate recommended well child visit based on AAP schedule to 90 percent.	0%	27.7%
xiii. Increase the proportion of HS women participants who receive intimate partner violence (IPV) screening to 100 percent.	60%	23.4%
xviii. 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.	60%	25.5%

Approximately 80% of sites of all tenure have hired fatherhood coordinators. Similarly, most sites reported having between one and five CLCs (55% of new sites, 88% of previously funded, and 67% of continuing grantee sites). It was not common for new and never funded and continuing sites to have IBCLCs, but over 40% of new but previously funded sites had at least 1 IBCLC. All sites previously funded and continuing grantees reported having a CAN in place, while 67% of new and never funded sites reported having CANs in place.

TA needs were examined by grantee as well. For newly funded sites, the top support needs included CAN development, whereas father and partner engagement were cited as a top need for previously funded

and continuing grantees. New sites also reported staff training as needed support. Supporting female participants was reported by new sites and continuing sites as well.

Discussion

Summary of Results

Across all need assessment activities, NICHQ gathered insights from 145 HS stakeholders, ranging from consumers, staff, Project Directors, and Project Officers. Focus group participants unanimously highlighted the importance of actively engaging and motivating the community as well as supporting participants with transportation, housing, and other non-service-related needs. Likewise, POs reported an immediate need for TA around recruitment and outreach. POs indicated that grantees would benefit from support around fatherhood and breastfeeding initiatives. PDs echoed this sentiment in their survey responses, particularly the need for TA to recruit and engage fathers and to support fatherhood coordinators. These needs are reflected in the benchmarks that PDs that grantees most commonly struggled to meet (benchmarks vii and viii related to breastfeeding and xiv and xv related to father/partner involvement).

Cross-Cutting Themes

Several themes emerged across multiple needs assessment activities. Below we summarize the cross-cutting topics that surfaced most prominently.

1. One Size Does Not Fit All

This needs assessment reveals that grantees possess unique TA needs depending on location and tenure. For example, previously funded grantees that are new to this funding cycle reported being less successful with benchmarks, compared to continuing grantees. It is likely that new and never funded grantees would require even more support to achieve benchmarks. Location appears to impact grantees' ability to meet certain benchmarks as well.

2. Fatherhood Program Assistance

Although nearly 80% of grantees have hired fatherhood coordinators, PDs reported that the most urgent TA need (in the next 3-6 months as well as the next 2 years) is related to fatherhood. PDs echoed this notion in a survey question focused on supports required to meet the target of 100 male partners and fathers per year. According to POs and fatherhood coordinators, a mentorship program for fatherhood coordinators may be warranted along with a universal HS-branded fatherhood marketing campaign. Grantees and staff also require clarity on what constitutes a father, as definitions may vary, as well as supports for handling complex situations related to fatherhood (i.e., how to handle situations if a female participant is fearful to involve a father, how to approach domestic disputes when both parents are participants, whether to enroll single dads with no mother enrolled and a recognition of "parenting penalties" and their implications for involving father in HS.)

3. Participant Retention

PDs reported that prenatal recruitment, outreach, enrollment, retention and engagement post-delivery was a top TA need for the next 3-6 months, and PDs also relayed this sentiment in a question related specifically to achieving the target of serving 300 women annually. Participant engagement may be especially challenging for rural grantees, according to POs, and for populations of undocumented and

homeless women, according to frontline staff. Although the insurance benchmark is generally being met, staff in focus groups mentioned the demands of enrolling participants in insurance, especially if English was not the participant's primary language. Staff requested additional training in order to more effectively aid participants. Finally, the need for providing incentives for participants was raised extensively by both staff and consumers in focus groups to encourage both engagement and retention in the program.

4. Addressing social needs

Although 92% of grantees screen for social needs, focus group participants revealed the importance of addressing participant concerns such as housing and transportation, which may preclude their ability to engage in HS. PDs also indicated that funds for transportation specifically would help with achieving the target of serving 300 women each year which echoed consumer voices on the importance of transportation being provided so that they can attend services and other events.

5. Community Action Networks

Even though 95% of grantees have a CAN in place, a need for support to develop CANs was reported across multiple needs assessment activities. This was especially true for new and never funded grantees. Support for CANs was one of the top four TA needs in the next 3-6 months raised by PDs. Frontline staff in focus groups also reported a need for more resources, including time, required to devote toward their CAN. This sentiment was echoed by PDs in the survey.

6. Breastfeeding

Fifteen percent of PDs raised support for breastfeeding services as a TA need for the next two years. In a survey question related to breastfeeding support specifically, PDs mentioned the need to address stigma around breastfeeding as well as funding for lactation consultants. There are few IBCLCs on staff at HS sites; the PD survey indicates that 78% of grantees do not have IBCLCs on staff, although CLCs are more common. Nevertheless, POs mentioned that dedicated time and space for lactation consultants to meet and share experiences was warranted

7. Data collection and reporting

One-fifth of PDs referenced data collection and reporting as a top need for support in the next two years, and over half of PDs reported that challenges with data systems management have hindered their collection and submission of participant-level data. Grantees may need specific supports related to FIMR, MMMR and PPOR as well as the use of screening tools. POs also mentioned concerns from their grantees about how to continue with data collection given the imminent expiration of the current screening tools.

Next steps

The primary objective of this needs assessment was to identify CBA needs of HS programs and develop a responsive CBA curriculum and plan to support the following areas: 1) improve women's health, 2) improve family health and wellness, 3) promote systems change, and 4) assure impact and effectiveness through ongoing HS workforce development, data collection, QI, performance monitoring and program evaluation.

NICHQ will disseminate and invite feedback on the needs assessment in several ways. First, NICHQ will present findings to MCHB on January 21, 2020. Following the presentation, this report will be available to the HS Faculty Planning Committee, which will use the needs assessment to inform the project's TA approach and capacity-building support from their respective organizations. Salient subject-matter experts will be actively engaged to respond to TA requests (submitted though the EPIC website) related to topics highlighted in the needs assessment. Finally, NICHQ has scheduled a TA launch for grantees on January 28, 2020 and will host an inaugural webinar to present the most important themes from this needs assessment and to describe the CBA plan. The TA Center will continue to utilize this report to develop webinars and TA offerings at the grantees meeting in the spring of 2020.

In addition to the provision of TA, data from this needs assessment will contribute to NICHQ's overall evaluation work led by DARE. Select data related to QI knowledge, partnership and sustainability that was collected as part of the PD survey may serve as baseline data for these domains, on which NICHQ can continue collecting data throughout the remaining years of the SHSPP grant.

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