

Findings from the Healthy Start National Evaluation – Phase II

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Overview of the National Healthy Start Program

- **Goal: Reduce Infant Mortality and Improve Birth Outcomes**
- **Healthy Start Grantees Funded in 2003 Cycle (n=96)**
 - 66% Urban, 21% Rural, 13% Urban/Rural
 - Size ranges from under \$3M to over \$4M for 4 year period
 - Administered by non-profit organizations (44%), local health departments (37%), state health departments (11%) and other agencies (8%)
- **Required Nine Components**
 - Service Components: Outreach, Case Management, Health Education, Depression Screening and Interconceptional Care
 - Systems Components: Collaboration, Consortium, Local Health System Action Plan, Sustainability Plan

Evaluation Overview

- **The evaluation is a four-year effort**
 - Phase I: project director survey of 95 grantees
 - Phase II: in-depth case study of 8 grantees
- **The evaluation is of the national program not of individual grantee performance**
- **Stakeholder inputs from**
 - Healthy Start grantees
 - MCHB staff
 - Secretary's Advisory Committee on Infant Mortality
 - Healthy Start Panel to review the evaluation

Phase II Evaluation Overview

■ Goals:

- To gain an in-depth understanding of a small group of grantee project models
- To determine methods that grantees are using to meet Healthy Start program objectives, with a particular focus on efforts that influence the community system of care
- To learn about Healthy Start from the participant's perspective

■ Two Major Components:

- Site visits with individual and group interviews
- Survey of Healthy Start participants

Grantee Selection Criteria: First Stage

- Grantees must have completed the National Survey of Healthy Start Programs

AND

- They must have implemented all nine required components of the Healthy Start program

AND

- They must track referrals to providers within and outside Healthy Start

AND

- They must maintain electronic records to facilitate access to data for the participant survey

Grantee Selection Criteria: Second Stage

- From the 26 eligible grantees, 8 were selected to reflect the following grantee characteristics:
 - Four U.S. census regions
 - Mix of urban and rural sites
 - Different funding levels
 - Range in size, according to the number of live births in 2004
 - At least one grantee had to be relatively close to the United States/Mexico border, if not considered an official Border grantee
 - At least one site had to serve a predominantly indigenous population

Overview of Site Visits

■ Goals:

- To gain an understanding of how projects are designed and implement the core components to improve perinatal outcome
- To assess the links between services, systems, and outcomes – test logic model
- To ascertain grantees' perceptions of their component strengths, accomplishments, and challenges

Grantee-reported Achievements

- **Both system- and service-level achievements were reported**
- **System-level achievements (34) were more frequently reported than service-level achievements (24)**
- **Improved birth outcomes, a long-term goal, was noted as frequently as intermediate outcomes (6 projects)**

Grantee-reported Achievements

Service-level Highlights

- **Provision of enabling services (5 projects)**
 - Transportation
 - Child care
- **Earlier entry into prenatal care (5 projects)**
- **Increased service use (4 projects)**

Grantee-reported Achievements

System-level Highlights

- **Increased community awareness (6 projects)**
- **Culturally diverse staff (6 projects)**
- **Consumer involvement (6 projects)**
- **Coordinated systems/ services (6 projects)**

Project Directors' Perception of Most Influential Components of Achievements

Service-level Components:

- **Outreach (5), case management (4), and health education (5)**

“Outreach is the pillar of the program.”

“Case management is the life thread of our project.”

System-level Components:

- **Consortium (4)**

“It’s important to have representation from the groups we’re targeting, to make sure we have stakeholders from different venues.”

Grantee-reported Challenges

- **Projects reported between one and eight challenges**
- **Both contextual and organizational challenges were reported**
 - Service availability, e.g. mental health (5 projects)
 - Lack of funding (5 projects)
 - Providing culturally competent care (4 projects)
 - Staff capacity (4 projects)
 - Mobile population (4 projects)

Summary Conclusions from Site Visits

- **Unique contextual and community issues influence projects' design, implementation, and successes**
- **There is no single “magic bullet” for reducing disparities in birth outcomes**
- **Service provision and systems development are both critical for successful Healthy Start projects**
- **System-level achievements are more likely to be identified via qualitative data collection than surveys**

Summary Conclusions from Site Visits

- **The roles of individuals who conduct outreach, case management and health education are interconnected, revealing these components work together**
- **Consortium relies heavily on the involvement of multiple collaborations within the community**
- **Sustainability efforts are less a priority than other areas**
- **Acknowledging and working to achieve cultural competence, consumer involvement, or “community voice” are key to reducing disparities**

Caveats

- Findings are based on respondents' perceptions and interpretations
- Findings were not verified by examining local evaluation data
- Findings are not generalizable to other projects

Participant Survey Results

Survey Methods

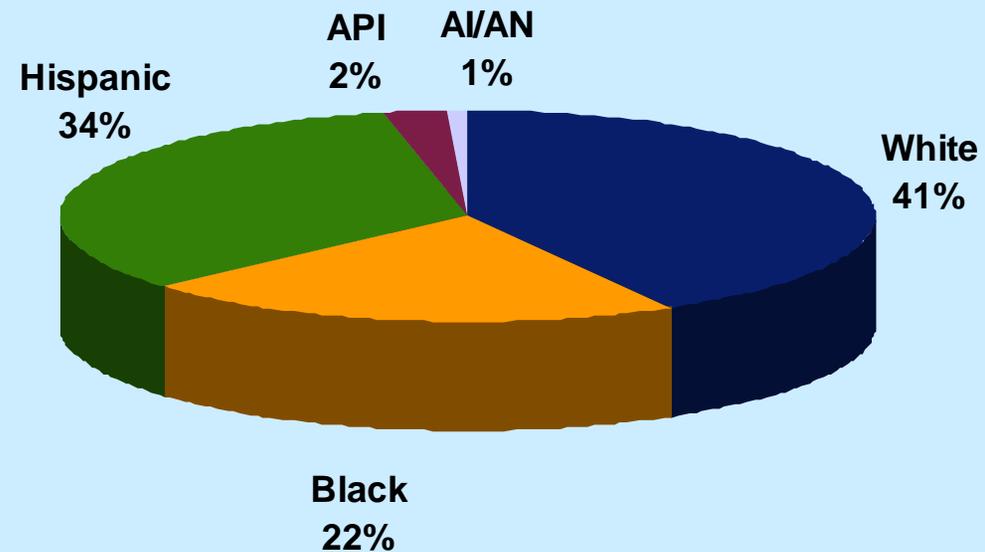
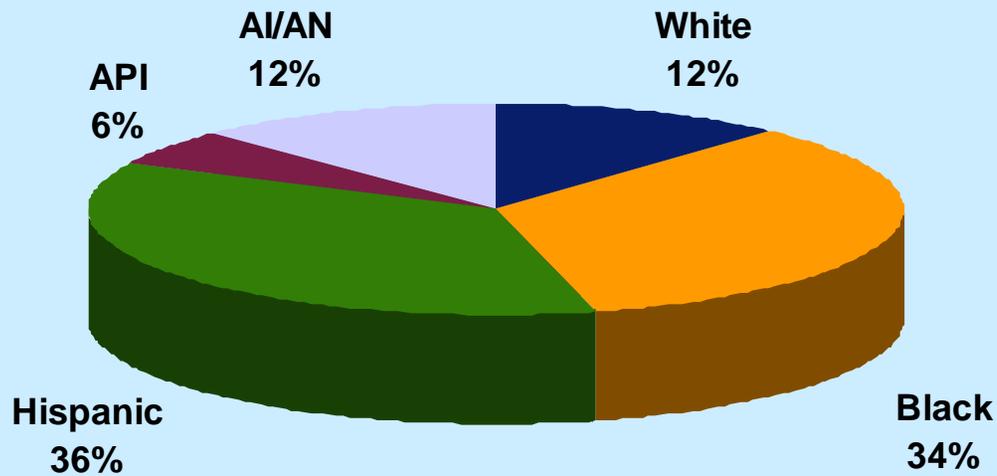
■ Methods

- Survey fielded October 2006 to January 2007
 - Interviews conducted using Computer Assisted Telephone Interviewing (CATI)
 - Interview took 30 minutes on average
 - Sample included Healthy Start participants with infants ages 6 to 12 months at time of interview
 - 646 completed cases across 8 sites (24 to 155 per site)
 - Overall response rate was 66% (more than 80% in 5 sites)
- **Used Early Childhood Longitudinal Survey as national context for Healthy Start results**

Race/Ethnicity

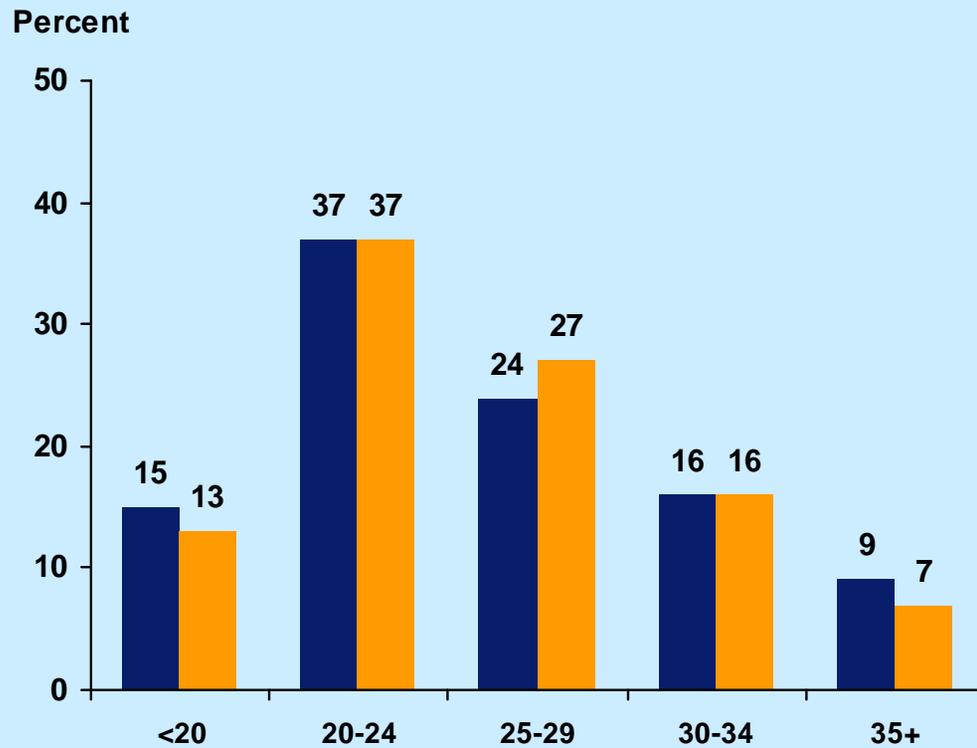
Healthy Start Participants (8 sites)

Low-Income Mothers (ECLS)

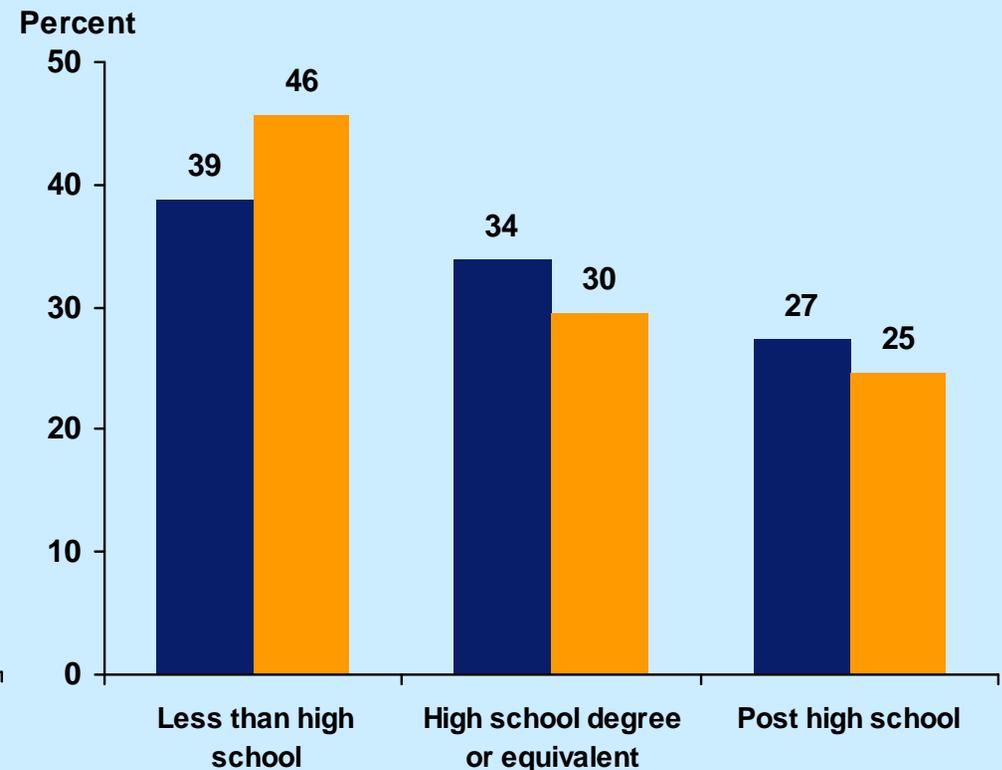


Age and Education

Mother's age



Mother's education



■ Healthy Start Participants (8 sites)
 ■ Low-Income Mothers (ECLS)



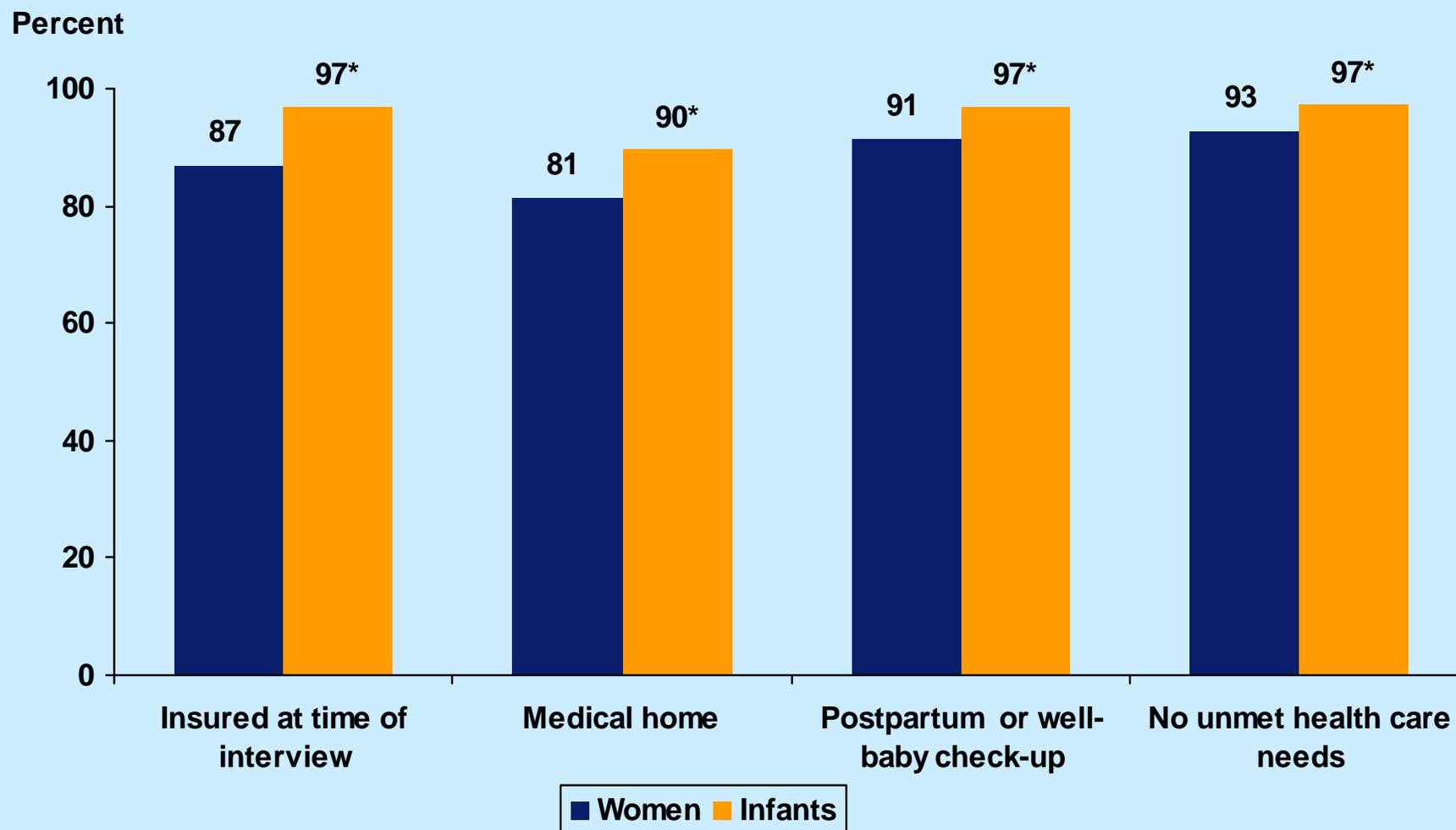
SOURCES: 2006 Healthy Start Participant Survey; 2001-2002 Early Childhood Longitudinal Survey.



Access and Utilization

- **Nearly all Healthy Start participants reported receiving prenatal and interconceptional health education on a wide range of topics**
 - Least frequent topics were drug use, stress, and weight gain during pregnancy
- **Healthy Start participants reported high unmet need for housing, childcare, and dental services**
- **Infants had greater access to care than their mothers**

Access to Care Among Women and Infants

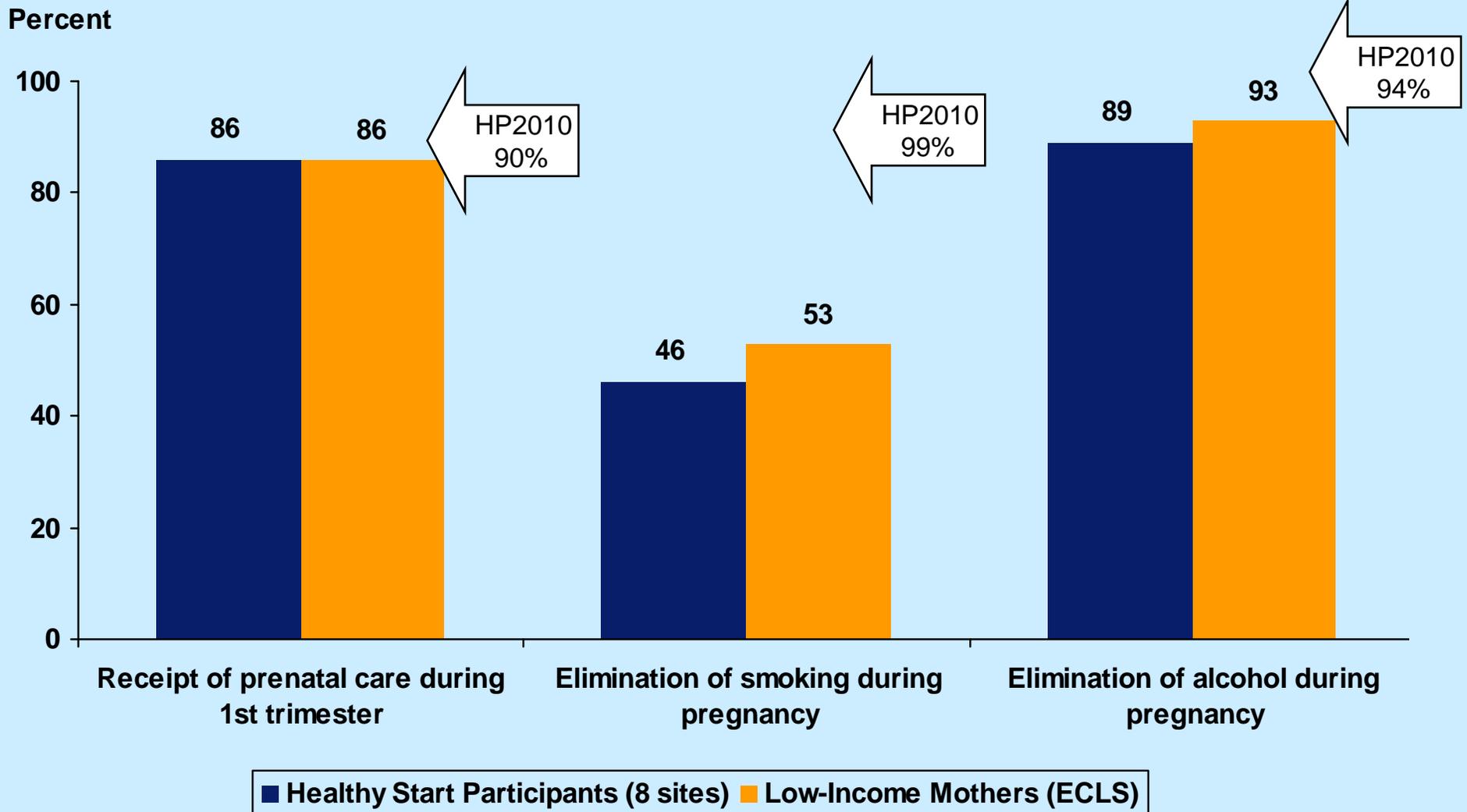


*Significantly different ($P < .01$)

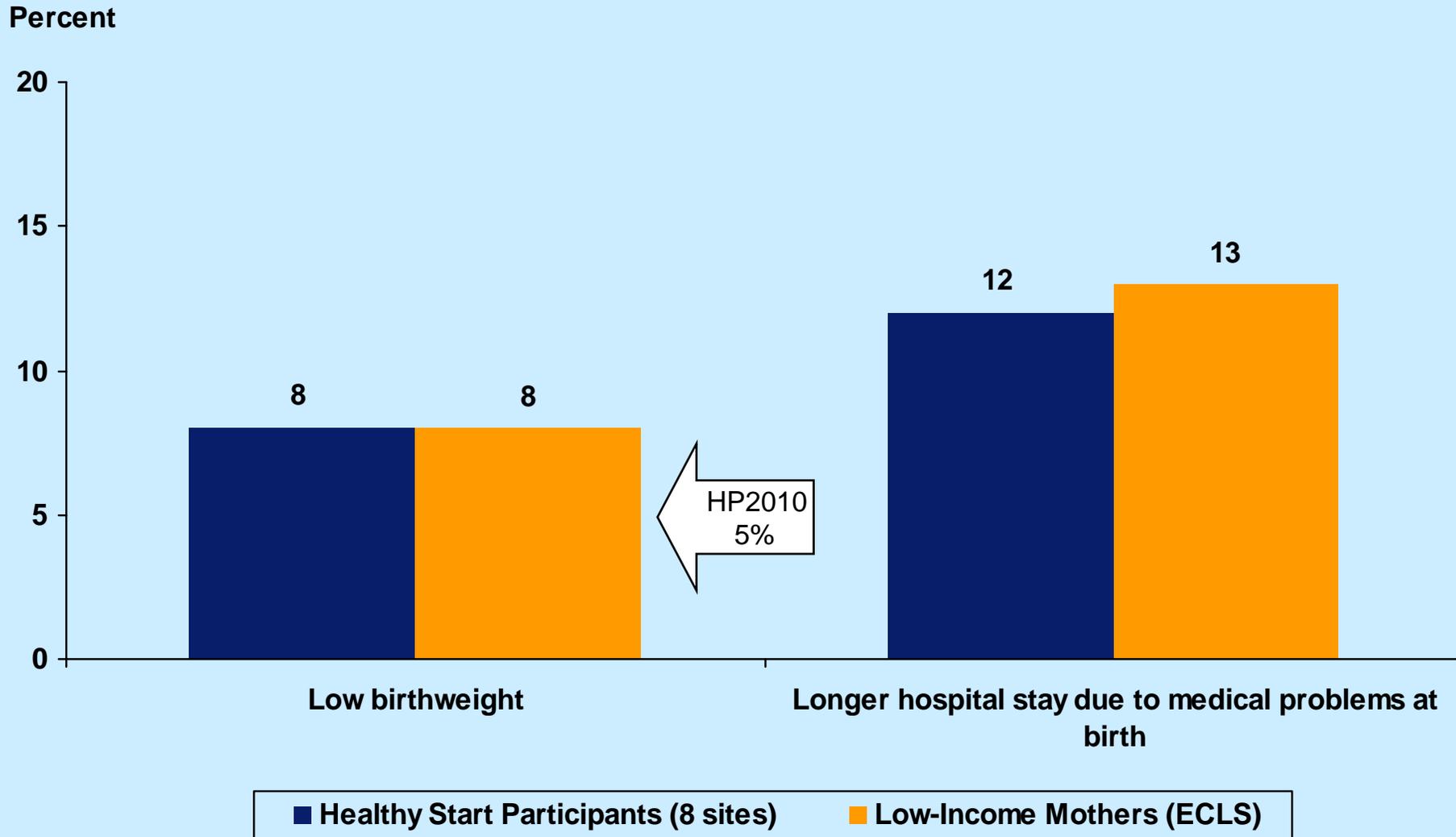
Satisfaction with Healthy Start Services



Prenatal Outcomes



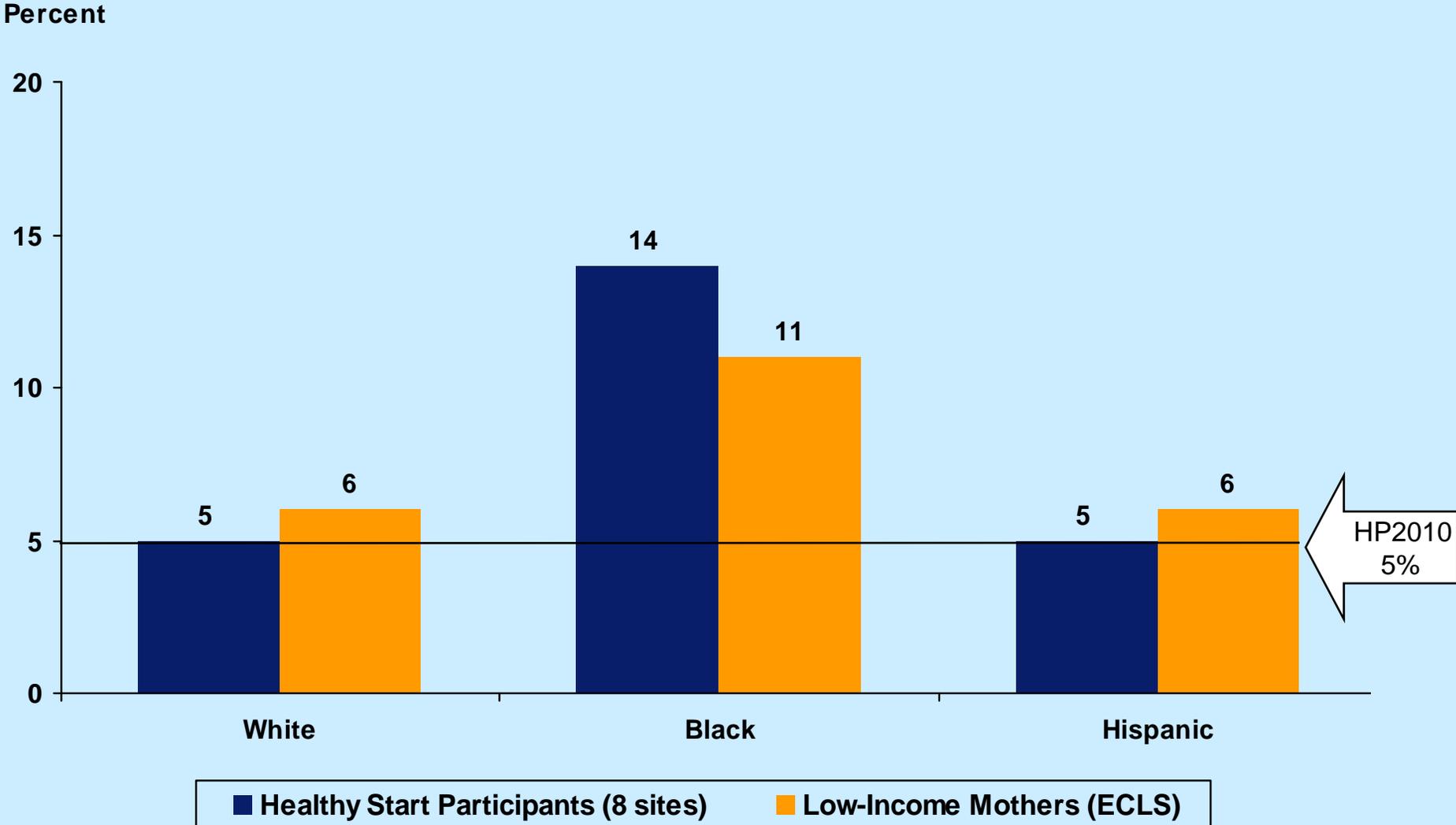
Birth Outcomes



SOURCES: 2006 Healthy Start Participant Survey; 2001-2002 Early Childhood Longitudinal Survey.



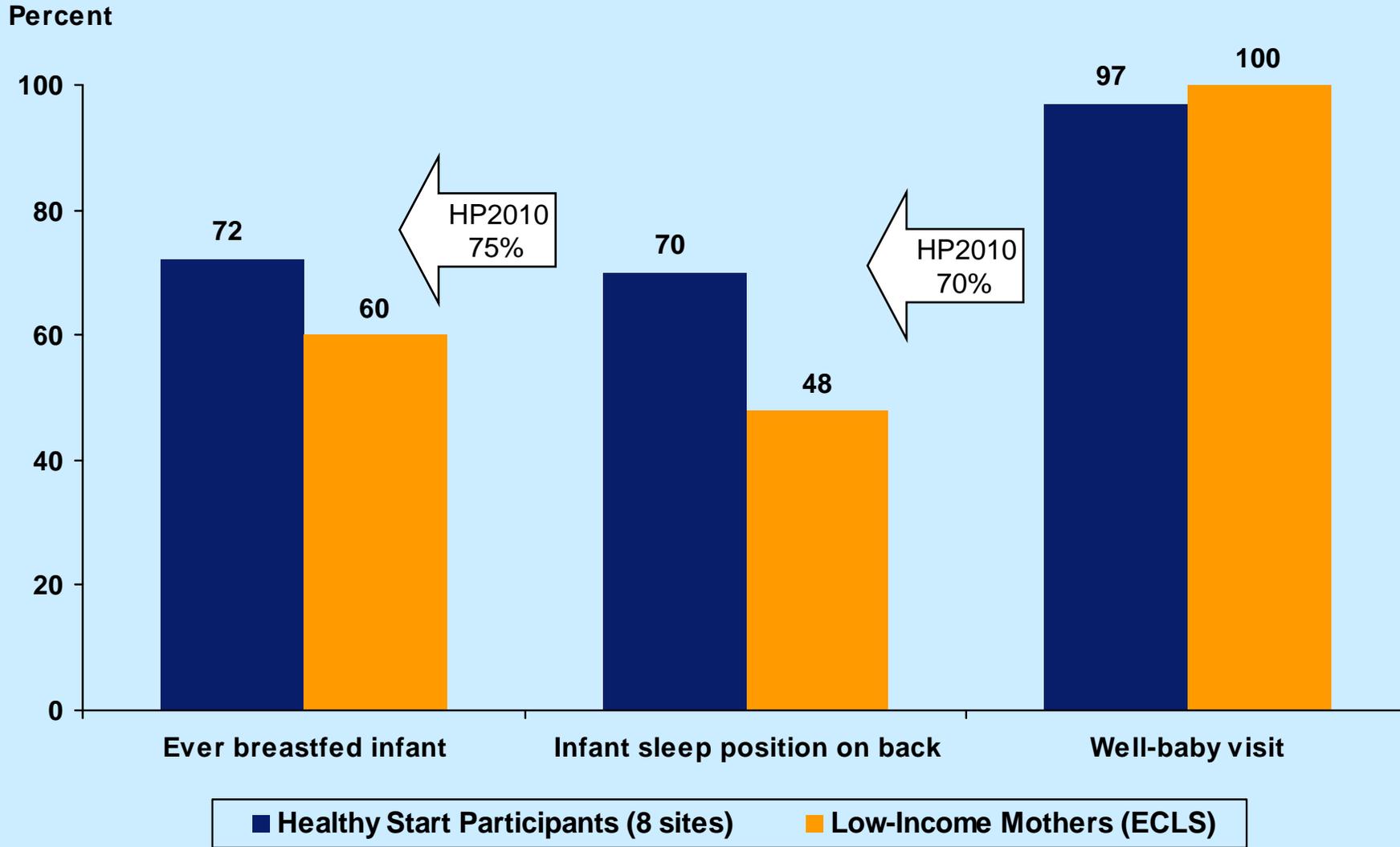
Low Birthweight by Race/Ethnicity



SOURCES: 2006 Healthy Start Participant Survey; 2001-2002 Early Childhood Longitudinal Survey.



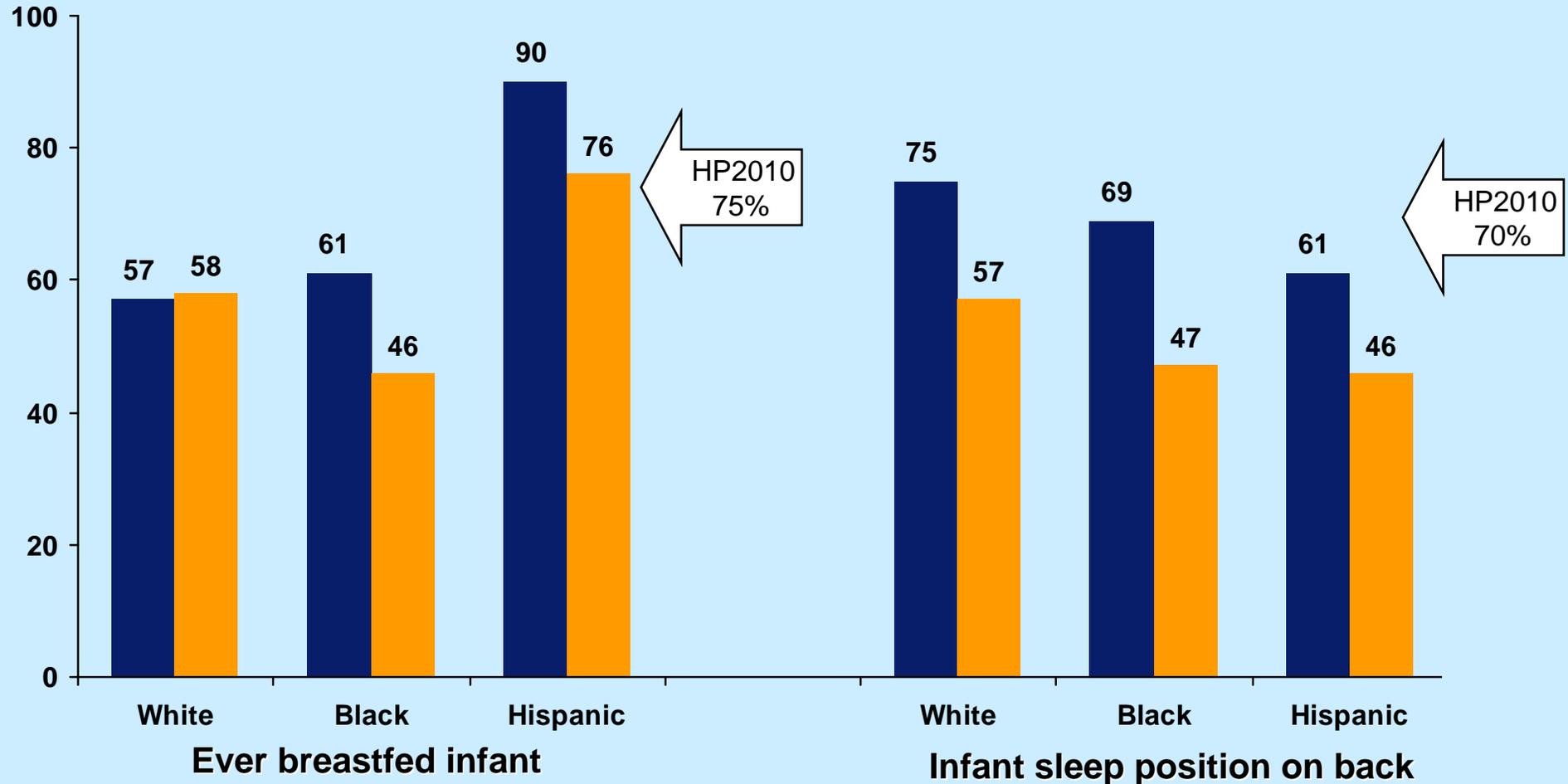
Infant Health Outcomes



SOURCES: 2006 Healthy Start Participant Survey; 2001-2002 Early Childhood Longitudinal Survey.

Infant Health Outcomes by Race/Ethnicity

Percent



■ Healthy Start Participants (8 sites)

■ Low-Income Mothers (ECLS)



SOURCES: 2006 Healthy Start Participant Survey; 2001-2002 Early Childhood Longitudinal Survey.



Summary of Key Findings

- **Healthy Start participants received health education on many topics (less frequent topics were drug use, stress, and weight gain during pregnancy)**
- **Highest unmet need was for housing, childcare, and getting help with dental appointments**
- **Infants had higher levels of access to care than their mothers**
- **Satisfaction with the program was high for all measures**

Summary of Key Findings (cont.)

- **Compared to a national population of low-income mothers, Healthy Start participants in 8 sites were more likely to:**
 - Breastfeed their infant
 - Put their infant to sleep on his/her back
- **Compared to a national population of low-income mothers, Healthy Start participants had similar rates of low birthweight**

Caveats

- **These are not causal relationships**
- **Differences may represent selection into the program rather than the impact of the program**
- **We cannot say what would have happened in the absence of Healthy Start**

Lessons Learned

Lessons Learned: Overall

- Both services and systems, as hypothesized in the logic model, are important
- There is no “magic bullet” for how to structure services or systems that works for all sites
- Implementation of the program components needs to be tailored to the culture and resources in the community
- Healthy Start fills important gaps for very vulnerable women and infants; Healthy Start is the “glue” and support for very vulnerable populations

Lessons Learned: Overall

- **Healthy Start is the first national program to emphasize the interconceptional period**
 - Focus remains on the prenatal period in all sites
 - Interconceptional focus in 8 projects is the infant
- **Developing systems of care is considered as important for achieving improved birth outcomes as are the individual services**
- **Collaborations, especially through a consortium, are critical for success and ultimately, sustainability**

Lessons Learned: Services

- **Services must be provided from many sectors (health, social services, housing, food, etc.) to address “root causes” of health disparities**
- **Two service components (outreach, case management) are interconnected and serve as the “heart” of all programs**
 - Health education is an integral part of these two components
- **Although all use multidisciplinary teams, there is no one model for delivery of services**

Lessons Learned: Systems

- The consortium is the “glue” to creating a system of care and a major way of promoting consumer involvement
- Service integration with other partners, such as Title V, is important for developing sustainable systems
- Consumer and/or community voice is a “hallmark” of Healthy Start and necessary for addressing cultural competence
- Sustained consumer involvement needs support from individual projects

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