A Profile of Healthy Start

Findings From Phase I of the Evaluation 2006

U.S. Department of Health and Human Services
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Health Resources and Services Administration

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PREFACE

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) has long believed in the importance of evaluation. Towards this end, in September 2002, a contract to conduct a multi-year evaluation of the implementation of the Healthy Start program was awarded to Abt Associates Inc. and its subcontractor, Mathematica Policy Research, Inc. (MPR). The purpose of the evaluation was to examine the projects involved during the funding cycle that covered the project period 2001-2005. The evaluation relies on a set of logic models (see Appendix) to illustrate how implementation of the nine program components may lead to the achievement of core program goals, which in turn, may translate into improved maternal and child health outcomes.

The national evaluation is designed to provide information for quality improvement by assessing implementation and program performance while also tracking program outcomes. The evaluation is consistent with the needs of MCHB to meet its Government Performance and Results Act (GPRA) requirements, and it is consistent with the nature of the program as a community-based intervention.

The Healthy Start evaluation contract was awarded in two phases. This report is the result of the findings from Phase I of the evaluation. More information is presented below regarding the two phases of the evaluation.

Table of Contents

ii Preface

1 Introduction

3 Profile of Healthy Start Projects

4 Healthy Start Components

5 Staffing

7 Outreach

9 Enrollment

11 Case Management

13 Health Education

14 Smoking Cessation

15 Male Involvement

16 Interconceptional Care

17 Perinatal Depression Services

19 Barriers to Care

21 Consortia

22 Consumer Involvement

24 Local Health System Action Plan

27 Coordination and Collaboration

29 Sustainability

31 Intermediate Program Outcomes

35 APPENDIX

INTRODUCTION

In the late 1980's, national concerns about persistently high levels of infant mortality led to a number of efforts to address this problem. Although infant mortality rates had declined over time, the rate of decline had slowed by the mid-1980's, and relative to other developed nations, the United States' ranking had slipped. Even more alarming was the racial disparity in infant mortality rates; Black infants in the 1980's were more than twice as likely to die in their first year of life as White infants. A White House study recommended the development of a major initiative to mobilize and coordinate the resources available in selected communities and demonstrate effective approaches to reduce infant mortality.

In response to this recommendation, the national Healthy Start program was initiated in 1991 as a demonstration project with 15 grantees. By 2005, Healthy Start had evolved into a broad effort to address racial and ethnic disparities in maternal and infant health outcomes utilizing the efforts of 97 grantees.

Healthy Start has more recently incorporated past program experience and new knowledge related to services and systems interventions to improve maternal and child health, with an expanded target population to include women and infants through two years postpartum. That is, as specified by the HRSA 2001 Guidance, the three core program goals for Healthy Start are to (1) reduce racial and ethnic disparities in access to and utilization of health services; (2) improve the local health care system; and (3) increase consumer/community voice and participation in health care decisions.

The 2001 HRSA Guidance identified nine core components that grantees were required to implement. They included five service components (outreach, case management, health education, perinatal depression screening, interconceptional care) and four systems components (consortium, Local Health System Action Plan, collaboration and coordination with Title V, a sustainability plan).

Throughout the evaluation, considerable input was provided by HRSA/MCHB staff, the Healthy Start Panel for the Evaluation of Healthy Start (HSP), the Secretary's Advisory Committee on Infant Mortality (SACIM), and Healthy Start grantees, which helped to refine and guide the approach.

The national evaluation is comprised of two phases. A key objective of the first phase of the evaluation was to provide information about the funded grantees and the implementation of the components that now comprise the national Healthy Start program. The following three questions directed the first phase of the evaluation:

> What are the features of the individual Healthy Start projects? By features, we mean the characteristics of a project that reflect how that individual project operates.

- What results have Healthy Start projects achieved? By results, we mean the intermediate outcomes a project has achieved.
- Is there an association or link between certain project features and the achievement of project results?

A survey of all grantees served as the primary data source to address these questions. The survey provided a "point-in-time snapshot" of the implementation of the Healthy Start program components, including the characteristics, activities, and results achieved by Healthy Start grantees during calendar year 2003. The survey was augmented by the abstraction of selected secondary data from grantees' continuation applications. The survey was conducted using an electronic survey instrument. In June 2004, grantees were mailed a packet containing the instrument on CD-ROM with instructions describing how to install, complete, and return the survey. Over the next three months, several e-mail reminders and phone calls were made to non-respondents to increase the response rate. Out of a total of 97 grantees, 96 were eligible to participate as recipients of an Eliminating Disparities in Perinatal Health grant. The survey was completed by 95 grantees.

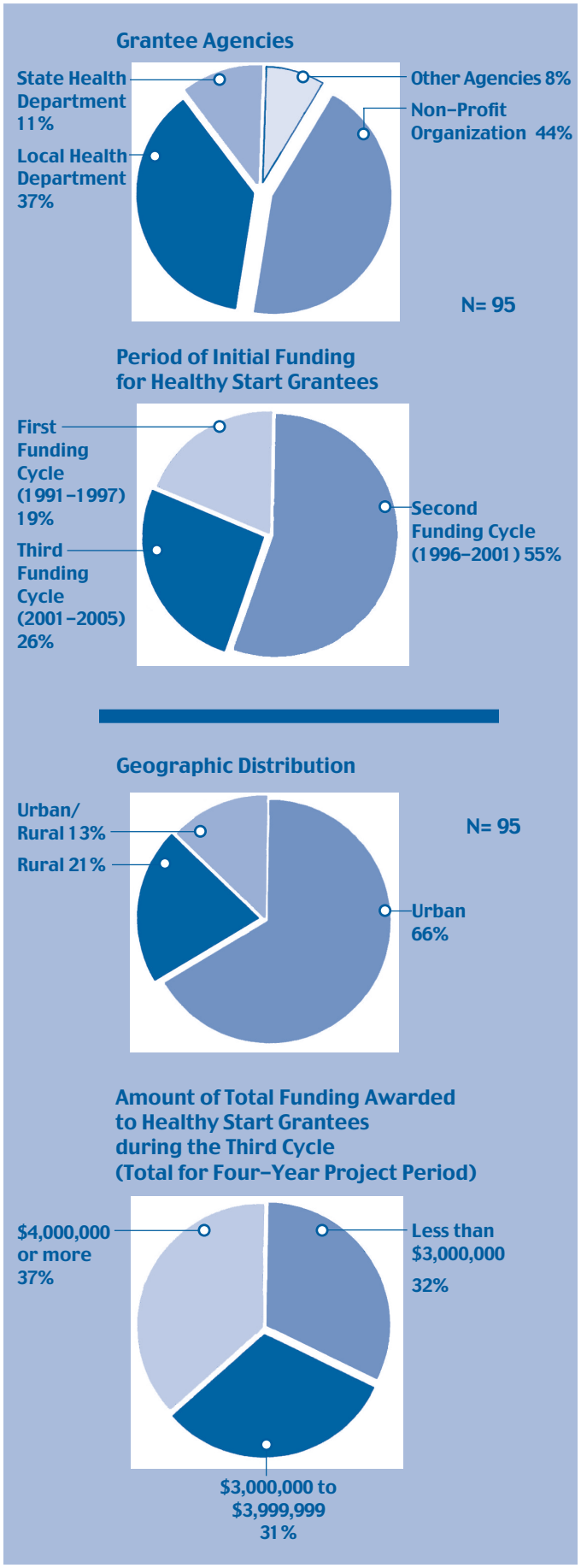
This report describes the results of the first phase of the evaluation effort. It provides a profile of the universe of Healthy Start grantees based on self-reported data. The data were collected in 2004, but asked about the grantees' Calendar Year 2003 activities and projects. All findings reported are statistically significant. Building on the findings from the first phase of the evaluation, the second phase will provide more in-depth analysis of a subset of eight grantees. The second phase concluded in 2007 and will result in a better understanding of Healthy Start's direct link to improved perinatal outcomes.

In addition to further examining the three research questions mentioned above, the second phase will explore a fourth question: What Healthy Start features are associated with improved perinatal outcomes? The second phase includes site visits to assess program implementation and outcomes, as well as a survey of Healthy Start program participants to ascertain their perspectives on services received during pregnancy and the interconceptional period.

PROFILE OF HEALTHY START PROJECTS

Healthy Start grantees varied on a number of characteristics. There were more grantees that were non-profit organizations (44 percent) and local health departments (37 percent) than State health departments (11 percent). Eight percent of grantees fell into the "other" category that included universities and tribal organizations. More grantees served a predominantly urban population (66 percent) than a rural (21 percent) or urban/rural mix (13 percent). In addition, the majority of grantees (55 percent) received their first Healthy Start grant in the second funding cycle as opposed to the first (19 percent) or third (26 percent) funding cycles.

Figure 1
Healthy Start Grantee Characteristics, 2003



HEALTHY START COMPONENTS

Although the HRSA Guidance specifies five service components (outreach, case management, health education, depression screening, and interconceptional care) and four systems components (consortium, Local Health System Action Plan, coordination and collaboration with Title V, and a sustainability plan), the authorizing legislation emphasizes three service components (outreach, health education, case management) and three systems components (coordination with Title V, consortium, and Local Health System Action Plan).

Based on feedback from the Healthy Start communities, as well as from the Healthy Start Panel (HSP) and the Secretary's Advisory Committee on Infant Mortality (SACIM) two service components (perinatal depression screening and interconceptional care) and the systems component of sustainability were added requirements in 2001. Overall, the service components were more likely to be implemented than the systems components.

New required systems components in the third cycle (2001 – 2005) included a Local Health System Action Plan (LHSAP) and a sustainability plan. As shown, these were implemented less frequently by grantees in 2003 than program components that had been required previously – this might be as a result of the time required to fully implement new components. Collaboration and coordination of the various agencies and organizations involved in the delivery of perinatal health care, particularly Title V, was implemented by 98 percent of the grantees.

Figure 2
Percent of Grantees that Implemented Healthy Start Services Components, 2003

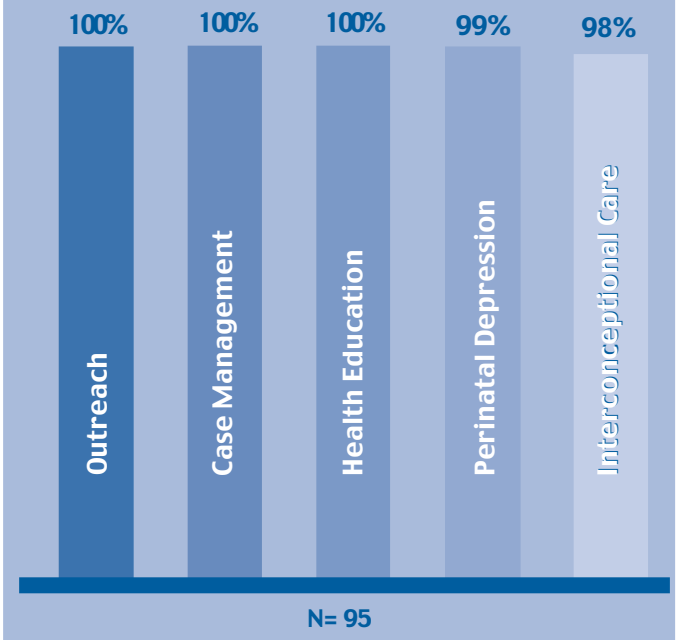
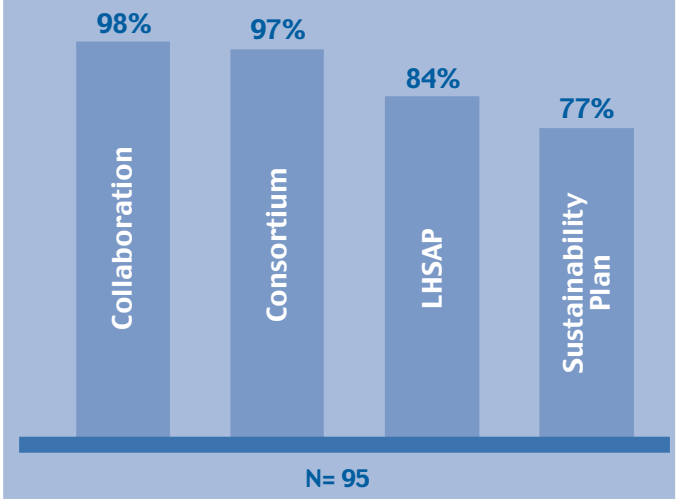


Figure 3
Percent of Grantees that Implemented Healthy Start Systems Components, 2003



STAFFING

Healthy Start projects serve a culturally diverse population. As a result, all projects employ strategies to ensure a culturally competent staff. Of the 95 grantees, 86 percent indicated that they hired staff who represented the racial and ethnic makeup of their target population; 64 percent provided cultural competence training/sensitivity training; and 44 percent required contractors to hire diverse staff that were racially/ethnically similar to the target population. Whether a grantee performed 1, 2, or all 3 of these activities was distributed fairly evenly, with 35 percent indicating that they performed 1, 36 percent indicating that they performed 2, and 28 percent indicating that they participated in all of these activities to ensure culturally competent staff.

Seventy-four grantees indicated that their target population included individuals whose preferred language was other than English (data not shown). Within this group, the number of other languages spoken was 1 or 2 languages (62 percent of grantees), 3 or 4 languages (20 percent), or 5 or more languages (18 percent). In addition, grantees reported a variety of ways to communicate with their participants who did not speak English. Of the 74 grantees to which this applied, the grantees primarily used 3 strategies: assigning participants to Healthy Start staff who spoke their preferred language (77 percent); enlisting participants' friends or family members to translate (46 percent); and/or contracting with outside agencies for translation/interpretation services (30 percent).

More than one-third of grantees found it challeng-

Figure 4
Cultural Competence Strategies Used, 2003

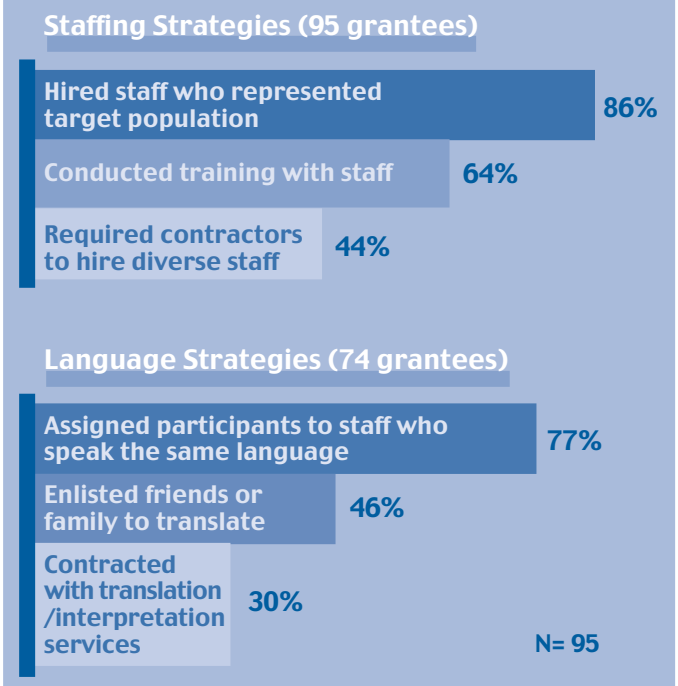
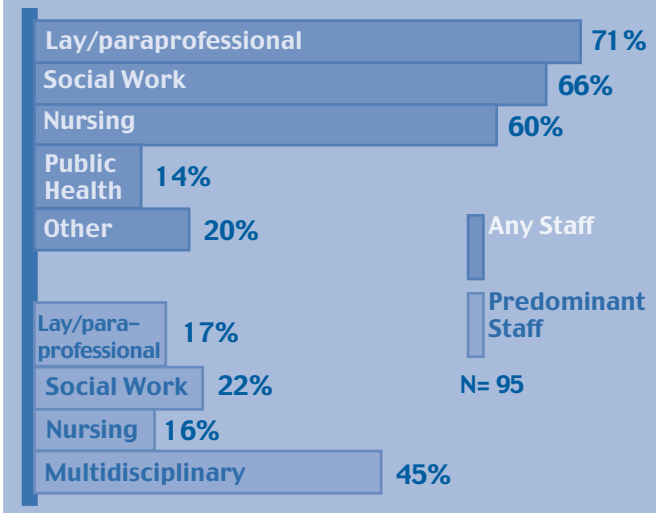


Figure 5
Predominant Case Management Staff Background of Healthy Start Grantees, 2003



Note:
Predominant case management staff background reflects grantees in which 75 percent or more of staff FTEs came from a single background. Multidisciplinary reflects grantees in which no single staff background represented at least 75percent of total FTEs. Other includes case management staff with disciplinary backgrounds in health education, nutrition, and mental health.

ing to ensure the cultural competence of Healthy Start staff (data not shown). The most frequently reported challenge was a lack of culturally competent applicants who met job specifications (reported by 19 percent of grantees), followed by strong competition in the community for culturally competent staff (18 percent). Only two percent of the grantees indicated that there was inadequate funding to hire culturally appropriate staff.

Healthy Start participants have diverse medical and social needs that can lead to adverse perinatal outcomes if not addressed during pregnancy or the interconceptional period (up to two years postpartum). Thus, a multidisciplinary approach to case management is intended to ensure that people with a variety of skills and experience are involved in care coordination to meet the needs of participants. Healthy Start grantees employed case management staff from a wide spectrum of disciplinary backgrounds, including lay/paraprofessional (71 percent), social work (66 percent), nursing (60 percent), and public health (14 percent). The strong use of lay/paraprofessional staff reflects their unique position as members of both the community and the Healthy Start staff. This dual role may enhance the projects' ability to address cultural and language barriers as well as obtain buy-in from the community.

Three-quarters of all grantees (74 percent) employed case management staff from two or more disciplinary backgrounds. The predominant staff background was multidisciplinary (45 percent), followed by social work (22 percent), lay/paraprofessional (17 percent), and nursing (16 percent).[1] Although lay/paraprofessionals represented the most common type of case management staff background, they were often part of a multidisciplinary team. Data shown in Figure 5 on page 5.

[1]Predominant case management staff background is defined as lay/paraprofessional, social work, or nursing when a grantee employeed 75 percent or more of their FTE staff from a single disciplinary background. Multidisciplinary programs are those in which no one single disciplinary background predominates; instead, they are staffed from a mix of lay/paraprofessional, social work, nursing, and other disciplines.

OUTREACH

Outreach and client recruitment services are the point of entry for Healthy Start projects. The ability of grantees to successfully reach, recruit, and retain clients of all backgrounds increases the likelihood that Healthy Start will be able to facilitate access to needed perinatal services. Recognizing the vital role of lay/paraprofessional staff in reaching members of the target population, almost all grantees (97 percent) involved at least some lay/paraprofessional staff in their outreach and client recruitment efforts.

Grantees used a variety of strategies to conduct outreach and client recruitment within their target populations. Strategies included both verbal (classes) and written (brochures) approaches, as well as mass media (newspaper advertising) and 1-on-1 (canvassing) approaches to reach new clients. All grantees used referral networks (100 percent) and most used community events (99 percent), brochures (99 percent), canvassing (91percent), and classes or presentations (91 percent). Among mass media strategies, newspaper advertising (69 percent) was used more often than radio (47 percent) or television (27 percent) advertising. About one-fourth (27 percent) of grantees used a hotline to reach potential participants. On average, grantees used 6.5 strategies per project. The use of multiple outreach strategies involving diverse settings and media is designed to reach as many potential clients as possible.

Grantees used many outreach strategies to recruit those who were potentially eligible for their project. Which strategies did grantees report to be the most

Figure 6
Percent of Grantees that Used Selected Outreach and Client Recruitment Strategies, 2003

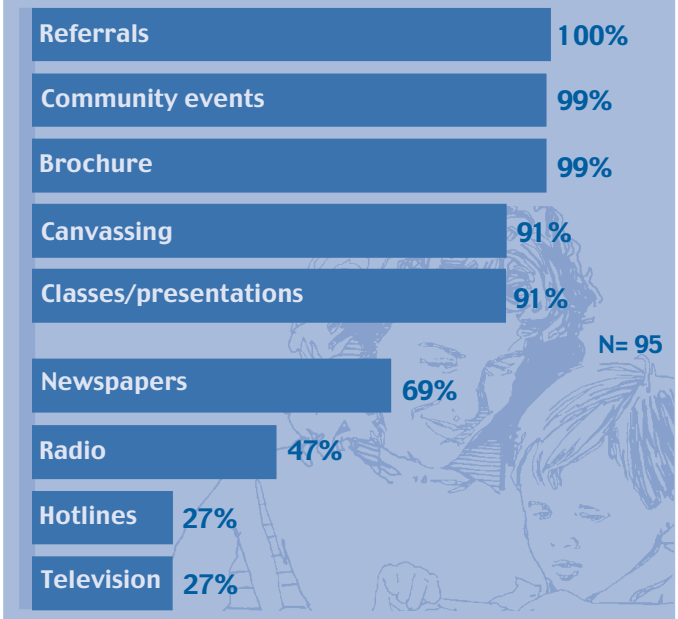
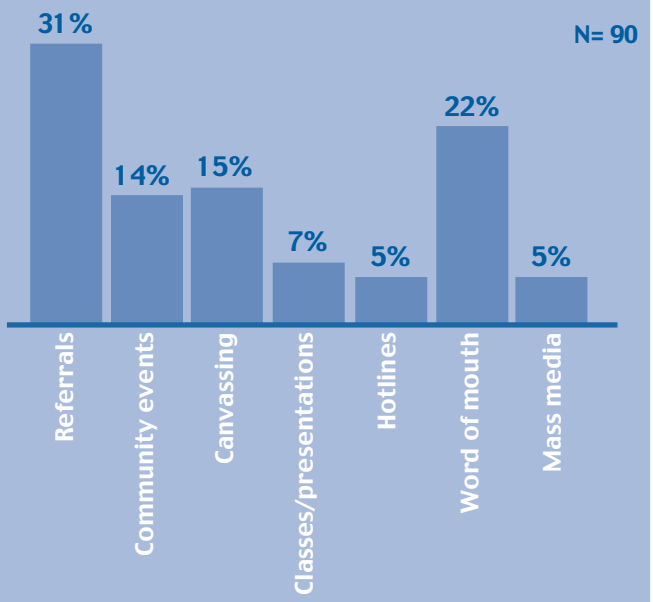


Figure 7
Percent of Participants Who Learned about Healthy Start through Selected Outreach and Recruitment Strategies*, 2003



Note for Figure 7:
This analysis is based on 90 grantees. Five grantees were excluded, including four grantees for whom the total number of participants was missing and one grantee for whom the total number of participants was more than two standard deviations beyond the mean.

*Responses of individual grantees were weighted by their total number of participants to obtain an aggregate estimate.

effective in reaching the target population? National Healthy Start program estimates of the use of different strategies were derived based on grantee estimates of the percentage of new clients who learned about their Healthy Start projects through each strategy. Responses of individual grantees were weighted by their total number of participants to obtain an aggregate estimate.

About one-in-three participants (31 percent) learned about Healthy Start through referrals from health care providers, schools, or other community agencies, which were the most often noted source of information about Healthy Start, according to Healthy Start project directors. Next in frequency were word-of-mouth or self-referrals (22 percent), canvassing of neighborhoods or community settings (15 percent), and community events (14 percent).

Although relatively few clients appear to have learned about Healthy Start through such strategies as classes or presentations (7 percent), these efforts may have served a dual purpose of providing health education to the larger community. Moreover, some strategies may have accounted for a relatively small share of participants but independently led to word-of-mouth or self-referrals. This may be particularly true in the case of mass media strategies (5 percent), such as brochures, newspapers, radio, and television.

ENROLLMENT

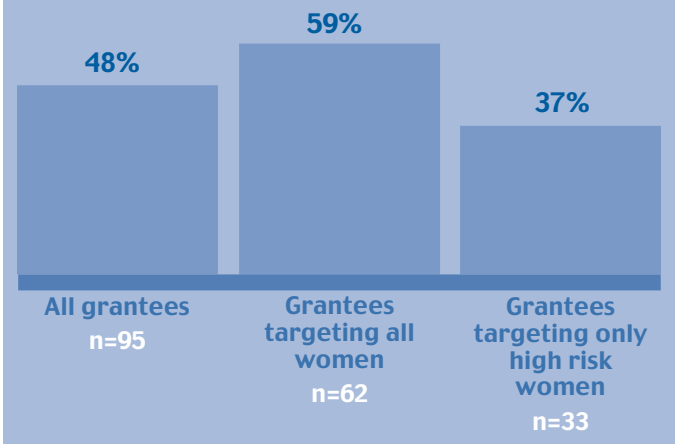
Earlier enrollment of pregnant participants enables Healthy Start staff to deliver more services, intervene early if problems arise, and more appropriately manage care according to prescribed protocols. Among pregnant clients, earlier enrollment may increase the percentage of clients who receive timely prenatal care or who curtail behavioral risks such as smoking or drug use. Among interconceptional women, earlier enrollment may help staff to more rapidly identify and address health concerns such as postpartum depression or infant safety issues such as SIDS prevention.

About half of grantees (48 percent) enrolled the majority of their prenatal clients in Healthy Start during the first trimester of pregnancy (See Figure 8). At least some of the difference in the timing of enrollment among grantees appears to be related to the target population of the project. Of those grantees that targeted all women in their catchment area, 59 percent enrolled the majority of pregnant clients in the first trimester of pregnancy. In contrast, of those grantees that targeted high-risk women, only 37 percent enrolled the majority of pregnant clients in the first trimester. This difference may reflect the challenges associated with reaching and enrolling high-risk women early in pregnancy.

The majority of grantees (66 percent) were able to retain more than three-quarters of their pregnant clients as long as they were eligible for participation in Healthy Start (data not shown). Grantees that enrolled the majority of their pregnant clients earlier in their pregnancies retained a greater percentage of their pregnant clients than those that enrolled their clients later (70 percent versus 65 percent).

Grantees identified four major barriers to enrolling and retaining clients in their Healthy Start projects: lack of transportation, unstable housing, mobility of clients, and client belief that Healthy Start services were not a priority (data not shown). A lack of belief in the relative importance of Healthy Start services was the greatest barrier reported for pregnant clients (70 percent), and a lack of housing or client mobility were the greatest barriers during the interconceptional period (64 percent each).

Figure 8
Percent of Grantees that Enrolled a Majority of their Prenatal Clients in the First Trimester of Pregnancy, by Target Population, 2003



Note:
Majority trimester of enrollment denotes whether a grantee enrolled at least 50 percent of its pregnant clients in the first trimester versus the second or third trimesters of pregnancy.

CASE MANAGEMENT

Grantees conducted home visits to engage clients in familiar surroundings and to better understand the environments in which clients live. Nearly all (99 percent) grantees provided home visits to Healthy Start clients in 2003. Seventy six percent of grantees provided home visits to at least three-fourths of their pregnant clients. Meanwhile, 64 percent of grantees provided home visits to three-fourths of their interconceptional clients. Grantees provided a broad array of home visiting services, including depression screening and treatment (84 percent), well baby care (75 percent), and smoking cessation and reduction services (73 percent). The majority of grantees scheduled home visits in accordance with client need (64 percent), while the remainder (35 percent) reported that they followed a specific schedule.

The reach of home visiting services varied according to the staffing arrangement. Grantees that relied solely on subcontracted staff were more likely to provide home visits to most or all of their pregnant clients (88 percent), followed by grantees that relied solely on direct employees (67 percent), and grantees with mixed arrangements (53 percent).

In addition to providing case management and home visits to pregnant and interconceptional women, most grantees provided services to infants and toddlers. Of the 86 grantees providing services to infants and toddlers, 97 percent conducted home visits to assess their home environment and 91 percent provided case management to coordinate their services. Compared to grantees that enrolled only infants whose mothers were prenatal clients, grantees that enrolled high-risk infants and their

Figure 9
Percent of Grantees that Conducted Home Visits for Pregnant and Interconceptional Clients, by Percent of Clients Who Received Visits, 2003

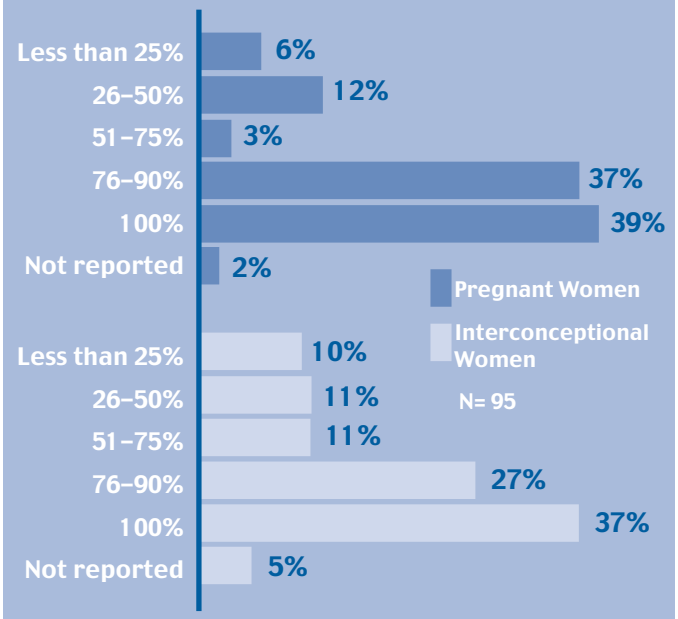
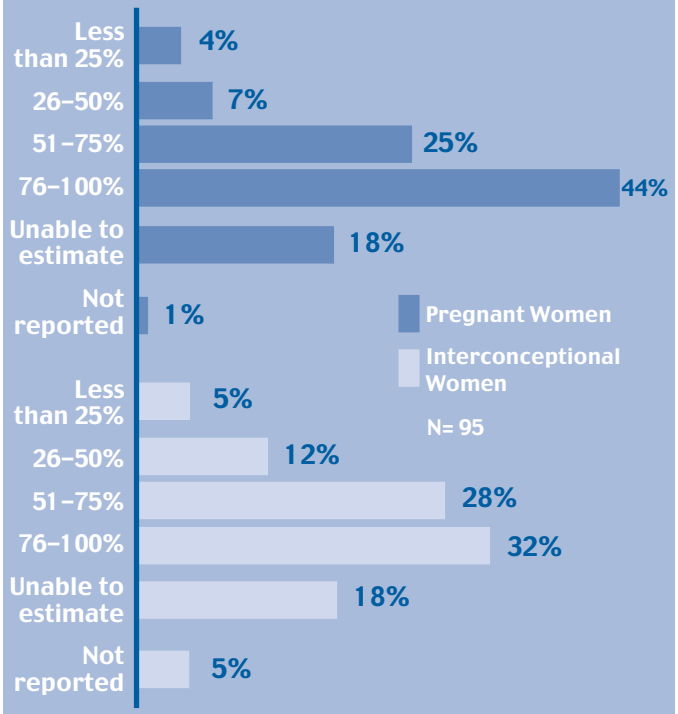


Figure 10
Percent of Grantees that Completed Referrals for Pregnant and Interconceptional Clients, by Percent of Completed Referrals, 2003



mothers after delivery were more likely to offer case management for infants and toddlers (96 percent versus 82 percent) and to offer different levels of case management depending on the infant's risk status (82 percent versus 54 percent).

Completion of referrals is an important indicator of the effectiveness of care coordination. It may also signal the level of collaboration within a community, to ensure that participants receive needed services. Grantees reported substantial variation in the percentage of referrals completed by pregnant and interconceptional clients. Forty-four percent of grantees reported that more than three-quarters of all referrals were completed by pregnant clients and 32 percent of grantees reported that more than three-quarters of all referrals were completed by interconceptional clients. Nearly one-fifth of grantees were unable to estimate their referral completion rate for pregnant (18 percent) and interconceptional (19 percent) clients.

The lower referral completion rates for interconceptional clients compared to pregnant clients may reflect the challenges in delivering services to this population. Healthy Start grantees reported that interconceptional clients have lower retention rates and were more likely to cite competing priorities or lack of medical coverage as barriers to care for their interconceptional clients.

HEALTH EDUCATION

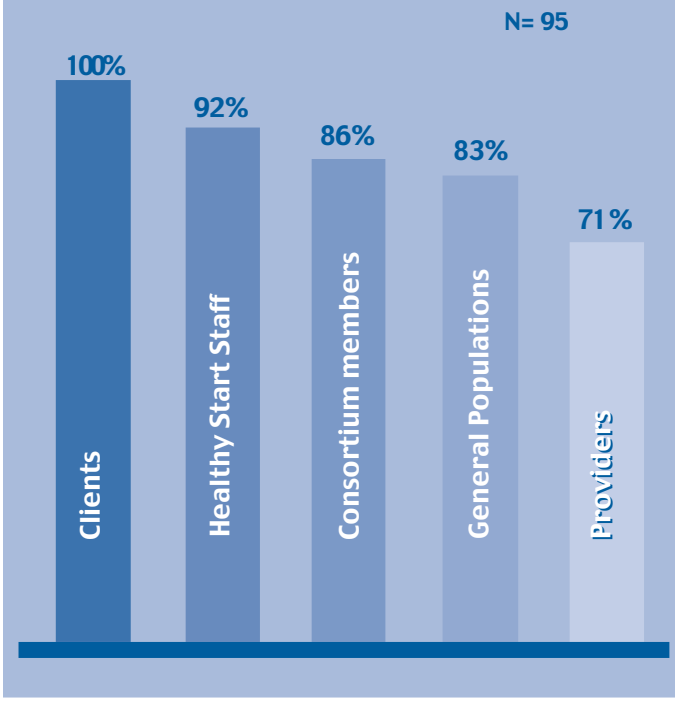
Healthy Start grantees offered health education and training through primary, secondary, and tertiary health promotion messages. Primary health promotion messages included education on increasing folic acid consumption to reduce occurrence of neural tube defects and placing infants on their backs to sleep to reduce risk of Sudden Infant Death Syndrome (SIDS). Secondary messages included early detection and treatment of diseases such as HIV and STDs. Tertiary health promotion approaches might, for example, reduce stress in order to help reduce disability or suffering caused by chronic conditions.

Recognizing that multiple factors influence health behavior and health outcomes, Healthy Start grantees provided health education and training to a variety of individuals. All Healthy Start grantees (100 percent) provided health education to clients and 83 percent provided education to the general population. Most grantees (92 percent) conducted health education training for their staff, 86 percent trained their consortium members, and 71 percent provided health education training for providers in the community.

Client health education covered a very broad range of topics, reflecting the wide-ranging needs of the population. Of the 19 topics included in the survey, 76 percent of projects provided health education to clients on all 19 topics, and another 18 percent covered all but one topic. On average, projects provided client education on 18.6 topics. Ninety-nine percent of grantees provided education to clients on drug abuse, alcohol abuse, depression, family planning, and domestic violence. Less common client health education topics were stress management (93 percent), exercise (87 percent), and management of chronic conditions (86 percent).

Some health education messages were targeted at the general population. The most common population-based health education topics were smoking cessation (61 percent of grantees), depression (57 percent), SIDS prevention (56 percent), and STD prevention, testing, and treatment (56 percent).

Figure 11
Percent of Grantees that Targeted Various Audiences for Health Education and Training, 2003



SMOKING CESSATION

The widespread availability of smoking cessation services in Healthy Start projects reflects a growing recognition that smoking during pregnancy is linked to low birthweight and infant mortality. Three-fourths (73 percent) of the Healthy Start projects provided smoking cessation services in 2003. Among the 69 grantees providing these services, the services most frequently offered were case management that included cessation counseling (77 percent), regular reminders by Healthy Start staff during each visit (71 percent), smoking cessation classes (52 percent), or behavioral support counseling (52 percent). Fewer grantees provided psychosocial counseling (22 percent) or pharmacological therapies (6 percent). It is not clear from these data whether some of these services, such as pharmacotherapy, may be available from other providers in the community. Moreover, the survey did not gather information on the intensity and duration of treatment (such as cessation counseling and reminders) during case management visits.

About one-fifth of the grantees (19 percent) indicated they relied on other strategies. Several grantees reported using the "4 R's" to motivate smokers to quit (relevance, risks, rewards, and repetition). Other interventions included secondhand smoke reduction strategies, provision of a self-help guide developed by the grantee or another organization, or life skills education classes.

Grantees with a predominantly nursing case management staff offered a broader mix of smoking cessation services than other grantees, providing an average of 3.3 types of services, compared to 2.3 for those with a predominantly social work staff, 1.9 for multidisciplinary staff, and 1.6 for lay/paraprofessional staff (data not shown). In particular, grantees with predominantly nursing staff were more likely to offer behavioral support counseling (79 percent) than those relying on social work staff (56 percent), multidisciplinary staff (43 percent), and lay/paraprofessional staff (33 percent).

Figure 12
Percent of Grantees that Offered Selected Smoking Cessation Interventions, 2003

MALE INVOLVEMENT

Healthy Start recognizes the importance of encouraging male involvement in the program. Grantees educated men about the role they can play in fostering positive pregnancy outcomes and in contributing to their children's health and wellbeing. The overall goal of male involvement services is to enable men to play a positive role in the lives of participants and their children.

Although not a required component of Healthy Start projects, the majority of grantees (61 percent) offered one or more types of male involvement services in 2003. Three grantees reported that these services were under development. The most common services were encouragement of male participation in prenatal and pediatric visits (48 percent); conducting classes on parenting skills (41 percent); and providing counseling and support related to the role of men in family planning (39 percent). Other services, reported by 15 percent of grantees, included fatherhood fairs, Fathers' Day activities, male involvement consortium activities, depression services, and health education.

Figure 13
Percent of Grantees that Offered Selected Male Involvement Services, 2003

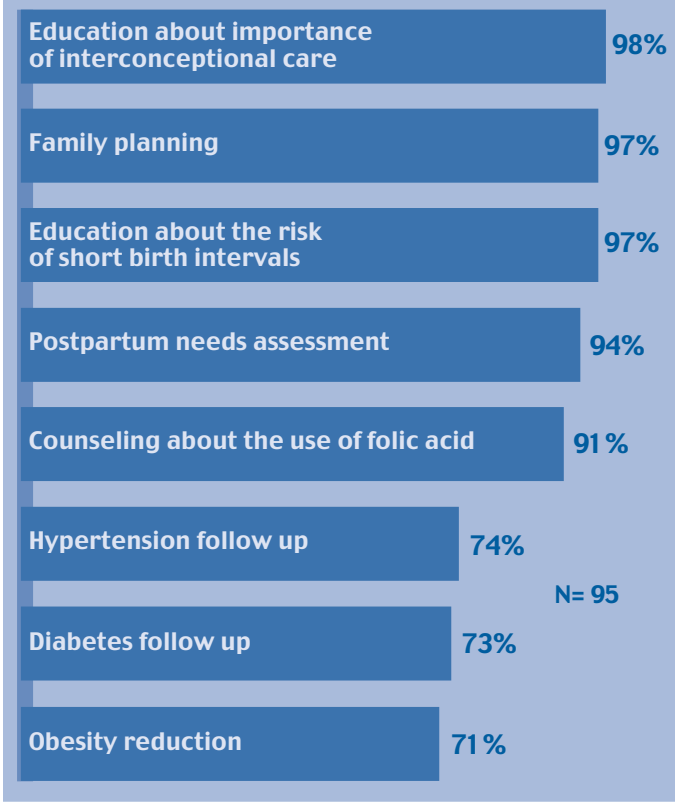
INTERCONCEPTIONAL CARE

The interconceptional period is a critical time to address both medical and social issues that can increase the risk of infant mortality, and particularly those that contribute to disparities in infant mortality. The national Healthy Start program included interconceptional care as one of its nine core components in recognition of its important role in eliminating disparities. All but 2 Healthy Start grantees provided interconceptional care services during 2003. However, both of these grantees reported that the services were under development at the time of the survey. Most grantees (74 percent) reported that they enrolled the majority of interconceptional clients when they were pregnant, and then followed them during the interconceptional period. The remaining grantees (26 percent) enrolled the majority of their clients after delivery.

The interconceptional period provides an opportunity to address women's acute and chronic medical issues (such as hypertension, diabetes, and obesity) as well as educate them about important practices that can improve the outcome of subsequent pregnancies (such as taking folic acid, quitting smoking, and birth spacing of 2 years or more). Counseling services were provided by most grantees on a wide range of topics, including the importance of interconceptional care (98 percent); family planning counseling (97 percent); and education about the risk of short birth intervals (97 percent). Projects offering these services typically provided them to three-fourths or more of their interconceptional clients.

Grantees were less likely to offer services that addressed medical risk factors, including hypertension follow-up (74 percent), diabetes follow-up (73 percent), and obesity reduction (71 percent). When these services were offered, grantees reported they were typically received by fewer than half of all interconceptional clients. However, because not all women require these services, it is not possible to gauge the extent to which the need for these services is being met by Healthy Start.

Figure 14
Percent of Grantees that Offered Selected Interconceptional Care Services, 2003



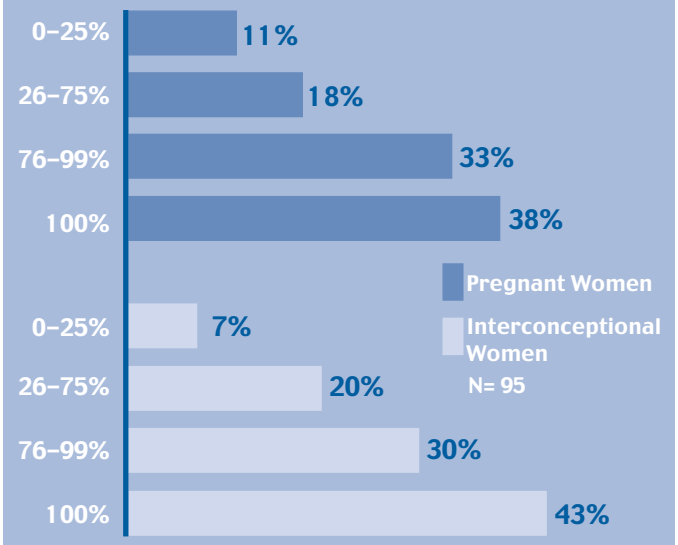
PERINATAL DEPRESSION SERVICES

Screening for perinatal depression became a required component in the third funding cycle of Healthy Start. The recent focus on perinatal depression is in response to increasing evidence that links depression and stress to adverse pregnancy outcomes. Maternal depression can lead to poor self-care and poor infant care, and in extreme cases, to suicide or infant death. With early detection and intervention, depression can be treated and functioning improved.

During 2003, all but one grantee provided perinatal depression services; the remaining grantee reported that services were under development. By far, the most commonly used screening tool was the Edinburgh Postnatal Depression Scale (EPDS) (used by 67 percent of grantees). More than two-thirds of the grantees reported that they screened at least three-fourths of their clients for depression. A sizable proportion of grantees reported that they achieved universal screening - that is, they screened all of their pregnant and interconceptional clients for depression (38 percent and 43 percent, respectively).

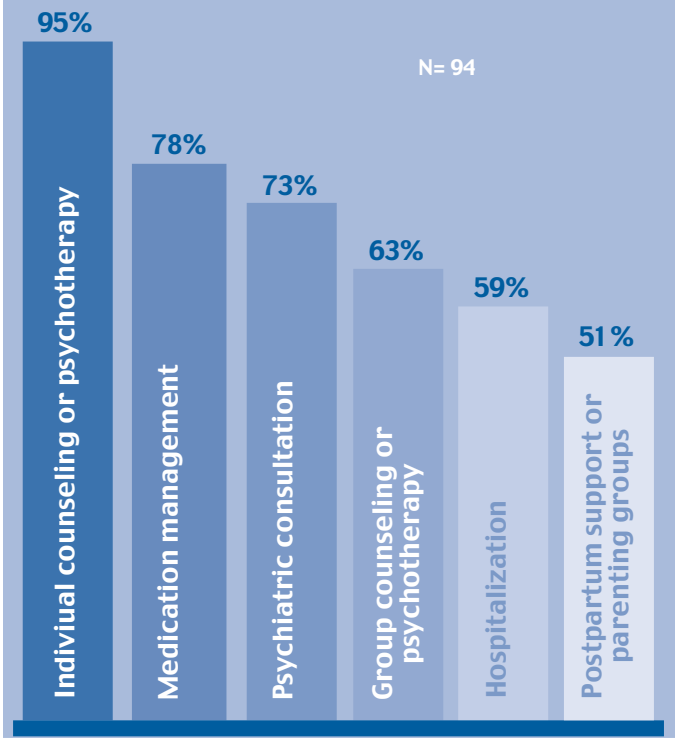
Several factors were associated with achieving universal depression screening of pregnant clients. Universal screening rates were higher among grantees that performed screening both separately and as part of a comprehensive screening (58 percent) compared to those that performed screening either separately (39 percent) or as part of a comprehensive screening (28 percent) (data not shown). Projects that screened at more points in time also were more likely to screen all their clients, suggesting that repeated screening attempts may reduce

Figure 15
Percent of Grantees* that Screened Pregnant and Interconceptional Women for Perinatal Depression, 2003



*Excludes grantees that did not provide depression screening to these clients or were not able to estimate the percentage screened. Estimates for screening pregnant clients are based on 90 grantees; estimates for screening interconceptional clients are based on 84 grantees.

Figure 16
Percent of Grantees that Offered Selected Types of Perinatal Depression Services to Clients, 2003



barriers and resistance to screening. Universal screening rates increased from 27 percent among grantees using only one screening interval, to 48 percent of those using four intervals, and 100 percent of those using five intervals. Grantees that involved direct employees or subcontractors in clinical assessment and diagnosis (49 percent) had higher universal screening rates compared to those that relied only on referrals (26 percent), suggesting that more monitoring and follow-up is required by grantees that use referrals.

When Healthy Start clients screen positive for depression, they require additional clinical assessments to confirm a mental health diagnosis and determine the necessary follow-up services. These subsequent clinical assessments can be provided by project staff or subcontractors, or through outside referrals, and by either specialty mental health providers or primary care providers. All of the grantees (100 percent) reported that further clinical assessment and diagnosis were available in their communities, and most (93 percent) indicated that these services were available from mental health providers, either alone or in combination with primary care providers. Specifically, 53 percent of grantees indicated that assessment and diagnosis services were provided by specialty mental health providers only; another 39 percent relied on both specialty mental health and primary care providers; while the remaining seven percent involved only primary care providers. However, grantees in rural areas (80 percent) were significantly less likely than urban grantees (95 percent) or urban/rural grantees (100 percent) to report that specialty mental health providers performed the follow-up assessments.

Forty-eight percent of the grantees offered additional clinical assessments through providers employed directly by or under subcontract to the Healthy Start grantee, while 52 percent provided these services through referrals outside of Healthy Start (data not shown). The larger projects (with total 4 year funding of $4 million or more for the 2001 - 2005 cycle) were significantly more likely to use direct employees or subcontractors to provide assessments (69 percent), while projects with lower funding levels were more likely to provide these services through referrals (62 percent to 68 percent). In addition, grantees in urban areas (57 percent) were more likely than rural (35 percent) or urban/rural (25 percent) grantees to use direct employees or subcontractors to provide clinical assessments.

Grantees reported that a wide range of services were available to those requiring treatment, with individual counseling or psychotherapy (95 percent) the most common and postpartum support or parenting groups (51percent) the least common (data not shown). Nearly one-third of grantees (31 percent) reported that all six types of services were available in their communities.

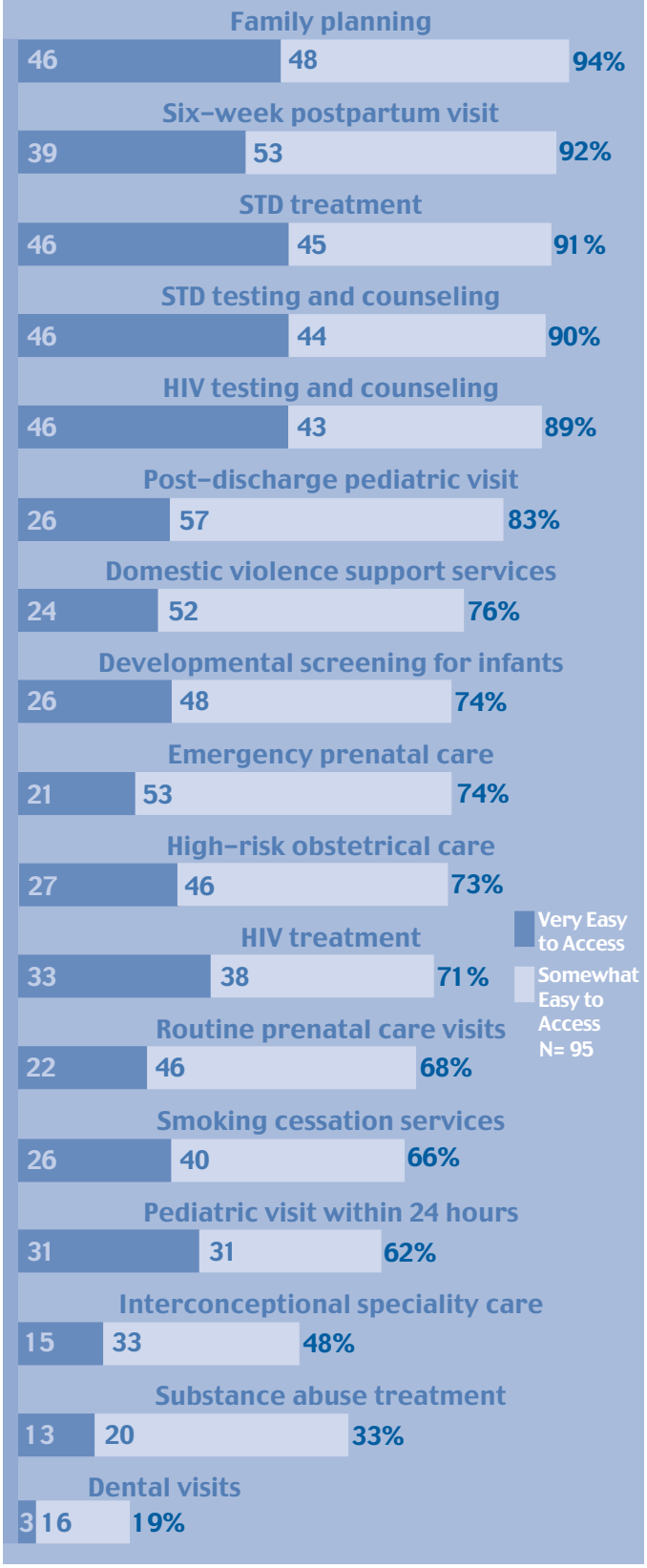
BARRIERS TO CARE

Information on ease of access and on barriers to care provides a context within which to understand the challenges faced by Healthy Start grantees in addressing their clients' needs, and ultimately, reducing or eliminating disparities in outcomes. Grantees rated the ease of obtaining access to 17 types of services for Healthy Start clients when they needed these services. Grantees indicated that routine interconceptional care, such as a 6-week postpartum visit and family planning, were relatively easy to obtain, while specialty care during the interconceptional period was viewed as difficult to obtain by the majority of grantees. Substance abuse treatment and dental care were the most difficult services to obtain for Healthy Start clients when they needed them.

Certain specialty services were perceived to be more difficult to access by grantees in rural areas. For example, 65 percent of rural grantees indicated that specialty interconceptional care was somewhat or very difficult to obtain, compared to 33 percent of urban grantees and 42 percent of those in urban/rural areas. In addition, 45 percent of rural grantees felt that HIV treatment was somewhat or very difficult to obtain, compared to 11 percent of urban grantees, and eight percent of urban/rural grantees. Finally, rural grantees (30 percent) were less likely to report that family planning services were very easy to obtain for their Healthy Start clients, compared to urban grantees (52 percent) and urban/rural grantees (42 percent).

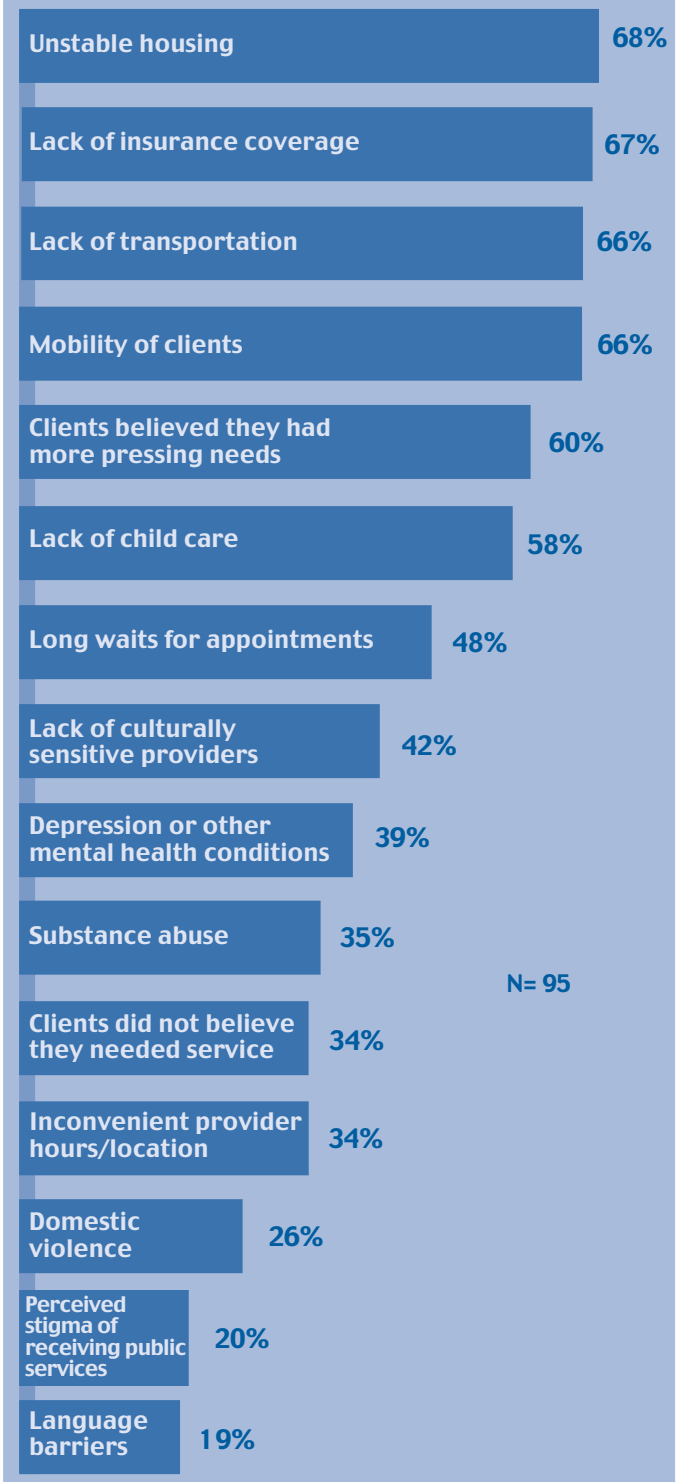
Services can be difficult to obtain for a variety of reasons, some of which may be systems-related,

Figure 17
Percent of Grantees that Reported that Access to Care was Very or Somewhat Easy, by Type or Service, 2003



while others may relate to clients' social or financial circumstances. The most common barriers reflected a mix of social and financial issues, including unstable housing, lack of insurance coverage, lack of transportation, mobility of clients, clients' belief that they had more pressing needs, and lack of child care. These six issues were reported by at least 50 percent of grantees. These issues reflect the multifaceted dimensions that Healthy Start case managers and service providers may need to address in order to reduce disparities among this highly vulnerable target population. Systems issues - such as lengthy appointment waiting times, lack of convenient or culturally sensitive providers, and language barriers - were much less frequently reported as significant challenges, perhaps because Healthy Start has made inroads in increasing the availability and cultural competence of services for this target population. Thus, the most significant challenges represent large social issues that Healthy Start case managers and other service providers may have limited resources to resolve. These findings highlight the importance of broad collaboration within Healthy Start communities to reduce barriers to care.

Figure 18
Percent of Grantees that Reported Selected Barriers to Care, 2003



Note:
Grantees were asked to report up to five barriers that presented the most significant challenges to obtaining services for their Healthy Start clients. Barriers were reported separately for prenatal care, infant/toddler care, interconceptional care, and perinatal depression care. The results were combined to reflect barriers encountered by any Healthy Start population.

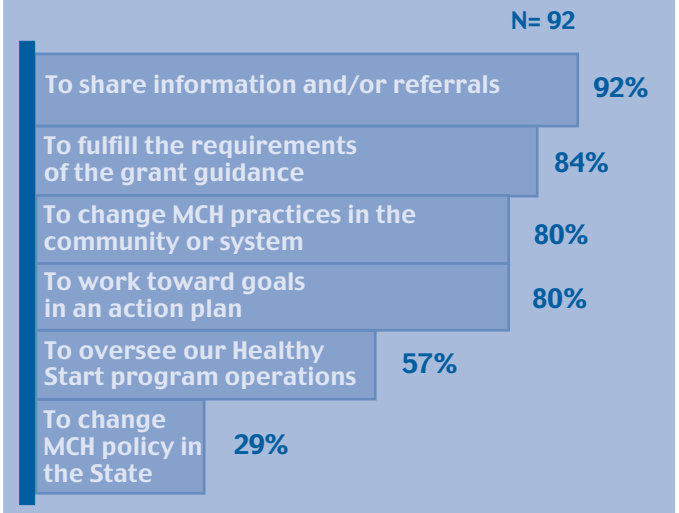
CONSORTIA

In the Healthy Start program, consortia are used to engage communities in systems change and service improvements to increase consumer voice and reduce disparities in infant mortality. Of the 95 grantees, 92 reported the existence of an active consortium. Grantees that did not have a consortium indicated that they were in the planning stages or relied on the consortium of a separate Healthy Start grantee.

Although the HRSA Guidance outlines roles for Healthy Start consortia, the purpose and priorities of the consortia are determined by the grantees. Grantees could report more than one purpose from among six relevant to their consortia; the average number reported was four. The consortium purposes most commonly reported by grantees were to share information and/or referrals (92 percent), to fulfill the requirements of the grant Guidance (84 percent), to change maternal and child health practices in the community (80 percent), and to work toward goals specified in the Local Health System Action Plan (80 percent).

One of the characteristics of a successful consortium is the inclusion of key stakeholders. Eighty percent of grantees strongly agreed that the consumers on the consortia were culturally representative of the target community, while 58 percent indicated providers were culturally representative (data not shown). Approximately half of the grantees (47 percent) strongly agreed that the consortium included all necessary stakeholders and fewer (39 percent) felt that membership was comprised of decision-makers from the organizations represented.

Figure 19
Percent of Grantees that Reported Selected Purposes of their Consortia, 2003



CONSUMER INVOLVEMENT

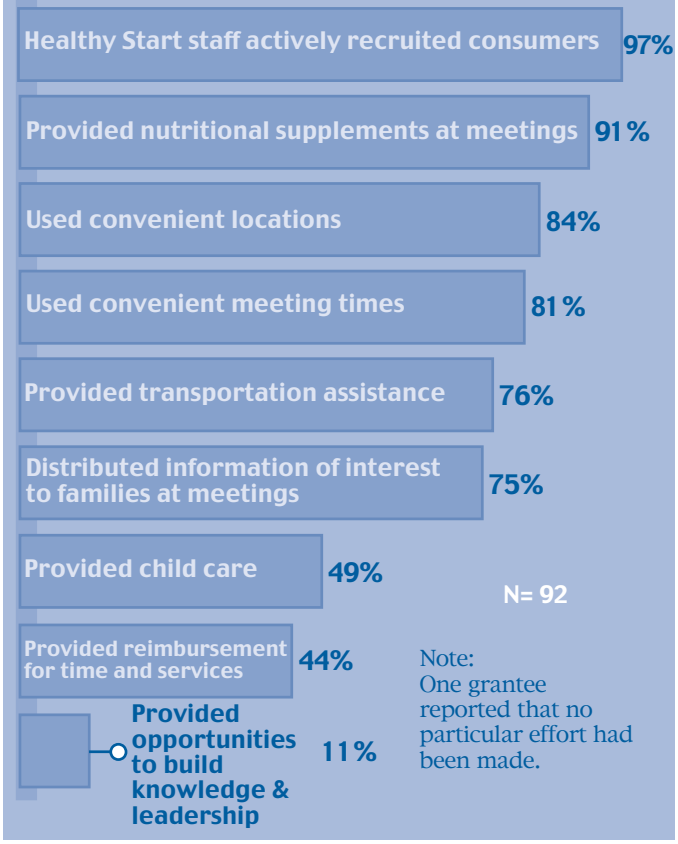
Consumer involvement is critical to the success of the consortium. With almost all grantees reporting consumer participation on the consortium, the importance of their involvement appears to be well understood. Although consumer involvement in their consortia was common, grantees were constantly challenged to ensure regular and ongoing consumer participation.

All grantees (100 percent) used at least one strategy to facilitate consumer involvement in their consortium. Almost all grantees (97 percent) actively recruited consumers to participate in the consortium. Other common strategies to motivate consumer involvement were to provide nutritional supplements (91 percent) and to schedule meetings at convenient locations (84 percent) or at convenient times (81 percent). Grantees used an average of six facilitating strategies to bring consumers to the consortium.

Grantees that provided nutritional supplements, used convenient meeting locations, and provided transportation asissistance were more likely to perceive that their consumer membership reflected the target population. Grantees that strongly agreed their consumer membership was culturally representative of the target population had more strategies (mean = 6) to encourage consumer participation in the consortium than grantees that somewhat agreed (mean = 5) or somewhat disagreed (mean = 5). These findings suggest an association between the use of facilitating strategies and the adequacy of cultural representation on consortia.

The goal of consumer involvement in Healthy Start is to create a vocal, participating cohort of active consumers who have leadership skills and are able to effectively advocate for change on behalf of the target population. Actively engaging consumers in the consortium is the first step toward creating increased consumer voice and developing a consumer leadership base in the community. Grantees were asked to report the various strategies that they used to promote leadership among consumers.

Figure 20
Percent of Grantees that Used Selected Strategies to Encourage Consumer Participation on Consortia, 2003



The mean number of strategies employed by grantees was three, and the most common strategies were inviting consumers to serve on subcommittees (75 percent), sending consumers to conferences (70 percent), and conducting training sessions for consumers (66 percent). Less than five percent of grantees did not engage in any activites to promote leadership among the consumers on their consortia.

Healthy Start projects focus on systems changes as well as traditional delivery of services. Systems change aims to provide long-term solutions, such as policy change or service integration, to the problems affecting the target population. The consortium is a major vehicle for this type of change because it involves a wide range of MCH stakeholders in the target community. The survey gathered information on grantees' perceptions of the accomplishments of their consortia in bringing about systems change in Healthy Start communities.

Among the 11 possible consortia-related accomplishments included in the survey, grantees reported six accomplishments on average. The most common accomplishment was an increased awareness of infant mortality (86 percent), followed by enhancing the community's ability to address disparities (70 percent) and creating sustainable partnerships between member agencies that are expected to endure beyond the Healthy Start contract period (70 percent).

Nearly all grantees reported challenges that they believed limited the effectiveness of their consortia. On average, four challenges were identified by each grantee. Some consortia were challenged by internal difficulties such as irregular attendance, insufficient leadrship, and competition among members. Others felt that external conditions, such as State or local politics and government resources, were obstacles to the consortium meeting its goals. The two most frequent challenges were the irregular attendance by key members (50 percent) and insufficient resources at the State or local level (48 percent). Other frequently reported challenges included insufficient staff time dedicated to consortium efforts (43 percent), lack of consumer involvement (43 percent), and lack of resources (42 percent) (data not shown).

Figure 21
Percent of Grantees that Reported Practices to Promote Leadership among Consumers, 2003

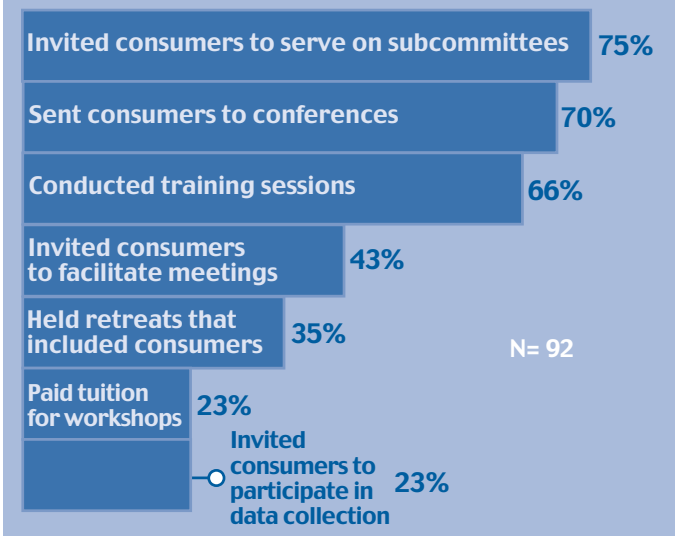
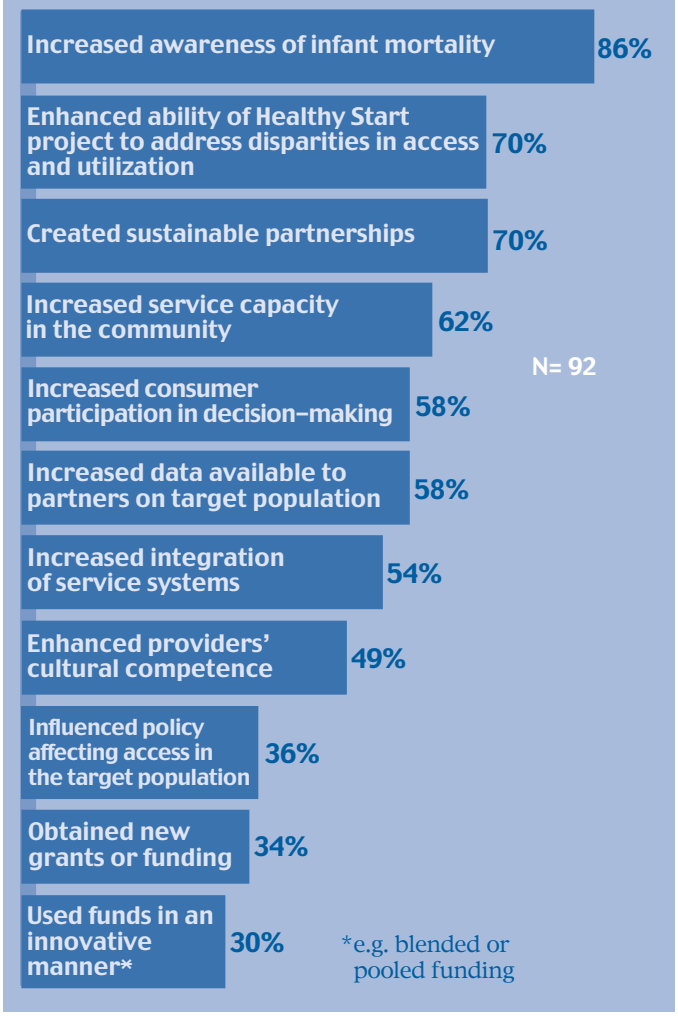


Figure 22
Most Frequently Reported Accomplishments of Consortia, 2003



LOCAL HEALTH SYSTEM ACTION PLAN

Planning is an important part of Healthy Start. The HRSA Guidance required each grantee to develop a Local Health System Action Plan (LHSAP) that identified one or two priority goals that could be achieved within the third grant cycle. The intent of this requirement was to focus the plan on improvements related to the perinatal systems of care and to ensure that the process involved collaboration with relevant organizations, especially Title V maternal and child health agencies.

Of the 95 grantees that responded to the survey, 80 grantees (84 percent) reported having an LHSAP as of December 2003. Among them, 54 grantees (68 percent) indicated that their action plan was developed specifically for their Healthy Start project while 26 grantees (32 percent) reported that their action plan was not exclusive to Healthy Start, but contained goals that the Healthy Start project was addressing.

The Guidance required that the LHSAP be linked to the State Title V plan, although only half of the grantees reported that this occurred. More than three-quarters of the grantees involved the consortium as required. Less than half of the grantees involved local Title V agencies (43 percent) or local governmental agencies (40 percent) other than the local health department (e.g. city housing authority).[2] Less than half of the grantees (46 percent) reported that consumers were involved, although they may have participated as part of the consor-

[2]Not all local health departments have a local Title V agency.

Figure 23
Percent of Grantees that involved Entities in the Development of LHSAP Goals, 2003

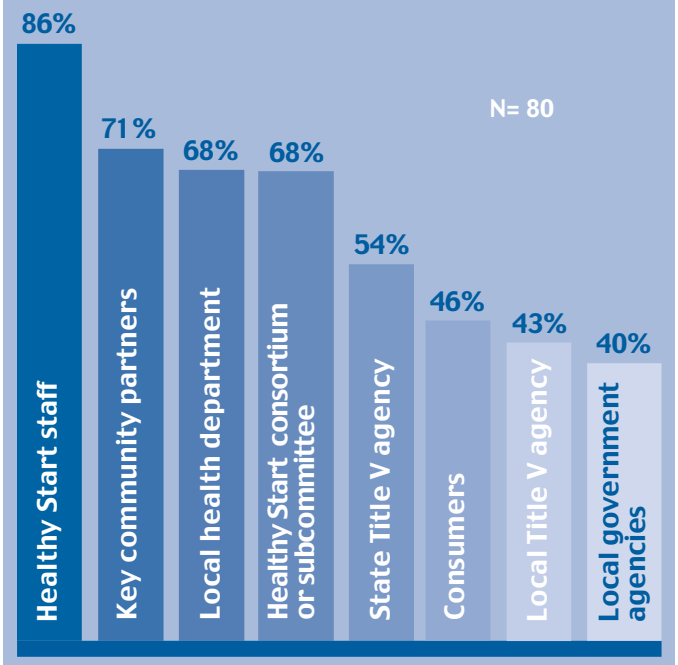


Figure 24
Most Frequently Reported Methods of Identifying Priorities for the Development of LHSAP Goals, 2003

tium or through key community partners.[3]

The 80 grantees with a LHSAP indicated that they used, on average, four methods to identify plan priorities. Discussions with various stakeholders were the most frequently reported method used to identify priorities, including discussions with community organizations or agencies (74 percent), providers (66 percent), the consortium (64 percent), and less frequently, consumers (55 percent).

In addition to conducting discussions with community partners, grantees reported using a variety of data sources to help identify goals, including findings from a local (or State) mortality review program (45 percent), another needs assessment (such as Title V or United Way-initiated plans) (45 percent), and their own needs assessment (44 percent). Overall, 80 percent of grantees with a LHSAP used existing data sources to help identify goals, including 37 percent that used a single data source, 32 percent that used 2 sources, and 11 percent that used all 3.

Grantees identified goals that were most often service-oriented (40 percent). About one-third of the identified goals were systems-oriented, with fewer goals that were program-outcome related (20 percent) and health-outcome related (19 percent). Although most grantees reported a great deal of progress in meeting their goals, they also identified resource constraints as a major barrier. Resource barriers may also be reflected in the fact that several grantees did not have plans or had not finalized their goals at the point in the grant cycle during which the survey was administered.

[3]Of the 57 grantees that involved community partners, 33 involved consumers. Of the 54 grantees that involved the Healthy Start consortium or a subcommittee of the consortium, 28 involved consumers.

COORDINATION AND COLLABORATION

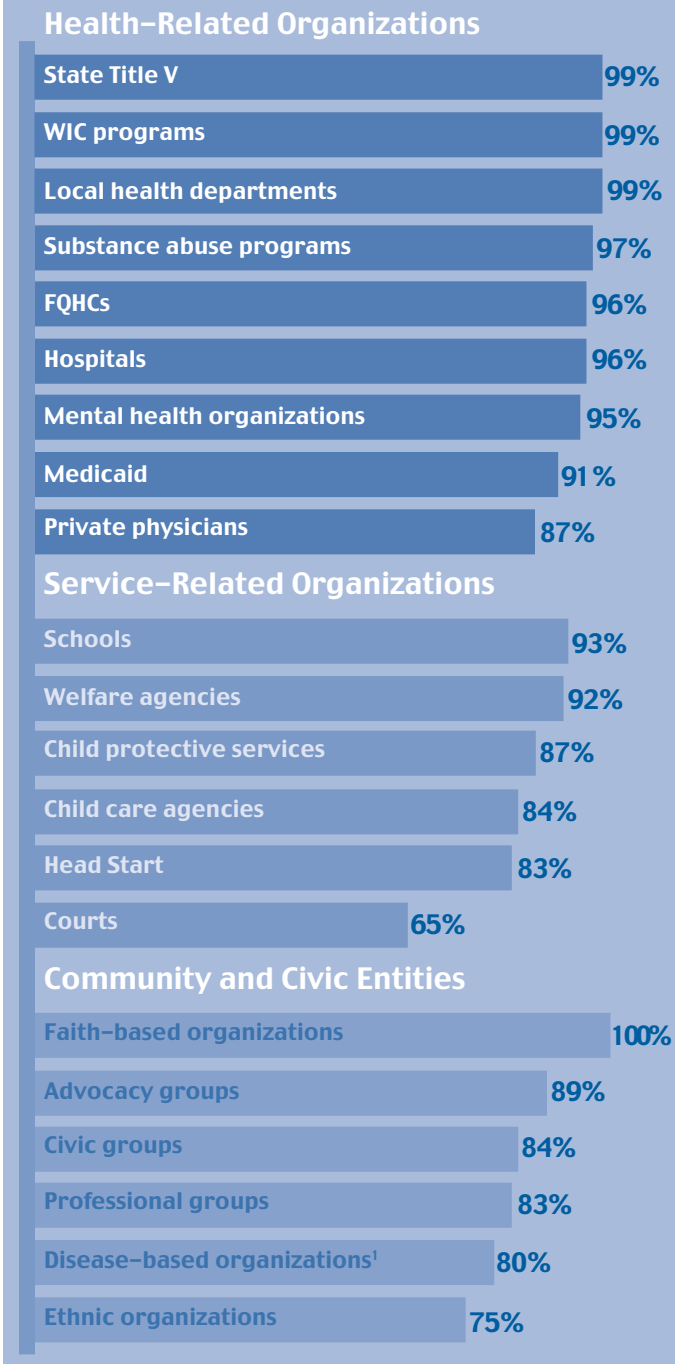
Healthy Start grantees have established relationships with many entities in their communities and engaged in a wide range of collaborative activities. Most grantees had relationships with health-related organizations. The most common were with State Title V, local health departments, and WIC. More than 90 percent of grantees identified collaborative relationships with faith-based organizations (100 percent), schools (93 percent), and welfare agencies (92 percent). Entities with which grantees were less likely to have relationships included courts, where 35 percent of grantees reported no relationship, ethnic organizations with 25 percent reporting no relationship, and disease-based organizations with 20 percent reporting no relationship.

Grantees reported relationships with State Title V. The majority of grantees (73 percent) indicated that they had informal relationships (such as attending the same meeting or casual contacts) with the State Title V programs while 22 percent reported a formal relationship (such as having a written memorandum of understanding or agreement) with the Title V agency. Less than a third of grantees (28 percent) reported that the State Title V program funded some of their programming and services.[4]

Many benefits of collaboration were cited by respondents, although no single benefit was mentioned considerably more than others. However, grantees indicated that collaboration was beneficial

[4]These percentages excluded the 10 grantees that are State health departments.

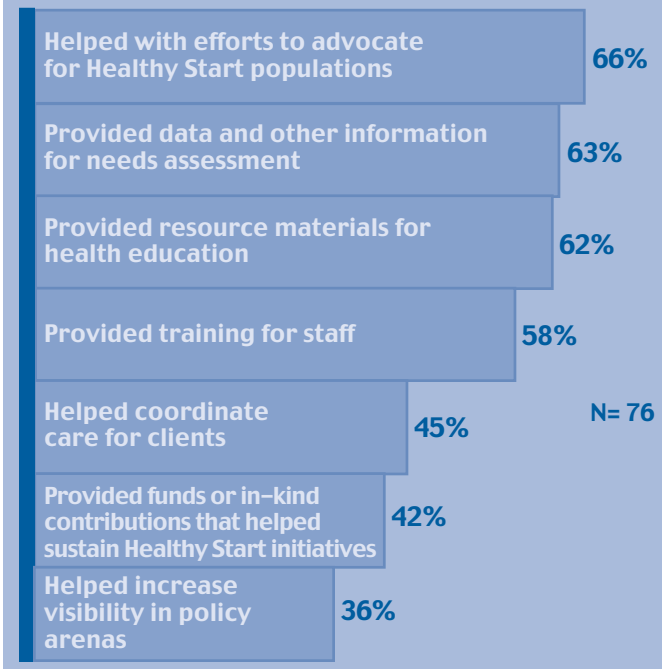
Figure 25
Percent of Grantees* with Collaborative Activities, by Type of Entity, 2003



Note:
Grantees could report more than one entity with which they collaborated.
*Percent is the number of grantees that reported a relationship out of the number of grantees that have that entity in their community.
[1] e.g. local diabetes chapter

in achieving staff training, performing needs assessments, and improving Healthy Start's visibility within policy arenas. This signifies that grantees are on their way toward achieving desired Healthy Start systems outcomes. Nonetheless, the most frequently reported challenge to collaboration with Title V was insufficient staff resources (65 percent), with almost half of the grantees indicating that existing bureaucracy made it difficult to coordinate.

Figure 26
Percent of Grantees that Reported Benefits They Received from Coordinating with State Title V Programs, 2003



Note:
Grantees could report more than one benefit. These results exclude the 10 grantee agencies that are State health departments, as well as grantees that do not have a relationship with the Title V programs.

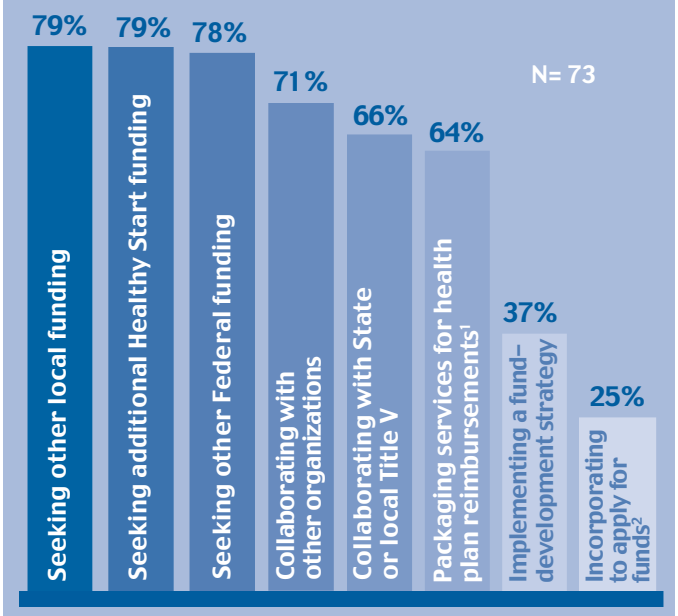
SUSTAINABILITY

In 2001, the national Healthy Start program emphasized the importance of sustainability, and directed grantees to develop a plan for the continuation of Healthy Start services at the end of their grant cycle. Three-quarters of Healthy Start grantees reported having a sustainability plan as of December 2003. A majority of them identified sustainability strategies that involved the pursuit of additional financial support – either through other local funding (79 percent), additional Healthy Start funding (79 percent), or other Federal funding (77 percent). However, over two-thirds of grantees with a sustainability plan indicated that they did not have agreements in place with any entities to absorb their projects' services.

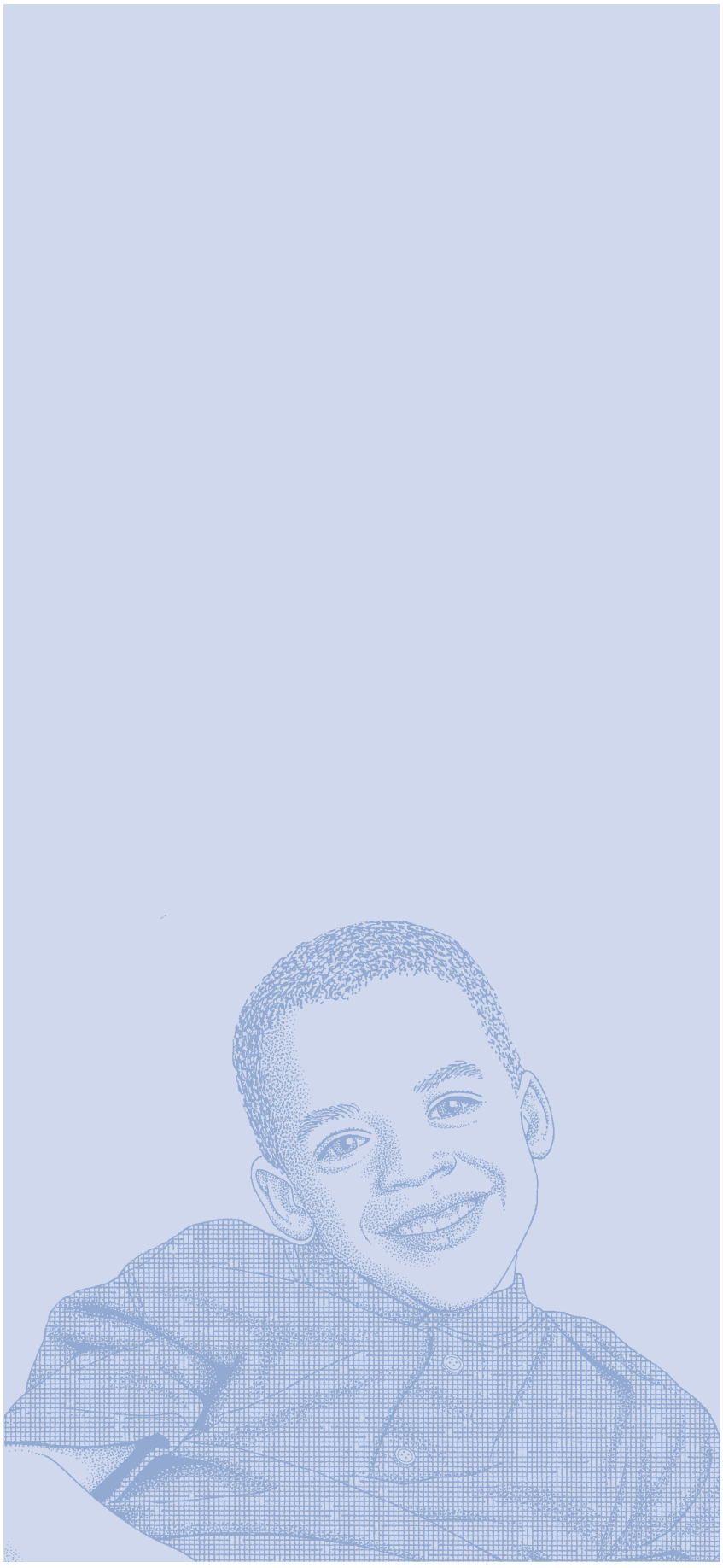
Sustainability strategies employed by State health departments differed significantly from those of other grantees. Of the 9 State health department grantees that had sustainability plans, less than half (44 percent) sought other State or local funding. In comparison, most local health departments (88 percent), non-profit organizations (84 percent), and all other remaining agencies (71 percent) sought such funding. Moreover, no State health department grantee had implemented a fund-development strategy, while a sizeable proportion of local health departments (38 percent), non-profits (48 percent), and all other agencies (29 percent) had implemented such a strategy. State health department grantees were also less likely to develop collaborative efforts with other organizations (22 percent), compared to grantees associated with local health departments (73 percent), non-profits (84 percent), and all other agencies (71 percent).

However, State health department grantees were more likely to incorporate in order to apply for other funds (70 percent), compared to local health departments (13 percent), non-profits (19 percent), and all other agencies (29 percent). The State health departments that listed incorporation as a strategy planned to apply for 501(c)(3) status for their local consortia, which would eventually assume responsibility for Healthy Start fundraising and become the body that oversees programming and services at the end of the third grant cycle.

Figure 27
Percent of Grantees that Pursued Selected Types of Sustainability Strategies, 2003



Note:
Grantees could report more than one strategy.
[1] e.g. Medicaid
[2] e.g. 501(c)(3)

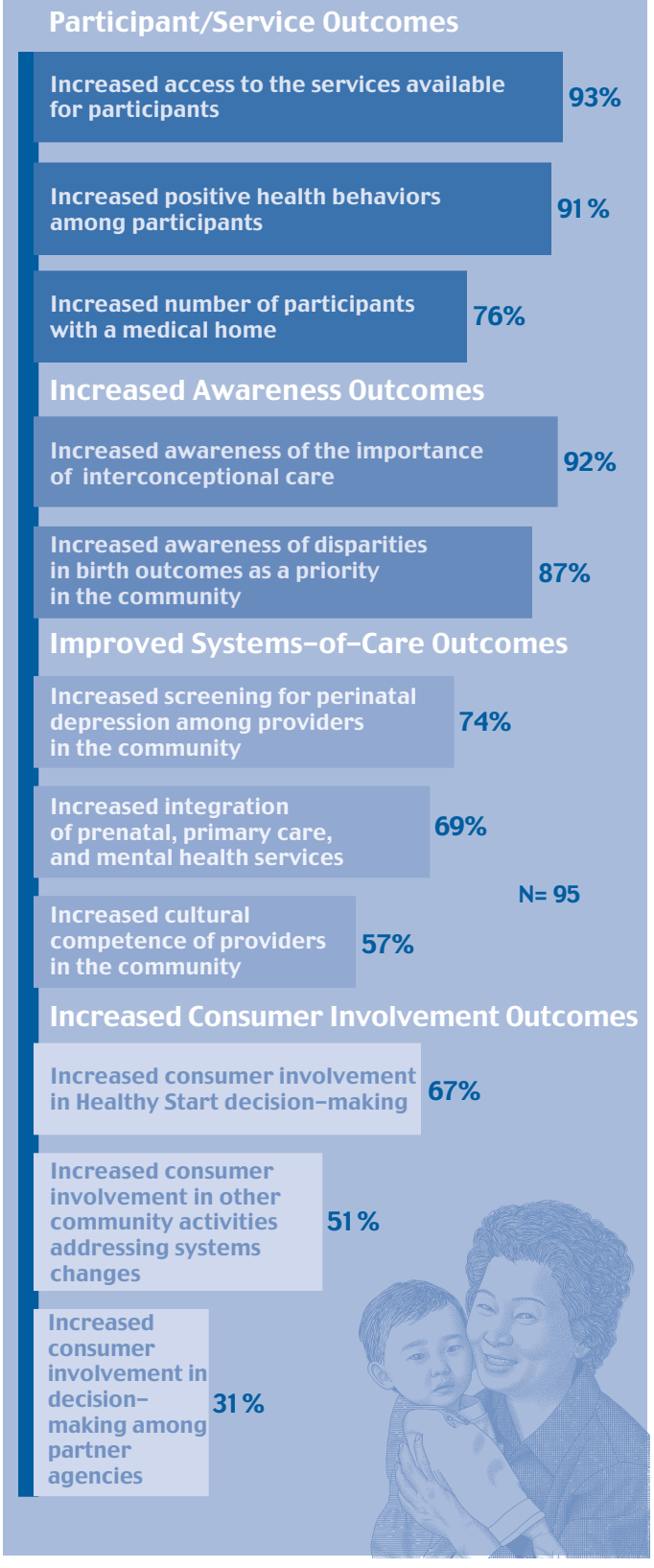


INTERMEDIATE PROGRAM OUTCOMES

Having provided a snapshot of individual program components, it is important to reflect on the Healthy Start program as a whole. Figure 28 indicates the percentage of grantees that self-reported achievements in 11 intermediate outcomes based on the Healthy Start logic model (see appendix). They are grouped into four categories: participant/service outcomes, increased awareness outcomes, systems-of-care outcomes, and consumer involvement outcomes. Grantees were more likely to report improvements in services than systems-related activities. This is consistent with the finding that grantees devoted the majority of their grant funding to the services components, with the average allocation being 80 percent to services and 20 percent to systems. Grantees also were more likely to report that they achieved outcomes related to increasing awareness than increasing consumer involvement. The former targeted providers and the general public, while the latter targeted consumers, perhaps signifying that there are greater challenges in reaching consumers than other populations.

To understand the extent to which particular program activities contributed to achieving the intermediate outcomes, the survey asked grantees to rate the perceived contribution of seven services-related and eight systems-related Healthy Start activities. For each activity, grantees indicated whether it made a primary contribution, a major contribution, a moderate contribution, a minor contribution, or no contribution at all. Grantees

Figure 28
Percent of Grantees that Reported They Achieved Selected Intermediate Outcomes, 2003

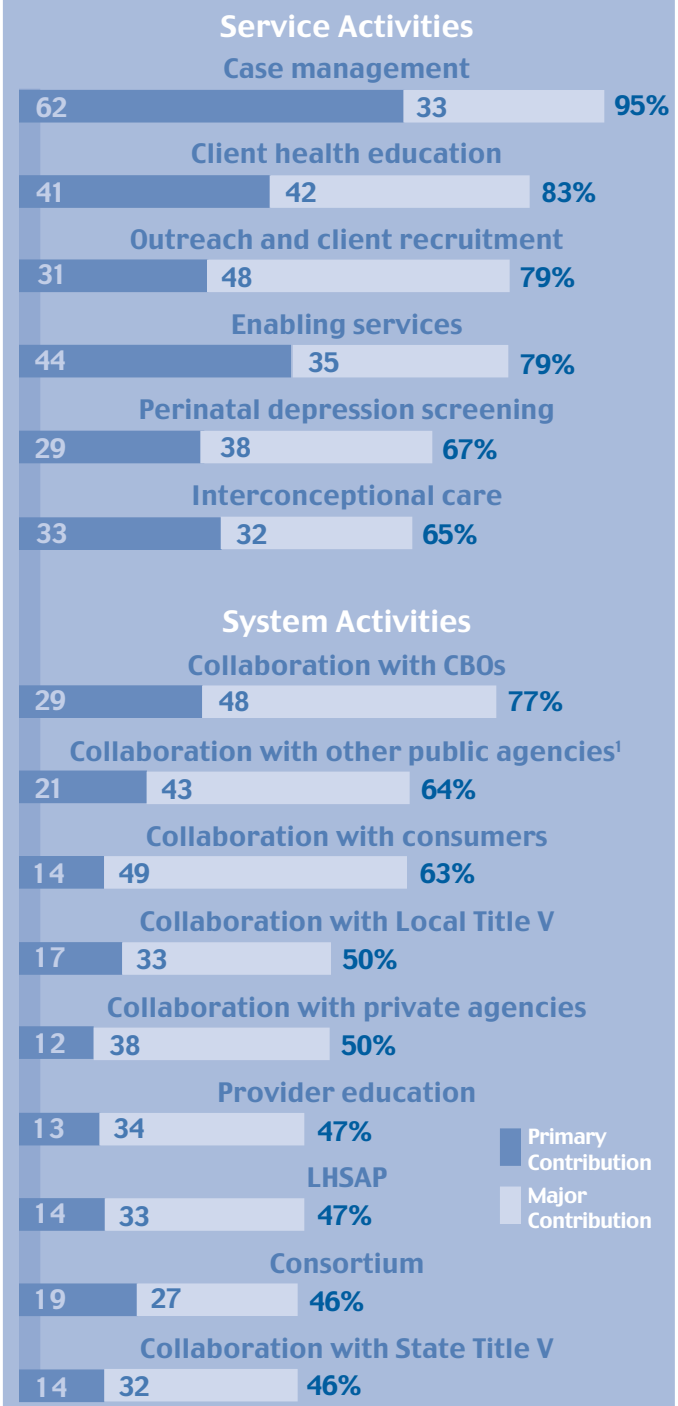


were more likely to report that services activities made a primary or major contribution to achieving their intermediate program outcomes. Case management was perceived to make the largest contribution, followed by client health education. Far fewer grantees reported that systems activities made a primary or major contribution, in particular, provider education, consortia, local health system action plan, and collaboration with State Title V agencies.

In addition to reflecting on their projects' inter-mediate outcomes and relative contributions of program components, grantees commented on 16 statements concerning Healthy Start's relationships to the communities in which they are based. These statements represented a continuum of program change, beginning with the identification of issues, progressing to building capacity for change, seeing tangible results, and finally, offering evidence of sustainable change. It was expected that grantees would be at different points along this trajectory and, indeed, found that grantees were more likely to report outcomes within the first three stages of systems change than in the final stage of sustainability.

All grantees (100 percent) expressed agreement that Healthy Start has identified access problems in the health care system and 99 percent agreed that Healthy Start has identified strategies for addressing disparities. In addition, a large majority of grantees agreed that Healthy Start has made progress in developing the basis for change. In particular, grantees reported the project was an integral part of the service delivery system in the community (96 percent) and that community residents are aware of the project (95 percent). Grantees were less likely to report that policymakers participate in or are accessible to the Healthy Start project (87 percent); and that Healthy Start is connected to the community's power structure (79 percent) such as local government

Figure 29
Percent of Grantees* that Reported Selected Services and Systems Activities to be a Primary or Major Contribution to Achieving Intermediate Outcomes, 2003



*Consortium calculations include grantees with a consortium (N=92); LHSAP calculations include grantees with a LHSAP (N=80). Local Title V calculations include grantees that are not local Title V agencies, in order to measure the degree to which all other grantees collaborate with local Title V (N=60). State Title V calculations include only grantees that are not State Title V agencies (N=85).

[1] Other than Title V

representatives and decision-makers within local institutions.

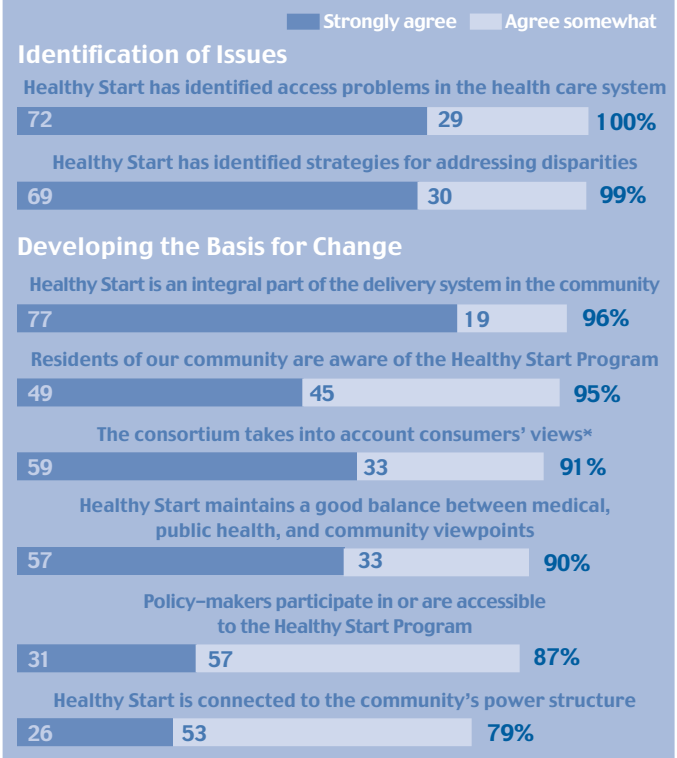
The majority of grantees agreed that the Healthy Start project yielded actual changes in results. Of the six items in this domain, at least 94 percent of the grantees agreed (either strongly or somewhat) with five of them. Grantees were less likely to report that many changes/solutions have been implemented as a result of Healthy Start recommendations (81 percent).

The final stage of the trajectory is sustainability. A relatively smaller number of grantees agreed that maternal and child health agencies/providers take ownership of Healthy Start goals (78 percent), or that an institutional and fiscal base of support sustains Healthy Start activities (52 percent).

The presence of a LHSAP has a significant effect on the assessment of the effect of the Healthy Start project on the community. Projects with a LHSAP were more likely to agree (either strongly or somewhat) that Healthy Start is connected to the community's power structure, has led to improved communications among agencies in the community, has contributed to the community's capacity for needs assessment, has created solutions to access problems, and can document a positive impact. These results suggest that a LHSAP may help Healthy Start grantees move along the trajectory toward having a lasting effect on their communities.

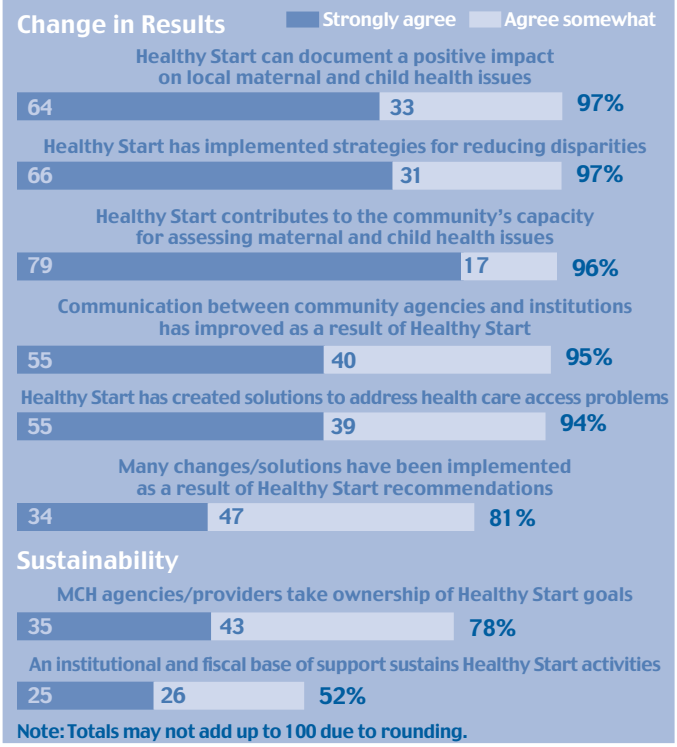
The existence of a Local Health System Action Plan or a sustainability plan did not result in any significant associations with regard to grantee perceptions of their project's effects on bringing about sustainable change. This result may not be too surprising in light of the findings which showed that most grantees with a sustainability plan did not have any resources in place to absorb their services – and thus would not have an institutional or fiscal base of support to sustain Healthy Start activities. Although grantees may be building a foundation

Figure 30–A
Percent of Grantees that Reported Selected Community Outcomes, 2003



*Consortium calculations include all grantees with a consortium (N=92).
Note: Totals may not add up to 100 due to rounding.

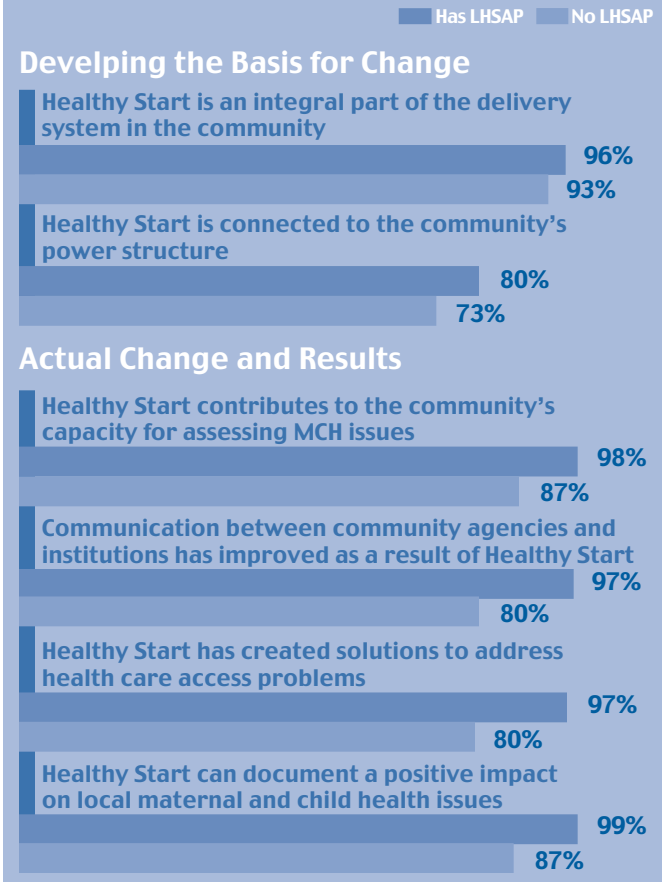
Figure 30–B
Percent of Grantees that Reported Selected Community Outcomes, 2003



Note: Totals may not add up to 100 due to rounding.

for sustainable change, these results suggest that grantees perceive substantial barriers to sustaining the Healthy Start program in the absence of Federal funding.

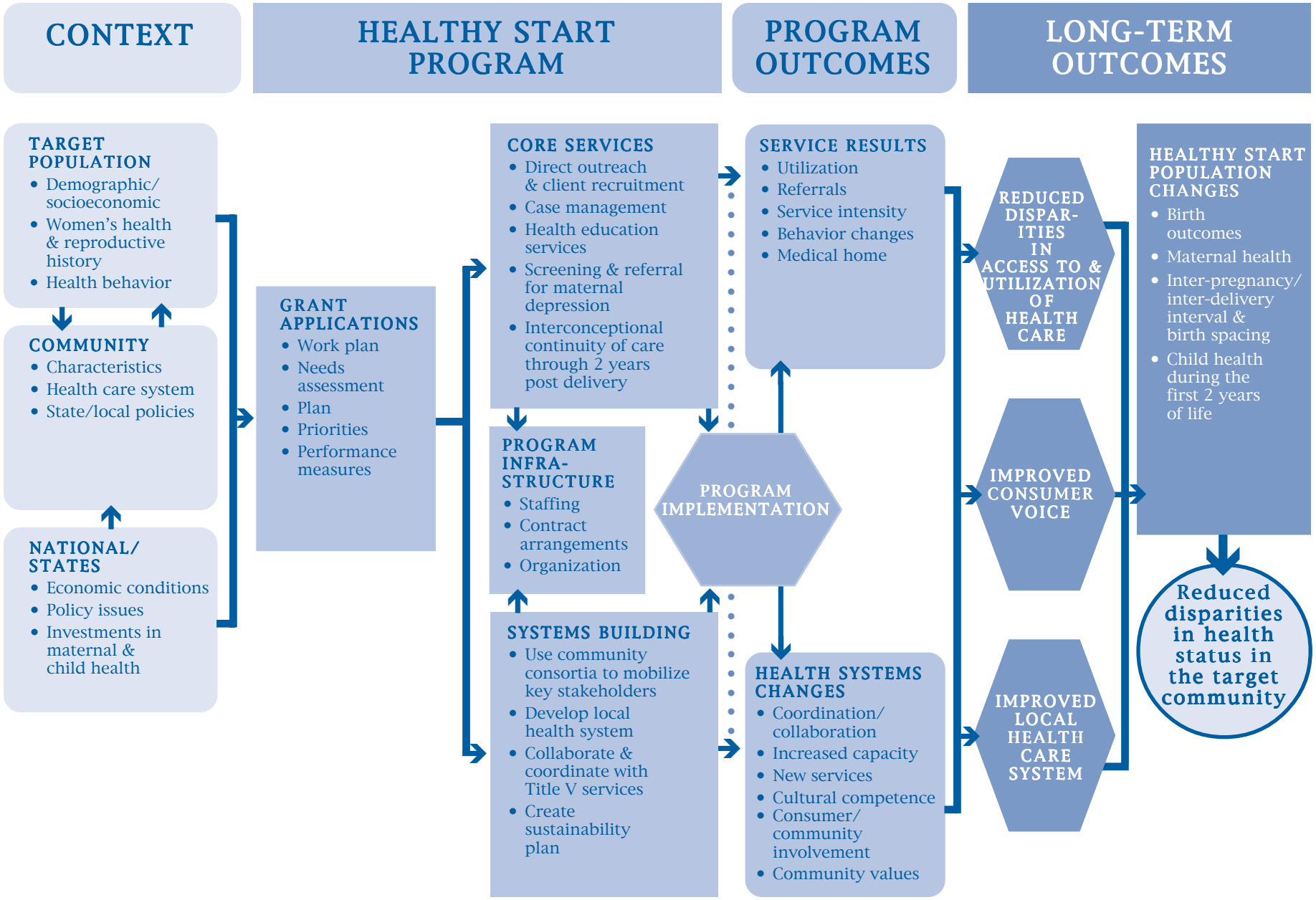
Figure 31
Percent of Grantees* that Reported Selected Community Outcomes, 2003



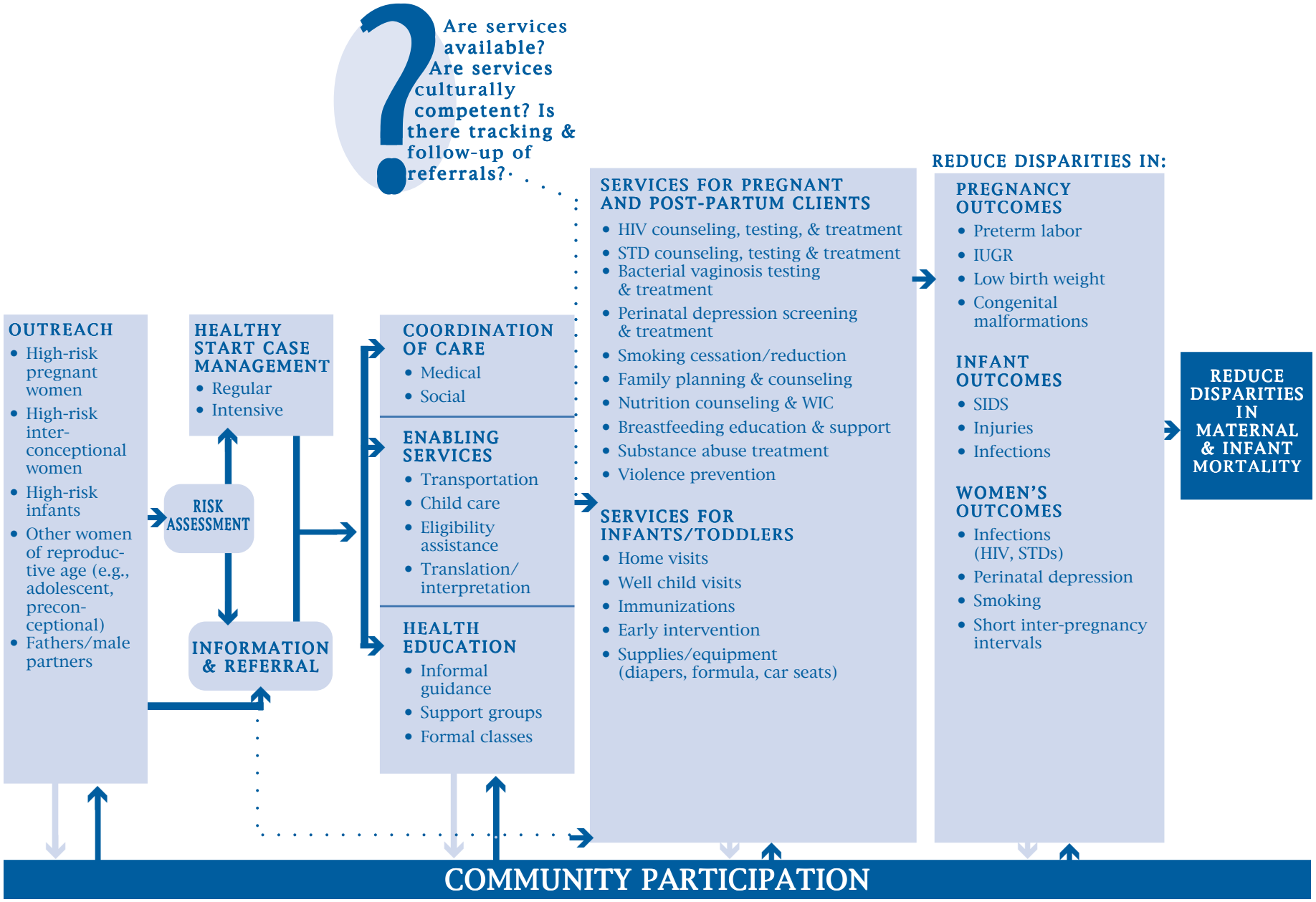
*Grantees could report more than one category. Data reflect percentage of grantees that strongly agreed or somewhat agreed with each statement.

Appendix...

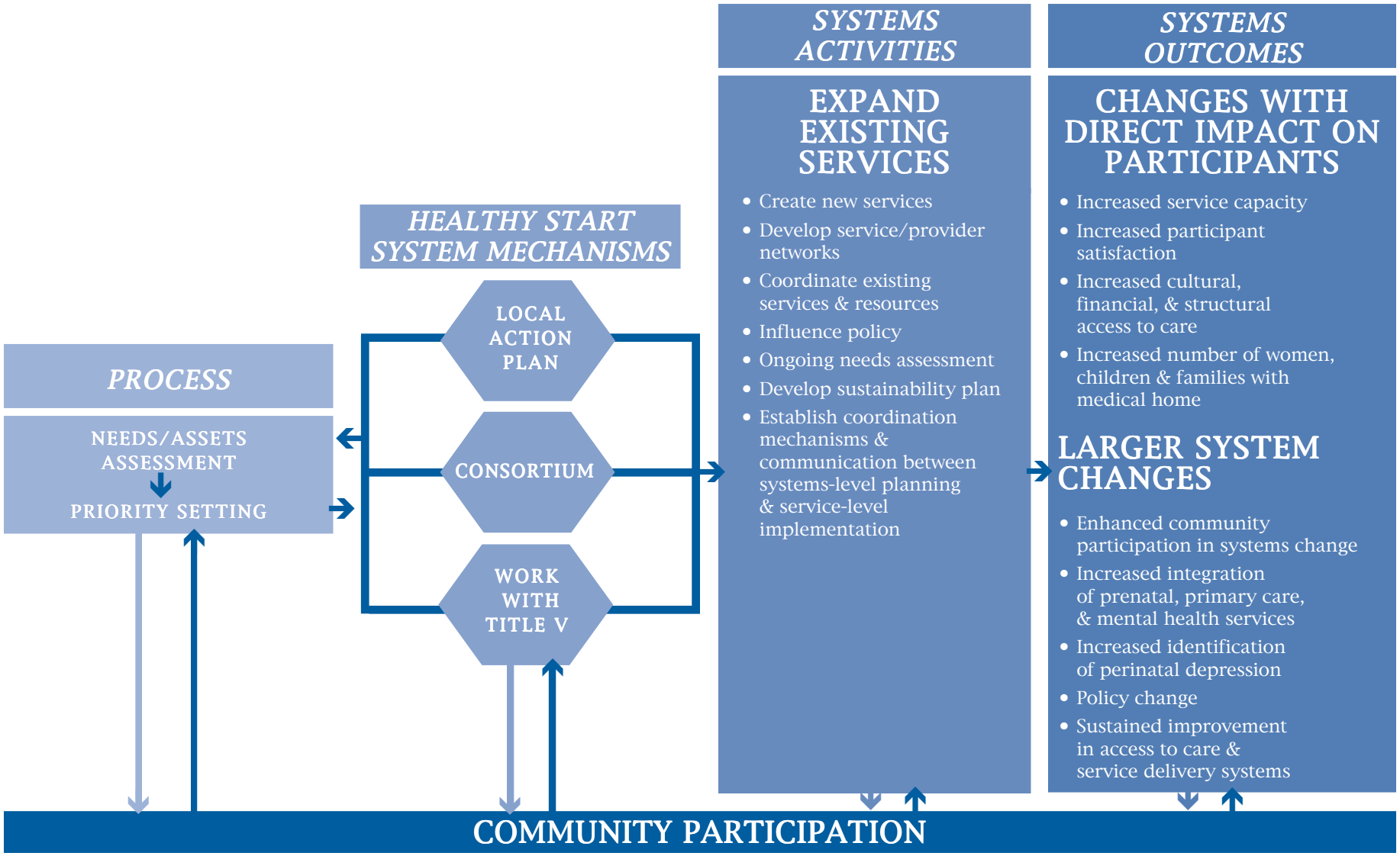
Appendix 1-1: Logic Model for the National Healthy Start Evaluation



Appendix 1-2: Hypothesized Link between Healthy Start Services & Results



Appendix 1-3: Hypothesized Link between Healthy Start Systems Efforts & Results



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