Reflections on the History of the Healthy Start Initiative

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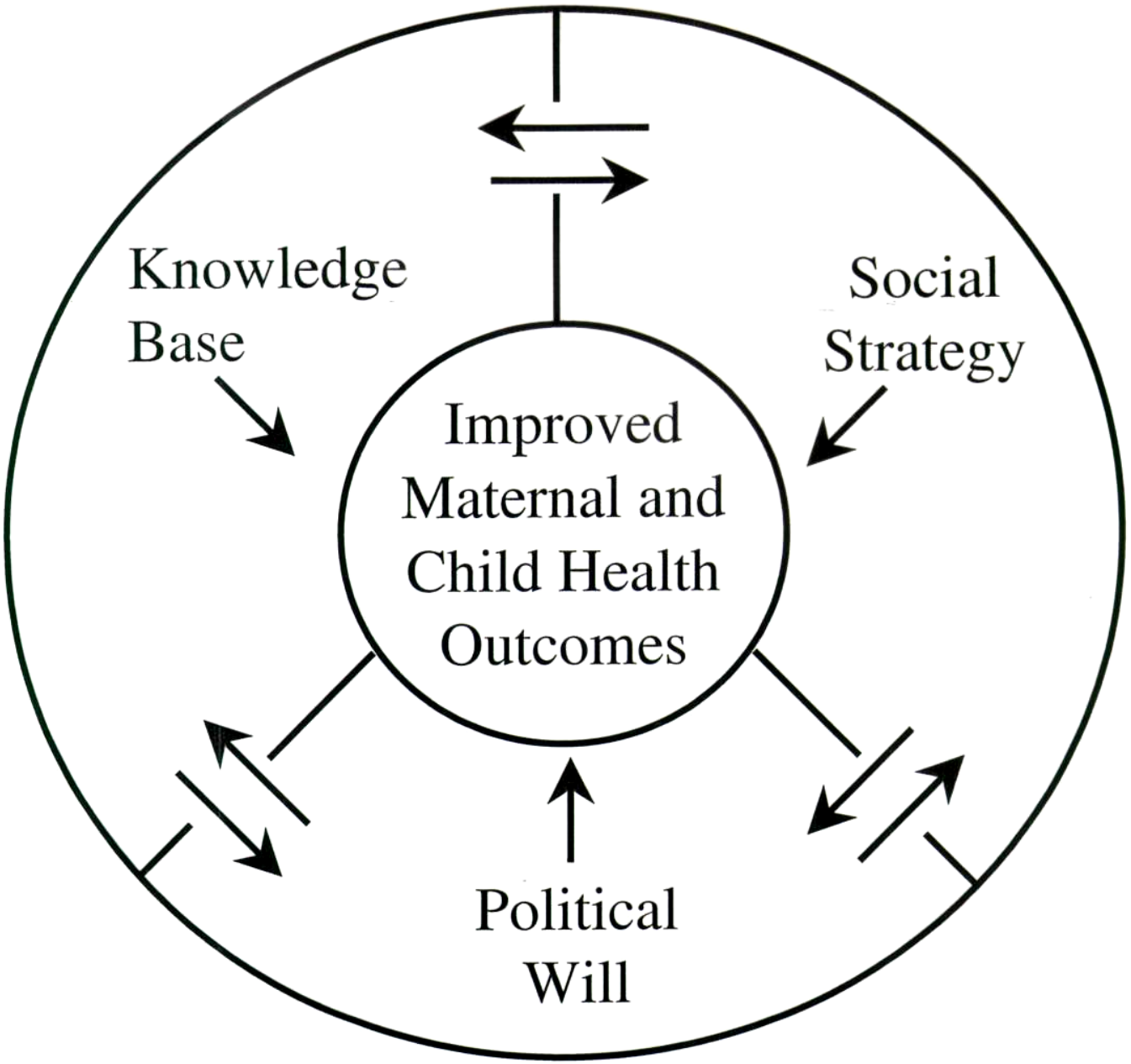
Knowledge Base
Social Strategy
Improved Maternal and Child Health Outcomes
Political Will

Origins of Healthy Start: context

- Builds off of three prior IPOs (Improved Pregnancy Outcome) Programmatic Initiatives (1965, 1978, 1987)
- Federal Interagency White House Task Force to Reduce Infant Mortality (1989)
  - Healthy Start was one of 18 proposals
  - Proposed by President George W. H. Bush (1991)
  - Goal to reduce IM by 50% in five years; Evaluate successes
- Final programmatic initiative of 2nd national era of Infant Mortality reduction - based on general belief that improved access to comprehensive prenatal care would reduce Infant Mortality and reduce disparities
- Community based initiatives had appeal to both the right (devolution of federal government) and left (community driven leadership)

Healthy Start Initiative (1.0)

- Community Driven Strategy
- Initial Programmatic Characteristics
  - Innovation; community commitment and involvement; increased acess to care; service integration; personal responsibility
  - Key components: community consortium; needs assessment; service package; service systems plan; public information and education plan; and evaluation plan
  - no specified menu of activities
- Eventually nine replication phase intervention models
  - Community-based consortia; care coordination/case management; outreach and client recruitment; family resource centers; enhanced clinical services; risk prevention and reduction; facilitating services; training and education; and adolescent services
- Consortia/Community Leadership was new
- Evaluation planned from the beginning
- 15 sites selected, received ~$4,600,000/ 5 years

Healthy Start Initiative (1.0): Unintended consequences; Both a rocky and an auspicious beginning

- Initial conflict over source of Healthy Start funding
- No unified vision of how to reduce Infant Mortality
  - communities implement best practices for local needs
  - perinatal/prenatal focused
- Directly funding Consortia didn't always prove workable
  - Consortia not always successful management organizations
  - State Title V, mayors not happy with governance
- Diminished broader focus on reproductive health in MCHB
- Partial abdication of federal programmatic content leadership, no national strategy on Infant Mortality

Healthy Start Initiative (1.0)

- Successfully implemented
- Strong local support, beginning of national Healthy Start movement
  - Authorized as part of Title V legislation in 1998
  - NHSA started in 1998
- Prior to the national evaluation results, Healthy Start began its growth (1996), albeit at smaller levels of funding with more modest interventions
- National Evaluation showed successful implementation, improved prenatal care, but no/limited impact on birth outcomes or disparities

Healthy Start National Evaluation Major Findings (Phase I)

1. Community-based programs could be successfully implemented
2. Very high risk populations were reached
3. Prenatal care utilization increased
4. No change in content of prenatal care, possible impact on family planning usage
5. Infant mortality was not reduced by 50%
6. No program impact on infant mortality
7. No program impact on LBW, prematurity
8. Four sites showed positive overall results

Healthy Start Initiative (2.0)

- HRSA policy dilemma
- Kotelchuck and Fine: Healthy Start Initiative: Strategic Assessment & Policy Options (2000)
  - Poor conception, poor implementation, or poor measurement
  - 38 specific recommendations
  - Rebalanced federal and local leadership
- Dr. Peter Van Dyck implemented report

Healthy Start (2.0): Kotelchuck and Fine: Healthy Start Strategic Assessment and Policy Options: Key Concepts

- No compelling science or grand overall theory of how to improve Reproductive Health, emphasis placed on what should be implemented/needed in every high risk community.
- Key new developmental idea; **extend Healthy Start focus from conception through two years of age**
- Organized programmatic initiatives around three core ideas, (9 required components)
- **Assure access/utilization of high-quality comprehensive health services for all HS participants** (beyond Title V services; ultimate safety net)
  - Outreach; Case Management; Health Education
  - Inter-conception Care; Maternal Depression Screening
- **Strengthen Local Health Systems**
  - Local Health Systems Action Plan; Sustainability; Improved Linkage to Title V
- **Bring a consumer/community voice to efforts to improve maternal and infant health**
  - Consortium; Programmatically institutionalize community voices
- Also extensive recommendations on program management, evaluation, communication, and federal/state/community partnerships.

Healthy Start (2.1, 2.2) Evolves

- Healthy Start utilized Kotelchuck and Fine strategic framework and continued to positively evolve
- New and improved content focus (direct health service content)
  - Inter-conception care collaborative
  - Maternal depression treatment
  - New topics – father involvement, pre-conception health, racism
- Continued expansion of sites/ decrease in funding
  - Four rounds of expansions, including border sites; now 105 sites with roughly $500,000-$1,000,000+ funding annually – no change in 9 core components/mandates
- Extensive comprehensive health services delivered by Healthy Start sites
- Improved national data gathering about participants and core project activities; continued national HS evaluations, though not outcome evaluations, and some further local evaluations
- Growth of strong NHSA; Increasing importance for training, advocacy,..
- Embraces pre-conception/inter-conception/life course focus

Healthy Start (2.0+) Reflections

- Healthy Start (2.0) will likely be seen as a transition in conceptualization of Infant Mortality improvement strategies from an PNC access to a more life course/women's health focused concept
- Healthy Start continues to lack a strong science base and an over-riding strategic conceptual framework
  - Increasingly removed from current early life sciences/ perinatal academics
  - Underlying strategic model still unclear (too prenatal/perinatal care focused to address root causes of disparities)
- Implementation of the three core programmatic recommendations mixed
  - Great strength in assuring utilization of high quality services for HS participants (enabling and health services)
  - Strengthening Local Health Systems has not worked well
  - Community voice, via consortium, is not that representative or articulate
- National evaluations continue, though not outcome evaluations, and evaluations not used for quality control

Healthy Start (2.0) Reflections

- Mixed implementation of managerial recommendations
  - No National Healthy Start Advisory Council established
  - Difficulty in recruiting new national director
    - Marybeth Badura became HS leader (1998-2010)
- Healthy Start has limited quality improvement orientation
- MCHB has abdicated much of its leadership role on reproductive health
  - Until recently, Healthy Start was MCHB's primary reproductive health initiative.
  - Healthy Start not part of a larger MCHB/HRSA reproductive health initiative;
  - CDC, MODs and others have moved into MCHB's leadership vacuum, e.g., pre-conception health, prematurity reduction
- Healthy Start appears to be a more isolated siloed program; Partnership development mixed
  - Limited or diminished ties with the clinical care community and their issues
  - Not well linked or included in other MCH programs, including Home Visiting
- Healthy Start has not reduced poor birth outcomes or reduced disparities

Healthy Start (3.0) Opportunities

- Healthy Start still able to engage the most high risk members of urban communities
- Programs exist in all major communities
- Only federal program with inter-conception focus or an exclusive focus on reproductive health and disparities
- Part of Title V legislation
- Strong NHSA and advocacy support
- Enthused by newer MCH Life Course theories
- New opportunities/mandates for change; New MCHB leadership, ACA, HHS National Infant Mortality Strategy
- Ten years of experience since last major revision, time for a re-assessment

Healthy Start (3.0) Opportunities; Initial thoughts

- Reinvigorate current reproductive and early life health and development sciences into Healthy Start
- Reframe Healthy Start within a life course framework (perhaps (late) pre-conception through 0-8)
- Healthy Start should become a component of a larger MCHB/HRSA coordinated Infant Mortality/reproductive health initiative – not its central element
- Healthy Start should improve the linkage of clinical and community efforts (continuity of prevention and intervention services)
- Healthy Start should drop its focus on Infant Mortality as its primary evaluative outcome measure
  - Be realistic about what it can truly achieve
  - Perhaps a focus on serving all high risk members of its community
- Healthy Start should adapt an explicit quality improvement orientation, goals and measurement

Healthy Start (3.0) Opportunities; Initial thoughts

- Re-focus on the three programmatic recommendations in the Kotelchuck and Fine Healthy Start Report
- Emphasize Healthy Start's great strengths in assuring access and utilization of comprehensive health services
  - Link to larger health navigator roles
  - Develop case management versus care coordinator roles
  - Assure new roles in Community Accountable Care Organizations
  - Link more explicitly to work force development roles
  - Add more Health Education on systemic root case themes impacting on reproductive health – eg Financial literacy
  - Empower of women, via group pre-natal and post-natal care
  - Utilize planned variations evaluation/quality improvement efforts to enhance these services
- Reconceptualize (and give guidance to) Local Health Systems Action Plans- as place-based community systems integrative initiatives
  - Link Healthy Start with Place based movements, systems integration efforts
  - Link reproductive health to 0-8 child development and parenthood systems
  - Utilize home visiting as means create early life systems of care
  - MCHB should give guidance on how to do this, but don't expect small sites to take lead – but be a central player on 0-8 systems linkage reforms
  - Improve handoffs of HS clients (and referrals of clients)
  - Parallel at community level, the state systems integration efforts
- Better Assure and Assess Community Voice
  - Move beyond consortia, as source of community voice
  - Engage in local social marketing, mother exchanges
  - Engage with PCORI initiatives
  - Empowered people

Healthy Start Historical Reflections

- Healthy Start (1.0) was the last federal program initiative deriving from increased access to comprehensive prenatal care movement (e.g., its focus is still predominantly on outreach, case management, health education)

- Healthy Start (2.0) reflects a transition to life course models, to an increased women, family orientation as source of disparities

- Healthy Start (2.0) remains too programmatically insular, and the funding of its multiple project sites are too small to be able to effect large scale change of the root causes of disparities

- Healthy Start (3.0) must become a component of larger reproductive, early life, and women's health system's integration initiatives- using the three enhanced HS programmatic efforts (with a key focus on assuring access and utilizing comprehensive health services)

- Healthy Start (3.0) must be part of efforts to improve the continuum of prevention/community-based and clinical intervention care;

The future

- It is time for Healthy Start to again refocus on its the goals, mission, theory of change, and programmatic initiatives.
- There are new perinatal opportunities through MCH life Course, Quality Improvement, placed-based models, PCORI initiatives, etc.
- ACA offers new opportunities and mandates for reproductive care and continuity, as well as the HHS National Infant Mortality Strategy.
- The core mission of Healthy Start to reduce reproductive healthy disparities in every community in the United States remains as needed as ever, it should still remain our national priority.

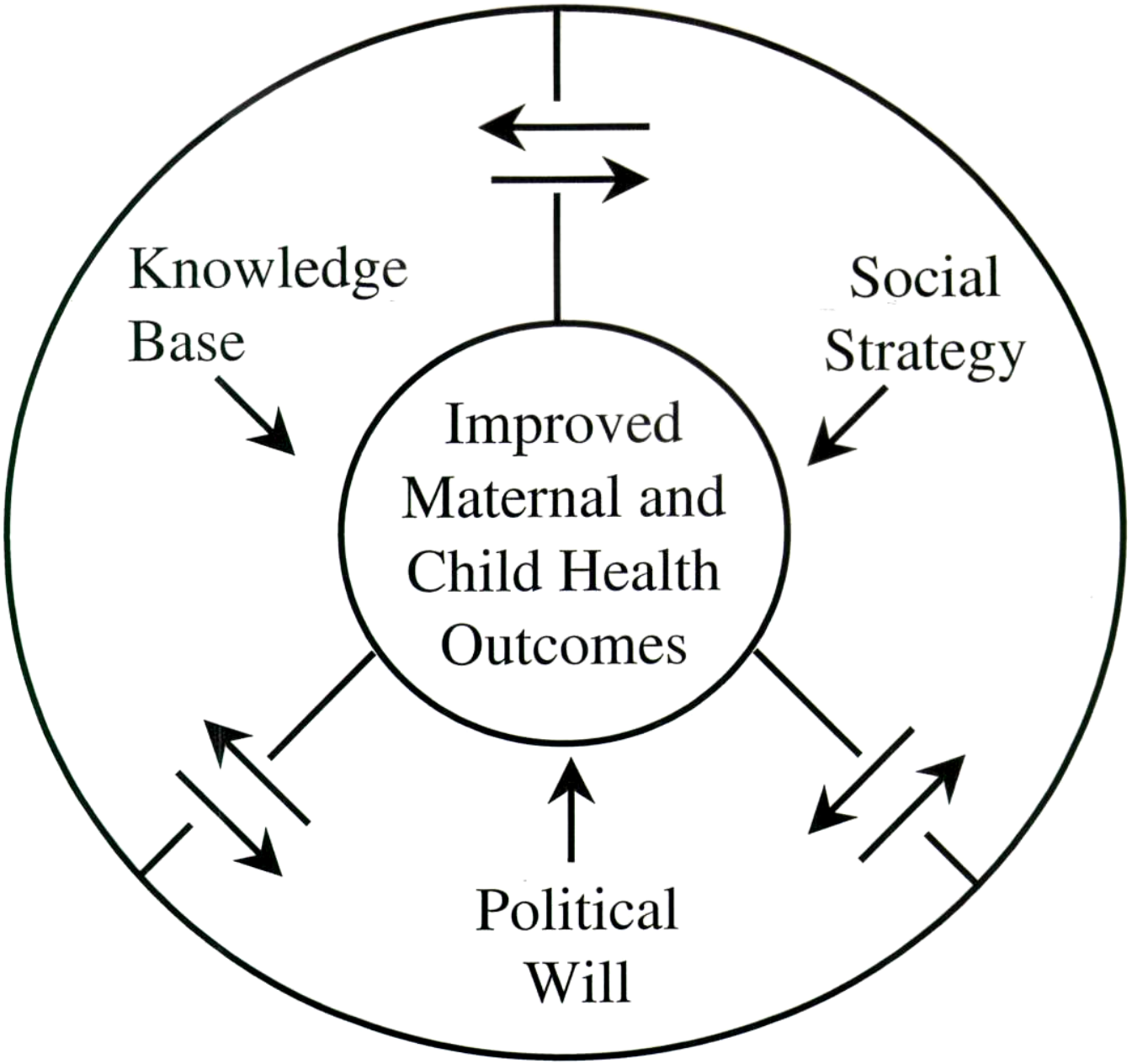
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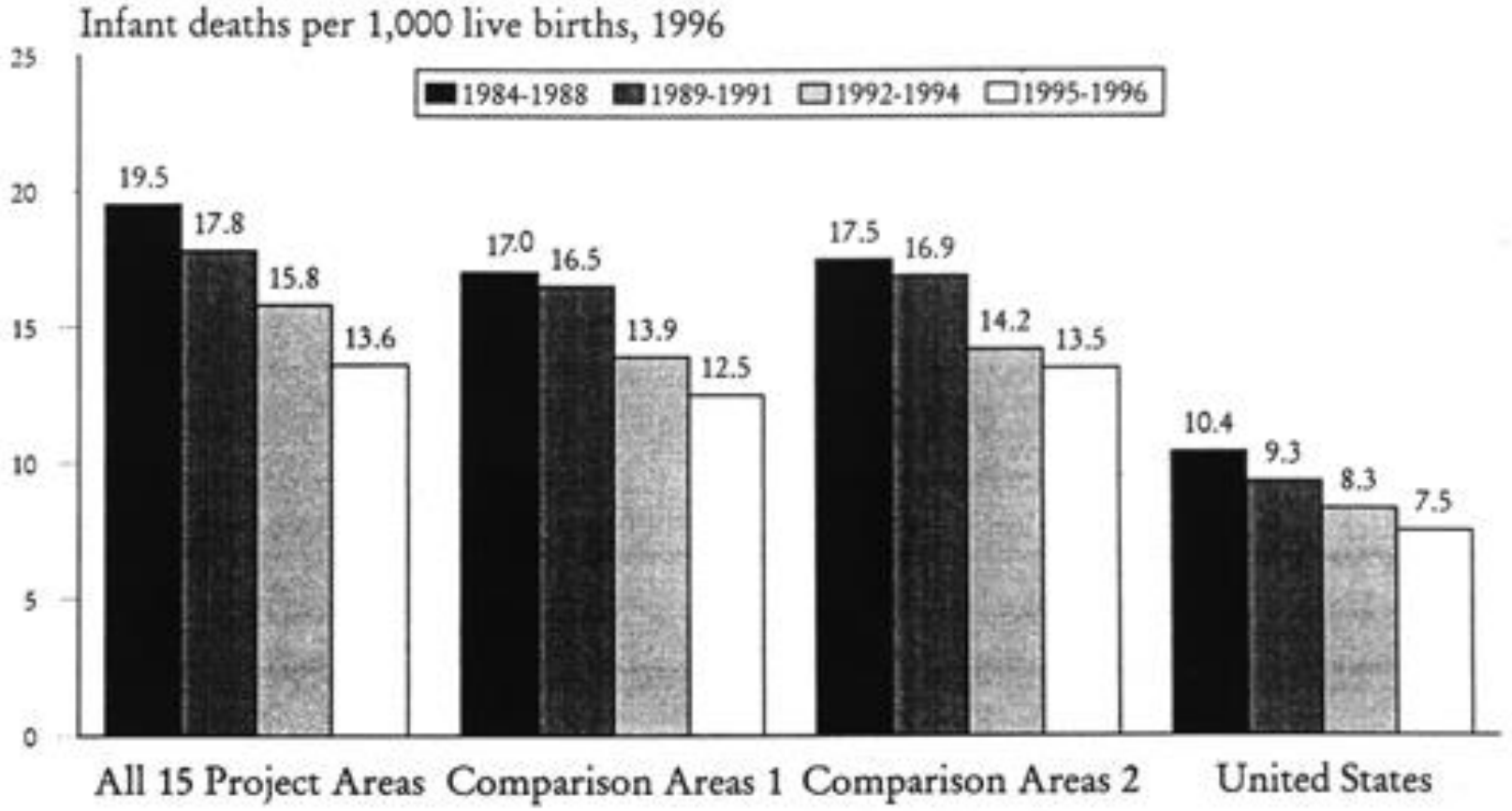
Figure 10

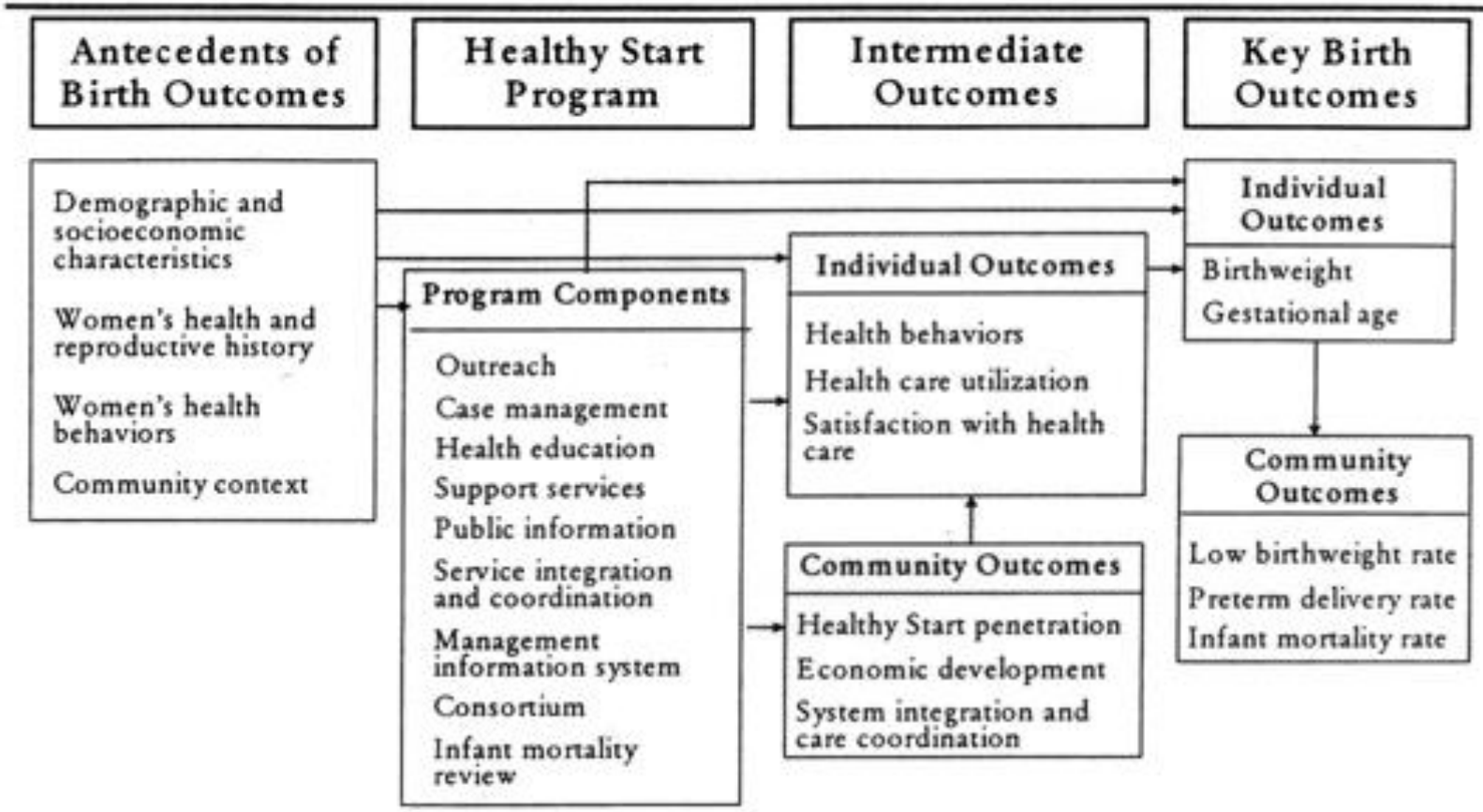
Infant Mortality Rates, Healthy Start Project Areas and Comparison Areas



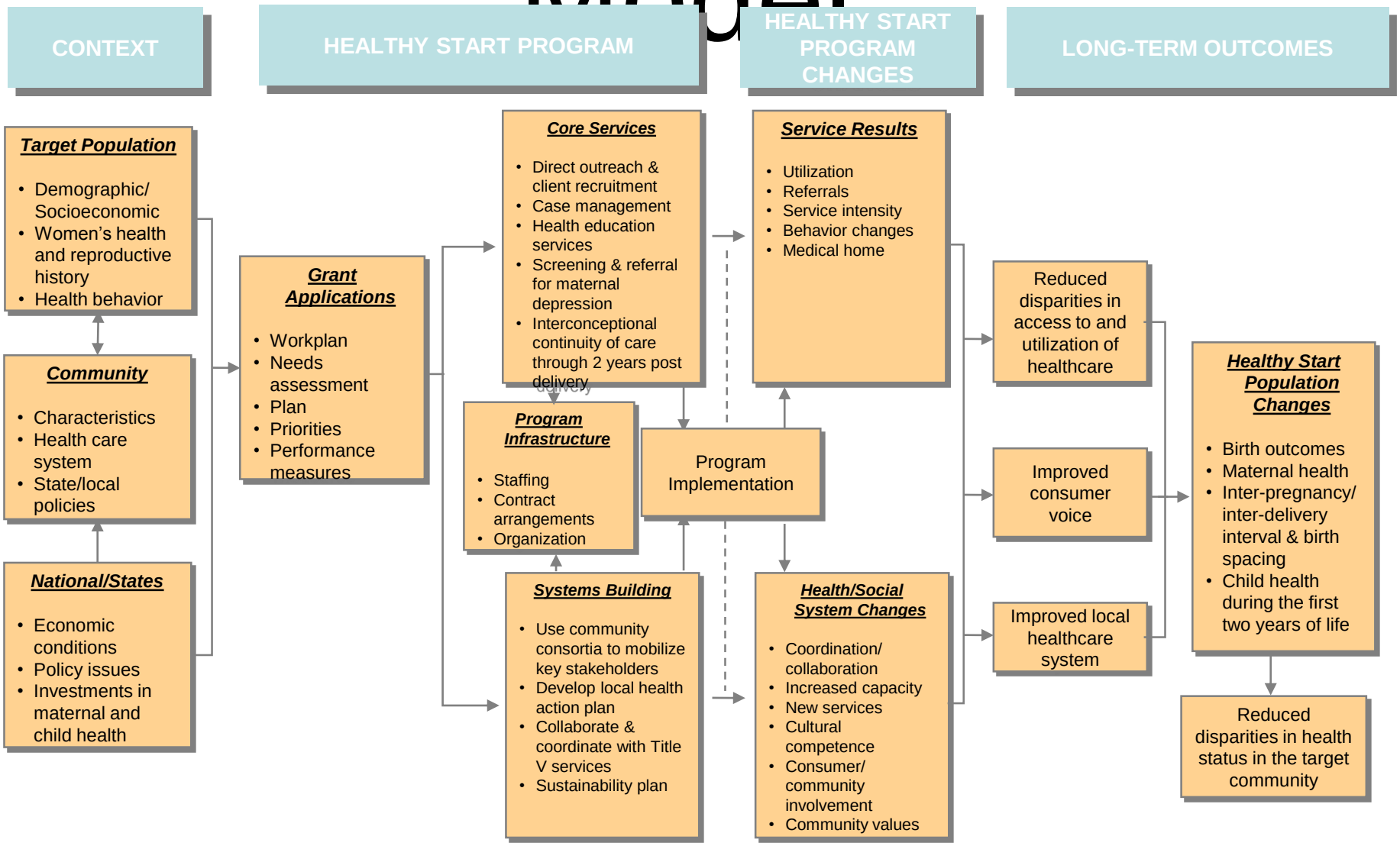
Source: State vital statistics birth and death files, 1984-1996.

Figure 1

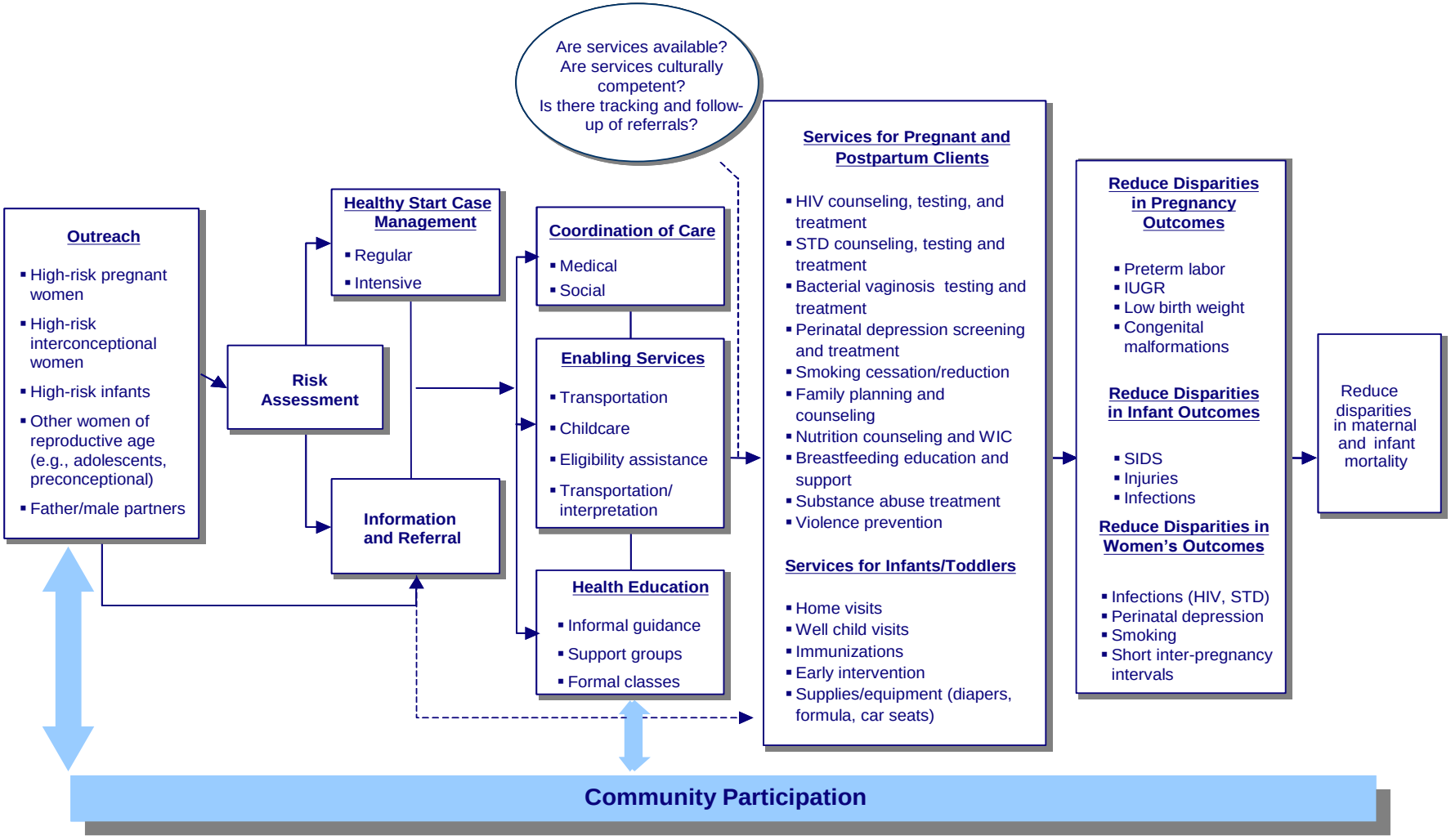
Conceptual Model of the Effects of Healthy Start



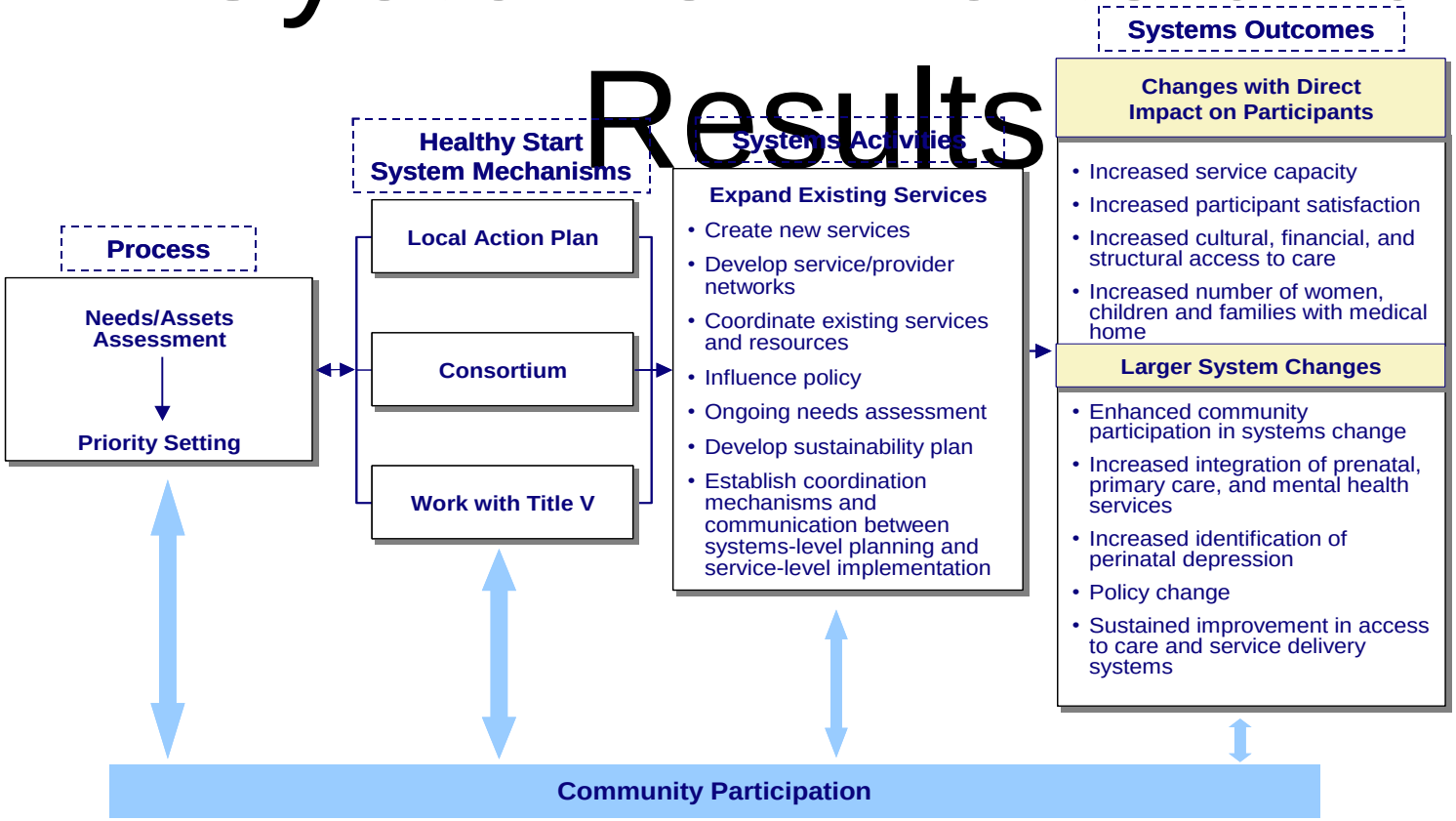
Healthy Start Logic Model



Conceptual Framework



between Healthy Start Systems Efforts and Results



The Healthy Start Initiative: Strategic Assessment & Policy Options

Milton Kotelchuck & Amy Fine

November 2000

Responses to Healthy Start Evaluation

- **Managing the national evaluation dissemination**
- **Strategic assessment and policy options**
- **Report (Kotelchuck and Fine)**
- **Modification and continuities in the Healthy Start Program**
- **New national Healthy Start leadership**
- **Permanent authorization of Healthy**

Healthy Start
Program Characteristics

Core

- Case Management
- Outreach
- Health Education
- Consortia
- Local Systems Action Plan
- Sustainability
- Coordination with State Title V Program

Optional

- High Risk Interconceptional Care
- Perinatal Depression

Core Services & Core Systems

- Outreach & client recruitment
- Case management
- Health education & training
- Interconceptional care
- Depression screening & referral
- Local health system action plan
- Consortium
- Collaboration & coordination with Title V MCH & other agencies
- Sustainability

MCH 20th Century Reproductive History Themes

- Improving the Birth Experiences for Mothers
- Maternity Insurance (Social/Community Orientation) versus Medical Care Focus to Enhance Maternal and Infant Health
- Public versus Private Responsibility for the Health of the Nation's MCH Populations
- Growth in emphasis on Women's Health (Beyond Reproductive Health or Infant Health
- Growth of Developmental Perspective (Broadened View of the Concept of Childhood)
- Enhancing MCH Knowledge/Database for

Evaluation must be incorporated into all phases of program cycle