2019-2024 HEALTHY START IMPACT REPORT[1]

Introduction

The purpose of the Healthy Start (HS) Impact Report is to provide a written summary, from the grantee's perspective, of the experience and impact of their Healthy Start program on their population and area of focus. Please use the following outline in writing your project's Impact Report. (Narrative must be limited to 30 pages. Attachments do not count against the page limit

Any materials that were developed by the project that are not electronically available and cannot be scanned and uploaded should be sent to your project officer in hard copy format by June 28, 2024.

I. Overview of Project's Focus on Disparities

Identify the geographic area and target population that were the focus of your project. Describe from your initial community needs assessment the perinatal health indicators that highlighted prevalent disparities in your community. Discuss whether your focus changed over the course of the grant; if so, please describe and explain why.

II. Project Implementation

Using as a framework the four Healthy Start approaches improve women's health; improve family health and wellness; promote systems change; and, assure impact and effectiveness, identify how your Healthy Start Project implemented each approach. For each approach, answer sequentially the following:

A. Based on your particular community's needs, service system assets, and challenges, describe your method and accompanying justification for addressing the four Healthy Start approaches to reducing disparities in infant mortality and adverse perinatal outcomes.

   i. For each of the four approaches, identify the components of your intervention and the resources (including personnel) needed to implement the intervention.

   ii. Include activities for any HS supplement (e.g. Action Plans for Infant Health Equity, Community-Based Doulas, Maternal Mortality Clinician Funding) received during the grant cycle in your discussion.

B. Discuss any changes over the project period and the rationale for the changes (e.g., How did your intervention change over the course of the 5-year grant cycle? Why did the intervention and/or resources change? How were the changes made?)

C. Highlight evidence-based practices, with an emphasis on activities improving participant services that you would like to share with other programs.

D. Describe resources that either supported or inhibited successful implementation of the four approaches, and how you overcame or addressed any resource changes.

Community Action Network (CAN)

[1] *This serves as the Final Report of your past project period.*

A. Describe the working structure of the CAN that was in place for the majority of the implementation and its composition by member name, name of organization represented and type of entity (e.g. local government, program participant, community-based organization). Detail the number of CAN members, the percent of community members and how the program provided leadership to the CAN.

B. Identify any barriers that emerged in your CAN's establishment and how they were addressed.

C. Describe the CAN activities utilized to assess ongoing program needs, identify resources, establish priorities for allocation of resources, and monitor implementation.

D. Identify key areas of focus of the CAN throughout the grant cycle. Highlight how the CAN actively participated in community collaboration, information sharing, and advocacy and how this participation contributed to achieving common goals and objectives.

E. Describe the CAN's major strengths, which enhanced development, and any weaknesses, which were addressed in order to support development.

F. Explain what CAN activities/strategies were implemented to increase program participation. How did these change over time?

G. Provide an example(s) of program participant input in the CAN decision-making process.

Collaboration and Coordination with Local, State, Regional and National Leadership

A. Describe collaboration efforts with others in the community to educate, establish, maintain, and make available a comprehensive perinatal system of care.

B. What type of linkages occurred with the State and Local Title V agencies? Describe how these linkages promoted cooperation, integration, and dissemination of information with other community services funded under the Maternal and Child Health Block Grant.

C. Describe any challenges in your attempts to collaborate and coordinate with Title V, and how you addressed them.

    i. If you were unable to overcome these challenges, what was not accomplished as effectively or efficiently as a result? What suggestions do you have for future collaboration?

    ii. If you were not successful in your collaboration with Title V, what were the negative results or repercussions? What suggestions do you have to improve future working relationships?

D. Describe your program's participation in one or more of the following activities: Fetal Infant Mortality Review (FIMR), Maternal Morbidity and Mortality Review (MMMR), and Periodic Periods of Risk (PPOR).

Sustainability

A. Describe your efforts to sustain the project through new or existing sources and/or to

acquire additional resources.

B. Describe major factors associated with the identification and development of resources to continue key components of your interventions without HS funding (or a reduction in funding).

C. Describe whether or not you were able to overcome any barriers to sustainability or to minimize the negative impact of those barriers.

Telehealth (if applicable)

A. Describe how telehealth was used for your project (e.g. clinical services, distance learning, workforce training).

B. Detail the telehealth focus of your project (e.g. COVID-19, maternal health, intimate partner violence, pediatrics).

C. Describe the type(s) of telehealth technology used (e.g. artificial intelligence, remote patient monitoring).

III. Project Management

A. Briefly describe the project management structure that was in place for the majority of the project's implementation. How did it change during the course of the project, and why?

B. Describe what the project did or used that proved to be essential for fiscal and program management.

C. Describe what process was developed to assure the appropriate distribution of funds and what happened with the process over time.

D. As the project moved forward with implementation, what additional (non-HS) resources were obtained for quality assurance purposes, program monitoring, service utilization, and technical assistance, such as existing contracts and additional staff members?

E. How did the project address the issue of cultural competency among contractors and project staff? What noticeable benefits were realized?

IV. Project Accomplishment

A. Please detail the project period objectives for all 19 Healthy Start benchmarks (*Appendix A*). Within the narrative (or using the suggested format in *Attachment A*) describe in both quantitative and qualitative terms the degree of success in achieving each project period objective. Highlight innovative projects that addressed unique challenges in your service area. Describe any challenges encountered during implementation and strategies/steps to overcome them. Summarize all lessons learned.

B. For those projects that received mentoring or technical assistance from another site, please discuss any activities/best practices/lessons learned from those projects that you utilized. If you provided technical assistance (i.e., were the mentor), describe your activities, feedback received on them, and any other lessons learned.

V. Project Impact

Based on a review of all of your project's HS grant submissions during the project period (i.e. Non-Competing Continuation (NCC) Progress Reports, Annual Performance Reports, Monthly Aggregated Data Reports), and the services and strategies implemented, describe the impact of Healthy Start on your focus area and community. Organize your description using the outline below.

A. Impact of Collaborations: Describe how the project has enhanced collaborative interaction among community organizations and services involved in advancing maternal and child health.

1. Describe the approaches utilized to enhance collaboration.
2. Identify the extent to which structured changes (i.e., procedures or policies) were established for the purpose of system integration.
3. Describe key relationships that developed as a result of Healthy Start efforts in the following areas:
    a. Interactions among health service agencies; between health and social service agencies; and, with other community-based organizations
    b. Efforts that focus on involvement of consumers and/or community leaders (who are not employed by a health or social service agency) with any of the agencies/organizations listed above or any additional agencies.
4. Describe the impact that your HS project had on the comprehensiveness of services among the focus population, particularly in the following areas:
    - Eligibility and/or intake requirements for health or social services (e.g., home visiting, food assistance, WIC, family planning, patient navigation).
    - Barriers to access and service utilization as well as community awareness of services, and how you addressed these barriers.
    - Care coordination, including descriptions of mechanisms implemented to assure continuity of care, quality improvement, and follow-up system(s) for client referrals.
    - Efficiency of agency records systems and data-sharing across providers (within the confines of confidentiality rules) to reduce duplication of effort and to ensure optimal case management and care provision.

B. Impact on the Community: Describe the impact the project has had on developing and empowering the community, at a minimum in the following areas:

1. Residents' knowledge of resource/service availability, location, and accessibility.
2. Consumer participation in establishing or changing standards and/or policies of participating service providers and local governments that affect the health or welfare of the community and have an impact on infant mortality reduction.
3. Community experience in engaging with diverse perspectives, resolving conflicts, and building teams/coalitions.
4. Creation of jobs within the community.

C. Impact on the State: Over the past five years, Healthy Start has supported activities to strengthen and develop relationships with the State Title V program. In some states where there was more than one HS project, the Division of Healthy Start and Perinatal Services (DHSPS) encouraged collaboration across these sites. Describe the activities and impact that this approach has had on your relationship to the state Title V Agency, state Children with Special Health Care Needs Program(s), state Medicaid and/or SCRIP programs, state Early Intervention Program, and other state programs. Highlight any lessons learned from these relationships.

D. Impact on Disparities in Perinatal Health: Describe how the project reduced racial and ethnic disparities in perinatal health in your community.

E. Local Government Role: Highlight activities/relationships at the state and local level that facilitated project development and implementation. Briefly describe barriers at the state and local level, and the lessons learned in addressing these barriers.

F. Lessons Learned: If not discussed in any sections above, please describe other lessons learned related to project impact.

VI. Quality Improvement Impact

Share the outcomes of your program's collaborative quality improvement (QI) activities and services with community partners or other service providers. Provide details on topics, proposed methodology, and how progress was measured through analysis. Highlight how your program addressed specific needs or problems? Did your program develop a QI plan to improve performance on any HS benchmarks and/or address data collection challenges? If applicable, describe the process and outcomes resulting from the implementation of the QI plan.

VII. Performance Monitoring and Evaluation Data

Period of Performance End Performance Reporting (PPER)

The following information must be completed in HRSA's Electronic Handbook (EHB) to complete the Project Period End Performance Report (***note: do not attach PPER forms to this report**):

- Complete all areas indicated in the **DGIS Quick Reference Guide** (***Appendix B*).** Page 11 details all the performance measures that must be reported. Tier 4 is

not optional for Healthy Start.

- Please include in this section indicators for **all performance measures for the January 1, 2023 – December 31, 2023** reporting period.
- Include indicator values/outcomes for the performance measures for the recently completed Calendar Year (CY) 2023.
- Mark all data for the recently completed grant year as Final.

Benchmark Reporting

Please provide final progress on the benchmark objectives outlined in your last approved CY work plan. **The benchmark reporting period is January 1, 2024 – March 31, 2024.** Please include the following for each benchmark objective:

1. Baseline measures.
2. Annual benchmark goals for every calendar year (CY 1, CY2, CY3, CY4, and CY5).
3. Indicators for each benchmark.
4. State every benchmark indicator as a fraction (numerator/denominator).
5. If you don't have indicators for a benchmark, explain current activities to obtain this data.

Table 1 below provides an example of how to report final outcomes on benchmarks in your report.

Table 1.

Project Period Objectives	Calendar Year (CY) Goals	Final Benchmark Outcomes: (1/1/2024 – 3/31/2024)
Approach 1: Improve Women's Health		

Project Period Objective #1: By 12/31/23, increase the proportion of Healthy Start women and child participants with health insurance to 90 percent. Year 1 Baseline: ___% Numerator: ____ Denominator: ____ Baseline Data Source(s): _____	**CY1: By 12/31/19** Goal: ___%, Outcome: ___% **CY2: By 12/31/20** Goal: ___%, Outcome: ___% **CY3: By 12/31/21** Goal: ___%, Outcome: ___% **CY4: By 12/31/22** Goal: ___%, Outcome: ___% **CY5: By 12/31/23** Goal: ___%, Outcome: ___%	**1. Proportion of Healthy Start women and child participants with health insurance.** Percent: ___% Numerator: ____ Denominator: ____ 1a. Proportion of Healthy Start women participants with health insurance. Percent: ___% Numerator: ____ Denominator:____ 1b. Proportion of HS child participants with health insurance. Percent: ___% Numerator: ____ Denominator:____

VIII. Supplemental Funding Data (if applicable)

- If you received a supplemental to support the **Maternal Mortality Funding for Clinical Service Provider**, please compete *Attachment B*.
- If you received supplemental funding to support **Community-Based Doulas**, please compete *Attachment C*.

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APPENDIX A: Benchmarks

Approach 1: Improve Women's Health

- Increase the proportion of HS women and child participants with health insurance to 90 percent (reduce uninsured to less than 10 percent).
- Increase the proportion of HS women participants who have a documented reproductive life plan to 90 percent.
- Increase the proportion of HS women participants who receive a postpartum visit to 80 percent.
- Increase proportion HS women and child participants who have a usual source of medical care to 80 percent.
- Increase proportion of HS women participants that receive a well-woman visit to 80 percent.

Approach 2 - Improve Family Health and Wellness

- Increase proportion of HS women participants who engage in safe sleep practices to 80

percent.
- Increase proportion of HS child participants whose parent/ caregiver reports they were ever breastfed or pumped breast milk to feed their baby to 82 percent.
- Increase proportion of HS child participants whose parent/ caregiver reports they were breastfed or fed breast milk at 6 months to 61 percent.
- Increase the proportion of pregnant HS participants that abstain from cigarette smoking to 90 percent.
- Reduce the proportion of HS women participants who conceive within 18 months of a previous birth to 30 percent.
- Increase proportion of HS child participants who receive the last age-appropriate recommended well child visit based on AAP schedule to 90 percent.
- Increase the proportion of HS women participants who receive depression screening and referral to 100 percent.
- Increase proportion of HS women participants who receive intimate partner violence (IPV) screening to 100 percent.
- Increase proportion of HS women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, etc.) during pregnancy to 90 percent.
- Increase 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.
- 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.

Approach 3 - Promote Systems Change

- Increase the proportion of HS programs with a fully implemented Community Action Network (CAN) to 100 percent.
- 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.

Approach 4 - Assure Impact and Effectiveness

- Increase the proportion of HS programs who establish a QI and performance monitoring process to 100 percent.

APPENDIX B: Quick Reference Guide – DGIS Performance Reports

Healthy Start Program Grantees — DGIS Performance Reports

Population Domain Forms

Applicable Forms	Report Types		
	New	NCC	PPER
WMH: 1, 2, 3, and 4	✓	✓	✓
PIH: 1 and 2 & CH:1	✓	✓	✓
LC: 1 and 2	✓	✓	✓

Tier 1: All
Tier 2, 3, 4: NCC and PPER
If Tier 1 is not being addressed, remaining questions are not applicable, and grantee must notify PO.

Additional Data Elements

Applicable Forms	Report Types		
	New	NCC	PPER
Healthy Start Site	✓	✓	✓
Products, Publications and Submission Form		✓	✓

Domain Specific Forms

Applicable Forms	Report Types		
	New	NCC	PPER
Core 1			✓
Core 2	✓	✓	✓
Core 3	✓	✓	✓
Capacity Building – CB4	✓	✓	✓

Tier 1: All
Tier 2, 3, 4: NCC and PPER
Core 1 form only has Tier 1
If Tier 1 is not being addressed, remaining questions are not applicable, and grantee must notify PO.

Financial Forms

Applicable Forms	Report Types		
	New	NCC	PPER
Form 1	✓	✓	
Form 2	✓	✓	✓
Form 3	✓	✓	✓
Form 4	✓	✓	✓
Form 5		✓	✓
Form 6	✓	✓	✓
Form 7	✓	✓	✓

Program Specific Measures

Applicable Forms	Report Types		
	New	NCC	PPER
HS: 1 through 9	✓	✓	✓

Section 1: New and NCC
New: Grantee must provide the objectives
NCC: System will pre-populate the objectives.
Grantee can update the objectives for future years if needed.

Section 2 and 3: NCC and PPER

Legend:
- WMH – Women's/Maternal Health
- LC – Life Course
- PIH – Perinatal Infant Health
- CH – Child Health

APPENDIX B: Quick Reference Guide – DGIS Performance Reports

Reporting Period – Healthy Start

Required Forms	Reporting Period Year 1	Reporting Period Year 2 to 4	Reporting Period Year 5
Financial Forms (1-4)	Budget Period: 04-01-2019 - 03-31-2020 (Past Year Expenditures)	Budget Year: YEAR 2: 04-01-2020 - 03-31-2021 (Past Year Expenditures) YEAR 3: 04-01-2021 – 03-31-2022 (Past Year Expenditures) YEAR 4: 04-01-2022 - 03-31-2023 (Past Year Expenditures)	Budget Year: 04-01-2023 - 03-31-2024 (Past Year Expenditures)
Financial Form 5 Number of Individuals Served (UNDUPLICATED)	Pro-rated Calendar Year: 04-01-2019 - 12-31-2019	Calendar Year: YEAR 2: 01-01-2020 - 12-31-2020 YEAR 3: 01-01-2021 - 12-31-2021 YEAR 4: 01-01-2022 - 12-31-2022	Calendar Year: 01-01-2023 - 12-31-2023
Financial Form 6 Abstract	Budget Period: 04-01-2019 - 03-31-2020	Budget Year: YEAR 2: 04-01-2020 - 03-31-2021 YEAR 3: 04-01-2021 – 03-31-2022 YEAR 4: 04-01-2022 - 03-31-2023	Budget Year: 04-01-2023 - 03-31-2024
Financial Form 7- Section 5 Demographic Characteristics of Project Participants	Pro-rated Calendar Year: 04-01-2019 - 12-31-2019	Calendar Year: YEAR 2: 01-01-2020 - 12-31-2020 YEAR 3: 01-01-2021 - 12-31-2021 YEAR 4: 01-01-2022 - 12-31-2022	Calendar Year: 01-01-2023 - 12-31-2023
HS Site Form – Current service sites	Current sites	Current sites	Current sites

APPENDIX B: Quick Reference Guide – DGIS Performance Reports

Performance Measure Forms Detail – Healthy Start

*Calendar Year (CY)

Performance Measures (PM)	Topic	*Assigned Sections	Reporting Period
WMH1	Prenatal Care	Tier 1, Tier 2, 3, and Tier 4	CY
WMH2	Perinatal/ Postpartum Care	Tier 1, Tier 2, 3, and Tier 4	CY
WMH3	Well Woman Visit/ Preventive Care	Tier 1, Tier 2, 3, and Tier 4	CY
WMH4	Depression Screening	Tier 1, Tier 2, 3, and Tier 4	CY
PIH1	Safe Sleep	Tier 1, Tier 2, 3, and Tier 4	CY
PIH2	Breast Feeding	Tier 1, Tier 2, 3, and Tier 4	CY
CH 1	Well Child Visit	Tier 1, 2, 3, and Tier 4 – **Outcome 1** (% of children who received recommended well child visits)	CY
LC1	Adequate Health Insurance Coverage	Tier 1, Tier 2, 3, and Tier 4 – **Outcome 1** (% with health insurance)	CY
LC2	Tobacco and eCigarette Cessation	Tier 1, Tier 2, and Tier 4 – **Outcome 2** (% of prenatal program participants that abstain from smoking cigarettes in their third trimester)	CY
Core 2	Quality Improvement	All	CY
Core 3	Health Equity – MCH Outcomes	All	CY
CB 4	The percent of MCHB funded initiatives working to promote sustainability of their programs or initiatives beyond the life of MCHB funding.	Tier 1 and 2	CY
HS 01	Reproductive Life Plan	All	CY
HS 02	Usual Source of Care	All	CY
HS 03	Interconception Planning	All	CY
HS 04	Intimate Partner Violence Screening	All	CY
HS 05	Father/ Partner Involvement during Pregnancy	All	CY
HS 06	Father and/or Partner Involvement with Child 0-24 Months	All	CY
HS 07	Daily Reading	All	CY
HS 08	CAN Implementation	All	CY
HS 09	CAN Participation	All	CY
Healthy Start Site Form	Site Information	All	

Attachment A

Suggested Format for Final Report/Implementation Plan

Grantee: _____

Benchmarks	**Accomplishments**	**Barriers/Challenges**
Project Period Baseline		

Attachment B

Maternal Mortality Funding for Clinical Service Provider Data

(as of March 31, 2024)

1. Number of Providers Hired by Clinician Type	
Number of each type of clinician hired (e.g., 1-OBGYN, 2-PAs, 1-APRN)	
Percentage of time for each clinician type hired (e.g., OBGYN-50%, PA-150%, APRN-100%)	
2. Number of Women Served by Clinician Type	
Number of women served by each clinician type (e.g., OBGYN: 75 women, PA: 300 women)	
Total number of women served across provider types hired with funds (e.g., 375 women)	

3. Services Provided and Number of Visits by Mode and Type

Visit Type	**# of Telehealth Visits**	**Services Provided via Telehealth Visits (e.g., diabetes education, counseling)**	**# of In-Person Visits**	**Services Provided via In-Person Visits (e.g., blood pressure monitoring, STD and other health screenings)**
Well Women				
Prenatal				
Postpartum				
Behavioral Health				

4. Training and Education Related to Maternal Early Warning Signs (MEWS)	
Number of staff trained on MEWS	
Frequency of staff trainings	
Education topics in staff trainings	
Number of community events related to MEWS	
Frequency of community events	
Education topics in community events	
5. Additional Questions	
If services were provided through a subcontractor, list each subcontractor and specify staff within each subcontract:	
Explain how your program activities improved direct access to well women and maternity care for women at high risk for maternal complications:	

Detailed instructions for completing each section in Attachment B

1. Number of Providers Hired by Clinician Type
    - Clinician Type: The following types of maternal-child health professionals may be hired with these funds:
        - Medical Doctors (MD): Indicate whether an Obstetrician-Gynecologist (OBGYN) or Other Medical Doctor (Other MD)
        - Physician Assistants (PA): Includes all PAs serving this population
        - Advanced Practice Registered Nurses (APRN): Indicate whether a Certified Nurse Midwife (CNM) or Other APRN (e.g., Nurse Practitioner, Clinical Nurse Specialist)
        - Registered Nurse (RN): Includes all RNs serving this population
        - Behavioral Health Specialist: Includes many types of Behavioral Health Specialists (e.g., Psychiatrist, Psychologist, Licensed Clinical Social Worker)
        - Other: Includes any approved maternal-child health advanced practitioner not mentioned above
    - Number of Each Clinician Type: Report the number of each type of provider hired
    - Percentage of Time for Each Clinician Type: For each clinician hired using these funds, specify for what percent of time (e.g., 25%, 50%, 100%) the clinician will work for the program
2. Number of Women Served by Clinician Type
    - Total number of women served (by clinicians hired with these funds)
    - Number of women served by each clinician type (unduplicated count)
3. Services Provided and Number of Visits by Mode and Type
    - Number of well women visits by mode (i.e., in-person and telehealth)
    - Number of prenatal visits by mode
    - Number of postpartum visits by mode
    - Number of behavioral health visits by mode
    - Description of services (e.g., blood pressure monitoring) provided via telehealth by visit type (e.g., prenatal visit)
    - Description of services (e.g., pregnancy testing) provided via in-person visit by visit type (e.g., well woman visit)
4. Training and Education Related to Maternal Early Warning Signs
    - Number of staff trained
    - Frequency of staff training (e.g., monthly)
    - Education topics (e.g., managing hypertension) covered in staff training
    - Number of community events held
    - Frequency of community events (e.g., quarterly)
    - Education topics (e.g., adverse symptoms) covered in community events
5. Additional Questions
    - If services were provided through a subcontractor, list each subcontractor and specify staff within each subcontract.
    - Explain how your program activities improved direct access to well women and maternity care for women at high risk for maternal complications.

Attachment C

Community-Based Doula Supplement Data
(as of March 31, 2024)

Note: Some questions are required for those funded under HRSA-21-121 only or HRSA-22-148 only. These questions are noted in the chart below. You may leave fields blank that do not apply to your program based on funding year.

Training/Certification		
Name of Training Organization		
Name of Certifying Organization		
Doulas		
TOTAL number of candidates provided with doula training		
Number of candidates provided with doula training by race	American Indian/Alaska Native	
	Asian	
	Black/African American	
	Native Hawaiian/Other Pacific Islander	
	More than One Race	
	White	
	Don't Know/Not Reported	
Number of candidates provided with doula training by ethnicity	Hispanic or Latino	
	Not Hispanic or Latino	
	Don't Know/Not Reported	
Number of doulas certified as a birth doula		
Healthy Start Participants Served by Doulas		
TOTAL number of Healthy Start participants provided with a visit and/or birth support		
Number of Healthy Start participants provided with a visit and/or birth support, including the number served by race	American Indian/Alaska Native	
	Asian	
	Black/African American	
	Native Hawaiian/Other Pacific Islander	
	More than One Race	
	White	
	Don't Know/Not Reported	
Number of Healthy Start participants provided with a visit and/or birth support, including the number served by ethnicity	Hispanic or Latino	
	Not Hispanic or Latino	
	Don't Know/Not Reported	

Number of Healthy Start women participants who used an epidural (*if funded under HRSA-21-121 only*)	
Number of Healthy Start women participants who had a caesarean birth	

(*if funded under HRSA-21-121 only*)	
Number of Healthy Start women participants who were satisfied with the doula services received (*if funded under HRSA-21-121 only*)	
Number of Healthy Start women participants who received a postpartum visit 4-6 weeks after delivery (*if funded under HRSA-21-121 only*)	
Number of Healthy Start child participants whose parent/caregiver reports they were ever breastfed or pumped breast milk to feed their baby (Note: Child must be connected to a woman that received doula services)	
Number of Healthy Start child participants whose parent/ caregiver reports they were breastfed or fed breast milk at 6 months (*if funded under HRSA-21-121 only*) (Note: Child must be connected to a woman that received doula services)	
Did your program contract with one or more doula training organization(s) to provide training for doulas?	
How many doula candidates did your program recruit to become doulas?	
If funded under *HRSA-21-121*, did you meet the goal of a minimum of 2 doula candidates?	
If funded under *HRSA-22-148*, did you meet the goal of a minimum of 3 doula candidates?	
Did your program facilitate training for each hired doula?	
Did each doula hired by your program complete all requirements for a birth doula certification?	
How many HS participants did your program provide prenatal, birth, and short term-postpartum (within 3 months after birth) to?	
If funded under *HRSA-21-121*, did you meet the goal of a minimum of 72 HS participants?	
If funded under *HRSA-22-148*, did you meet the goal of a minimum of 100 HS participants?	
Additional Questions	
Provide a brief summary of overall project accomplishments during the reporting period, including any barriers to progress that have been encountered and strategies/steps taken to overcome them. Identify any innovative activities and/or partnerships as relevant.	

HRSA Contacts

Grantees are encouraged to request assistance, if needed, when submitting their Impact Report. As your first point of contact, please contact your HS Project Officer to obtain additional information regarding

these instructions or overall program issues.

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Grantees may need assistance when working online to submit their information electronically through HRSA's EHBs. For assistance with submitting information in HRSA's EHBs (i.e. technical system issues), contact the HRSA Contact Center, Monday-Friday, 9:00 a.m. to 5:30 p.m. ET:

HRSA Contact Center
Phone: (877) 464-4772
TTY: (877) 897-9910