


Healthy Women, Healthy Babies: Year 1 Evaluation Report

Prepared for: Delaware Health and Social Services, Division of Public Health

By: Health Management Associates

April 16, 2021

Contents

History, Structure and Goals of the Initiative

More than eight years ago, in response to high infant mortality rates and racial disparities in these rates, the Delaware Healthy Mother Infant Consortium (DHMIC), in collaboration with the Division of Public Health (DPH), started initiatives to reduce the number of babies who die before their first birthday and to improve the health of women before during and in between pregnancies.

DHMIC efforts were largely medical interventions, particularly through the Healthy Women Healthy Babies (HWHBS) program, implemented over 8 years ago. The strategy has been to identify women, in the Healthy Women Healthy Babies Zones, at the highest risk of poor birth outcomes and to address any underlying health conditions that predispose them for poor outcomes before they get pregnant or if they are already pregnant, to work with them to mitigate their risk.

The success of this effort lies in the fact that since its inception over a decade ago, our infant mortality rate has dropped by almost 25%. Even so, the current five-year average of 7.3 deaths per 1,000 live births is still above the national average and is driven almost entirely by the racial disparity in infant death rates. For the period 2015-2019, the Black infant mortality rate of 12.3 is more than two and a half times as high as the White rate of 4.3 deaths per 1000 live births.

In the past few years, substantial funding has shifted to address the social determinants of health, which are the major drivers behind the racial disparity. The aim of the Healthy Women Healthy Baby Zones, as part of the Infant Mortality reduction work in Delaware, is to build state and local capacity, and test small scale innovative strategies in the community to shift the impact of social determinants of health tied to root causes related to infant mortality. Primary strategies include: 1) Social Networking for Empowerment, 2) Father/partner involvement and engagement, 3) Toxic Stress/Adverse Childhood Experiences and 4) Financial Empowerment/Self Sufficiency.

In 2019, DPH began to work with Health Management Associates (HMA) to implement this collective impact initiative. HMA serves as the "backbone organization", working closely with DPH to develop and administer a grant-making structure, provide training and technical assistance to mini-grantees, and support to the mini-grantees.

Cycles 1 and 2 of the HWHB Initiative: Six Mini-Grantees

In late 2019, six mini-grantees were awarded funding and support for grant Cycle 1, which ran from January 1, 2020 through June 30, 2020. Grant Cycle 2 of the initiative began on July 1, 2020 and continued through December 30, 2020. Grantees for both Cycle 1 and Cycle 2 were:

1. Delaware Adolescent Program Inc. (DAPI)
2. Delaware Multicultural and Civic Organization (DEMCO)
3. Delaware Coalition Against Domestic Violence (DCADV)
4. Hispanic American Association of Delaware (HAAD)
5. Reach Riverside Development Corporation (Kingswood)
6. Rose Hill Community Center

In addition to the initial funding, capacity building grants were awarded to all six organizations during grant Cycle 2. These capacity building grants were designed to provide additional funding and support in targeted areas of need for mini-grantees and the women and girls they serve.

A capacity building grant was also awarded to one organization that applied for funding initially and was not awarded funding: Black Mothers in Power. Unfunded organizations were eligible for capacity building funding, to support their efforts to be more competitive for funding in future cycles Black Mothers in Power applied for and receive capacity building funding to develop a blueprint for their organization, a website, and to obtain 501c3 status so they could apply for funding in the future.

The six mini-grantees proposed to provide a variety of services and supports to women and girls, including social supports, educational opportunities, flex funds for critical needs, mental health and counseling supports, and nutrition and fitness opportunities. Some programs also included supports for partners. Full descriptions of mini-grantees' programs are provided in the sections below.

Evaluation

Purposes of the Evaluation

As part of their application and as a condition of funding, each mini-grantee developed an evaluation plan (with support from HMA coaches and evaluation experts) designed to collect data that would be helpful to the mini-grantee for continuous quality improvement and that would contribute to understanding the collective impact of all of the mini-grantees. Additionally, these evaluation plans were designed to help assess the extent to which the state can and should continue funding these community efforts.

Overall, each mini-grantee's evaluation was designed to:

1. Provide information that would help mini-grantees learn what works and what doesn't, and make program improvements (local evaluation);
2. Provide some consistent information across mini-grantees (using some common measures) to facilitate understanding of the collective impact of the initiative (cross site evaluation); and
3. Provide an opportunity for mini-grantees to build evaluation capacity by requiring mini-grantees to examine their existing processes for data collection, tracking and reporting and improve upon these where needed so they are better positioned to collect and use data for this initiative and others.

Evaluation Plans

Included in each grantees' original evaluation plan are the purpose of their evaluation, their evaluation designs, their data collection processes, their evaluation questions, their hoped-for short-term (and sometimes medium-term) outcomes, and notations about what they are able to measure and answer within the funding cycle and within the short-term or medium-term.

These short-term and medium-term measures, outcomes and evaluation questions are then linked with the long-term outcomes of the overall initiative. In many cases, other research indicates that these short-term outcomes are linked with longer term outcomes of healthier pregnancy and birth outcomes. While these longer-term outcomes will not be measured as part of this evaluation, they are the intended longer-term outcomes toward which each program contributes.

Evaluation Designs

Each grantee undertook a non-experimental evaluation that assesses process and outcome measures using mixed-methods. Quantitative outcomes data were collected primarily using single-group pretest and posttest design. Qualitative data were collected via open-ended questions in surveys and/or via interviews or focus groups with participants. Process data were collected in the form of sign-in sheets

(for classes and other activities) or via tracking of provision of case management services to measure service delivery, and a core set of demographic data is being collected on all participants.

In all cases, grantees made it clear to potential participants that participation in services is not linked with participation in the evaluation. Participants were made aware that they could still receive all services, even if they chose not to participate in the evaluation.

Evaluation Questions

Each grantee had unique evaluation questions that were particularly relevant to their program. All of these questions were outlined in the individual evaluation plans. Common themes across questions included the following:

Mental Health (Including Stress, Depression, Wellness)

- To what degree does the program have an impact on reducing levels of stress and/or improving mental health and well-being among participants?

Physical Health

- To what degree does the program have a positive impact on the nutrition, fitness, and physical health of participants?

Healthy Lifestyles

- To what degree do participants have an increase in knowledge about health, mental health, stress, self-care, nutrition, etc.?
- To what degree does the program increase knowledge and use of healthy life skills? How effective is the program activities at helping young women make healthy life choices and preventing teen pregnancy moving forward?
- To what degree does the program help participants with other challenges that might affect their health and their birth outcomes?

Financial Stability

- To what degree does the program improve participants' professional skills, and future employment prospects and financial stability?

Father Involvement

- To what degree do the services offered as part of the fatherhood engagement component help fathers become more aware of their critical role in supporting a healthy pregnancy, healthy development and a healthy environment?

Social Networking

- To what degree do the care management services help women connect to the services they need? And if women are able to connect with needed services, to what degree do these services improve their health, mental health, and quality of life?
- In what ways do victims and survivors of domestic violence use flexible financial assistance and what are the potential health impacts? To what extent does flexible financial assistance mitigate financial stress related to meeting social needs like childcare, transportation, etc. that could affect birth outcomes for Women of Color? To what extent does flexible financial assistance impact participants' hopefulness for the future?

- What is the best approach for integrating universal education/domestic violence screening into health care providers' practices? In which ways does education/outreach for DV screening differ among OBGYNs, Pediatric providers versus other types of health providers?
- What are the best practices and barriers to creating a referral pathway between Health Care Practitioners (particularly HCPS working in maternal and child health) and community DV providers?

Satisfaction/Process Questions

- To what degree were participants satisfied with the program? What were the barriers to participation? What could be improved to make the program even better or more effective?

Outcomes of Interest

Similarly, grantees had unique outcome measures of interest, but there were many common themes across the outcomes of interest. These included the following:

Mental Health (including Stress, Depression, Wellness)

- Reduced stress, anxiety, depression
- Improved quality of life and mental health
- Increased knowledge, attitudes, and intentions towards mental wellness
- Increased knowledge and attitudes about how to cope with stress
- Increased feelings of social support

Physical Health

- Increased participation in physical activities
- Increased knowledge, attitudes, and intentions towards nutritional food options

Healthy Lifestyles

- Increased knowledge, attitudes, and intentions towards making healthy life choices
- Increased resilience to relationship pressure and intention to apply refusal skills
- Increased knowledge, attitudes, and intentions about sex, how to build healthy relationships, and strategies to prevent pregnancy Increased knowledge about how to use and intentions to implement an individualized reproductive life plan

Financial Stability

- Increased knowledge, attitudes, and intentions towards improving economic mobility
- Increased knowledge about technical and professional skills among students
- Increased job readiness among students

Father Involvement

- Increased knowledge about strategies to create a supportive learning environment among students' male partners
- Increased awareness of a father's role in a healthy pregnancy and in a child's healthy development
- Increased feelings of empowerment to be more integrated in the social and emotional support of the mother and child(children)

Social Networking

- Increased awareness of needed services and how to access them
- Increase health care providers' (especially maternal and child health providers) perceived understanding of the dynamics of domestic violence from a health perspective, how to promote health relationships through universal education, and how to connect individuals experiencing domestic violence to community resources
- Increase referrals to community health workers from health care providers, especially those serving pregnant and parenting Women of Color
- Improve care/service delivery and availability of resources for victims and survivors of domestic violence, particularly Women of Color who are pregnant and newly parenting

Longer Term Outcomes

- Long-term improvements in mental health and physical health
- Long-term improvements in quality of life, financial stability, and strong social networks
- Healthier pregnancies
- Improved birth outcomes

The logic model below visually illustrates the activities, outputs, short term outcomes and longer-term outcomes that were originally proposed by the mini-grantees. It also visually demonstrates how the activities and services provided by the six mini-grantees work together to address some of the underlying social determinants of health that contribute to factors like poor physical or mental health that can, in turn, have an impact on premature birth, low birth weight, and other poor birth outcomes.

Delaware Healthy Women Healthy Babies Initiative: Draft Logic Model DRAFT: February 2020

Target Population and Needs	Activities	Outputs	Short Term Outcomes	Medium Term and Long Term Outcomes; Vision
Target Population: Women at risk of disparities in maternal and infant outcomes, primarily women of color, ages 15-45 in targeted zip codes Needs: Delaware's infant mortality rate is higher than the US. rate of 5.9 deaths per 1000 and the average black infant mortality rate in Delaware is 12.5/1000, more than twice as high as the white rate of 5.1/1000 live births.	Love Notes curriculum about building healthy relationships; reproductive life plans; mentoring	45 women; 12-15 1-hour weekly/bi-weekly sessions	Increased skills around healthy relationships and reproductive planning; Increased knowledge and skills around stress	Medium Term Outcomes • Improved mental health • Improved physical health • Improved financial security • Increased knowledge and skills among fathers Long Term Outcomes and Vision • Decrease in premature births • Decrease in low birth weight (LBW) and very low birth weight babies (VLBW) • Decrease in disparity ratio of poor birth outcomes (for e.g., neonatal mortality and postnatal mortality between African American and White infants) • Decrease in infant mortality • Decreased birth defects
	Outreach and training to providers who engage with target women; Access Fund dollars to women	4 provider trainings; engagement w/125 women; Access Fund $ as needed	Increased connections to providers with skills in serving women's needs; Improved delivery of services to target population particularly with needs around DV; financial stability	
	IT workforce development program; father and parenting lessons for the women's partners	25 women; up to 25 partners	Increased skills to support economic mobility; increased job readiness; Increased knowledge about parenting, postpartum health and mental health, and healthy relationships among male partners	
	Support group, community liaison referrals, family network event, wellness section in local Hispanic magazine	45 women in 48 sessions; 10 hrs/wk of referrals; one event w/100 attendees; 6 sections	Reduced stress, anxiety and depression; increased connection to resources among participants; Increased knowledge among fathers about pregnancy and postpartum mental health; Increased pregnancy and postpartum wellness; reduced stigma of mental health	
	Mindfulness/wellness training; care management; father support and education groups	10 women in 8-week training; 50 women care management; 25 men in groups	Increased knowledge and use of mindfulness skills that support the management of trauma and toxic stress experiences; reduced stress; increased skills to promote resilience and well-being	
	Fitness classes, nutrition classes, other health and mental health classes; access to mental health counselor	65 women; activities 3-5 times/week	Increased participation in physical activities; increased knowledge, attitudes, and intentions towards nutritional food options; Increased knowledge, attitudes, and intentions towards mental wellness; reduced stress	

Data Collection Methods, Processes, and Instruments

Data collection methods and processes varied by organization, but some data elements were common across grantees. These common data elements include demographic data and a social determinants of health screening tool called Health Leads. All grantees were required to collect these "cross-site" measures to allow for an examination of similar data across all funded initiatives.

Cross-Site Demographic Data

Each grantee collected demographic data upon intake or initiation of services. All grantees collected a common set of demographic data to be collected at intake or initiation of participation in services. These demographic data elements are part of the cross-site measurement that allows for an examination of similar data across all funded activities. Specifically, grantees were required to collect the following for each participant:

- ZIP Code
- Ag (either birth date or actual age)
- Race
- Ethnicity
- Gender
- Primary language
- Education level
- Employment
- Marital status
- Referral source (to the program)
- Doctor or usual source of health care
- Pregnancy history (including current status)
- Desire to become pregnant in the next year

Cross-Site Participation Data

All grantees collected data on participation in services. While each grantee's data collection process was unique to its services and activities, all grantees collected data on dates of service and types of services provided by participant.

Cross-Site Social Determinants of Health Screening Data

Four of the grantees collected the Health Leads screening tool questions at intake or initiation of services (Rose Hill and Kingswood did not collect these data). Questions include the following:

1. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?
2. In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?
3. Are you worried that in the next 2 months, you may not have stable housing?
4. Do problems getting child care make it difficult for you to work or study?
5. In the last 12 months, have you needed to see a doctor, but could not because of cost?
6. In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?
7. Do you ever need help reading hospital materials?
8. Do you often feel that you lack companionship?

9. Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight
10. If you checked YES to any boxes above, would you like to receive assistance with any of these needs?

Grantee-Specific Data

In addition to the demographic data, participation data, and the social determinants of health screening data, grantees collected data that were specific to their program, their goals, and their evaluation plan. Each grantee has its own set of pre/post or post-only instruments (i.e., surveys) to measure changes in the outcomes of interest.

Most grantees collected data at the beginning of services and at the end (of services or of the initial grant periods) to assess changes in the outcomes of interest. A few grantees collected outcome data only at the end of services (post-only). The table below provides more information about grantee data collection instruments.

Figure 1: Grantee Data Collection Instruments

Grantee	Instruments
DAPI	Pre/post survey designed by DAPI with HMA coaches changes in attitudes, knowledge, and behaviors related to mental health, goal setting, decision-making, and pregnancy prevention, as well as questions about satisfaction with the program.
DEMCO	A single post-program survey containing survey items from several benchmark instruments used to measure changes in technical and professional skill knowledge.
DCADV	Services/Referrals Provided Tracking Spreadsheet; Health Access Fund Requests Tracker; a retrospective, two-question post survey to measure the impact on financial stress and hopefulness among flex fund recipients
HAAD	Depression, Anxiety, and Stress Scale (DASS) pretest in the first meeting of the support group and DASS posttest and at the end of each client's participation in the support groups
KINGSWOOD	Post-survey measuring satisfaction with the workshops
ROSE HILL	Perceived Stress Scale (PSS) pretest and posttest; weekly weight survey (self-reported weight); additional survey of health behaviors

Data Collection Processes

Participation data and survey data were collected either on paper by staff who were providing services and/or facilitating group sessions, or via an electronic data collection protocol using Survey Monkey or Google Docs. Data security was addressed in each grantee's individual evaluation plan. Data were transmitted to HMA monthly via a secure server.

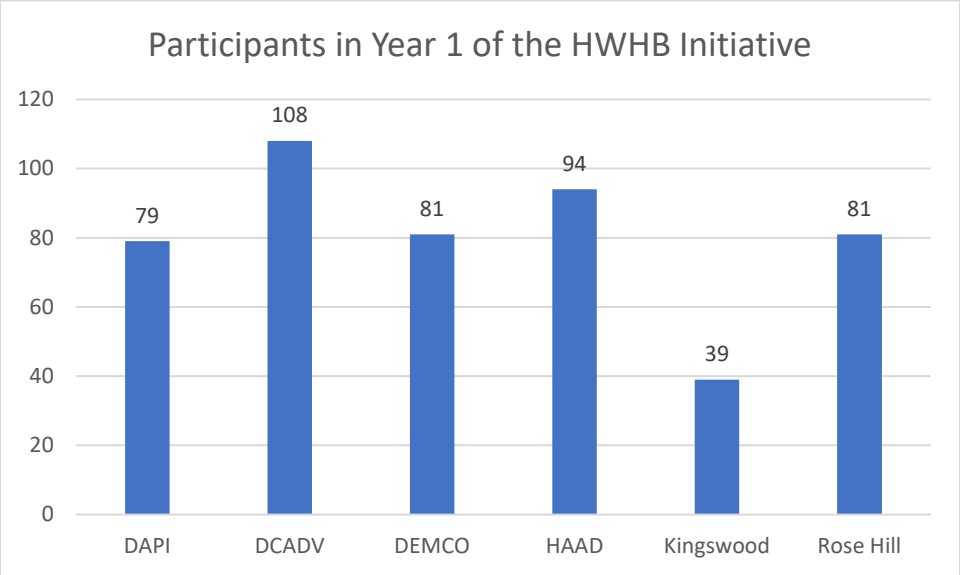
Summary of Cross-Site Data

The following are summary data across all six mini-grantees for both Cycles 1 and 2.

Demographics

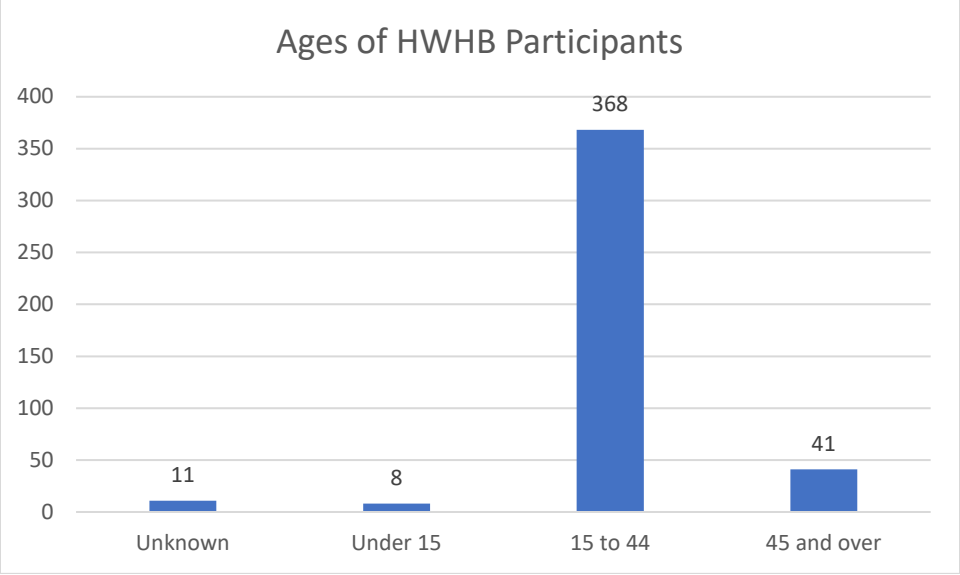
Across the initiative, over the course of 2020, mini-grantees provided services to 482 women and girls. Most grantees served between 79 and 108 women and girls, with Kingswood serving fewer (39).

Figure 2: Participants in Year 1 of the HWHB Initiative



The vast majority (86%) of women and girls served were between the ages of 15 and 44. About 3% were under 15 and 9.6% were over age 44.

Figure 3: Ages of HWHB Participants



Over ½ (53%) had a high school diploma or GED, and 21% had some college, or an associate, bachelor or master's degree.

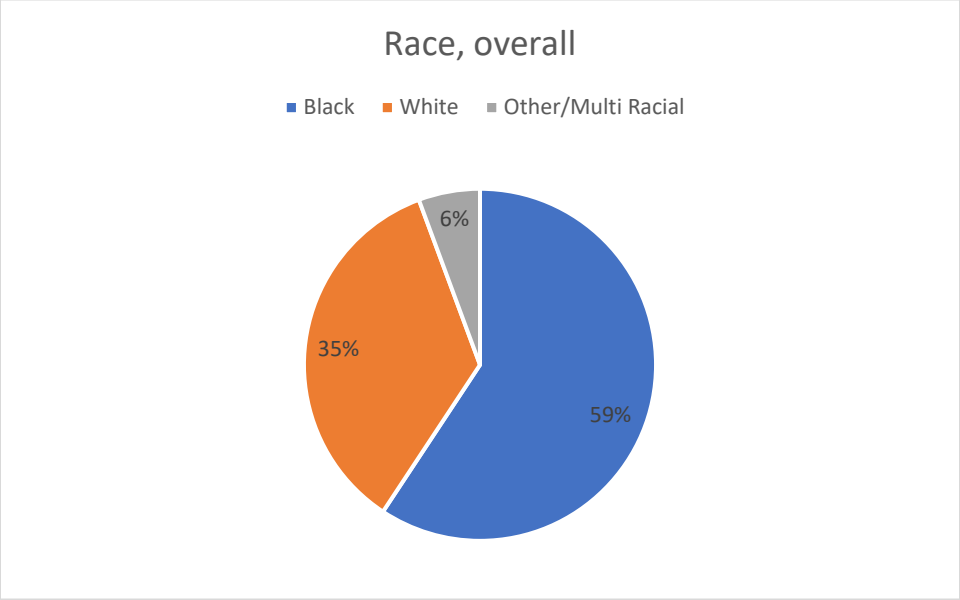
Figure 4: Educational Attainment of HWHB Participants

Education Level*	Number	Percent
Less than High School	42	12.5%
High School Diploma/GED	179	53.4%
Some High School	35	10.4%
Some College	22	6.6%
Associate Degree	9	2.7%
Bachelor's Degree	28	8.4%
Master's Degree	10	3.0%
Unknown	1	0.3%

*These numbers do not include data from DCADV since they reported these numbers in aggregate.

In terms of race, nearly 60% of participants are Black, 35% are White, and 6% identify as "Multi-Racial/Other". In terms of language, 105 participants said their primary language is Spanish, one said Creole, one said "other", and the remaining participants said their primary language is English.

Figure 5: Race of HWHB Participants



About 52% of women and girls reported being single, 17% are married, and 26% did not respond to this question.

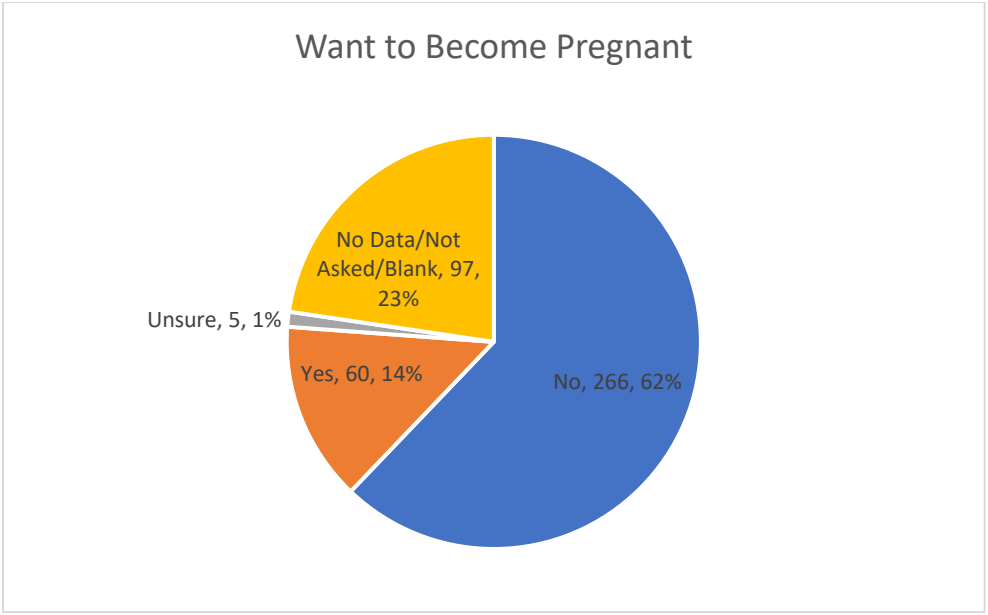
Figure 6: Marital Status of HWHB Participants

Marital Status	Number	Percent
Single	174	51.9%
Married	57	17.0%
Divorced	15	4.5%
Widowed	1	0.3%
Separated	0	0.0%
Unknown	88	26.3%
Not Applicable	0	0.0%

*These numbers do not include data from DCADV since they reported these numbers in aggregate.

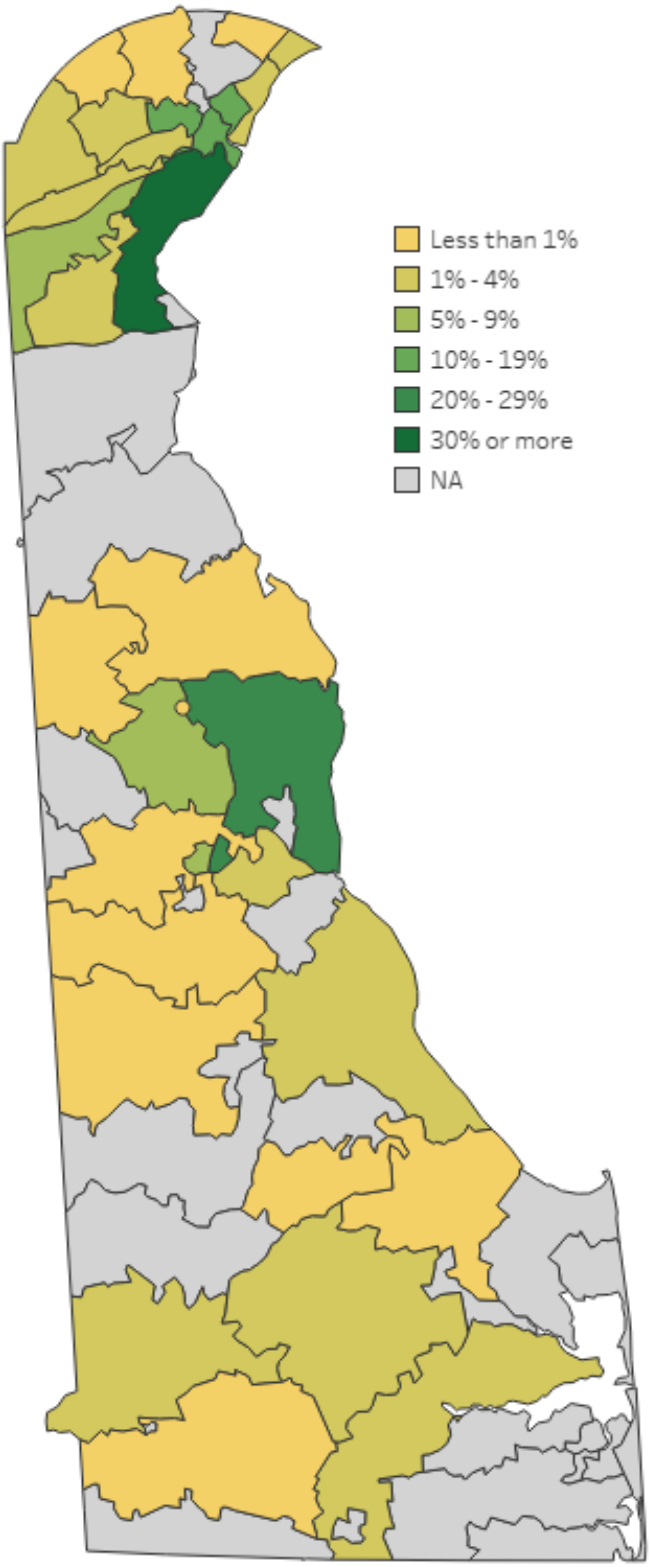
The majority of participants (62%) said they did not want to become pregnant in the immediate future, and 14% of participants said they did want to become pregnant. Additionally, over 65% said they had been pregnant in the past or were currently pregnant.

Figure 7: Percentage of Women that Want to Become Pregnant



The vast majority of HWHB participants live in zip codes 19720, 19901, 19805, 19801, 19702, 19904, and 19804.

Figure 8: Zip Codes of HWHB Participants



Social Determinants of Health Needs

All mini-grantees were required to screen each participant at the beginning of services for needs around social determinants of health, using the Health Leads screening tool. Of the 302 participants who were screened, over 19% said they had urgent needs in one of the areas and 35% requested assistance with one or more of these needs. Of the needs discussed, food was the need most frequently identified, with more than 55% of people screened saying they had a need in this area. Understanding hospital materials was next, with 54% of people screened indicating a need around this. This could indicate a general need around literacy, a more specific need related to health literacy, or a need around translation if materials were not provided in the individual's first language. Housing was another critical need, with nearly 54% of participants indicating a need for housing. Almost 17% of people screened noted a need in all eight areas.

Figure 9: Identified Needs of HWHB Participants

Screened Needs	%
Food	55.3%
Health Literacy	54.0%
Housing	53.6%
Utilities	51.7%
Childcare	48.3%
Transport	46.7%
Companionship	44.4%
Doctor	42.7%

Grantee-Specific Data and Results

The following sections of this report provide evaluation findings for Year 1 for each mini-grantee.

Delaware Adolescent Program Inc. (DAPI)

The Delaware Adolescent Program Inc. (DAPI) serves teen mothers and their partners in high-risk zones across Delaware, providing mentoring, support for social and emotional wellbeing, and support navigating the health and social services system, including maternal and child health care services, housing programs, financial management, and economic empowerment, and stress reduction and maternal health courses and co-parenting workshops. Most of the components of DAPI have existed since 1968 and the target population for this evaluation was young women ages 12– 19 who are residing in the identified HWHB high risk zones in New Castle, Kent, and Sussex counties. Through the HWHB program funding, DAPI implemented the evidence-based Love Notes curriculum, where their Nurses and Student Service Coordinators (SSCs) were trained on how to implement Love Notes and used it to educate participants about building healthy relationships. In addition to implementing Love Notes other activities included Nurses and SSCs helping participants draft individual life plans, matching participants to mentors, and sessions on specific life skills development.

DAPI's goals are to:

- increase resilience to relationship pressure and intention to apply refusal skills
- increase knowledge about how to use and intentions to implement an individualized reproductive life plan
- increase knowledge and attitudes about how to cope with stress
- increase knowledge, attitudes, and intentions about sex, how to build healthy relationships, and strategies to prevent pregnancy

Their primary evaluation questions are related to effectiveness of the program in helping young women make healthy life choices and preventing teen pregnancy. In order to answer these questions, their evaluation includes data collection around participation in services (process data) and a pre and post survey designed to capture changes in these intended outcomes. During the COVID-19 pandemic, DAPI has remained resilient despite many challenges in outreach and recruitment of young women in need of services and have found innovative ways to pivot their programming to continue to provide the best services possible for their DAPI daughters.

Year 1 Data

Process Data

Over the course of the first year of the initiative, DAPI served 69 young women. A total of 63 participants were still engaged in services at the end of 2020. DAPI provided educational and support sessions on a number of topics, as noted in the table below.

Figure 10: Average Number of Events Attended by Service Activities Completed

Service Activities Completed (Cycle 1 and 2)	Average # Events attended for each Topic
Finance Empowerment (1-10)	6
Open Gym/ Exercise/Nutrition (1-10)	9
Career /College Readiness (1-10)	2
Toxic Stress/ Adverse (1-10)	3
Father/ Partner Involvement (1-10)	2
Empowerment/Self esteem (1-10)	2

Outcome Data

To understand the impact of their program, DAPI utilized a pre/post survey that asked participants a number of questions about their relationships with trusted adults, their belief in their own abilities to plan for the future, make healthy decisions, and about their mental health. The survey also assessed knowledge about, attitudes toward, and intended behaviors around pregnancy prevention.

Participants who responded to the survey were asked about their agreement or disagreement with the following statements. (1=Strong Agree; 2=Agree; 3=Neither; 4=Disagree; 5=Strongly Disagree)

Figure 11: DAPI Pre- and Post-Survey Results

Question	Pre Mean	Post Mean	Change in the desired direction?	Statistically Significant?
It is important to always use condoms to protect against disease and help prevent pregnancy.	1.35	1.22	Yes	No
It is important to have a plan about how sex will fit into my life.	2.58	1.73	Yes	Yes
It is important to always use or make sure my partner uses other forms of contraception to protect against unplanned pregnancy.	1.59	1.41	Yes	No
I would feel comfortable saying no to my partner when I don't feel like having sex.	1.59	1.22	Yes	Yes

Respondents were also asked the degree to which the following statements were true for them. (1=Not true at all; 2=Rarely true; 3=Sometimes true; 4=Often true; 5=True nearly all the time).

Figure 12: DAPI Pre- and Post-Survey Results

Question	Pre Mean	Post Mean	Change in the desired direction?	Statistically Significant?
When I'm in a stressful situation, I feel like I have a trusted adult who I can ask for help.	3.82	4.11	Yes	No
In a crisis or chaotic situation at school, I know how to calm myself and focus on taking useful actions.	3.68	4.16	Yes	Yes
I feel like I am in control of when I become pregnant.	3.53	3.89	Yes	No
I know how to set a goal and take the steps to achieve it.	4.03	4.42	Yes	Yes
I believe I can achieve my goals, even if there are obstacles.	4.13	4.58	Yes	Yes
I have at least one close and secure relationship with an adult I trust (this includes parents, teachers, mentors, etc.)	4.05	4.66	Yes	Yes

Delaware Multicultural and Civic Organization (DEMCO)

The Delaware Multicultural and Civic Organization (DEMCO) was funded by the HWHB Initiative to provide academic and life skills supports and job training education to young women of childbearing age, including those who are pregnant and parenting, who are living in Dover ZIP Codes 19901 and 19904.

Each woman served is matched with a mentor to provide social and emotional support. The program progresses through a series of educational workshops to develop hard and soft skills to better prepare them for gainful employment and a career in the IT field. The program also includes support for fathers/partners, including effective fathers/partner parenting lessons, and an opportunity to engage in job shadowing and internship placement.

For the first year of the HWHB Initiative, DEMCO's primary evaluation questions were:

- How effective are program activities at helping women develop healthy life skills and prepare for economic mobility?
- How the program supported the individuals served, as well as their families, to meet their needs related to the impact of COVID-19?
- To what degree were students satisfied with DEMCO services?

DEMCO's goals for their program were that participants would develop increased knowledge about (and intentions toward) making healthy life choices and improving economic mobility; increased technical and professional skills; and increased job readiness. Another goal was increasing knowledge among students' partners about how to create a supportive learning environment for the women served. Since the COVID-19 pandemic began, an additional goal was added, which is to mitigate immediate needs related to social determinants of health, due to the impact of COVID-19, among participants served, based on the provision of flex funding. In addition, given that many of the women served were caring for school-age children, DEMCO utilized the IT skills development activities to not only support their clients to prepare for a career in the IT field, but to also help those who are mothers to support their children's remote learning in terms to technology skills.

Year 1 Data

Process Data

In the first year of the initiative, DEMCO served 42 women who participated in classes on the following topics:

- Academic, Life Skills, and Healthy Living Training
- Keyboarding Education
- Microsoft Office Skills Education
- IC3 Computer Basics Certification Training
- Workforce and Life Skills Readiness Support
- Mentoring

Additional program activities originally included job shadowing and job placement, but due to the COVID-19 pandemic, these activities were few and far between. Therefore, DEMCO has continued to remain connected to the women from Rounds 1 and 2 who "graduated" from the skills development part of the program, so that once internship and job shadowing opportunities are safe to pursue again (and available) in Delaware, they can support these women to engage in these opportunities. Of the 42 participants, 40 attended classes on all six of the topics.

Outcome Data

Outcome data were collected via a post-survey only, which asked a number of questions about the impact of the program and classes on participants. Questions included a focus on:

- perceived effectiveness of program activities at helping women develop healthy life skills, prepare for economic mobility, and be successful in the future;
- specific skills gained in the program;
- the extent to which participants felt that the Effective Fathers and Partner Parenting lessons helped them and their male partners create a supportive learning environment at home; and
- satisfaction with services.

Participants were asked "Overall, how would you rate the support DEMCO provided?" Nearly ¾ of respondents said the program was excellent. Another 10% said it was good. Only 5% rated it as fair.

Figure 13: DEMCO Participant Satisfaction

Rating	Number	Percent
Excellent	30	71%
Good	4	10%
Fair	2	5%
No response	6	14%
Total	42	100%

Participants were also asked very specific questions about the program and their experience with it. In all cases, the majority of participants strongly agreed that what they learned will help them be successful in the future. They indicated that they felt that the program increased their confidence, helped them develop new skills, and helped them develop strong plans for their future. They also strongly agreed that they enjoyed the program.

Figure 14: DEMCO Participant Experience

Question	What I experienced and learned as part of DEMCO's program will help me be successful in the future	Participating in this program increased my confidence	Because of this program, I have gotten better at communicating my strengths to others.	This program helped me identify and understand my skills	Because of this program, I developed new skills that helped me be successful
Strongly Agree	31 (74%)	34 (81%)	32 (76%)	31 (74%)	30 (71%)
Agree	8 (19%)	4 (10%)	6 (14%)	6 (14%)	8 (19%)
Neutral	1 (2%)	1 (2%)	1 (2%)	1 (2%)	0 (0%)
Just Started	0 (0%)	2 (5%)	0 (0%)	0 (0%)	0 (0%)
No response	2 (5%)	1 (2%)	3 (7%)	4 (10%)	4 (10%)
Total	42	42	42	42	42

Figure 15: DEMCO Participant Experience

Question	While I was participating, I felt like an important part of DEMCO's community	I discovered career pathways aligned to my life goals	Participating in this program made me even more committed to my educational and employment goals	My mentor gave me feedback that improved my skills	I enjoyed what I did in this program
Strongly Agree	30 (71%)	29 (69%)	29 (69%)	29 (69%)	28 (67%)
Agree	7 (17%)	6 (14%)	7 (17%)	7 (17%)	9 (21%)
Neutral	1 (2%)	2 (5%)	2 (5%0	2 (5%0	2 (5%0
Just Started	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
No response	4 (10%)	5 (12%)	4 (10%)	4 (10%)	3 (7%)
Total	42	42	42	42	42

DEMCO also asked participants an open-ended question about what they thought were the most helpful aspects of the program. Responses were varied, but the most highlighted aspects of the program included (1) Technology training and support; (2) Employment services (i.e., resume building, interview practice); and (3) Additional Support (i.e., support with community connections, etc.). Five participants indicated that "everything" about the program was helpful to them.

Figure 16: Helpful Aspect of DEMCO Program

Helpful Aspects of Program	Number (N = 40 participants responded)	Percent
Employment Services (i.e., office skills, interviewing skills, resume building)	6	15.0%
Technological Training and Support	6	15.0%
Additional Support (i.e., receiving support in general was helpful)	5	12.5%
Everything	5	12.5%
Other	4	10.0%
Emotional Support	3	7.5%
Flex Funds	2	5.0%
Life Skills	1	2.5%
Mentoring	1	2.5%

In addition, participants were asked three questions about the degree to which the father/partner training helped them feel more supported in their goals. Most (28 of 30 who responded to this question) said they feel that their family/partner is supportive of their goals related to their education and employment. Most (28 of 32 who responded to this question) said their family/partner's ability to support them in their goals improved during the time that they have participated in DEMCO's program.

When asked what they think is the best way that the family/partner supports them to achieve their goals related to education and employment, many participants responded that the family/partner supports them by providing encouragement and praise, and by being happy for them. Others noted

other forms of support, such as financial support, giving them “quiet space”, helping with homework, focusing on having a healthy lifestyle, and watching children so they can study. Others noted that their family/partner “respects my opinion” now or “trusts me more”. Others noted focusing on making college goals or discussing making goals for savings.

Delaware Coalition Against Domestic Violence (DCADV)

In their original proposal for the HWHB Initiative, DCADV proposed to expand integration of its services with health services in New Castle County through its Community Health Worker Collaborative Project. The project as proposed would integrate domestic violence and health services in order to improve the health and safety of victims and survivors. Specifically, through the HWHB initiative, DCADV proposed to expand service delivery to the HWHB target population, administer flexible Health Access Funds to support the safety and health of the participants, and train health care providers on best practices for domestic violence assessment and response. They also proposed to work with direct service providers in the maternal and child health care and victim services fields to learn challenges and explore possible solutions. DCADV's original goals for their HWHB funding and participation were to increase health care providers' (especially maternal and child health providers) perceived understanding of the dynamics of domestic violence from a health perspective, how to promote health relationships through universal education, and how to connect individuals experiencing domestic violence to community resources.

Because of COVID-19, there were some changes to DCADV's program. First, provider trainings could not occur as planned, so fewer trainings were held. Second, the flex funds component became even more important as the economic impacts of the pandemic were felt by participants.

DCADV's primary evaluation questions were:

- In what ways do victims and survivors of domestic violence use flexible financial assistance and what are the benefits?
- To what extent does flexible financial assistance mitigate financial stress related to meeting social needs like childcare, transportation, etc. that could affect birth outcomes for Women of Color?
- To what extent does flexible financial assistance impact participants' hopefulness for the future?
- What is the best approach for integrating universal education/DV screening into health care providers' practices?
- What are the best practices and barriers to creating a referral pathway between HCPs and community DV providers?

To answer their evaluation questions, DCADV collected data on services provided, data on the dissemination of flex funds, data on participants' perceptions of the value and impact of these flex funds, and data on trainings provided to providers.

Year 1 Data

Process Data: Demographics

Over the course of the year under the HWHB initiative, DCADV served 108 women who are pregnant, parenting a child under the age of five years old, and/or of reproductive age (ages 18-44 years old), who are living in Wilmington, Claymont, Newark, and New Castle (ZIP codes 19703, 19809, 19802, 19801, 19805, 19804, 19702 and 19720).

Process Data: Services Provided

Participants received services including linkages to health care providers and social services, education and empowerment services, and counseling services. Another key use of the HWHB grant funding throughout Year 1 was the dissemination of "flex funds". In Cycle 1, HWHB funds were provided to 51 women. In Cycle 2 (July 1 – December 31, 2020), HWHB funds were used to provide flex funds to 53 women. Funds were most commonly used to meet basic needs such as food, diapers, winter coats, and

feminine hygiene products and for specific needs of the children of the participants. Other common uses of the flex funds were to pay utility bills, meet physical needs and buy essential furnishings. Grantees were encouraged to specify a maximum amount for flex funds requests, as well as a maximum number of requests per person, in order to maximize the use of funds for all clients served by the project.

Figure 17: DCADV Participant Use of Health Access Funds

What were the Health Access Funds used for?	Count (Cycle 1)	Count (Cycle 2)
Other Basic needs	69	50
Children's needs	32	18
Essential furnishings	16	8
Physical needs	13	9
Utility Bills	12	10
Transportation	7	4
Employment assistance	6	5
Rent	6	5
Other	6	4
Move-in costs	4	1
Education	1	1
Moving costs	0	1

Outcome Data

As one measure of the impact of the flex funds, participants were asked to respond to a short two-question post survey, asking if the funds reduced their financial stress, and whether they felt more hopeful after receiving the flex funds. Almost 96% of participants who responded said the flex funds "completely" or "significantly" reduced their financial stress. Almost 96% of respondents said the receipt of the flex funds made them feel more hopeful.

Figure 18: Impact of Health Access Funds on DCADV Participant Financial Stress

Did the funds reduce your financial stress?	Count and % (Cycle 1)	Count and % (Cycle 2)
Completely	13 (28.3%)	6 (18.2%)
Significantly	31 (67.4%)	20 (60.6%)
Somewhat	1 (2.2%)	6 (18.2%)
A little	1 (2.2%)	1 (3.0%)
Not at all	0 (0.0%)	0 (0.0%)

Figure 195: Impact of Health Access Funds on DCADV Participant Outlook

Would you say you are more hopeful about the future than you were before the funds? Less hopeful? Or no change?	Count and % (Cycle 1)	Count and % (Cycle 2)
More Hopeful	44 (95.7%)	33 (94.3%)
Less Hopeful	0 (0.0%)	0 (0.0%)
No Change	2 (4.3%)	2 (5.7%)

In terms of services delivered, participants received a wide range of services, including referrals, counseling, and educational services. The services provided in Cycle 1 are noted in the table below.

Figure 20: Referral of Services

Links to Services	Number of Services between December 2019 and June 2020
Links to Care Coordination and System Navigation Services	1,328
Counseling and Supportive Services	2,570
Education and Empowerment Services	1,152

Links to care coordination and system navigation services includes making referrals to housing services, language and education services, medical services, social security benefits, life skills services, and many other services. The counseling and supportive services included safety planning, emotional support, counseling, and other services. The education and empowerment services included education and support on legal services and processes, domestic violence, housing, health education, parenting, and other related issues.

Hispanic American Association of Delaware

The Hispanic American Association of Delaware provides pregnancy and postpartum support in Spanish to women ages 15-44 who live in ZIP code 19720 in New Castle County. The support group meets twice weekly during pregnancy and postpartum to provide support, reduce cultural stigma around mental health in the Latino population, provide support to families with recent migration and acculturative stress, and offer referrals to insurance and other needed services. The program also hosts a family network event to involve the whole family (especially fathers) and to connect the community to pregnancy and postpartum mental health resources.

The program, called Mamas felices, hijos felices (Happy Mothers, Happy Children), had the goals of creating wellness, resilience, hope, and connection for women adjusting to parenthood and experiencing pregnancy and postpartum emotional ups and downs.
The primary evaluation question associated with this work is:

- Does the support group program reduce participant stress, depression, and anxiety?
- The primary measurable outcomes are:
- reduce stress, anxiety, depression symptoms of 80% of the participants of the support group
- achieve 90% satisfaction rates of participants of the support group

In order to answer these questions, their evaluation includes data collection around participation in services (process data) and a pre and post survey designed to capture changes in these intended outcomes.

Year 1 Data

Process Data

The Hispanic American Association of Delaware provided services to 94 women over the course of Cycles 1 and 2 of the initiative. A total of 92 support group sessions were provided. Additionally, referrals to additional services were made as needed and a family networking event was held.

Outcome Data

To measure progress toward the goal of reducing stress and anxiety, the Hispanic American Association of Delaware used a modified version of a validated scale, the Depression, Anxiety, and Stress Scale (DASS), at the beginning of services and again after the participant's last session. A total of 20 of the 21 questions in the DASS were asked in Cycle 1 and all 21 questions were asked in Cycle 2. Respondents could answer yes or no to each question, and each "yes" was coded as a "1".

In Cycle 1, 30 participants took the DASS and pre and post. The mean number of "yes" responses was 3.1 at pre and 1.6 at post. This decrease was statistically significant (p=.00). In Cycle 2, 45 participants took the DASS at both pre and post. The mean number of "yes" responses was 10.31 at pre and 9.75. This change was statistically significant (p=.00). In both cycles, the change from pre to post indicates a significant improvement for participants in their self-reported depression, anxiety, and stress. It is interesting to note, however, the much higher starting point for depression, anxiety and stress for participants in Cycle 2. This could be, in part, due to the impacts of the COVID-19 pandemic.

In addition to the DASS, participants were asked if they were satisfied with the program. Of 49 participants who were asked this, 48 said yes.

Reach Riverside Development Corporation (Kingswood)

In their original proposal for the HWHB Initiative, Riverside Development Corporation (REACH) proposed to provide targeted services (at the Kingswood Community Center) designed to reduce toxic stress to women of childbearing age and their partners. The services that were proposed were to consist of a multi-generational maternal and child health program that provided mindful and empathetic services pre-, during, and post pregnancy through the establishment of a peer-to-peer program. The program also proposed to provide referral and resource services as well as case management through a community family and support service liaison focusing on financial empowerment/self-sufficiency and Housing. The program intended to include workshops with tools to assist with parenting dynamics, support of the mother and children in avoiding the impact of toxic stress and its components on a child. REACH had a goal of training 20 women in two cohorts, who would then in-turn provide peer support to other women (up to 100 community members) during the period of the grant.

In addition to training and case management, the third component of the program was to provide workshops to increase fatherhood/partner engagement, using strategies for inclusion and to assist with parenting dynamics, and support mothers and their children to avoid the impact of toxic stress. The "Every Man Counts" program was implemented, as was the "24/7 Dads" program. In addition, men were provided with case management sessions.

Because of challenges with startup, the REACH program shifted focus to provide Flex Fund to parenting mothers and to offer the fatherhood/partner engagement component (with reduced funding). REACH shifted their case management funding by pivoting to providing support for securing approved basic need items and crisis alleviation needs. The shift to using the funding in the form of Flex Funds to address the social determinants of health included case management but through a different mechanism. REACH partnered with the Metropolitan Urban League/Black Mothers in Power initiative to support the COVID-19 related needs of women of childbearing age and the men who support them, through the 24/7 Dads effort in the 19801 and 19802 zip codes.

To address the digital divide that was noted by the women, REACH disbursed nine Chromebooks to families needing to access virtual school and Summer learning programs. Additionally, the families benefited by being able to search for jobs and health resources. Women ranged in age from 18 to 60 years old and the majority were African American.

The goals of the fatherhood component were to

- engage at least 25 men who are fathers or serve in the role of fathers
- increase awareness of a father's role in a healthy pregnancy and in a child's healthy development and
- increase feelings of empowerment to be more integrated in the social and emotional support of the mother and child(children) – reduction in parent isolation
- The evaluation of this component of the REACH program focused on the following questions:
- To what degree do the services offered as part of the fatherhood engagement component help fathers become more aware of their critical role in supporting a healthy pregnancy, healthy development and a healthy environment?
- How satisfied are participants with the delivery of the program services? What works well and what could be improved?

- To what degree did implementation of the program, evaluation and data collection progress as planned? What could be improved in developing a process for delivering programs of this type?

Year 1 Data

Process Data

A total of 26 men enrolled in either the "Every Man Counts" workshop series (26 men) or the "24/7 Dads" workshop series (16 men), or both. All 26 men were Black/African American and were between the ages of 15 and 79. About 2/3 were fathers. Those who were not fathers, were age 19 or younger. About half (12) were married or had a partner.

For Every Man Counts, four men attended all six workshops. Another four men attended two workshops, and five attended only one workshop. Eight men attended all six of the 24/7 Dads workshops. One attended three workshops, three attended two workshops, and five attended one workshop.

In terms of case management, five men were provided with case management sessions. Two men had two sessions each, and three men had one case management session.

Outcome Data

Participants were asked to compete a survey at the end of the Every Man Counts workshop series and at the end of the 24/7 Dads workshop series. Four men completed the survey at the end of Every Man Counts and eight men completed the survey at the end of the 24/7 Dads workshop series. Results for both were very positive.

For both courses, all of the survey respondents rated the course content, instructor, and overall quality of the course as excellent. In terms of the course format, 10 of 12 said it was excellent. Nearly all survey respondents (11 or 12 participants responded) strongly agreed that they learned new things, that the course was helpful for them as a father or future father, that they will use what they learned in their daily lives, and that they have become better fathers as a result of the course. All strongly agreed they would take the course again and recommend it to others. When asked about the most helpful things about the course, one participant said: "It made me became a better father in helped me get involved more with my community." Another said it helped him "get knowledge of what being a future father really means."

Rose Hill Community Center

Under the HWHB Initiative, the Rose Hill Community Center provided fitness classes, nutrition classes, and self-improvement classes to women of childbearing age in New Castle County, specifically residing in 19720 and 19801 at no cost. Specifically, offerings included fitness classes including yoga, Zumba, and cardio kickboxing; one-on-one appointments with an on-site nurse; nutrition classes; and self-improvement classes to discuss ways to handle stress, positive self-image, combating negative attitudes, conflict management, effective communication, parenting 101, couponing, social media, professionalism, discipline verses punishment, financial literacy, community resources, stress management, and goal setting. Free childcare was available during classes. Participants also had access to an on-site mental health consultant, who is a National Certified Counselor and Licensed Professional Counselor of Mental Health. Fitness activities and other services were tailored to pregnant and other participants with specific needs through meetings with a nurse and Women's Wellness Program staff.

The goals of the program implemented by Rose Hill under this initiative were to:

- Increase participation in physical activities
- Increase knowledge, attitudes, and intentions towards nutritional food options
- Increase knowledge, attitudes, and intentions towards mental wellness
- Reduce stress
- Their primary evaluation questions were:
- Are high levels of stress and lack of self-care related to being in poor health?
- Will fitness classes and self-care workshops help reduce the stress levels of participants?
- Will weekly fitness and monthly self-care and nutrition workshops improve the health (and reduce the health disparity) of participants?

Year 1 Data

Process Data

Through this initiative, in Cycles 1 and 2, Rose Hill served 81 women. Those 81 women participated in fitness classes 2,792 times over the course of the year and participated in nutrition classes 157 times. A total of 20 mental health services were provided.

Figure 21: Number of Rose Hill Participants in Fitness Classes

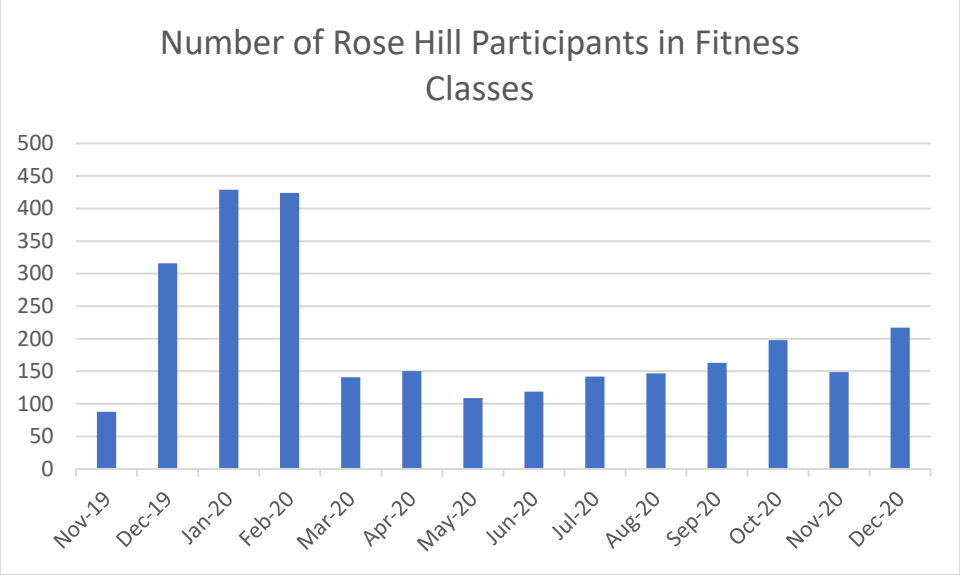


Figure 22: Number of Rose Hill Participants in Nutrition Classes

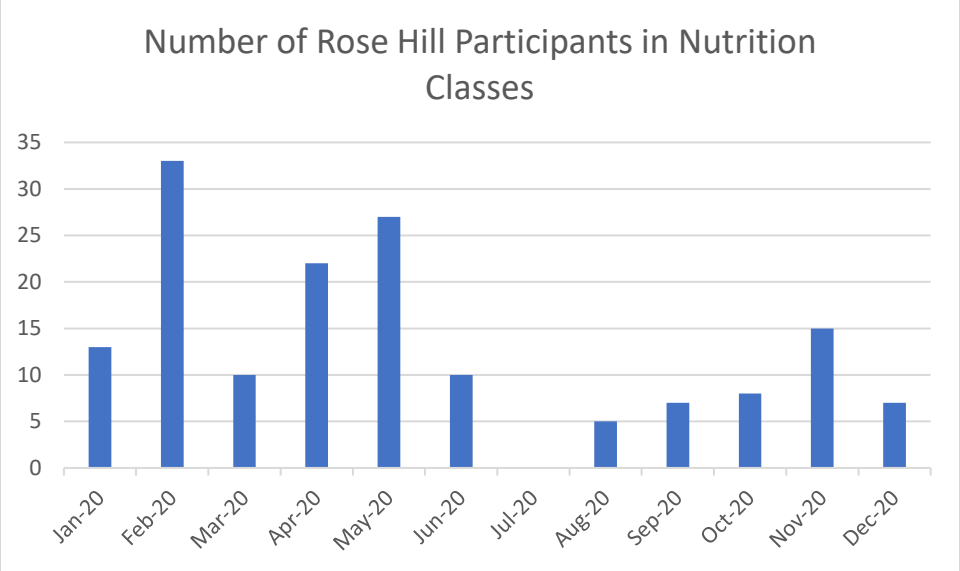


Figure 23: Number of Rose Hill Participants in Mental Health Consultations

Mental Health Consultation	Number of Participants
January	10
May	4
July	6

Outcome Data

To measure progress toward their short-term outcomes, Rose Hill collected data on a number of health measures, including participants' weight changes, changes in diet and water consumption, and self-reported benefits from participating. Additionally, the program administered the Perceived Stress Scale

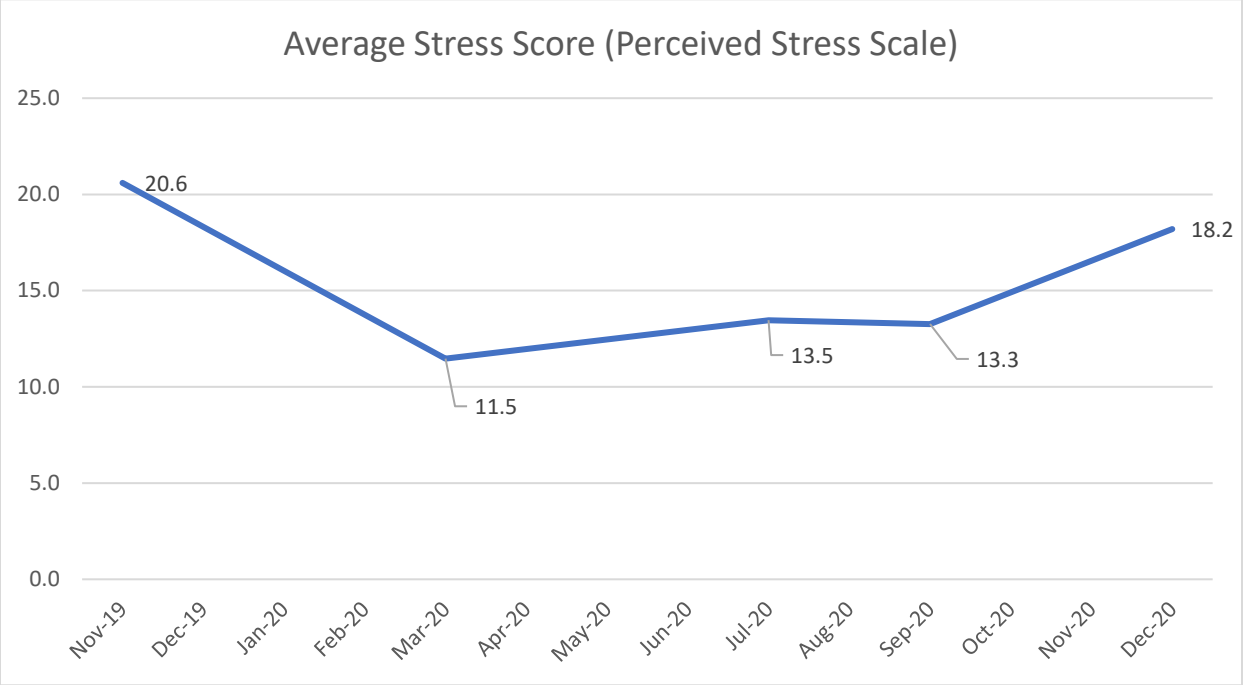
(PSS) five times throughout Cycle 1 and 2 (in November 2020, March 2021, July 2021, September 2021 and December 2021).

Participants' levels of self-reported depression, anxiety and stress dropped between November 2019 and March of 2021, but began to increase again after March 2021. Figure 24 below notes average stress scores for participants who took the PSS all five times it was administered. Scores for participants who took the PSS four or fewer times followed a similar trend.

Program staff noted that stress scores started increasing for most participants as the COVID-19 pandemic continued, and as participants began to realize their children would not be going back to school, job losses became more permanent, and resources that formerly were available to their children were not as available. By December, job loss was becoming even more permanent and resources became even more limited. Stress scores increased even more then.

Throughout the year, Rose Hill program staff were very in tune with participants' results on the PSS and checked in with participants who had higher scores, to find out how they were doing and what Rose Hill could do to help them. In addition, the increase in stress scores is what prompted Rose Hill to apply for additional funding for a new program focused on stress (for Cycle 3).

Figure 24: Average Stress Score Across Participants Who Responded to PSS Five Times



Lessons Learned

Overall, the first two rounds of the HWHB Mini-grant program were incredibly successful. We were able to provide mini-grants to six small, community-based agencies located in the HWHB Target Zones across the state, inclusive of all three counties. In sum, the HWHB served 482 unduplicated individuals total, most of whom were women of childbearing age, with the rest being partners of these women. Overall, during Cycles 1 and 2, most grantees met or exceeded targets for number of people they planned to serve, even despite the challenges presented by COVID-19 pandemic.

The bulk of the women served came to the program with significant needs related to social determinants of health (as measured by the Health Leads screening, which four mini-grantees used as part of their program evaluation). About a third of women served spoke a language other than English, with most of them speaking Spanish.

Summary of Outcome Data

Outcome data for Year 1 are very promising. In some cases, grantees are already showing statistically significant improvements in the short-term outcomes that were their focus, such as depression, anxiety and stress. All are reporting high levels of program satisfaction, and that participants say the services and activities are helping them. In addition, in many cases, grantees have built strong capacity for data collection in a very short amount of time.

Coaching and Capacity Building

At the outset of their program's start, each grantee was assigned a coach from HMA, who was tasked with providing technical assistance (TA) and support to help each grantee participate in the HWHB program and build agency capacity. Originally, HMA anticipated our TA would relate to the following topic areas (as presented in our Round 1 HWHB Application Webinar):

- Data Collection & Evaluation, including Continuous Quality Improvement (CQI) processes
- Strategies to ensure ongoing community involvement and collective impact
- Strategies for supporting partnerships with diverse stakeholders
- Strategies for moving towards sustainability
- Ongoing support re: alignment with existing resources, including referral/coordination with existing Healthy Women Healthy Babies Grantees and the work of the SDOH Advisory Workgroup

In practice, each agency's coaching plan and topics varied slightly based on their needs, but overall, coaches focused on two "levels" of technical assistance during Rounds 1 and 2:

1. Ensuring mini-grantees were able to meet all HWHB grant requirements
2. Supporting mini-grantees to build and expand on their programs

Within these two coaching "levels," coaches focused on many specific topics, including but not limited to addressing and supporting:

- Programmatic issues and troubleshooting, supporting grantees to amplify their successes and address identified issues
- HWHB Grant Deadlines, making sure grantees are submitting everything accurately and on time
- Data Collection and Reporting Process and Quality, supporting grantees to fully participate in the Evaluation (with minimal burden) and use their data to inform programmatic improvements
- Funding diversification and program sustainability, supporting grantees to identify options for programmatic expansion through additional funding

- Innovations and Best Practice recommendations, including sharing available resources and educational materials related to supporting the HWHB target population
- Supporting program adaptations due to COVID-19, as well as identifying strategies for expanded and more effective outreach to women in the target communities during the pandemic

Not surprisingly given the fact that these grantees are very small nonprofits, HMA's coaches spent the a good bit of time during the first two cycles helping mini-grantees to meet requirements related to the HWHB grant, including making sure that data, program, and fiscal reports were submitted in a way that is complete and on time. As part of this work, the coaches (supported by the evaluation team) focused on helping grantees to set up internal processes to help them adhere to grant requirements that can be sustained and leveraged for other grant opportunities. This included processes like setting up text-based surveys for data collection using Qualtrics and/or Google Suite tools, as well as individual level coaching around fiscal management to support accurate (and efficient) reporting on grant expenditures. This capacity building was further supported by small, capacity building grants that DPH was able to provide to five of the mini-grantees during Round 2 to support them to build capacity within their organization, such as funding additional staff time to help with data collection and reporting.

> *"This program has been a blessing. It's great that the state had the idea to contract with HMA to be able to provide this kind of support. It hasn't been intrusive or overbearing. It's actually been nurturing." – Grantee*

During Cycle 2, HMA's evaluation team conducted a set of key stakeholder interviews with each coach and grantee to identify how the coaching was going, including whether mini-grantees were finding the technical assistance helpful, as well as other topics on which they would like to focus moving forward. Based on these interviews with the grantees, we learned that overall coaching and TA provided to the grantees Rounds 1 and 2 was very well received. Overall, all grantees reported feeling satisfied with their coaching experience. In several cases, grantees reported that working with the coaches helped them to brainstorm creative ways to pivot their programs in the middle of the pandemic. The full coaching assessment findings are documented in HMA's Coaching Report, presented to DPH on the slide deck prepared for the DHMIC meeting in March of 2021.

Given this feedback, HMA looks forward to continuing our coaching relationship with each mini-grantee. Based on our capacity building support that was provided in Rounds 1 and 2, we are working to expand our coaching topics with mini-grantees that are continuing in Round 3 to include more topics in Level 2, related to building and expanding their programs, as well as sustainability.

Beyond this individual level coaching, grantees were also invited to attended a set of Learning Collaboratives, each of which had a specific set of topics on which we focused together:

- December 2019: HWHB Program Overview, Data Collection 101, and Coaching TA
- May 2020: Managing Stress During COVID-19, Plan-Do-Study-Act (PDSA) Processes, Data and Evaluation Strategies
- October 2020: Cycle 3 Preparation, Unite Us, Data Training, and Discussion of Mini-Grantee Success Stories

Most grantees attended each of these Learning Collaboratives (which was a stated requirement for the HWHB grant program), and many expressed positive feedback about them. In addition to topic-specific education, the Learning Collaboratives offered grantees an opportunity meet and coordinate with each other, and a number of grantees have continued to collaborate outside of these formalized group meetings. Because of COVID-19, we transitioned from planned in person Learning Collaboratives to

virtual starting in May of 2020. Finally, to promote further connections across the system, mini-grantees were invited to attend the Delaware Healthy Mother and Infant Consortium (DHMIC) meetings, which is something we look forward to continuing to expand moving into Round 3.

Next Steps

Cycle 3 of the HWHB Initiative began in January 2021, with five of the six original grantees continuing into Cycle 3 and the addition of three new grantees: Parent Information Center, Metropolitan Wilmington Urban League (Black Mothers in Power), and Breastfeeding Coalition of Delaware. All continuing grantees completed a revision of their evaluation plan to add new elements, modify those that needed changes, and remove those that were ineffective or not feasible. All new grantees developed new evaluation plans.

In the upcoming year, the HMA team will work with both new and continuing grantees to support continued improvement of data collection processes, use of data for continuous quality improvement, and use of data to understand the collective impact of the whole group of grantees.