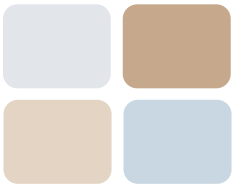
National Healthy Start Association AUGUST 2010

FEDERAL HEALTHY START INITIATIVE:

A National Network for Effective Home Visitation and Family Support Services



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FOREWORD

The federal Healthy Start Initiative has built its history and a substantial track record on serving vulnerable residents whose health and health care have been marginalized by virtue of race, gender, health status, economic status, and/or geography. Throughout its history, a variety of effective home visitation models have been deployed to achieve positive outcomes for some 524,484 women, children, and families in underserved urban and remote rural America (reported in 2007 Healthy Start grant reports).

The recent health reform legislation and the federal Healthy Start Initiative are aligned as both **strategy** and **response** for the delivery of key provisions for addressing the health and health care needs of women and families. After almost 20 years of serving more than 500,000 women and families, the original Healthy Start demonstration project, consisting of 15 projects, is now fully authorized by the Maternal and Child Health Bureau (MCHB) and has succeeded in ways that were not anticipated at its inception in 1991. Little did we know when we were originally funded to improve birth outcomes that Healthy Start would grow to 104 projects by 2010, and that not only would we be steadily improving birth outcomes at every one of those projects, but we would also be addressing health care outcomes across the life course.

The reviews of federal Healthy Start as a community-based core service centered program have focused on its impact on birth outcomes and the delivery of varied case management services to at-risk women living in vulnerable communities across our nation. But the true success of the federal Healthy Start Initiative is the nationwide delivery system that has emerged for addressing community needs specific to maternal and child health, as well as enhancing access to a continuum of health care and social services and supports for at-risk populations, inclusive of comprehensive preventive care services, women's health care, and the care coordination for chronic diseases taking place in both clinic and home settings.

The collaboration and integration of health care and social service professionals with community health workers fostered by the network of Healthy Start projects is well-grounded in communities. With its commitment to culturally responsive and inclusive care delivery systems and protocols the services are adapted to the unique needs of each of the 104 federally-funded Healthy Start projects. More than any other family support initiative, federal Healthy Start has a grassroots foundation with an enrolled base of program participants that are actively engaged in managing their health care through the assistance of community health workers, whom they know and trust. Program participants are empowered to participate in a system of care where they have access to a continuum of services for every member of their family, all coordinated through one point of contact. Through community consortia, a key ingredient to the implementation of promising practices, communities lend their voices to help fashion health care delivery as an essential part of their lives. Thus, federal Healthy Start is distinguished as a unique delivery system where program participants are engaged and active in the quest to eliminate health disparities in their own lives, in their communities, and across the nation.

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EXECUTIVE SUMMARY

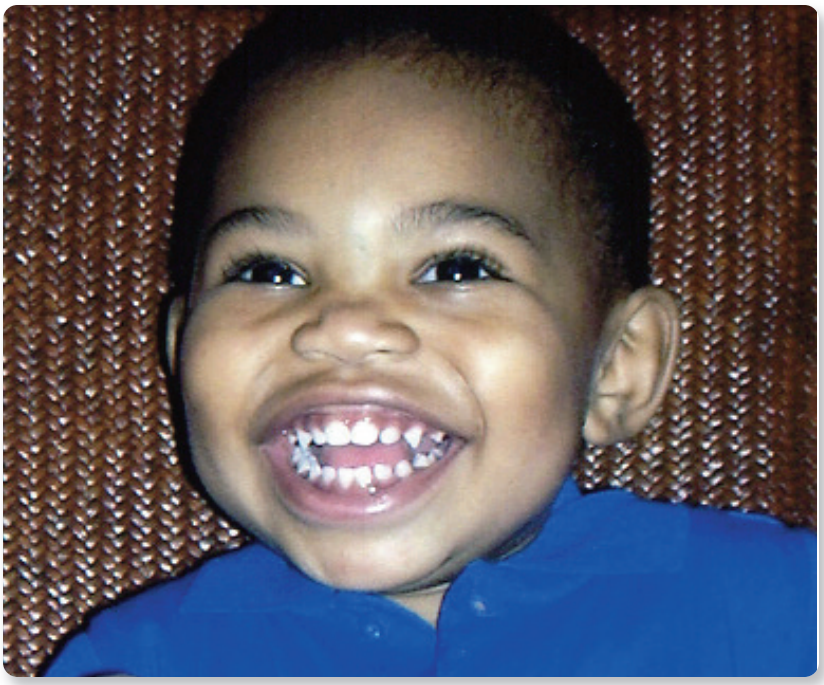
The federal Healthy Start Initiative has been an integral, though often unrecognized, part of this nation's health care safety net for 20 years. Federal Healthy Start has built its history and a substantial track record on serving vulnerable residents whose health and health care have been marginalized by virtue of race, gender, health status, economic status, and/or geography. Throughout its history, effective home visitation models have been deployed to achieve positive outcomes for some 524,484 women, children, and families in underserved urban and remote rural America. This impressive and steady growth has been accompanied by a relatively modest investment by the federal government with a return that has been at least as much in savings as was spent – savings resulting from projects moving low weight births to healthy higher weight births and thus avoiding expensive and lengthy hospital stays as well as the costs of continued care throughout the early years of life and possibly beyond.

Currently, the major implication of federal Healthy Start with regard to the newly emerging landscape under health reform (community-based participatory approaches, the development of evidence-based and best/promising practices, and systems change and policy development) is an important one. The program provides a defined framework or core components to improve health outcomes, and to engage disenfranchised populations, including: outreach and participant recruitment; case management/home visiting; health education; maternal depression screening and referral; and interconceptional care**. Federal Healthy Start represents a network with 20 years of experience and cultural authenticity to assist in serving underserved and marginalized communities throughout our nation.** It is an evidence-informed, community-driven model of home visitation and service delivery. Additionally, federal Healthy Start is one of the only Health Resources and Services Administration (HRSA) program initiatives that both seeks out and works directly with the vulnerable populations in America and creates the linkages necessary to coordinate and translate the efforts of other federal programs to address the provisions of health reformat local levels across America and across the life course.

Community involvement is probably the feature of federal Healthy Start that most distinguishes it from previous maternal and child health programs. Placing community engagement and mobilization at the center of all thought and action, has provided an expanded lens through which all our partners could see us. This approach increases civic engagement, utilizes social capital, and fosters resiliency in communities by building on the strengths and assets of caring citizens who take responsibility for themselves, their families, and their communities.

The true success of federal Healthy Start has been the fact that this network of projects is successfully emerging as a delivery system for addressing not just community needs specific to maternal and child health but for enhancing access to a continuum of care and social supports for vulnerable populations that include comprehensive preventive services, women's health, and care coordination of chronic diseases both in clinic and other group settings and in participant homes. Specifically, federal Healthy Start incorporates provisions such as:

- **Preventive care/**linkages to medical homes during preconception and interconceptional periods;
- Holistic and inclusive supportive services for **women's health** throughout their life course;
- In-home and clinic/in-center targeted services and care coordination for **chronic diseases**;
- Core services provided through **evidence-based and promising home visitation practices**;
- Core services provided through **Community Health Workers and professional staff**;
- Services that have the overarching goal of **reducing perinatal disparities**; and
- A means to access **low cost, high quality health care options**.



Central Hillsborough Healthy Start

INTRODUCTION

The federal Healthy Start Initiative, with its cost-effective, community-driven model of care, has a major role to play in the historic Health Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program's national efforts to build quality, comprehensive statewide early childhood systems for pregnant women, parents, caregivers and children from birth to eight years. The 104 federal Healthy Start sites are "shovel ready" to assist in improving quality of health care, enhancing disease prevention and strengthening the health care workforce.

Over the course of the next several years as health reform rolls out, some 32 million newly insured Americans needing a plethora of services are set to flood our nation's health care delivery system. Additionally, greater focus on prevention, social determinants of health, and racial/ethnic and socioeconomic inequalities in health and community-based health care models will stretch already scarce providers of care to the limit. The federal government, as well as other organizations committed to educating, organizing, and advocating for change, will need a well-tested, successful delivery system of preventive care like federal Healthy Start to assist in implementing the key provisions of health reform as well as health equity promotion in a timely and efficient fashion.

The policy implication of the 20 year work of the Federal Healthy Start Initiative emanates from the fact that low birth weight and fetal-infant morbidity in disadvantaged communities such as the ones highlighted in this paper can be reduced. It is therefore essential that government support, especially in terms of financial infusion, be maintained and increased to support the current federal Healthy Start programs as well as new Healthy Start programs so that the persistent health disparities suffered by disadvantaged groups right from birth can be reduced over time. Federal Healthy Start is committed to continuing the work that we have started. We desire to maintain the partnerships we have built with local, state, and national partners who have worked tirelessly to help us achieve the success documented in this paper, and we seek ongoing funding for both current and new federal Healthy Start sites because every baby deserves a Healthy Start.

Soon the federal government will need a well-tested delivery system like the federal Healthy Start Initiative to assist in implementing the key provisions of health reform in a timely and efficient fashion. We STAND ready!

BRIEF HISTORY OF THE FEDERAL HEALTHY START INITIATIVE

The infant mortality rate in the United States saw an overall decline throughout the 1980's and 1990's. The first Bush administration was concerned about the international ranking of the U.S. infant mortality rate (21st in infant mortality of industrialized nations), and the international standing appeared to be deteriorating. In 1989, George HW Bush created the White House Task Force to Reduce Infant Mortality. The Task Force consisted of representatives from the Departments of Health and Human Services (HHS), Housing and Urban Development, Education, Commerce, and the Centers for Disease Control (CDC). The Task Force was asked to research disparities and to recommend interventions that could assist the nation in decreasing infant mortality rates. Federal Healthy Start was one of several funded activities recommended by the Task Force and was initiated as a five-year demonstration project. Originally, 15 urban and rural projects, in areas with infant mortality rates 1.5 to 2.5 times higher than the national average, were funded to implement innovative approaches to improve birth outcomes. Communities were charged with developing community-based efforts to reduce infant mortality by 50% within the four year project period and to improve the health and welfare of women, infants, and their families. The funding for the original 15 sites was extended by one year until 1996 to ensure 5 years of comprehensive implementation.

In 1994, seven additional sites were funded with the goal of reducing infant mortality through more limited interventions. These seven sites were considered special projects. In 1997, lessons learned from the first 22 sites were used to fund 55 replication sites as federal Healthy Start moved into Phase II. These sites were charged with replicating four core components of the original 15 sites: outreach, case management, health education, and community consortiums. Many of these projects were also mentored by the first 22 sites.

In 1999, 19 additional projects were added with a specific focus on eliminating racial and ethnic disparities in perinatal health. Three more sites were added in 2000. These three sites began with a one-year infrastructure/capacity-building phase. In 2001, federal Healthy Start moved into Phase III and added nine additional sites, and in 2002, 12 existing sites who were previously "approved, but not funded" were added for a total of 96 federally-funded Healthy Start sites.

Phase IV began with the refunding of the 96 sites and the addition of one grantee in June 2005. In 2007, two Border Health Projects were added. In 2009, three Eliminating Racial and Ethnic Disparities grantees were added, and in 2010, two additional sites were added, bringing us to our current total of 104 Healthy Start projects in 39 states, the District of Columbia, and Puerto Rico. Originally funded under the authority of Section 301 of the Public Health Services Act, Healthy Start was authorized by the United States Congress as part of the Children's Health Act of 2000 under the Clinton Administration. Healthy Start was re-authorized in 2008 under the Bush Administration.

Since its initiation in 1991, federal Healthy Start has served hundreds of thousands of families, and over 90% of those families have been African American, Hispanic, Native American, Native Hawaiian, or Appalachian. Federal Healthy Start Core Components and Services have evolved into:

- Outreach
- Case Management
- Health Education
- Interconceptional Care
- Depression Screening and Referral

Correspondingly, as indentified in the federal Health Care Reform Legislation (HR 3590), federal Healthy Start has a history of addressing factors that adversely impact health through its services and collaborations that include:

- Poverty
- Crime
- Domestic violence
- High rates of high-school drop-outs
- Substance abuse
- Unemployment
- Child maltreatment

STRONG ROOTS, HEALTHY FRUIT: OVERVIEW OF FEDERAL HEALTHY START NETWORK AND CORE SERVICES

Federal Healthy Start offers a unique delivery system of health and social services to pregnant and parenting (interconceptional) women while simultaneously providing Maternal and Child Health (MCH) home visiting promising practices that implement standardized core services developed by MCHB. As a network rooted in the local community, federal Healthy Start has the keen ability to absorb other practice models within its overall service structure. Within a number of the 104 federal Healthy Start sites, there are elements of several evidence-based and promising practice models being used independently or as stand-alone models of care, allowing federal Healthy Starts sites to vibrantly and successfully execute the core services of the federal Healthy Start framework. There are five direct practice core services and four systems building core components that define the federal Healthy Start model.

Healthy Start Direct Practice Core Services

Outreach & Participant Recruitment — Each of the federal Healthy Start programs targets a segment of their population that is at-risk for poor pregnancy outcomes or family support issues. The program hires dedicated outreach and/or professional staff that are responsible for developing and implementing an annual outreach and participant recruitment plan. Very specific messages and value propositions are delivered to each targeted area, and these are communicated through a variety of delivery channels to persuade pregnant and parenting (interconceptional) women to enroll into the program. Healthy Start projects target a variety of women: first-time moms, women with previous pregnancy complications, teenagers, substance abusing women, homeless women, women released from prison or currently serving time in a work release facility, women over thirty-five years of age, immigrant women, and women with family support issues. Healthy Start programs are experts at executing social marketing core principles to recruit at-risk women into their service network.

Home Visitation/Case Management — Federal Healthy Start programs utilize home visiting/case management interventions as their main tool to manage the care of pregnant and parenting (interconceptional) women, and some projects combine those home visits with group education and clinic visits based on community and individual participant need. Each local project has a well-defined intake and screening process that ensures all women who reside in a Healthy Start targeted area who meet program criteria are enrolled in the program and are connected to a medical/wellness home. If the client does not meet program criteria or is not interested in services, Healthy Start procedures are well documented to ensure that the client is connected to appropriate community resources. All projects have a clinical assessment procedure that identifies program participant assets and deficits and develops goals to ensure a healthy baby and a healthy mommy, pre- and post-pregnancy. All participants are involved in developing their own service plans that have specific, measurable, realistic, and time-framed goals and tasks to achieve their clinical, interconceptional, educational, work-force development, and relationship-building objectives. Healthy Start programs incorporate case conferencing, charting, quality assurance, and supervisory policies and procedures to ensure that individual and program performance objectives are achieved.

Federal Healthy Start programs utilize a variety of home visiting/case management approaches to achieve the goals outlined above. Some Healthy Start programs use the Nurse Family Partnership (NFP), Healthy Families America (HFA), or Parents as Teachers (PAT) models while other programs choose to modify those models or create their own models using a mixed provider model that is a combination of lay or Community Health Workers and Registered Nurses to provide the home visits and other wraparound services. Regardless of the home visit service delivery model selected, each project adheres to specific, defined protocols for initial and on-going staff training, screening, selection, assessment, outcomes, and risk-appropriate service provision. Services are participant-centered, with anticipatory guidance by the home visitor, and on-going assessment of achievement of goals to ensure the fidelity to the model and protocols selected. In addition, at a number of the Healthy Start programs, home visitation services are delivered in tandem with group prenatal care and/or group education. Use of both evidence-based and promising practice models of care offer the flexibility of the programs to adapt to the specific needs of the population they are serving while also addressing level funding issues. Please refer to the attached Federal Healthy Start Logic Model for a visual approach to the home visitation protocols and systems utilized to achieve individual and system development goals and successes.

Perinatal and Parental Health Education — Federal Healthy Start ensures that pregnant and parenting (interconceptional) women are knowledgeable about a variety of health education topics to prepare them to have healthy babies and adopt a healthy lifestyle. Healthy Start providers conduct individual and group health education sessions with program participants. The provider team reviews individual and program data from the intake and assessment stage to ascertain the specific pregnancy, general healthcare, and personal hygiene education needed. Although Healthy Start programs do not use a common curriculum, all curriculum and supplemental materials are from evidence-based and promising practice sources. All Healthy Start providers

receive extensive training on how to utilize the curriculum and materials prior to delivering the education to the program participant and her family. The following health education topics are offered to enrolled participants:

- Nutrition for the pregnant, breastfeeding, and interconceptional woman;
- Prenatal care (why various tests are performed) and preterm labor;
- Signs and symptoms of preterm labor;
- Prevention, early detection, testing, and treatment for HIV and STIs, especially syphilis;
- Stress prevention and management;
- Family violence and relationships;
- Smoking cessation education and referral;
- Substance abuse prevention and treatment;
- Safe sleep;
- Breastfeeding;
- Infant care and development;
- Car seat safety;
- Infant parental bonding;
- Importance of father's involvement;
- Home safety and travel safety for the infant and toddler;
- Family planning and interconceptional care; and
- Prevention, management, and impact of chronic diseases such as diabetes, hypertension, obesity, asthma, and depression on pregnancy outcomes.

Maternal Depression Screening & Referral — All federal Healthy Start programs are mandated to conduct depression screening and refer positively screened women for treatment. Healthy Start providers receive training on the use and interpretation of the screening tools used by their program in addition to characteristics and interventions of perinatal mood disorders. A variety of evidence-based screening tools (Edinburgh Postnatal Depression Scale Tool, Beck Depression Tool) are administered for both pregnant and interconceptional women. Depression screening must be completed by the third visit for pregnant and parenting women. Program participants are to be screened at six month intervals following the first screening and again during the postpartum (interconceptional) period. All Healthy Start programs are responsible for developing clinical capacity at the local level to refer formally diagnosed women for ongoing group and individual talking therapies and/or medication treatment and compliance.

Interconceptional Care — Healthy Start programs are responsible for continuity of care through two years post-delivery for each program participant and her family. According to Dr. Michael Lu, Associate Professor of Obstetrics and Gynecology and Public Health at UCLA, interconceptional care is defined as "a set of interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management from the conception of one pregnancy to the conception of the next pregnancy." Per the Healthy Start interconceptional care protocol, program participants will develop a reproductive life plan with their Healthy Start provider that will plot when mom and her significant other plan to have their next child. During this eighteen month to three year planning period, the program participant and Healthy Start provider develop specific goals for the postpartum examination, weight loss objectives and tasks, childcare, birth spacing, folic acid intake, chronic disease management, birth control methods, mental health screening and treatment considerations, and stabilizing personal and family relationships. Promotion of and referrals to preconception health care, reproductive history, genetic counseling, and substance use cessation and support are addressed during this level of service offered to Healthy Start program participants.

Healthy Start Systems Building Core Services

Federal Healthy Start differentiates itself from other evidence-based home visiting programs by integrating four key system development core components as part of its model of care. These components are designed to move beyond individual interventions to address systemic barriers impacting maternal and child health and well-being. The rationale for developing a systems strategy was communicated by the Secretary's Advisory Committee on Infant Mortality (SACIM) in a 2002 report to the HHS Secretary which stated, "Healthy Start interventions are inherently limited in their focus and cannot change systemic structures such as insurance coverage, hospital practices, unemployment, poverty, and violence in the community. It is unrealistic to expect that community coalitions and case management can impact infant mortality rates. In summary, Healthy Start interventions implemented in the demonstration phase could not be expected to have an impact on infant mortality rates unless other systemic changes which remove barriers to care had been made at the same time."

Community Consortium — Every Healthy Start program is mandated to organize a Community Consortium that is made up of program participants, community members, and providers who serve as an Advisory Board to the Healthy Start staffing structure. The consortium provides advice on new community health needs, helps to evaluate the Healthy Start program, completes advocacy and communication tasks, and promotes the social and economic development of consumers of Healthy Start services. Consortium members also participate in helping to financially sustain the Healthy Start program, participate in the execution of the Local Health Systems Action Plan (LHSAP) and works with staff to build strong relationships with their State Title V Agency.

Local Health Systems Action Plan (LHSAP) — The LHSAP is developed during the competitive Healthy Start application stage where each applicant must develop a five year action plan to transform systems that negatively impact infant and maternal health. Each Healthy Start program develops a comprehensive needs assessment that identifies structural and environmental barriers to reducing local infant mortality and low birth weight rates. The LHSAP identifies one or two systems barriers and develops specific, time-framed, and measurable objectives and tasks to overcome the barriers. Examples of health system actions are: developing a plan to recruit more nurses at a local hospital; developing a business plan to start-up a birthing center; and educating the local municipal government to sustain and expand the work of the Healthy Start program or developing a job readiness program for Healthy Start program participants.

Collaborate with State Title V Agency — The Human Resources and Services Administration Maternal and Child Health Bureau (HRSA/MCHB) mandates that all Healthy Start programs develop a collaborative relationship with their state Health Department and align Healthy Start public health and systems agendas with the State Title V Block Grant priorities. Examples of Title V coordinating activities are: building more maternal mental health clinic capacity; assisting in developing a regionalized system of perinatal care; or working with the Health Department on health workforce development goals. Other Healthy Start projects have worked with their state Medicaid agency to pay for Healthy Start home visitation, case management, and health education services, integrating primary care and substance abuse services in hospital settings, and integrating life course and interconceptional principles in the day-to-day work of the Health Department. Implementing the above actions assists pregnant and parenting (interconceptional) women to improve the health of the newborn and women's health over the life course.

Healthy Start Sustainability Plan — All Healthy Start programs are mandated by MCHB to develop five year sustainability plans and action steps to prepare the program to continue in the local community after HRSA/MCHB funding ends. Local projects have developed comprehensive plans to secure state Medicaid funding to sustain core Healthy Start direct practice and system components. Other programs have taken their core competencies and developed income producing businesses where the profits are allocated to meet Healthy Start program sustainability needs. Still other entities have developed elaborate fund development plans by writing proposals to secure funding from local, state, and federal funding streams and private foundations to sustain Healthy Start core components. Finally, some programs have developed local public health social movements through media campaigns and consumer direct actions to convince local governments (i.e. Mayor's Office & City Council) to allocate city tax-levy dollars to sustain Healthy Start's core direct practice and systems development components.

These systems components are crucial to explaining why Healthy Start is a "shovel ready" network for home visitation. For example, systems components like coordination/collaboration with Title V and other entities and the LHSAP links federal Healthy Start programs to larger geographically-based public health planning efforts and supports the premise that local Healthy Start projects have the skills and connections to coordinate family home visitation for perinatal health, immunizations, and chronic disease management.

KEY ATTRIBUTES OF THE FEDERAL HEALTHY START HOME VISITATION MODEL

As states continue the intense process of creating a needs assessment for the Maternal, Infant and Early Childhood Home Visitation Program under the Patient Protection and Affordable Care Act, they will also be charged with identifying those home visitation models and programs that the Administration for Children and Families (ACF) and HRSA have deemed evidence-based and have demonstrated that they improve outcomes for families.

The federal Healthy Start mixed provider model used by most federal Healthy Start projects using lay or Community Health Workers, or a combination of Community Health Workers and professionals, has proven to work to improve the quality of care among individuals (Witmer, Seifer, Finocchio, Leslie, & O'Neil, 1995). Used in some of the most disadvantaged areas, many of which are served by federal Healthy Start, Community Health Workers serve as the conduit between the communities they work in and the health care delivery system. Studies have shown that in this role, Community Health Workers can increase access to care and help participants facilitate appropriate use of health resources by providing outreach and cultural linkages between communities and delivery systems (Witmer, et.al., 1995). It is important to utilize individuals who resonate with the community and reflect the culture of that community as a method of building trust. The literature has shown that using "health promoters, Promotoras, or Community Health Workers" is effective as seen in the late 1960s through the Indian Health Service's Community Health Representative programs (Murphy, 1995), in the 1980s with low-income African American women around cancer screening (Sung, Blumenthal, Coates, Williams, Alema-Mensah, & Liff, 1997), and in 1989 among Hispanic mothers at risk for not seeking prenatal care in a program funded by the March of Dimes (Mahan, McFarlane, & Golden, 1991).

Using Community Health Workers also reduces costs when they provide health education, screening, detection, and basic emergency care. Mahan, McFarlane, and Golden also found that it improves quality by contributing to patient-provider communication, continuity of care, and consumer protection. To that end, Community Health Workers are also inexpensive to train, hire, and supervise (Giblin, 1989).

As it pertains to improving birth and pregnancy outcomes, research has shown that the Community Health Worker's role and contribution can improve childhood immunization rates (Stewart & Hood, 1970) and decrease rates of infant mortality and low birth weight (Warrick, Wood, Meister, & de Zapien, 1992). In addition, evaluations of maternal and child health programs have demonstrated that Community Health Workers can successfully teach concepts around primary and secondary prevention and improve access to prenatal care (Meister, Warrick, de Zapien, & Wood, 1992).

The federal Healthy Start mixed provider model is designed not only to be used by first time mothers, but it has no limitations to other at-risk mothers. Specific training, curriculum, and materials on working with at-risk multi-gravida mothers are used to provide successful case management and education within the home and community environment. The federal Healthy Start home visitation program targets communities with risk factors for poor birth outcomes and subsequent poor child health outcomes, including young, first-time parents, low-income households, parents with less educational attainment, and families that live in isolated geographic areas or otherwise lack access to other sources of social support (Stoltzfus & Lynch, 2009). Generally, these types of communities are very culturally diverse and consist largely of minority populations. Studies have shown that "health promoters or lay health advisors" serve a critical role in health care settings when serving multi-ethnic populations (Poss, 1999). The patient/participant, and the health promoter, who is of the same ethnicity, shares a culture, or speaks the same language, is a source of comfort and ease for the patient/participant. Community Health Workers are cultural brokers who bridge the gap between mom and the health care services she needs to have a positive pregnancy and healthy birth. Federal Healthy Start sites have the flexibility and ability to meet the varying needs of their local community. Many of the programs choose the mixed provider model referred to above, which allows them to hire the type of provider that best meets those needs and who can mirror their targeted population.

As demonstrated in this review, the aforementioned model combines components of health care, parental education, child abuse prevention, and early intervention services for infants and toddlers. This model also allows providers to help improve the lives of mothers and fathers by encouraging them to continue their education, find stable employment, and improve family planning knowledge and practices. In addition, the use of Community Health Workers and paraprofessionals enables families to work with someone they trust and who is from the same community. That is paramount when you are working with populations who have a lack of trust of our nation's health care system.

Baltimore Healthy Start, Inc.

FEDERAL HEALTHY START EVIDENCE-BASED AND PROMISING PRACTICE MODELS IN HOME VISITATION SERVICE DELIVERY

The federal Healthy Start Initiative has a long-standing reputation of success as presented in both evidence-based research and promising practice designation (Programs that Work: Proven and Promising Programs, 2008). This reputation is apparent from numerous research and evaluative reports published in national publications for the past twelve years, using data from nearly half of the federal Healthy Start projects across the country. This section of the document will focus on evaluative evidence of program outcomes collected nationally and locally, self-published Impact Reports, and publications in nationally acclaimed peer review periodicals.

Since 1991, all federal Healthy Start programs in the United States have shown effectiveness in programming based on increased positive birth outcomes and maternal health cataloged as evidence in the MCH Library at Georgetown University. Copies of each individual Healthy Start site Impact Report outlining major impacts can be accessed through the administrative office of the HRSA/MCHB.

Currently, all 104 federal Healthy Start programs in the country deliver home visitation services as a key method of delivering perinatal case management, risk assessment, depression screening, health education, and outreach core services. A vast majority of the federal Healthy Start programs use a foundational model of home visitation that includes mixed provider types.

The mixed provider model for core service delivery is a unique model of home visitation as it employs a team mixed of professional and paraprofessional staff such as registered nurses, baccalaureate or master's prepared social workers, counselors, case managers, and lay workers (Community Health Workers, Promotoras, Doulas) in the delivery of home visitation services. The mixed provider team works together in delivering services to at-risk women at any stage of her perinatal health and reproductive life and their families, including male involvement components. The mixed provider model takes place not only within participant families' homes but other locales within a specific target community (clinics, schools, churches, community centers, multifamily housing complexes, etc.). Using lay workers, from the community from which they identify and share through

language, socio-economic status, race/ethnicity, and life experiences as part of the provider team for home visitation, helps to engage and strengthen individual and family involvement in the home visit, which in turn improves pregnancy outcomes, infant health, and decreases cost of medical care (Roman, Gardiner, Lindsay, Moore, Luo, Baer,... Paneth, 2009).

The mixed provider model used by the federal Healthy Start cohort addresses not only the medical conditions and health issues of at-risk perinatal women but also their stressors of everyday life. The mixed provider model was the subject of research conducted in Michigan with one of the local Healthy Start projects that hypothesized that during the perinatal period women who received a mixed model of case management intervention would report less perceived stress, fewer depressive symptoms, and increased levels of self-esteem, mastery, and social support. The research established that the mixed model of Nurse/Community Health Worker team home visiting intervention can alleviate perinatal depression symptoms and may also ameliorate stress, improve mastery in low income women (Roman, et al., 2009).

Research conducted with the initial 15 federal demonstration Healthy Start projects with women screened during a five month period in 1995 and 1996 showed that the federal cohort of Healthy Start projects were more successful in enrolling high risk women into case management using outreach models and lay Community Health Workers at community-based locations than clinical and WIC models (McCormick, Deal, Devaney, Chu, Moreno, & Raykovich, 2001).

A report published for the Office of Rural Health Policy in February 2004 defined case management as a community-focused approach to augmenting prenatal and well child care which incorporates health education and social support. Lay health care Community Health Workers from the participant's community are thought to be influential in the process of modifying behavioral and environmental determinants because of their common social, cultural, and environmental milieu. This report presented an evaluation of the effectiveness of a home visitation model using lay health Community Health Workers at the Low Country Healthy Start Resource Mothers Program in southwestern South Carolina. The study concluded that an effective community-focused maternal-infant health promotion program will produce changes in participant knowledge, beliefs, behavior, and/or environmental conditions, which in turn, facilitate improved infant health and decreased medical costs (Erkel, Moore, & Michel, 2004).

A recent survey of current federal Healthy Start projects showed that nearly 70% of responding projects use a risk-based level of intervention system to determine the acuity, frequency of home visits and staffing support provided. A post Hurricane Katrina local evaluation analysis was conducted of the Healthy Start in New Orleans and found that 95% of participants reported that outreach in the home environment was a key issue in keeping them involved in the Healthy Start services. Furthermore, the analysis reported that highest risk level participants receiving at least one face-to-face home visit per month while enrolled in Healthy Start generated the highest percentage most desired birth outcome with optimal birth weight at 88%. It also found that home visitation increases self-efficacy of the participants to manage their pregnancy and linked to positive birth outcomes (Parent, 2009).

A research article generated in 2009, and currently pending publication, focuses on the home visitation practice of the Caring for 2 Healthy Start project in Columbus, Ohio. The qualitative research found that responsive and prompt advocacy and linkage to resources by program staff contributes to improved outcomes for pregnant women in at-risk populations. Additionally, it found that the trusting relationships formed between program participants and "sister-like" caregiver or program staff correlate with the successful delivery of home-based services focused on health promotion, lifestyle choice, prenatal and parenting information, and education in high risk populations. Relationships with participants are established through building trust, by staff working to promptly meet mothers' needs, active listening, and attention to mothers' concerns and hopes, and advocating on her behalf. These act as precursors to readiness to receive perinatal health, development, and parenting information. Caring for 2 Healthy Start uses the mixed provider model named the C.O.A.T. - Community Outreach Assistance Team. This is a multi-agency, multidisciplinary approach to providing health care, linkages, and services to families. The study concluded that trust and relationship building should be an integral part of a home visiting model and acts a predictor for the overall effectiveness of the health promotion messaging and health education outcomes (Boone & Kolliesuah, pending).

An additional research study conducted with the Omaha Healthy Start project in 2007 cited findings that using the mixed provider model and a combination of screening instruments at various points of their perinatal experience, more depressed women with different risk profiles were identified and referred to further diagnostic and treatment resources than when a single approach of screening is used (Harrington & Greene-Harrington, 2007).

Syracuse Healthy Start in Onondaga County, New York, participated in evidence-based research, published in 2006, around the use of the mixed provider model specifically focused on the health education component and the use of health promotional materials by Healthy Start team members during home visits. The research found that interventions implemented by the Healthy Start project that address the low literacy level of the parents and its apparent correlation to the risk factors that contribute to

infant mortality lead to higher levels of perceived empowerment and to the number of participants who began making changes that positively affected their health and their infants' health outcomes (Levandowski, Sharma, Lane, Webster, Nestor, Cibula, & Huntington, 2006).

A 2006 publication in the *Maternal and Child Health Journal* presented a 16 month study of 14 Healthy Start projects comprised of urban and rural projects. The study found that women's compliance rates for postpartum visits were highly dependent on the existence of challenges and barriers to enabling requirements such as transportation, income, domicile, language, and even reminder calls. The home visitation services offered during the postpartum and interconceptional period provided by the federal Healthy Start programs using "practical considerations" and "non-medical factor centered services" increased overall compliance in postpartum visits (Bryant, Haas, McElrath, & McCormick, 2006).

A five year study conducted January 2002 through September 2007 in Central Hillsborough County, Florida, with the Central Hillsborough Healthy Start project found that the federal Healthy Start project in Tampa did reduce the incidence of low birth weight and prematurity by about 30% among disadvantaged community setting service participants. The analysis used a validated and rigorous statistical approach to determine program effectiveness. The study included socio-demographic data that linked women with specific characteristics or determinants including stressors that directly correlate with compromised birth outcomes and morbidity. It was concluded that "one might reasonably speculate reduction in overall psychosocial stress" which then would act as a mediator to reduce impacts on perinatal health. Policy implications were outlined as recommendations including further government funding and support of programs that reduce health disparities suffered by black infants (Salihu, Mbah, Jeffers, Alio, & Berry, 2009).

NE Wichita Healthy Start Initiative

Another unique feature of the Healthy Start model of delivery is the context in which the service is delivered – the context of the entire community in which the family lives. Howell, Devaney, McCormick, & Raykovich (1998) assert that community involvement is probably the feature of federal Healthy Start that most distinguishes it from previous maternal and child health programs. Placing community engagement and mobilization at the center of all thought and action has provided an expanded lens through which all of our partners could see us. This approach increases civic engagement, utilizes social capital, and fosters resiliency in communities by building on the strengths and assets of caring citizens who take responsibility for themselves, their families, and their communities. Community involvement is interpreted by each Healthy Start to include involving the provider community, the nonprofessional community, community institutions and businesses (including faith based organizations), local residents through employment, and other economic development strategies (Howell, Devaney, McCormick, & Raykovich, 1998).

Healthy Start projects across the country implement a set of core system efforts that assist in managing the effectiveness and continuous quality improvement of the service delivery. It is part of the conceptual framework for the federal Healthy Start model that these core systems along with access to health care must be in place to effectively promote healthy lifestyles, modify individual behaviors, identify community assets that support perinatal individuals and families, leverage sustainable resources, change policy, and, ultimately, impact positive birth outcomes. These core systems illicit direct involvements from the community in outreach, recruitment, public awareness, local needs assessment, and program planning. The Community Consortia model used by the federal Healthy Start was the subject of research published in 2003 by the National Association of Social Workers. This research consisted of a nine Healthy Start site, ethno-geographic case study that examined site-specific and cross-site themes and processes of community involvement. The research found that the Community Consortia model used by the Healthy Start projects to augment direct core services was successful in empowering individuals, organizations, and communities, in addition to capacity building – both serving as important intermediate variables to the achievement of health and health system outcomes (Thompson, Minkler, Bell, Rose, & Butler, 2003).

Partnering with communities is a critical aspect of contemporary health promotion (Merzel, Burrus, Davis, Moses, Rumley, & Walters, 2007). In 2007, they published the results of a study around the experiences of the Downstate New York Healthy Start partnership between the local university and several community-based organizations. The partnership described in the article resulted in significant capacity building, co-learning opportunities, research, and the development of shared goals and values for the target community, and, ultimately, contributing to increased public awareness of perinatal health messaging and delivery of core services to the communities' families (Merzel, et al., 2007).

Since the late 1990's many of the federal Healthy Start projects throughout the country have implemented evidence-based practices and strategies using the mixed provider model to promote and achieve positive birth outcomes. Additionally, national evaluation has produced remarkable results in the birth outcomes that Healthy Start works diligently to improve. Currently, approximately 30% of the federal Healthy Start projects throughout the U.S. have evaluators, either on staff or on contract, to produce research studies demonstrating the results of the variations of federal Healthy Start programming around the central model of service delivery.

Data from several Healthy Start programs provide both quantitative and qualitative data from carefully crafted studies which document success in improving maternal and child health outcomes with the most vulnerable populations. For example, the federal Healthy Start Magnolia Project (Jacksonville, Florida) published results of a study entitled, "Impact of Pre-Conception Health Care: Evaluation of a Social Determinants Focused Intervention," in the *Maternal and Child Health Journal.* The study evaluated the outcomes of the social determinants component of a multiple determinants model of pre- and inter-conception care. The program showed promising results related to reducing infant mortality and reducing other high-risk factors for poor birth outcomes, including low birth weight and sexually transmitted infections. The focus on building resilience to negative social forces through peer mentor-based case management complemented but differed from nursing models of case management, which also have reported a positive impact. The evaluation of the project in Jacksonville documents promising outcomes of preconception and interconception interventions to improve birth outcomes, and it highlights areas for continued development. Social determinant interventions, designed to mitigate the impact of social class and stress, should be considered with efforts to reduce infant mortality, particularly the disparities associated with infant mortality. Additional research should be conducted to refine replicable social determinant focused interventions, and confirm and generalize these results.

The work of Healthy Start in Louisville, Kentucky, over the past 11 years in reducing infant mortality is now seeing results. The 2009 Competitive City Report prepared by the Greater Louisville Project, an independent initiative organized by The Community Foundation of Louisville, indicates that Louisville now has the lowest infant mortality rate among 15 comparably-sized cities including Nashville, Charlotte, Cincinnati, and Indianapolis. Since it was established in Louisville in 1998, Healthy Start has helped more than 6,000 families. The Healthy Start initiative in Louisville is one of only a very few across the country that had no infant deaths among participants from 2002 to 2005 and in 2007. The Healthy Start Initiative has increased the number of women receiving preventive services after the delivery of the baby from 51% in 1999 to 91% in 2007. Program data also document a 54% reduction in smoking rates among Healthy Start participants.

South Phoenix Healthy Start

In Kalamazoo County, Michigan, case management and home visitation programs, such as Healthy Babies Healthy Start (HBHS), have proven effective at improving health and health care among high-risk perinatal women through support, education, referrals to community agencies, and practical assistance meeting basic needs. These findings were showcased in a secondary analysis of a population-based data set of birth data compiled by the Michigan Department of Community Health (MDCH), Division for Vital Records and Health Data Development. Despite substantially higher demographic and psychosocial risk, HBHS black participants have birth outcomes that are comparable to not just their black pregnant neighbors but also their white neighbors. HBHS reported a significant effect on reducing prematurity, a leading factor in racial disparities and fetal-infant mortality.

The Central Hillsborough Healthy Start Project (CHHS) in Tampa, Florida, was found to reduce the risk for very low birth weight (VLBW) and preterm births by about one-third among service recipients as compared to non-recipients in a community setting. The in-depth evaluation study, *Healthy Start Program and Feto-Infant Morbidity Outcomes: Evaluation of Program Effectiveness*, evaluated the impact of the Healthy Start intervention program on fetal-infant morbidity within a community setting. Methods prospective data from 2002 to 2007 within the ongoing federal Healthy Start intervention project in Central Hillsborough County were merged with corresponding birth outcomes data from the Florida Department of Health. As a result of the aforementioned study and performance, the CHHS team has been called upon to participate in the National Children's Study (NCS) covering Hillsborough and Orange Counties over the next 20 years. The evaluation team is currently involved in sampling procedures of women to be included in the study. The team will also assist the NCS in analysis of collected data and in enhancing analytic procedures involving future adjunct studies carried out under the umbrella of the NCS.

South Phoenix Healthy Start

FEDERAL HEALTHY START: AN EVIDENCE-INFORMED, COMMUNITY-DRIVEN MODEL OF HOME VISITATION AND SERVICE DELIVERY

With over 20 years of implementation and development based on sound research and evaluation, the federal Healthy Start program offers an evidence-informed, community-driven model of home visitation and service delivery tailored to meet the needs of the country's most vulnerable populations.

The program provides a defined framework of core components to improve health outcomes and to engage disenfranchised populations, including: outreach and participant recruitment; case management/home visiting; health education; maternal depression screening and referral; and interconceptional care. In each federally-funded Healthy Start community, services are targeted to an identifiable, defined population. Core components of each local program are organized and delivered consistent with population needs and community resources. Specific polices and protocols form the foundation for each of the core components. Services and staffing are consistent with program models adopted by individual projects to meet identified needs.

Home visiting is a primary method of delivering case management, education, and support by the federal Healthy Start program. Protocols for each community-driven program encompass screening, selection, assessment, and risk-appropriate service provision. Services are participant-led with anticipatory guidance by the home visitor and on-going assessment of success in achieving goals. The home visitors are uniquely qualified, because they are first and foremost community-oriented, home-oriented, and family-oriented. Fidelity to the selected model is ensured by local projects through rigorous, ongoing staff training and integrated quality assurance provided through case conferences, supervision, and chart reviews.

Health education and risk reduction services and support are participant-determined and curriculum-based. Curricula selected by local Healthy Start projects are promising practice, evidence-based, or locally adapted to ensure culturally-competent, accurate, and relevant information is provided to program participants. Fidelity to adopted curricula is ensured through staff training, ongoing tracking of behavior change and risk reduction, and federal Healthy Start required outcomes and objectives.

Federal Healthy Start projects utilize data systems designed to consistently report to HRSA defined and required process, outcome, and performance measures. Local evaluations consistently document the impact of federal Healthy Start projects on key measures of maternal and child health.

IMPLICATIONS FOR HEALTH REFORM

The Affordable Care Act (ACA) of 2010 shifts the health care system's focus to the gaping disparities in health by allocating significant resources and evidence-based vehicles to address the care of those whose health and health care have been marginalized by virtue of race, gender, health status, economic status, and/or geography. With 104 local projects established and invested in communities across the country, the federal Healthy Start Initiative provides the critical infrastructure and service delivery model needed to respond to the Maternal, Infant and Early Childhood Home Visitation Program under the Patient Protection and Affordable Care Act.

The Affordable Care Act incorporates key provisions for:

1) **Preventive Care** for better health;
2) Advancements for the platform for **Women's Health and Wellness**;
3) Innovations in care coordination for the control of **Chronic Diseases**;
4) Significant funding for the replication of **Home Visiting Models**;
5) Expansion of initiatives to increase ethnic **Diversity in Providers** of care;
6) Elevation of the importance of **Minority Health and Health Disparities** through the creation of more highly visible and permanent federal agency oversight and funding; and
7) **Affordability**.

Federal Healthy Start incorporates the following provisions:

1) **Preventive Care** during preconception and interconception periods for women of childbearing age, and early childhood development services for infants and toddlers. Federal Healthy Start also links women and children to medical homes and assists in making and keeping appointments -- all critical services necessary for implementing a preventive care strategy.

2) Women's Health and Wellness - supportive services for women's health as women comprise the majority of the federal Healthy Start participant base and most projects serve this participant base in a holistic and inclusive fashion in support of entire families with an array of services and programs. The MCH *Life Course Perspective* (Drs. Lu and Halfon) emerging construct that is endorsed by HRSA/MCHB and embraced by many federal Healthy Start projects lends itself to delivering preventive services preconceptionally and interconceptionally for women. Linkages between federal Healthy Start, the Federally Qualified Health Center (FQHC) Network and Early Head Start should be fostered in an effort to assure continuous preventive care for women and children.

3) **Chronic Diseases** - In-home and in-center targeted services and care coordination for chronic diseases such as diabetes, depression, obesity, HIV, and substance abuse (reference the work of Northern Manhattan Perinatal Partnership, Inc. as well as the work of REACHUP, Inc.- Central Hillsborough Healthy Start).

4) **Home Visiting Models** - An array of core services provided through evidence-based and promising home visitation practices. There are decades of data housed at HRSA/MCHB and at each federal Healthy Start project that document the impact of each project in fragile communities and tell numerous success stories that often go unmeasured in national and local evaluations.

5) **Diversity in Providers** - Core services provided through the employment of Community Health Workers, often alone or in tandem with professionals, who reside in the communities from which participants are recruited. The Community Health Workers represent the racial and ethnic make-up of each community served and assist in building levels of trust and respect that directly improve the ability of participants to navigate the broader health care system.

6) **Minority Health and Health Disparities** – Services that have the overarching goal of the reducing perinatal disparities which literature shows are not eliminated simply by providing insurance coverage but for which federal Healthy Start projects across the nation are achieving major successes in closing disparities in infant death and very low birth weight (VLBW) births. In the

disadvantaged community setting serviced by the Central Hillsborough Healthy Start (Florida), its intervention program was found to reduce the risk for VLBW and preterm births by approximately 30% (Salihu, et al, Maternal and Child Health Journal, 2008).

7) **Affordability** - Federal Healthy Start reaches thousands of the most disadvantaged people, dramatically improves access to essential prenatal health care, and saves taxpayers at least as much as it spends every year (Washington-Business Wire, August 2007). Federal Healthy Start projects can document the amount of savings they contribute to state and federal Medicaid through reductions in neonatal intensive care unit (NICU) days. Interventions, such as Baltimore Healthy Start, Inc., that shift VLBW infants into higher weight categories save substantial amounts of medical care dollars. An increase in an infant's weight of 250 grams saves an average of $12,000-$16,000 in the first year of life. An increase of 500 grams generates savings of $28,000 (Cost Benefit Analysis, Johns Hopkins School of Public Health, 2000).

The major implication of federal Healthy Start with regard to the newly emerging landscape under health reform is an important one. **Federal Healthy Start represents a "shovel ready" network with the experience and cultural authenticity to assist in serving the newly insured and the marginally served in at-risk communities throughout our nation.** Federal Healthy Start has served as part of this nation's health care safety net for 20 years. Additionally, federal Healthy Start, along with the FQHC Network that is heavily funded under provisions of the new health reform law, is one of the only HRSA program initiatives that seeks out and works directly with the vulnerable populations in America and that can also create the linkages necessary to coordinate and translate the efforts of other federal programs to address the provisions of health reform at local levels across America and across the life course.

South Phoenix Healthy Start

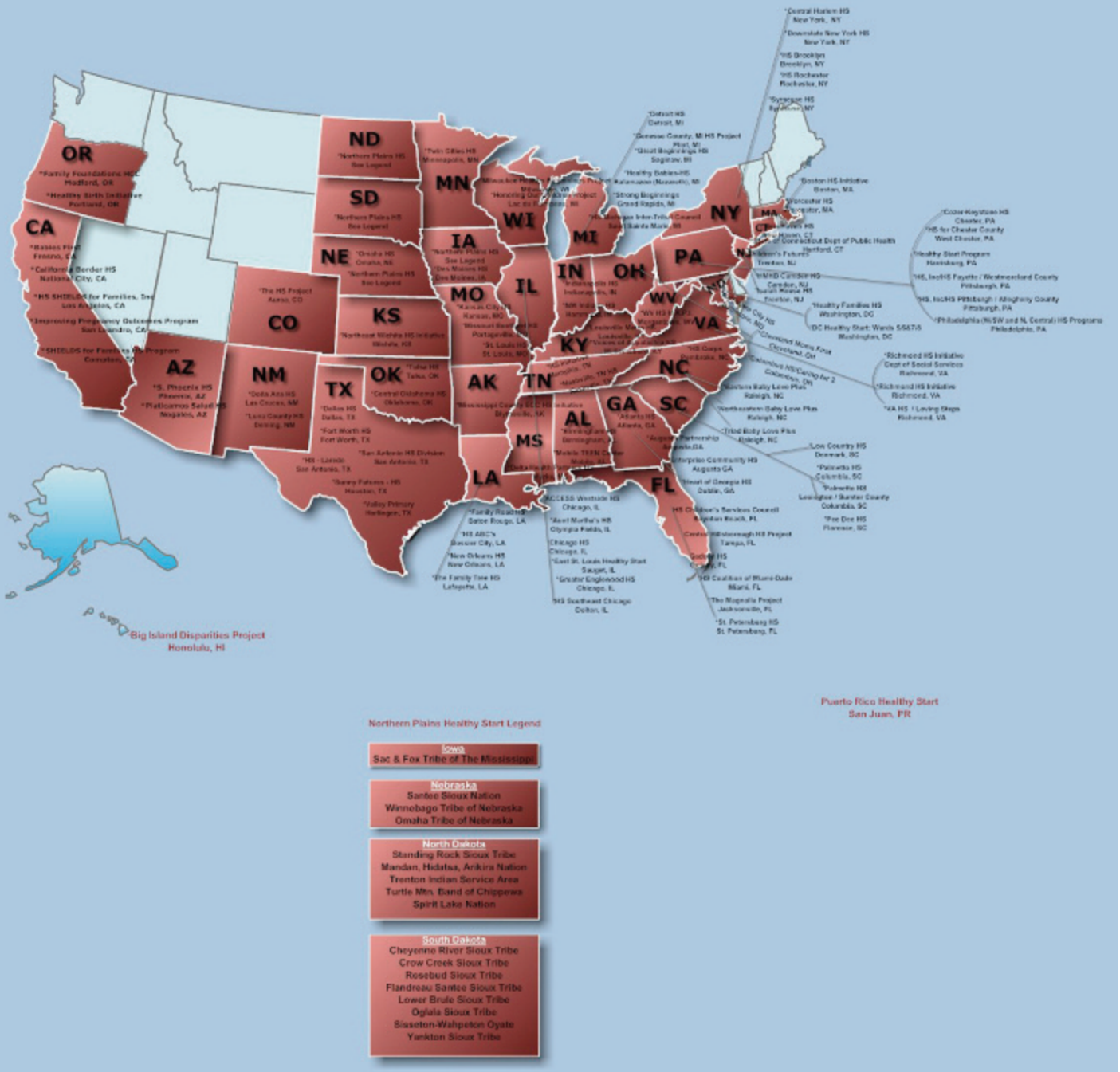
There is value and cost savings in using an existing social and public health infrastructure rather than building a new one. A cogent example is Baltimore Healthy Start, Inc., which has consistently closed the disparity for its enrolled participants in VLBW births (0% VLBW rate in 2009) through its effective home visiting and outreach services. VLBW births costs an average of $5,700 per family while "neonatal intensive care and first year re-hospitalization due to VLBW births costs Medicaid an average of $100,000 per case in Baltimore City" (Baltimore FIMR, 2003).

This is what health reform is about -- extending cost-effective models that work to people who need them. That is an astounding difference of $94,300 per participant, on average, that could be diverted from reactionary spending to preventive spending with programs such as federal Healthy Start.

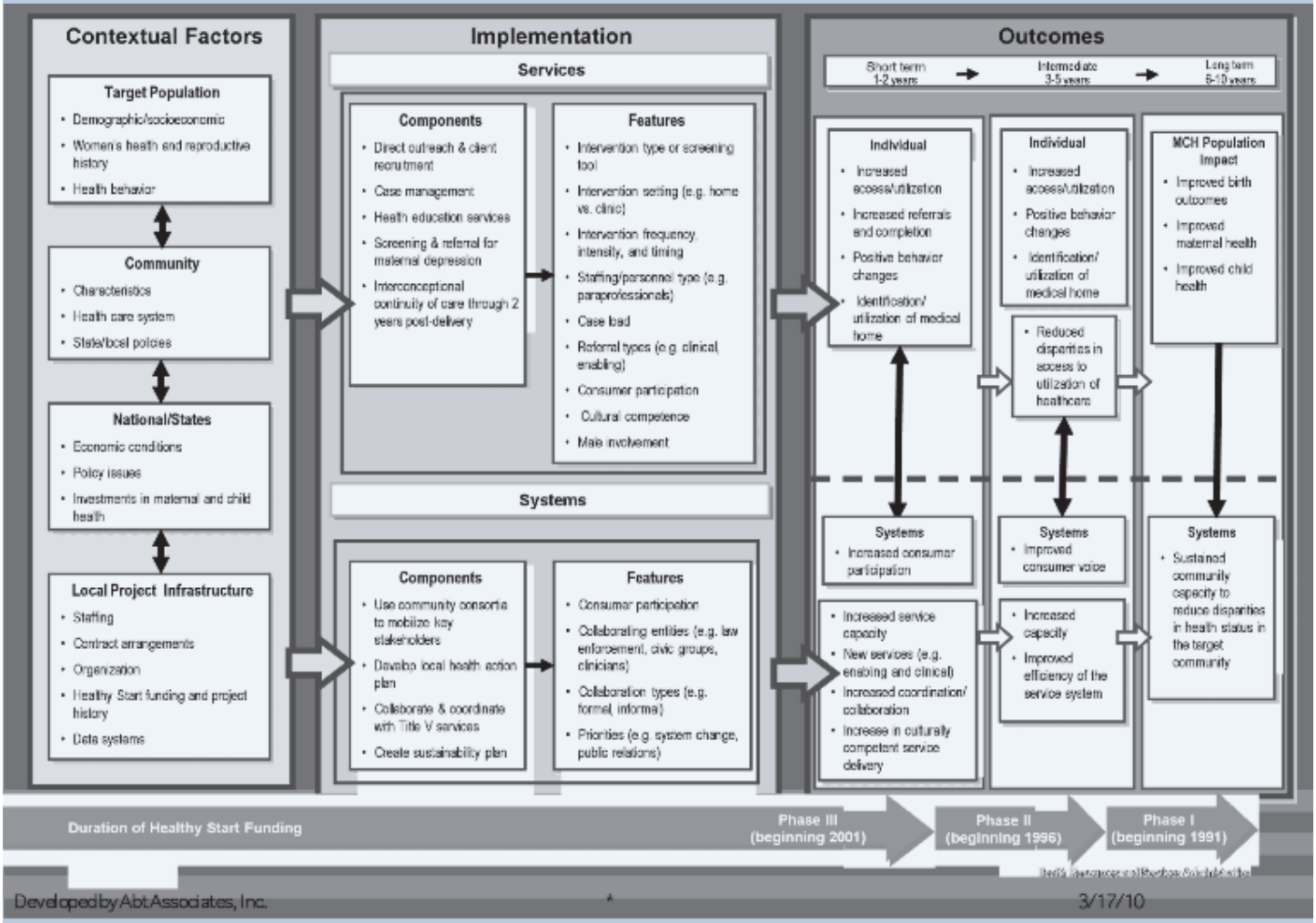
Over the course of the next several years, as health reform rolls out, some 32 million newly insured Americans with all of their pent-up demand for services are set to flood our nation's health care delivery system and stretch to the limit already scarce providers of care. Over the next few years, federal Healthy Start is positioned and ready to assist the nation in:

- working with states to develop criteria for needs assessments that identify local communities that are experiencing disparities in birth outcomes and other factors contributing to the level of risk experienced by perinatal families;
- developing measurable intermediate benchmarks that will contribute to the evaluation of program results and quality improvements;
- developing criteria for evidence-based evaluation and promising practices around Healthy Start service delivery models;
- evaluating and assessing the parent/child component outcomes and activities that will improve health care and decrease disparities; and
- participating in the research and evaluation activities that will increase knowledge about the implementation and effectiveness of home visiting program

Healthy Start Locations (2010)



Logic Model for National Evaluation of Healthy Start



REFERENCES

MCH SearchLine. *Various Healthy Start Project Directors' Impact Reports*. . Retrieved from The Maternal Child Health Library at Georgetown University: http://www.mchlibrary.info/databases/

H*ealthy Start. Programs that work: Proven and promising programs.* (2008, September). Retrieved from Web site: http://www.promisingpractices.net/program.asp?programid=118

Bill, D. (2006). *Healthy Start: Closing the gap improving the health of mothers and children in Chester County*. West Chester, PA: West Chester University Department of Health.

Boone, B. J., & Kolliesuah, G. (Pending). *Expanding the theory of change for a home visitation program*. Columbus, OH.

Bryant, A. S., Haas, J. S., McElrath, T. E., & McCormick, M. C. (2006). Predictors of compliance with the postpartum visit among women living in Healthy Start Project areas. *Maternal Child Health*, 10, 511-516.

Erkel, E. A., Moore, C. G., & Michel, Y. (2004). *Development of a methodology for assessing the effect of lay home visitation program for rural high-risk women and infants*. Columbia, SC: South Carolina Rural Health Research Center Arnold School of Public Health.

Giblin, P. T. (1989). Effective utilization and evaluation of indigenous health care workers. P*ublic Health Rep*, 104, 361-367

Harrington, A., & Greene-Harrington, C. (2007). Healthy Start screens for depression among urban pregnant, postpartum and interconceptional women. *Journal of the National Medical Association*, 99, 226-231.

Howell, E., Devaney, B., McCormick, M., & Raykovich, K. T. (1998). Back to the future: Community involvement in the Healthy Start Program. *Journal of Health Politics, Policy and Law*, 23, 291-317.

Kothari, C., Wendt, A., Liggins, O., Overton, J., & Sweezy, L. (2010). Assessing maternal risk for fetal-infant mortality: A population-based study to prioritize risk reduction in a Healthy Start community. *Maternal Child Health J.* doi: 10.1007/s10995-009-0561-3.

Levandowski, B., Sharma, P., Lane, S., Webster, N., Nestor, A., Cibula, D., & Huntington, S. (2006). Parental literacy and infant health: An evidence-based Healthy Start intervention. *Health Promotion Practice*, 7, 95-102.

Livingood, W. C., Pierce, K., Hou, T., Bryant III, T. (2010). Impact of pre-conception health care: Evaluation of a social determinants focused intervention. *Maternal Child Health J, 14,* 382-391. doi: 10.1007/s10995-009-0471-4.

Mahon, J., McFarlane, J., & Golden, K. De Madres a Madres: A community partnership for health. (1991). *Public Health Nurse,* 8, 15-19.

McCormick, M. C., Deal, L. W., Devaney, B. L., Chu, D., Moreno, L., & Raykovich, K. T. (2001). The impact on clients of a community-based infant mortality reduction program: The National Healthy Start Program Survey of Postpartum Women. *American Journal of Public Health,* 91, 975-977.

Meister, J. S., Warrick, L. H., de Zapien, J.G., & Wood, A. H. (1992). Using lay health workers: case study of community-based prenatal intervention. *J Community Health,* 7, 37- 51.

Merzel, C., Burrus, G., Davis, J., Moses, N., Rumley, S., & Walters, D. (2007). Developing and sustaining community academic partnerships: Lessons from Downstate New York Healthy Start. *Health Promotion Practice,* 8, 375-383.

Murphy M. (1995). Lay health programs: Public health services that work. *Migrant Health Newsline,* 12, 1-3.

Parent, C. (Pending). *Healthy Start New Orleans: Home visitation analysis.* New Orleans LA.

Poss, J. E. (1999). Providing culturally competent care: Is there a role for health promoters? *Nursing Outlook, 37,* 30-6.30-6.

Roman, L. A., Gardiner, J. C., Lindsay, J. K., Moore, J. S., Luo, Z., Baer, L. J.,..Paneth, N. (2009). Alleviating perinatal depressive symptoms and stress: A nurse-community health worker randomized trial. *Archives Women's Mental Health, 12,* 379-391.

Salihu, H. M., Mbah, A. K., Jeffers, D., Alio, A. P., & Berry, L. (2009). Healthy Start Program and feto-infant morbidity outcomes: Evaluation of program effectiveness. *Maternal Child Health J,* 13, 56-65.

Stewart, J. C., & Hood, W. R. (1970). Using workers from "hard-core" areas to increase immunization levels. *Public Health Rep, 95,* 177-185.

Stoltzfus, E. & Lynch, K. (2009). *Home visitation for families with young children.* Washington, DC: Congressional Research Service.

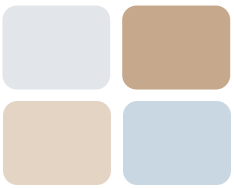
Sung, J. F., Blumenthal, D .S., Coates, R. J., Williams, J. E., Alema-Mensah, E., & Liff, J. M. (1997). Effect of a cancer screening intervention conducted by lay health workers among inner-city women. *Am J Prev Med, 13,* 51-57.

Thompson, M., Minkler, M., Bell, J., Rose, K., & Butler, L. (2003). Facilitators of well-functioning consortia: National Healthy Start Program lessons. *Health and Social Work, 28,* 85-195.

Warrick, L.H, Wood, A.H., Meister, J.S., & de Zapien, J.G. (1992). Evaluation of peer health worker prenatal outreach and education program for Hispanic farmworker families. *J Community Health, 17,* 13-26.

Witmer, A., Seifer, S. D., L Finocchio, Leslie, J. & O'Neil, E.H. (1995). Community health workers: Integral members of the health care work force. *American Journal of Public Health, 85,* 1055-1058.

Woods, T. A., Smith, S., & Cooper, J. L. (June 2010). *Promoting the social-emotional wellbeing of infants and toddlers in early intervention programs: Promising strategies in four communities.* Columbia University, New York, NY: National Center for Children in Poverty, Mailman School of Public Health.



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