

Summary of Findings from the 2017 National Healthy Start Evaluation

BACKGROUND

Healthy Start (HS) was established in 1991 by HRSA's Maternal and Child Health Bureau to improve health equity by providing services and interventions that improve birth outcomes and family wellbeing. In 2017, HS supported community interventions implemented by 100 grantees across 37 states and the District of Columbia.

This evaluation was intended to be the first large-scale, independent analysis of the data yielded from HS following its transformation and emphasis on the life course model – the comprehensive view of the individual, community, and societal factors influencing health outcomes (Lu & Halfon, 2003). The evaluation aimed to: (1) describe HS participants, allowing us to assess whether the program serves specific, intended populations; (2) identify factors among HS participants that are associated with a higher risk of adverse outcomes in order to inform targeted efforts of the program; and (3) compare maternal and infant health outcomes among the HS population to those among socio-demographically similar non-participants; as well as (4) compare participant outcomes to program targets.

HRSA experienced several limitations in executing the project, including data quality challenges, time-consuming data linkage processes, and a lack of baseline data that made it difficult to account for preexisting risk factors. The work ultimately resulted in a descriptive assessment of HS participants at a single point in time and represents the HS population in various stages of the reproductive cycle. Another limiting factor was the variability in the duration of services provided to individual clients during this time. Together, these factors have limited our ability to attribute observed differences to the program.

Although there were several challenges and limitations, we identified a number of key outcomes from the analysis. HS participants show positive outcomes related to program goals, including earlier and more-frequent prenatal care, greater engagement in infant safe sleep practices, and lower rates of low birth weight. HS participants also met or exceeded targets with respect to having a usual source of healthcare care and having been screened for depression. Participants did not, however, achieve program targets on receiving screenings for intimate partner violence (IPV), and on the duration of breastfeeding. These are seen as areas for program improvement.

DATA SOURCES

This point-in-time assessment includes data from the third year of a five-year grant cycle. Analytic samples were assessed using three data sources from the calendar year 2017: (1) program data for 29,112 HS participants and their infants from the Healthy Start Monitoring and Evaluation Data (HSMED) system; (2) Centers for Disease Control and Prevention Pregnancy Risk Assessment Monitoring System (PRAMS) data from 655 HS and 1,736 non-HS participants; and (3) live birth and infant death data for 7,932 HS and 459,196 non-HS participants from state vital records offices (VROs).

KEY FINDINGS

Who Does HS Serve?

Over half (56.8%) of HS participants for whom we had complete data and who had consented to participate in the evaluation were enrolled for services during pregnancy. This is consistent with the guidelines put forward for grantees in the 2014 Notice of Funding Opportunity (NOFO), which specifies that at least half of individual clients served must be pregnant women (i.e., in the prenatal phase). Approximately 28% of HS participants were postpartum women and 15% were participants enrolled for preconception and parenting/interconception services.

Overall, across all HS participants for whom we had complete data and who had consented to participate in the evaluation, the majority were under 35 years old, reported that they were Black/African-American, non-Hispanic, spoke English at home, did not have education beyond high school/GED completion, and had public health insurance, such as Medicaid. In addition, the majority reported living below the Federal Poverty Line (FPL), with incomes under \$20,000 per year. However, the FPL and income results should be interpreted with caution given the large percentage (>25%) of participants missing data for these items.

Differences among Healthy Start Participants

Tobacco Use: Participants with lower educational attainment, participants living below the poverty line, white participants (vs. Black participants), and non-Hispanic participants were more likely to use tobacco during pregnancy.

Breastfeeding: Participants with lower educational attainment were less likely to breastfeed.

Partner/Father Involvement: Participants living below the poverty line were less likely to have partner/father involvement.

Safe Sleep: Black/African American participants were less likely than White participants to use safe sleep practices.

Health Insurance: Participants who spoke a language other than English were less likely to have health insurance.

HS Participants Compared to non-HS Participants

HS participants were more likely than non-HS participants to have their first prenatal care visit at earlier weeks of gestation and more prenatal care visits. They also were more likely to follow recommended infant safe sleep practices (defined as placing the baby to sleep on his/her back and in his/her own crib or bed).

For HS participants, who were also part of the PRAMS analyses, they were less likely to have a low birthweight infant than non-HS participants.

We also found that HS participants were more likely to have pre-existing high blood pressure/hypertension than non-HS participants, which are risk indicators for poor birth outcomes. In the analysis comparing HS and non-HS participants, differences were not seen in some key pregnancy outcomes including preterm birth and infant mortality.

HS Participants' Outcomes Compared to Program Targets

Across relevant reproductive phases, HS participants were consistently at or above program targets on having a usual source of care for themselves and their children, and receiving depression screenings.

In contrast, HS participants were consistently below program targets on receiving screenings for intimate partner violence, and on the duration of breastfeeding.

CONCLUSIONS AND RECOMMENDATIONS

Who Does HS Serve?

Overall, the HS program primarily serves women in the prenatal and postpartum periods, with fewer participants in the preconception and interconception/parenting phases. HS may want to consider whether they want to increase participation of women in the preconception and interconception phases in the future.

In addition, HS participants who have not completed high school or a GED, and those living below the poverty line are at highest risk of selected adverse health outcomes. HS grantees could consider increasing outreach to these vulnerable populations.

A high proportion of HS participants reported using tobacco during pregnancy. The program could consider incorporating additional strategies to help participants quit smoking during pregnancy.

HS appears to be reaching women who are at higher risk medically, as evidenced by the greater prevalence of high blood pressure/hypertension among HS participants as compared to non-HS participants.

Whether this is due to recruitment efforts by the program or due to the desire of women at higher-risk to be more likely to seek care, HS programs could consider addressing high blood pressure/ hypertension among service recipients, as well as providing relevant education, resources, and referrals to reduce adverse pregnancy outcomes in this population.

HS Compared to non-HS Participants

HS participation was associated with several indicators of maternal and infant health, including prenatal care attendance, safe sleep practices, and infant birth weight. These findings may reflect HS program success in facilitating access to recommended prenatal care and encouraging safe sleep practices among participants.

If HS participants are, as a group, less healthy than non-HS participants, then the benefits of HS participation could be offset by their greater health risk, making the two groups appear similar in birth outcomes. Future analyses could address this by accounting for medical risk factors, such as hypertension, in the analytical plan.

HS Participants' Outcomes Compared to Program Targets

In the 2014 transformation of the HS program, HS established high standards for program performance, with some performance measures set at 100 percent of participants achieving a given outcome. Given this, it is noteworthy that across relevant reproductive phases, HS participants were consistently at or above program targets on having a usual source of care for themselves and their children, and in receiving depression screenings. In contrast, HS participants were consistently below program targets on receiving IPV screenings and engaging in breastfeeding. These findings suggest two areas of particular strength in program performance, and two areas needing improvement to meet target goals.

GENERAL SUMMARY

In summarizing, we identified a number of key outcomes and program recommendations. HS participants show positive outcomes related to program goals. These include earlier and more-frequent prenatal care, greater engagement in infant safe sleep practices, and lower rates of low birth weight. HS participants also met or exceeded targets with respect to usual source of care and depression screening. Finally, the HS program might be improved by ensuring participants receive IPV screening and support to extend the duration of breastfeeding.