

**Findings from Phase II  
of the National Healthy Start Evaluation  
Monday June 2, 2008**

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**>> Gopal Singh:** Welcome to today's DataSpeak web conference on the findings from phase 2 of the Healthy Start national evaluation. My name is Gopal Singh, and I am the project officer for the Health, Maternal and Child Health Bureau's MCH information resource center, which sponsors the DataSpeak series. Today we are pleased to present the third DataSpeak program for this calendar year. Archives of the first two DataSpeak programs for 2008, as well as all other programs held since 2000, can be found on the MCHIRC website at the address on the slide.

Today's program will focus on the methods and findings of phase 2 of the national evaluation of the Healthy Start program. We are fortunate to have with us the co-principal investigators for this evaluation.

Our first speaker will be Dr. Deborah Klein Walker, vice-president at Abt Associates. Dr. Walker will discuss the process of selecting the eight grantees and the results of the grantee interviews. This will include an overview of grantee reported achievements and challenges, and summary conclusions.

Our second presenter will be Dr. Margo Rosenbach, vice-president at Mathematica Policy Research. She will present the results of the participant survey portion of the evaluation.

Dr. Rosenbach will discuss seven methods, participant demographics, and results, including information about access to care, satisfaction with services, and best outcomes among participants.

Dr. Walker will close the presentation with a comprehensive discussion of lessons learned about the Healthy Start program from the overall evaluation and its multiple data sources.

It is now my pleasure to introduce Vivian Gabor, the moderator for today's program. Vivian, I will now turn the floor over to you.

**>> Vivian Gabor:** Thank you, Gopal. And welcome to all of our participants today. We are delighted to have everyone with us.

Before we start our presentations I have just a few housekeeping items to take care of. For those of you who are logged in via the internet, you'll be seeing an ongoing slide show through the next hour. At the end of the program we would greatly appreciate it if you could just take a moment to complete the short feedback form. We will provide instructions for filling out that form at that time.

Your phone will be muted during the presentations. After we hear all of the presentations, we'll have a question and answer session. Those of you on the phone will have an opportunity to ask questions through the operator who will come on at that time to provide instructions for doing so.

You can also post questions online at any time during the program. If you're logged in via the internet, you may enter your questions in the questions box which is located on the left side of the screen, and hit enter.

If you encounter technical problems during the presentation, please feel free to call the MCHIRC health line. That number is 202-842-2000.

I'll let you know that there are additional resources available on the Healthy Start program which have been posted on the DataSpeak website, including those that our speakers will highlight in their presentations. Additional resources and publications will be available on the website in about a month or two months, as well as the information that's being discussed today is available in publications.

Now I'd like to turn to our first presenter, Dr. Deborah Klein Walker. She will begin our discussion of the Healthy Start national evaluation. Good afternoon, Debbie.

**>> Deborah Walker:** Good afternoon, it's a pleasure to be here.

**>> Vivian Gabor:** I'd like to start out by asking you to provide our audience with a brief overview of Healthy Start.

**>> Deborah Walker:** Sure. Well, first of all, this is a program that's been in existence since the early 90s, and it was established to reduce infant mortality and improve birth outcomes. Our evaluation that we're going to talk about today is on the set of grantees that were funded in the 2003 cycle. There were 96 programs funded at that time.

Most of them or the majority were from urban areas, 21 percent were from rural areas. The size of the grants ranged from under \$3 million to over \$4 million for a four year period.

They are currently administered by a wide range of folks, including the majority were administered by nonprofit organizations, community organizations, 37 percent by local health departments, and 11 percent by state health departments, and then other agencies.

Now, what's interesting about Healthy Start, as it has evolved over time, these grantees, in the guidance to which they applied, were required to include nine different components in their applications, and in their ongoing programs. Five of them dealt with service issues, and they are outreach, case management, health education, depression screening, and interconceptional care. And four of them dealt with systems components of their programs. And those were collaboration, with a special focus on Title 5; the consortium, development of a consortium; and a local health systems action plan, and a sustainability plan.

**>> Vivian Gabor:** Great, thank you. Now could you give us an overview of the evaluation that your firm and Margo's firm conducted over the past four years?

**>> Deborah Walker:** Sure. For this evaluation that we partnered on, the evaluation was a four year effort in two phases. The first phase was actually a survey of the project directors of all the 95 grantees. And we'll come back to that later, because documents on the results of those surveys are available today online.

Phase two, on which we're reporting today, was really an evaluation which was conducted as an in-depth case study of eight grantees. The evaluation, I want to just point out again, is of the national program, and not of individual grantee performance. And we were committed from the very beginning, and have continued to do so throughout the evaluation, involve many stakeholders.

First and foremost were the Healthy Start grantees themselves, the maternal and child health bureau staff has been incredibly helpful and useful. In addition, we have made several presentations at the Secretary's Advisory Committee on Infant Mortality, and actually there was a Healthy Start subcommittee of that group that was charged with kind of monitoring and helping to assist with the evaluation.

And finally, there was a Healthy Start panel that reviewed the evaluation. That convened several

times during this process. And this panel consisted of grantees, NCH staff, experts, et cetera.

So I just want to make it clear that there was a real commitment to the stakeholders in shaping this evaluation, so that the findings for all could be used in a way to improve the quality of these programs.

**>> Vivian Gabor:** Splendid. And how would you frame the goals of this part of the evaluation, and tell us about the data collection methods for phase two.

**>> Deborah Walker:** Okay, sure. So following that phase two focused on these eight case studies, it very much was set up to really gain in-depth understanding from a small group of grantee project models.

It was set up so that we could go on site and talk to a variety of folks to understand from the perspective of the different people participating in the program, and delivering the program, what was going on.

In addition, it was set up to really learn from the participants' perspective, as well. We were especially interested in talking with the program staff about what was really happening from their perceptions in the community, and how did that influence the community system of care that really related to what the interim and long-term goals of their programs were.

We had two major components. We did site visits with individual and group interviews, and then a survey of Healthy Start participants.

**>> Vivian Gabor:** The site visits, I know there were eight sites, how were they selected?

**>> Deborah Walker:** Okay, let me just say a little bit about this, and you have a couple slides here to guide you through. Well, first of all, we had all the grantees who completed the national survey of the Healthy Start program in phase one, and that was 95 programs.

We actually then only wanted to visit only programs that had implemented all nine required components, and that actually dropped the number to 55. I have to note here that the project directors were very honest in terms of filling out their surveys, and some did report that some of the components had not been implemented yet.

Next, because of the needs of the survey and being able to identify the participants to participate, we wanted to track referrals to providers within and outside of Healthy Start, and have an electronic records system that could facilitate the participant survey. So after we had applied the screens on all of the grantees, we came to the -- a set of 26 eligible grantees. From them, eight were selected, and these reflected the following grantee characteristics, which is on the next slide.

These grantee -- so from these we wanted this kind of representation, even though this was not a nationally representative sample, but we wanted to pick them from four U.S. census regions, we wanted a mix of urban and rural sites, a mix of the different funding levels. We had a range in size, according to the number of births in 2004, and at least one of the grantees we wanted to be relatively close to the U.S.-Mexico border, and at least one we wanted to be predominantly serving an indigenous population.

So when we did that kind of a screen we ended up with eight sites, which are not listed here, but I will tell you what they are. They are Fresno, California; Tallahassee, Florida; Des Moines, Iowa; East Baton Rouge, Louisiana; Worcester, Massachusetts; Las Cruces, New Mexico; Pittsburgh, Pennsylvania; and Lac du Flambeau in Wisconsin.

**>> Vivian Gabor:** Thanks, Deb. For your site visit, what were the goals for that portion of the research?

**>> Deborah Walker:** Okay, kind of building on what I've already said, then, the site visits were really to get a really in-depth understanding of how these projects were designed and implemented. We focused on getting the perspective of a number of people in the project on our questions, and we wanted to really understand each of the nine core components, and what they were doing.

We also wanted to understand better, from the point of view of the program staff here, because it is their perceptions, how they thought of, and linked to services, systems, and their intermediate program outcomes, as well as what they hypothesized would happen with the long-term birth outcomes. We really wanted grantees' perceptions of their component strengths and accomplishments.

So I just wanted to say from the outset, this is really a case study methodology where we interviewed a number of people on a number of -- and got the perceptions of these issues from a number of folks. This is not an in-depth study that's going to link what was happening in the programs to the birth outcomes, which are the long-term outcomes. This is more related to what they were doing, and their perceptions, and how those were linked.

And I also wanted to say that we did have a quite developed Healthy Start logic model which was in place from the beginning of the evaluation, which really set up these links that we expected would happen.

**>> Vivian Gabor:** What did you find in terms of the grantees reporting on achievements?

**>> Deborah Walker:** Okay, now, first because we are limited in time at this webcast, I wanted to say we found out many, many things, and actually have quite good descriptions of what people said they were doing for each of the nine components. However, we will not be able, obviously, to present those today, so we thought it would be most important to jump to kind of the aggregate level, what the grantees said were their reported achievements.

Well, first, these eight grantees were proud and reported both system and service level achievements. System level achievements seemed to outnumber those that were the service level achievements, and the only thing that's important about that is we think that the only way you could understand these systems level type achievements is to be on site and actually do this kind of case study methodology.

Improved birth outcomes, which were indeed the longer term outcomes hypothesized for these programs, were noted as frequently as some of the intermediate outcomes. So project staff were already stating that they saw those kinds of changes, and hypothesized longer term birth outcomes, as well.

In terms of the grantee reported achievements at the service level, on the -- they spoke about the provision of enabling services as an achievement. And remember, these Healthy Start sites are in contexts which have, in many cases, really poor resources, or we should say are underserved for the amount of services that are needed for the population included in these programs. And many of the programs were struggling to hold together that kind of safety net, and gap for those kinds of things.

Also, five of the eight projects reported earlier entry into prenatal care, and four reported increased service use.

At the systems level, we noted a number of different reported achievements, and those were: Increased community awareness, which the grantees felt were really important as an important piece that would later lead to more resources and more system development.

Many were very also happy and proud about the culturally diverse staff that they had been able to put in place. I must say that was also a challenge for many of the sites, as well. Consumer involvement was reported as an achievement for six of the eight sites. That also has many stories behind it, in how they did that, because that is also a challenge.

And then finally, the coordinated systems and services was reported as an achievement by six of the projects.

**>> Vivian Gabor:** What program components did the grantees say were key to their achievements?

**>> Deborah Walker:** Okay what is interesting, and there are lots that could be filled in here on how people reported on this, but interestingly, outreach case management and health education were the things that were constantly named as the key service level components that were essential for the program.

People would say things like outreach is the pillar of this program. Case management is the life thread of our project. So those components really came together as being critical on the service side.

On the systems side, people mostly talked -- or the largest number talked about the consortium, and how the consortium was kind of the glue that pulled together all the resources in the community that helped with the community awareness, and later the sustainability.

For instance, one quoted it's important to have representation from the groups we're targeting to make sure we have stakeholders from the different venues.

**>> Vivian Gabor:** And in light of their achievements, or on other side, what kind of implementation challenges impact the report?

**>> Deborah Walker:** Right. So on the challenges, which I just began to kind of talk about, they reported anywhere from one to eight challenges.

And they both talked about contextual and organizational challenges, and you can see from this slide that some of the challenges also relate to what some of their achievements are. But a major challenge in the service availability was the availability of mental health services. Consistently, across the program. Lack of funding, to be able to actually deliver the services they thought were important and sustain the projects was another key challenge.

Providing culturally competent care was a challenge. In all of these Healthy Start sites, even though there might be one predominant racial or ethnic group, they all had a mix of a variety of different cultural groups, of which they needed to make sure that all of their services represented what was the most important in reaching those women.

Staff capacity, and then the fact that many of the populations are also mobile. Those were all the challenges or the main ones that were reported by the sites.

**>> Vivian Gabor:** Thanks. What are -- stepping back a little bit, what would you say are some of the summary big picture conclusions from the site visit data?

**>> Deborah Walker:** Okay, again, this is summary big picture from a lot of data across lots of different staff in the different sites. But in the end, after doing, you know, the very complicated kind of analysis across all of those, these are the big major pictures.

There is unique contextual and community issues in all of these sites that influence their design implementation and successes. So even though they're doing each of the components, you know, there's not one cookie cutter that fits all. They really are uniquely designed for their particular site, particular culture of their community, and the resources of their community.

Another way to say that is there's no single magic bullet for reducing disparities in birth outcomes, or even moving toward reduction in disparities.

Service provision and systems development are both critical. So the fact that these sites were required to have components related to both of these issues we found was really important, and the site itself say they're important for what had to be achieved in terms of the long-term goals of improving birth outcomes.

And then the systems level achievements were more likely to be identified by qualitative data, which just shows why there was an advantage of doing this. As opposed to learning more about the services, which we feel that the survey data really reflects a lot on those.

Next, the roles of individuals who conducted outreach case management and health education were connected. And actually, there was no one model here, and there was a lot that we learned both in the provider -- or the project director survey, and these site visits, about this. But frankly, in most of the sites, we found that these three components were very linked in what they were doing.

The consortium relied heavily on the involvement of multiple collaborations within the communities.

Sustainability efforts to this point we found in the programs were less of a priority than in the other areas. And acknowledging and working to achieve cultural competence, or consumer involvement, or the community voice, were what were often stated in some form or another, about the key things that needed to be in their community to address and reduce the disparities.

**>> Vivian Gabor:** Finally, as with all studies, we know there are some caveats. Given the case studies and qualitative research, what would you say are the caveats or limitations associated with the findings of this part of the study?

**>> Deborah Walker:** Okay, great. Yes, there definitely are, and we want people to remember this. This was a case study, and these findings are based on the respondents' perceptions and interpretations. We did ask a lot of different respondents at all the sites, so we have some consistency across that, but it is a respondent perception study.

Also, we were not able to verify any findings with local evaluation data, and that's for a variety of reasons. But this is not one where we went in and looked at birth outcomes and validated that. And findings are not generalizable to other projects.

**>> Vivian Gabor:** Thank you, Debbie. Thank you very much for your presentation. We'll move on to the other part of part two of the evaluation, the participant surveys. I'd like to turn to Dr. Margo Rosenbach, vice-president at Mathematica Policy Research. Welcome, Margo.

**>> Margo Rosenbach:** Thanks, Vivian, I'm really glad to be here.

**>> Vivian Gabor:** Before we get to the findings of the participant survey, can you explain the goals of the survey and the methods you used to survey Healthy Start participants?

**>> Margo Rosenbach:** Sure, I'd be glad to. First of all, starting with the goals. The primary goal of the participant survey was to provide the participant voice in the evaluations. And as Debbie has just talked about with the site visits, the participant survey was really designed to complement the site visits, to gain insight into the implementation of Healthy Start from the participant perspective.

So the kind of things that we looked at in the survey were the kinds of services the participants received, their satisfaction with the program, and their outcomes.

Now turning to the survey methods. As you can see in the slide, the survey was fielded between

October 2006 and January 2007, although most of the cases were completed by the end of December. We conducted the interviews using computer assisted telephone interviewing, or CATI, but if a participant did not have a phone at home, the interview was conducted at the Healthy Start site or by a cell phone.

The interview took about 30 minutes on average, but slightly longer if it was conducted in a language other than English or Spanish. And I think it's interesting, we did use interpreters for interviews that were conducted in Brazilian Portuguese, Creole, Mung, Vietnamese, Mandarin, Dingi and Twi, Mixteco and Arabic. So in fact, language was really not a barrier in the survey. We wanted to be as inclusive of the culturally diverse population as we possibly could.

In terms of the sample, we included Healthy Start participants with infants that were ages six to 12 months at the time of the interview, and this age range was chosen because of our interest in prenatal and postpartum outcomes, as well as infant health outcomes

We obtained 646 completed cases across the eight sites, and that ranged from 24 to 155 per site. We wanted to make sure that we included small as well as larger sites in the study. And our overall response rate was 66 percent, which was more than 80 percent in five of the sites, and more than 70 percent in two of the sites. And we were really pleased with our response rate. We owe a lot of gratitude to the grantees, because they provided enormous support in helping us to achieve this high response rate, and helping us to locate and update contact information. And we also provided a \$25 gift card as way of saying thank you to the respondents. And we heard that that was also very much appreciated

And finally, another method that I'd like to mention is we used the Early Childhood Longitudinal Survey, or the ECLS, as a national context for Healthy Start results. As we'll talk about during this presentation, we did not have a comparison group. So we used the ECLS as a benchmark. We created a subsample of women with infants ages six to 12 months, like our sample of Healthy Start participants, who were below 185 percent of the federal poverty level.

**>> Vivian Gabor:** And when you did the survey what are the demographic characteristics of the participants at these sites?

**>> Margo Rosenbach:** Sure. Now, first of all, looking at race and ethnicity, which is a key demographic, we can see that the eight sites served a very diverse population. About one third were African American, and another one third were Hispanic. And then when we compare it to the low income mothers nationally based on our ECLS benchmark, which is also shown here, we see that Healthy Start participants in the eight sites were much more likely to be African American, Asian Pacific Islands, or American Indian. But that finding is not surprising, given the Healthy Start focus on eliminating disparities.

Now, the next set of slides shows the distribution by age and education for both groups, both Healthy Start participants in the eight sites, and the national sample of low income mothers. And there weren't any significant differences in the age distribution and education status between the two groups. In both groups, the largest age group was ages 20 to 24. And in terms of the mother's education, the largest group had less than a high school education.

We did find a couple of other differences that were worth noting. For example, Healthy Start participants were less likely to be married, and also less likely to consider English their primary language.

**>> Vivian Gabor:** What did you learn about access to health care and other services among Healthy Start participants?

**>> :** Well, this is a really important part of the survey, and we looked at several indicators of access and utilization, including health education services, unmet need, insurance coverage, usual source of care,

and a whole host of other issues. But here we can only present a few highlights in the interest of time.

So first of all, as Debbie mentioned, health education is one of the core components of the Healthy Start program. And we did find that nearly all Healthy Start participants reported receiving health education on a wide range of topics. And these topics covered issues both during the prenatal as well as the interconceptional period.

The three most common topics included nutrition, the child's sleeping position, and breastfeeding. But the least frequent topics which were reported by the were counseling on drug use, stress, and weight gain during pregnancy. We also looked at unmet need for a wide range of services, including both health care and other services. And here what we did is first we asked participants whether they had received each service, and these services could have been provided outside of Healthy Start. If they said no, then we asked whether the women needed but not received the service.

And areas of low unmet need include making appointments for prenatal care checkups for their kids. Most women who needed those services got it. But where we found high unmet need was for housing, where 13 percent said they needed but did not receive housing. For child care, 11 percent said they needed but didn't receive it. And making appointments for dental services. Again, 11 percent said they needed assistance, but didn't receive it.

And I think these data demonstrate the diverse needs of Healthy Start participants, which we'll come back to again at the end.

We also found that infants had greater access to care than their mothers. And this is one of the few surveys that provides comparable information on women and their babies. So if you turn to the next slide, we looked at four measures of access for women and infants, and these were insurance coverage at the time of the interview, whether the women and infants had a medical home, postpartum or wellbaby checkups, and no unmet health care needs.

And here what we see is on all measures, women reported their children's access was significantly better than their own. And one thing that I'd like to particularly highlight is the 10 point differential for insurance status. Where I think not surprisingly, babies were more likely to have insurance coverage at the time of the interview than their mothers. And we'll come back to that again at the end, as well.

**>> Vivian Gabor:** What kind of information did you find out about Healthy Start participants' satisfaction with the care they received?

**>> Margo Rosenbach:** We asked about five measures of satisfaction which are shown in this graph. Overall relationship with the staff, frequency of contact with Healthy Start staff, how we were treated by Healthy Start staff, the amount of time we spent with them, and your overall satisfaction with the services received. And we found satisfaction was universally high across all five measures. I'd like to point out a couple of things, though. Participants reported the highest level of satisfaction about how they were treated by Healthy Start staff, but they were somewhat less satisfied with the frequency of contact with staff.

And one way to interpret this finding is that is that they like the Healthy Start program so much, based on how they were treated by staff, that they would have preferred more contact with the staff.

**>> Vivian Gabor:** Interesting. Now, let's turn to outcomes among the participants, the reported outcomes. What did you learn about prenatal outcomes?

**>> Margo Rosenbach:** Well, first let me tell you how we assessed outcomes. As I mentioned earlier, we did not have a traditional comparison group, so we constructed two benchmarks. One was based on the

ECLS, which I mentioned before, and these rates were age and race ethnicity adjusted to be more comparable to the Healthy Start participants. And the second one was from Healthy People 2010.

So in terms of prenatal outcomes, we found that the likelihood of receiving prenatal care in the first trimester, which is the first set of bars on the left, was very high in both groups, and close to the Healthy People 2010 goal. And then if you go to the last set of bars, we also found that elimination of alcohol during pregnancy was very high, and close to the national goal.

But what we found really interesting, which is the middle set of bars, has to do with elimination of smoking during pregnancy. And here, the performance in both groups, both Healthy Start participants as well as the national sample of low income mothers, it really falls far short of Healthy People 2010 goals. And I think what that highlights is the challenges associated with smoking cessation during pregnancy. This isn't unique to Healthy Start, it's really common I think across the general population.

**>> Vivian Gabor:** That's very interesting. What about birth outcome, how did Healthy Start participants fare?

**>> Margo Rosenbach:** Well, we looked at two birth outcomes. Low birth weight, which is really a sentinel indicator for Healthy Start; as well as another measure that was included in both surveys, our survey and ECLS, which is prolonged hospital stays at birth. And with regard to low birth weight, the rate among Healthy Start participants was very similar to the rate in the national sample, but we found that both were substantially higher than the Healthy People 2010 goal of 5 percent. So while it's comparable in both of the groups, it's still higher than what the national goal is.

In terms of the proportion of infants that stayed in the hospital longer due to medical problems at birth, this too was very similar in the two groups.

But in the next slide, we look at low birth weight by race and ethnicity. Because here, given that Healthy Start's goal is really to eliminate or reduce disparities, it's really important to break this out by race and ethnicity. And what we see here is that the rate for whites and Hispanics who participated in Healthy Start are actually at the Healthy People 2010 goal of 5 percent. But the disparities do persist for African American women, and we see the same pattern in the national sample of low income women, as well.

We can't say from these data what the rate would have been in the absence of Healthy Start, because we don't have a true comparison group. But we can show the gaps that remain specifically in the African American population.

**>> Vivian Gabor:** Do you find any -- what were your findings regarding infant health outcome?

**>> Margo Rosenbach:** Well, we did find some variations in infant health outcomes. Specifically, in two areas. First, we found that Healthy Start participants were more likely to breastfeed their infants; and second, they were much more likely to put their infants to sleep on their backs.

You can see that the rates of the Healthy Start population, at least in these eight sites, compare very favorably to the Healthy People 2010 objective.

And one way of thinking about this is perhaps it's related to the health education emphasis in the Healthy Start program. Because as I mentioned earlier and as Debbie has mentioned, that is a core component. And what we found is that among the most common topics that women reported getting counseling and education on, were breastfeeding and their infant's sleep position.

The final comparison here looks at whether babies had a wellbaby visit, and here we can see that virtually all babies, both in Healthy Start and nationally, received a wellbaby visit. So no differences there.

And when we look at infant health outcomes by race ethnicity, we do find that in general the

strong Healthy Start outcomes persist by race and ethnicity, and in most cases they do substantially exceed the outcomes in the national sample by a really large margin, by about 15 to 20 points. So I think again, what we see is that some of the efforts with regard to health education, that then have really important impact on infant health outcomes, really do show very favorable results in Healthy Start.

**>> Vivian Gabor:** Wrapping up, Margo, what would you say are the major or key findings from the survey component of your study?

**>> Margo Rosenbach:** Well, first I would highlight the health education emphasis that we've already talked about. We did note that the less frequent topics were drug use, stress and weight gain during pregnancy, and still about 80 or 85 percent of women did report counseling on these topics, so still a lot of women were getting counseling. But one of the things that I think is evolving is that stress and weight gain may take on greater prominence with the increasing focus on interconceptional care, and particularly, as the life course theory is becoming more prominent, and so I think we are seeing more of an emphasis on some of these other issues coming forward.

The other thing that I'd mention about unmet need. As I mentioned, unmet need was highest for housing, child care, and getting help with dental appointments. And so although many needs are getting met, these gaps do remain. And one of the key things is that many of these gaps are beyond the resources have available to Healthy Start programs. And it reflects that women have multifaceted needs, and the need for extensive community collaboration. And that goes back to what Debbie was talking about earlier, in terms of the system components within Healthy Start. That in order to meet these needs, collaboration is important. But also really thinking about the resources that are required to serve women.

Next I would emphasize that infants had higher levels of access to care than their mothers, and noting especially the lower rates of health insurance among women. And I think this is really important, given the current policy that discontinues Medicaid coverage for some women just 60 days postpartum, and that accounts for the lower insurance coverage. And of course, with state health reform initiatives there definitely are efforts to try and rectify that, but I think we do show in our study how women and their children really do have different levels of access on this one dimension.

And then finally, in terms of satisfaction with the program being high for all measures, but particularly high for satisfaction with how the participants felt they were treated by staff. And I also noted that we found evidence suggesting participants would have liked even more contact with have staff, but of course limited resources often preclude that.

Now, turning to the findings related to outcomes, we found that compared to a national population of low income mothers, Healthy Start participants in the eight sites were more likely to breastfeed their infants and put their infants to sleep on their backs. Again, that might be related to health education during Healthy Start visits both during the prenatal and the postpartum periods. And I think it's really important to note we haven't had a lot of time to talk about what happens in Healthy Start during the interconceptional care period, but it really is important to note that Healthy Start continues generally two years postpartum. So that provides an important opportunity for the program to have a positive impact, not just on women's health, but also infant health.

And then finally, compared to a national population of low income mothers, Healthy Start participants had similar rates of low birth weight. And I think this is an important finding, given the high risk demographic as well as medical profile of Healthy Start participants.

**>> Vivian Gabor:** Thank you. Finally, as I asked Debbie, what would you say are the caveats associated with the findings in this part of the study?

**>> Margo Rosenbach:** Well, this one definitely had some important caveats that really need to be kept in mind, specifically because of the limitations in our design, without a true comparison group. As I said, we relied on the ECLS and Healthy People 2010 benchmarks to provide a context for our results, and I think that was a rather creative approach to take in the absence of the comparison group.

But there are three caveats that I want to leave you all with. First, when we talk about comparisons, these are not causal relationships. For example, we can't say that the Healthy Start program caused higher breastfeeding rates, but we can note the association.

Second, differences may represent selection into the program, rather than the impact of the program itself. So in other words, to the extent that women with a higher propensity toward positive outcomes participate in the program, the outcomes we observed could reflect subselection, and not necessarily the impact of the program, per se.

And as I mentioned before, we can't say what would have happened in the absence of Healthy Start, because we don't have the treatment and control group design. So we can't say definitively what the outcome, such as low birth weight, would have been without Healthy Start.

But I still want to end on a positive note to say that despite these caveats, we feel confident that the participant survey has demonstrated that Healthy Start is serving a vulnerable population, delivering much needed services, and also achieving important outcomes. But as we've also noted, gaps remain due to limited resources, and also the inherent challenges of eliminating disparities.

**>> Vivian Gabor:** Thank you very much, Margo, for sharing your results from the participant survey. It's obviously a key component of the national evaluation. I'd like to turn back at this end of our session to Dr. Walker, she's going to finish our discussion about the evaluation results.

**>> Deborah Walker:** Sure. Okay, so we had then the results of the case study and the survey. We also had our findings from the project director surveys in phase one. And we had hoped that we would be able to use the results of the performance measure system that's being put in place, but unfortunately the measures that we had for the programs during this time was really not a complete enough set for us to feel confident in using.

So based on the two -- the case studies and the survey, and then some of what we had also learned from the project director survey in the earlier phase, this is kind of our overall snapshot. And I have to say that you might -- when we do these sometimes we'll say, well, you might have found that anyway, but we really dug down and found out a lot of information that the secretary's advisory committee and our Healthy Start panel and others had encouraged us to document more fully, as to how these programs worked. And it's kind of a set of information that can be and I know is already being used by many of the programs in the national Healthy Start program to make kind of improvements for improving Healthy Start in the future.

So those lessons overall are that both services and systems, as hypothesized in our logic model, are important. You need both. But there is no magic bullet for how to structure these services or systems, that really they have to be tailored to a particular site and a particular culture and the resources within those communities, and those vary widely.

Healthy Start plays an important role in providing gaps in services for a very vulnerable group of women and children, that's just building on what Margo just said. And Healthy Start really is the glue and support for very vulnerable populations, and in some of the communities, without Healthy Start there basically would be no services, or very limited services for these vulnerable women and children.

Next, Healthy Start is the first national program, and I'd like to give the bureau credit for doing

this, and seeing this, in their leadership, that has emphasized the interconceptional period. No other program has done that to date. Now, even though that was true, there are a lot of programs -- components here to implement, and there wasn't really consistent implementation of this component, it was evolving. And in most cases the emphasis during this period was more on the infant than on the woman. And that could be for a variety of different reasons. But it was a focus on the infant in eight sites.

Developing systems of care is considered as important as achieving improved birth outcomes, as are the individual services. In other words, if you don't work on developing these systems of care which can be sustained over time and left in the community, you will not have and achieve the long-term impacts that Healthy Start had hoped to achieve for all vulnerable women in the community. So again, it's just another way of saying services and systems are both important.

Collaborations, especially through the consortium, are critical for success and ultimate sustainability. And I might point out that the consortium was a required component from the very beginning of the start of the Healthy Start programs.

Collaborations -- okay, more on services. The next ones, okay, are just more specifics about the services. Services must be provided from many sectors. And we found that this was key, and that the programs themselves acknowledge really what we would call a social determinants model of health today. That you have to have the services, the basic services -- health, social services, housing, food -- to address those root causes which really are linked to the kinds of health disparities that we see in these communities.

Two major components, outreach, case management, are interconnected and serve as, quote, the heart of all the programs. Again, I think our findings across the case studies, and what Margo just reported, are consistent with that.

And although all use some kind of a multidisciplinary team, there is no one model for delivery of services. Some had nurse with community health workers, or paraprofessionals, others had social workers. There were all kinds of combinations, but they all used some form of that multidisciplinary team.

Finally, overall lessons learned on systems. The consortium again is that glue that creates a system of care, and a major way of promoting consumer involvement. Service integration with a partner such as Title 5 is important for developing sustainable systems. And in addition to Title 5 there were a whole range of other partners that were important and reported to be important in those collaborations in communities.

The consumer and/or community voice is really the hallmark of Healthy Start and is really necessary for addressing the cultural component issues and making sure that both the services and the systems sit within that cultural context for that community.

And finally, sustained consumer involvement needs support from individual projects. And we have found that, you know, projects were doing that in a variety of ways. In other words, it doesn't just happen, you really need to work on supporting that to happen.

And so I'd say that kind of overall is the high level set of findings that we found as a result of our phase two evaluation.

**>> Vivian Gabor:** Thank you, Deb. If our audience would like more information about the national evaluation, how can they contact you and Margo?

**>> Deborah Walker:** Well, first of all, you have both of our e-mails and phone numbers. But let's say just within the last month, two reports from our phase one were posted on the NCH website. One is a chart book which gives the overall findings of the survey of project directors, and the second is a book which is really a review of all the literature related to disparities in birth outcomes that Mathematica took

the lead on. Both of those products are listed on the MCH website.

Now, the two -- we have currently two papers out for review at peer review journals that we're hoping will be accepted shortly, and when that happens those two papers, as well as this presentation, will also be posted on the website.

**>> Vivian Gabor:** Just to clarify, Deb, all these reports are on this -- on the DataSpeak website?

**>> Deborah Walker:** You know, I thought they were on the MCH bureau website. I'm sorry.

**>> Vivian Gabor:** No, they're on the bureau website, and they're also on this DataSpeak website, on the resource list. The links. I have to say they're not on the site, the links to them are here. So all you have to do is go to DataSpeak to get the addresses, I apologize. And thank you for offering to give us the links for this article, we are excited about seeing the full information.

Thank you both for the valuable information you've provided today. I'd like to remind our audience that there are a variety of resources like the ones I've just mentioned, including some past other work on Healthy Start, which is up on the resource page of the DataSpeak website.

We're now in the question and answer period of our program, and we're fortunate to have both of our presenters here with us to answer your questions. As I mentioned at the beginning, we'll be taking questions both online and on the telephone. We've received a few already online.

To post a question online, if you haven't done so already, simply enter your question in the field at the bottom of the questions box and hit enter.

We have an operator, as well. We have an operator for the phone line questions. Could you please tell our telephone participants how they can ask a question of you on the phone?

**>> Operator:** Thank you, we will now be conducting a question and answer session. If you would like to ask a question, please press star 1 on your telephone keypad. A conference tone will indicate your line is in the question queue. You may press star 2 if you would like to remove your question from the queue.

For participants using speaker equipment, it may be necessary for you to pick up your handset before pressing the star keys. One moment, please, while we poll for questions. Again, that's star 1 to ask a question.

**>> Vivian Gabor:** Operator, while we're waiting, we also have our online question operator. Can you tell us, give us any questions that have come in online so far, Gretchen?

**>> Operator:** Yes, we've had a number of questions already. Margo, here's one that I believe would pertain to your part of the presentation.

One of our audience members would like to know, when surveying participant satisfaction did you specify whether mothers wanted more frequent or less frequent contact, or whether they were just satisfied with the frequency of visits that they received?

**>> Margo Rosenbach:** Actually, that's a good question. We just asked it in a neutral way, whether they were satisfied with the frequency. We did not have a directional component to that.

**>> Operator:** Okay, thank you. We have another question. I'm not sure which one of you would like to answer this, but someone in our audience would like to know whether you suggest that programs conduct case study approaches for part of their evaluation, that is, following your model, and why or why not.

**>> Deborah Walker:** Well, I think both Margo and I could answer this. I think -- I think this depends on the situation and evaluation question, okay? I actually do think in this case, given the resources we had, and what we were trying to do, it was very important to use both components. This is the first time, especially with Healthy Start, that there's been this in-depth look at the very community level, and that's hard information to get back.

It doesn't mean that every time you would do a combination, but I personally think that both are needed, and that case studies can augment and add to what other data, you know, is available in the evaluations. I know this time we feel it is because of the kinds of things that had never really been looked at in depth in Healthy Start.

Margo, do you want to add anything to that?

**>> Margo Rosenbach:** Yeah, I think so. I would agree that having the qualitative and quantitative going hand in hand is really important, because there's really things that you learn from talking to people, and from documenting progress, that you can't always pick up in the data. Whether it's your program records, or surveys, or focus groups, or other mechanisms. And so I think it really is important to document implementation experiences, whether it be your challenges, or even just a program description. Because each program is so unique and varies so much one to another, that I think it's really important to have that kind of information. So you really get behind the data, and really understand what's going on.

**>> Vivian Gabor:** Thank you. Operator, are there any questions that have come in over the phone line?

**>> Operator:** We have no questions in the queue at this time.

**>> Vivian Gabor:** I know we have more that have come in online.

**>> Operator:** We do. Given your findings -- this is for either Margo or Debbie -- what recommendations might you be able to make to HRSA program leaders for changes in the Healthy Start requirements?

**>> Deborah Walker:** Margo, do you want me to start first, or do you want to?

**>> Margo Rosenbach:** Go ahead.

**>> Deborah Walker:** Okay. I mean, this is actually something that I don't think we've discussed fully. I think basically some of the findings that I talked about at the end I think are key. That really there is no one magic way to do this, and that you really do need to have both component requirements in the services and the systems area, those are both important.

I think we also have given strong recommendations that we would like to see the performance indicators actually really improve so that kind of baseline for every site is available, and reported in a consistent manner. Because that would have really helped us also. And I know that's in evolution, and that the bureau is working on that.

And we also have -- you know, think that this approach of using kind of methodologies like this, with participants themselves, the grantees, and others, provides a kind of a feedback loop, which I think that the bureau also has been using to actually improve what they do as they go along.

I think both of us would say evaluation is critical at all levels. We've got to have it at the local level, and make sure that's going on, so that some of these sites need to be, you know, really connected,

we'd say, with their local and/or state public health MCH department, so that some of that data and stuff could be, you know, actually available in an ongoing way to help these sites have a baseline and follow it. I guess that's probably what I would add, that you need continuous kind of -- this is a continuous kind of quality improvement approach that we used, and would encourage the bureau to continually do that.

**>> Margo Rosenbach:** I think picking up on what Debbie just said, I think one of the areas that we found where there were some challenges, for example, were in smoking cessation during pregnancy. So it's not necessarily something that would be a recommendation to HRSA to change Healthy Start, per se, but to provide some technical assistance to grantees, develop best practices.

What are grantees doing that seems to be working, this is definitely a challenge. And it's a challenge among many challenges. And so how can HRSA better support grantees. Because we know that smoking during pregnancy is one of the big precursors to low birth weight. So that would be one example.

Interconceptional care, we haven't really talked about that here, but we saw a fair amount of variation in the programs, in part because this is a new and emerging area. So again, thinking about what are best practices, how can HRSA help grantees to do what they're doing, do a better job, learn from each other.

So I think my sense about some of the issues that come out of this study are really just learning from the variation within Healthy Start, and trying to help across the grantees, Whether it be cultural competence or consumer involvement, you know, whatever the issue would be. Because I think there is a lot of learning that can go on just across grantees.

**>> Deborah Walker:** Right. And Margo, I think another good example, following your line, is that each of them were required to do the depression screening, and something we didn't even talk about, but they all were doing that in different ways. And so how do you share that kind of learning and, you know, go the next step with that, as well.

**>> Vivian Gabor:** Operator, are there any more questions that have come in on the phone, queued up by phone?

**>> Operator:** No, ma'am, there are no questions at this time.

**>> Vivian Gabor:** Gretchen, if we could go on with another question from online?

**>> Operator:** Absolutely. One of our audience members would like to know what best practices have you identified for delivering case management services to low income women.

**>> Vivian Gabor:** I'll ask if Debbie or Margo would to answer that.

**>> Margo Rosenbach:** I could take a --

**>> Deborah Walker:** Yeah, go ahead.

**>> Margo Rosenbach:** And I would say that our focus was not so much on identifying best practices, but I would encourage people to take a look at what we learned from the project director survey, which is now available. And I think what we learned is the diversity of approaches. We can't necessarily correlate that

with outcomes, to say which approach works best, but I think one of the things that you do take away from what we learned is the importance of having community health workers, lay workers, promontories, whatever the term is that is appropriate for the program, that that is a really key element to making connections with this population. I think another thing that we learned is the importance of the team approach.

**>> Deborah Walker:** Yeah.

**>> Margo Rosenbach:** And so I think there are a number of things that we've learned that suggest where there's more -- more development, or more (inaudible), but we ourselves have not been able to connect that to the impact or the outcomes of the program, per se.

**>> Vivian Gabor:** Next question, Gretchen?

**>> Operator:** Sure. We have an audience member who would like to know as an evaluator, excuse me, I normally ask how we can say with confidence that it's because of Healthy Start that we have good outcomes in the participants. We would like to know if you have any suggestions for a discussion like that.

**>> Margo Rosenbach:** Oh, I think the issue is that we haven't developed strategies, evaluation strategies that can support that kind of (inaudible), that we would really need to be able to look at people who have been, quote, exposed to Healthy Start, and a comparable group of people who haven't been exposed to Healthy Start. But there are some real challenges to doing that, both in terms of finding that comparable group, but also I think there are some concerns about just whether -- whether we could find that group.

**>> Deborah Walker:** Right. And of course, if you do that on a big national level, that's a very expensive in-depth kind of study. But I would encourage people, when people ask that question -- this is true of a lot of public health issues, okay, you really do go back to that logic model of what you expect, and where do you expect to see changes along the way.

In these programs, you would expect to see changes in kind of service delivery outcomes, maybe like in entry into prenatal care, or whatever it is, as you hypothesize in a model that you're going to start changing things that will ultimately change the birth outcomes, both for the individuals and on the population of women in the community.

So I think it's really important to make sure that each Healthy Start program is anchored well in a community, with a good baseline, and that's why one of the other recommendations we've made to HRSA is that those connections with maternal and child health, epidemiologists at the local or state level are key, so that you can monitor over time.

If you will, in a way, that is a quasi-experimental pre-post design, if you have a number of things before and after something. And oftentimes in public health we use that and make corrections as we go along. This is not a true random control assignment, but that is very difficult, you can't do that with this.

So I think there's a commitment to have measurable things that you can track over time, and you can look to see where changes are, and hypothesize directions that should help people to understand the answers to that question.

**>> Vivian Gabor:** Operator, phone operator, I'm going to go back to you just a second. Any more

questions, any questions at all on the phone?

**>> Operator:** Once again, that's star 1 to ask a question. We are currently holding for questions.

**>> Vivian Gabor:** Okay, well, I think everyone found it much easier to just simply type in a question online, as we do have a couple more questions. Gretchen, I'll go back to you for two more questions before the end of the program

**>> Operator:** Okay. Here's a question actually from one of your case study projects. This person would like to say that since the case study, their project has changed significantly in terms of their focus on pre-interconceptional care, and they're wondering if HRSA is planning any other evaluations in the near future that might focus on new information, whether you might know of anything coming.

**>> Deborah Walker:** You know, I think that's an important thing, and we -- in terms of evaluations, we do not know of what their plans are at the current time. I know that they're really stretched for resources. But you know, that's a good point, again, of how you can feed back information as you change over time. So. We do not not know.

**>> Operator:** Okay, we have another question, here. This audience member would like to know if it's possible for individual programs to administer the survey to their own participants; that is, the survey you developed through the evaluation.

**>> Margo Rosenbach:** That's a great question. It's possible, to the extent that we can work through HRSA to make the instrument available. We've talked a little bit about that, but we haven't finalized any plans about that. But we'll certainly follow up with HRSA.

**>> Vivian Gabor:** Thank you. That is all the time we have for discussion today. If you have more questions, you can submit them to us after the program via e-mail. We'll be collecting the questions to the end of the week. And additional questions that we didn't have time for today will be forwarded to our speakers, and get responses to you. The e-mail address to send us those questions is [MCHIRC@Altarum.org](mailto:MCHIRC@Altarum.org).

Before you log out today, we would greatly appreciate it if you could take a moment now and provide us with feedback on today's program. You can do so by clicking on the feedback link that's on the screen, it's called the evaluation, a feedback form, a short survey will open up in a new window.

Again, we really hope you can take the time to do that, it's very helpful to us as we improve the program, as we create new DataSpeaks. We will be broadcasting several more DataSpeaks in the coming months. The next program will be on MCH Data and Issues on the U.S.-Mexico border, and the date and time for that is July 23rd from 2:00 to 3:00 p.m.

You'll be receiving announcements, if you've registered of course for this, about the future DataSpeak programs, by e-mail. And you can of course check the DataSpeak website in the coming months. That website is [www.mchb.hrsa.gov/mchirc/dataspeak](http://www.mchb.hrsa.gov/mchirc/dataspeak).

This program is now adjourned.