THE NATIONAL HEALTHY START PROGRAM

• Developed in response to President George H.W. Bush’s call to re-energize progress toward better infant health

• Healthy Start established in 1991 as a 5-year demonstration project
THE NATIONAL HEALTHY START PROGRAM

• Secretary Sullivan recognized that a one-size-fits-all-approach to infant mortality and low birth weight would not work in underserved areas.

• Healthy Start was designed to allow local health care providers and community residents to develop individual programs that work best in their communities.
• Slow improvement in infant mortality

• We have to look at infant mortality through the eyes of the young mother herself

• We can do better – by:
  o Targeting communities where infant mortality is highest
  o Enlisting fuller community support
  o Encouraging innovation, and
  o Concentrating first and last on the real world of our "clients," young low-income women and their children
"Healthy Start" expectations:

• Community-wide commitment and innovative

• Government commitment:
  o Provide resources, and
  o Develop usable model programs that work

• Sustainability, and

• Replication and dissemination
THE NATIONAL HEALTHY START PROGRAM

Secretary Louis Sullivan, Healthy Start Press Conference 1991

• Federal investment:
  • 1991-1997: 15 sites
  • 1994-1997: 7 additional sites
  • 1998-2001: additional funding made available to “Replicate best models/lessons learned from the demonstration phase with existing sites serving as resource centers”;  
    o 20 Mentoring and 50-76 New Communities
Federal Healthy Start Projects, 2013

105 grants serving areas or populations in 191 counties located in 39 States, DC, and Puerto Rico.
9 core components:

- **Service Components:**
  - Outreach and participant recruitment,
  - Health education,
  - Case management,
  - Maternal depression screening, and
  - Interconception care services;

- **Systems-building components:**
  - Implementation of a consortium,
  - Development of local health system action plans,
  - Development of sustainability measures, and
  - Collaboration and coordination with Title V
How Have We Done?

• In 2010, over 90% of all healthy start sites were implementing all 9 core components.

• Most Healthy Start sites offer the following services:
  o Home visiting,
  o Breastfeeding support and education,
  o Smoking and other tobacco use cessation,
  o Healthy weight services,
  o Male and family involvement,
  o Domestic/intimate partner violence screening, and
  o Child abuse screening or services
How Have We Done?

The Good News: Statistics 2010

- Number of infant deaths = 90; Expected number of infant deaths = 172*
  - IMR in HS sites = 4.78 compared with 6.15 nationally, 5.2 for non-Hispanic Whites, 5.47 for Hispanics, and 11.63 for African Americans
- Number of babies born low birth-weight -1877
  - Low birth-weight rate =10% compared with 8.1% nationally, 7.14% for non-Hispanic Whites, 6.97% for Hispanics, and 13.53% for African Americans
- Number of babies born very low birth-weight 316
  - Very low birth-weight rate 1.7% compared with 1.45% nationally, 1.16% for non-Hispanic Whites, 1.2% for Hispanics, and 2.98% for African Americans

*Estimated number of infant deaths are race/ethnicity adjusted.
Percent of WHS participants who received prenatal care in first trimester

Source: WHS annual performance reports.
Westside Healthy Start Program - Chicago, IL

Percent of WHS participants who initiated breastfeeding

- CY 09: 46.6%
- CY 10: 46.2%
- CY 11: 47.9%
- Prelim CY 12: 60.6%

Source: WHS annual grant applications
Have We Lived Up To The Expectations Of Communities And Law Makers?

• Have we completed the “demonstration phase?”

• Have we “tested innovative, locally driven approaches to reach pregnant women and improve the health of their babies?”

• Have we “demonstrated the effectiveness of these approaches?”

• Are we able to “replicate best models/lessons learned from demonstration?”

• Have we “developed and implemented sustainable programs?”
“Now the test is over, and it is time to find out what worked and what did not.

- It is time to analyze as objectively as possible, the impact of Healthy Start initiatives on the leading causes of infant mortality.

- It is time to determine what Healthy Start demonstrated about the effectiveness and sustainability of community action to improve the health of infants at risk”.

Representative Christopher Shays (Connecticut)
• “The decisions affecting the lives of 30,000 babies each year should be based on facts, not hopes or theories.

• Federal policies and programs must be based on sound research and current data, not anecdotal information and purely local evaluation.

• Good intentions are no substitute for good health outcomes.

• We invite Healthy Start project directors to describe their work, to bring local solutions to a national problem.”

Representative Christopher Shays (Connecticut)
• On what basis did the Department declare the program a success?

• Can reductions in infant mortality rates be linked directly to Healthy Start initiatives prior to completion of a national evaluation?

• On what empirical data can communities rely to replicate the successes and avoid the missteps of Healthy Start?

*Representative Christopher Shays (Connecticut)*
Our Challenge

- Number of pregnant women served per year = 30,759
  0.78% of the 3,953,593 women who give birth in 2010

- Number of babies born in HS communities per year = 19,273
  0.49% of the 3,953,593 babies born nationally

- Number of infant deaths in Healthy Start sites = 90
  0.37% of the 24,586 infant deaths nationally
All US Deliveries in 2010
= 3,953,593

HS Deliveries in 2010
= 19,273
All US Infant Deaths in 2010
= 24,586

HS Infant Deaths in 2010
= 90
THE NATIONAL HEALTHY START PROGRAM

What Should Healthy Start be Doing Next?

We have a responsibility to:

• Demonstrate effectiveness with a focus on health outcomes
• Demonstrate sustainability and impact on systems
• Scale up and disseminate interventions to serve the larger population

We must respond to critics and acknowledge the need to change
THE NATIONAL HEALTHY START PROGRAM
HEALTHY START 3.0

Two Themes

1. Doing the right things, and

2. Doing things right
1. Informing policy to ensure access
2. Promoting resilience
3. Assuring cultural and linguistic competency
4. Ensuring consumer engagement and involvement, and
5. Promoting health equity
1. Community-Based Service Delivery
2. Comprehensive Health Care
3. Care Coordination
4. Systems Integration
5. Quality Improvement and Evaluation
1. Objectively proven effective interventions
2. Uniformly implemented interventions
3. Monitoring of interventions AND outcomes
4. Ongoing evaluation of activities and their impact
5. Feedback for action
6. Documentation of interventions and outcomes

• Research not published is research not done
THE NATIONAL HEALTHY START PROGRAM – 3.0
From Demonstration to Replication

- Build on lessons learned over the past 22 years
- Develop clear evidence-based tools and guidelines and practice for all interventions at all levels
- Ensure skilled workforce at all levels
THE NATIONAL HEALTHY START PROGRAM – 3.0
From Demonstration to Replication

Region 4 – Atlanta: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee
Region 5 – Chicago: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin
Region 6 – Dallas: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

• The CoIIN - Now in 19 States: Regions IV, V and VI

• Place Based Initiatives, Promise Zones, Best Baby Zones, Fatherhood Initiatives, Breastfeeding Initiatives, Home Visiting, etc

• Is Healthy Start at the table? Sharing experiences? Leading the way? Weren’t we there first?
THE NATIONAL HEALTHY START PROGRAM – 3.0
What Will It take?

• A strong infrastructure and competent management and guidance

• Knowledgeable, skilled, competent, passionate and hard working individuals AT ALL LEVELS

• A feedback loop including collection, analysis, dissemination and use of relevant data

• A strong consortium and meaningful collaboration with Title V and other relevant organizations

• Documentation, documentation, documentation!
Our Next Steps

- Division internal strategic plan
- Input from key stakeholders
- Strategic planning principles will be reflected in the guidance for funding in the future
For More Information

Hani Atrash, MD, MPH
5600 Fishers Lane
Rockville, MD 20852
Office: 301-443-0543
Direct: 301-443-7678
Email: hattrash@hrsa.gov