*Testimony*

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# Responsible Resource Management at the Nation's Health Access Agency: The Healthy Start Program


***Statement of***

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Good afternoon, Mr. Chairman and members of the Committee. I am Dr. Peter Van Dyck, the Health Resources and Services Administration's Associate Administrator for the Maternal and Child Health Bureau in the Department of Health and Human Services. Thank you for the opportunity to testify today concerning responsible resource management at HRSA, the nation's health access agency. Today I will concentrate my remarks on the Healthy Start program, one of the programs within the Maternal and Child Health Bureau and one about which we have a good story to tell.

In the late 1980's, national concerns about persistently high levels of infant mortality lead to a number of efforts to address this problem. Although infant mortality rates had declined over time, the rate of decline had slowed by the mid-1980's, and relative to other developed nations, the United States' ranking had slipped. Even more alarming was the racial disparity in infant mortality rates; black infants in the 1980's were more than twice as likely to die in their first year of life as white infants. A White House study recommended the development of a major initiative to mobilize and coordinate the resources available in selected communities and demonstrate effective approaches to reduce infant mortality. Concerned about the persisting high rates of infant mortality among both urban and rural populations, President George H.W. Bush's administration created the Healthy Start Initiative to fund 15 projects in areas both urban and rural where the infant mortality rates were 1.5-2.5 times the national average. Healthy Start began as a demonstration program in 1991.

Each year in the United States, about 4 million women give birth. Most have safe pregnancies and deliver healthy infants, but some women give birth too early, see their babies die during or soon after birth, or die themselves in pregnancy-related deaths. These difficulties

continue to occur in greater numbers among women who are members of racial and ethnic minorities.

According to the most recent available data released by the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics, the national infant mortality rate in 2003 was 6.9 deaths per 1,000 live births. The racial and ethnic breakdown was 14 deaths per 1,000 live births for African-Americans, 5.9 per 1,000 for Hispanics, and 5.7 per 1,000 for whites.

Healthy Start began with a five-year demonstration phase to identify and develop community based system approaches to reducing infant mortality and to improve the health and well being of women, infants, children and their families. Since its inception, Healthy Start has been located in HRSA. Originally funded under the authority of Section 301 of the Public Health Services Act, Healthy Start was most recently authorized as part of the Children's Health Act of 2000.

Healthy Start was founded on the premise that communities can best develop and implement the strategies necessary to eliminate the factors contributing to infant mortality, low birth weight, and other adverse perinatal outcomes among their own residents, especially among populations at high risk. Healthy Start communities form local coalitions of women, their families, health care providers, businesses, and various public and private organizations that work together to address disparities in perinatal health. Every Healthy Start site is guided by its consortium. Local residents are recruited, trained, and employed as case managers and outreach providers.

HRSA provides the Healthy Start communities with national leadership in planning, directing, coordinating, monitoring, and evaluating the implementation of the various Healthy

Start programs throughout the country. Specifically, the national program collects and analyzes information regarding the Healthy Start projects; provides program policy direction, technical assistance, and professional consultation on Healthy Start activities; administers the Healthy Start grants and contracts; and serves as the Healthy Start focal point for the Department. The program now reaches into 96 communities in 37 states, the District of Columbia and Puerto Rico. Each of the vulnerable communities receiving funds has suffered from poor perinatal outcomes and/or an infant mortality rate in one or more racial, ethnic or geographically disparate population that is at least one and a half times the national average.

While each Healthy Start project is as unique as its community setting, there are certain hallmarks of all Healthy Start projects.

Healthy Start was one of the pioneers in the use of women living in the community as outreach workers and home visitors. This approach achieves several things: It saves money (extending services of professionals through the use of lower cost paraprofessionals or lay workers), pregnant women respond better to other community based women who have "walked in their shoes", and it has provided real and meaningful jobs to hundreds of unemployed or underemployed women in vulnerable communities.

As mentioned earlier, every Healthy Start project has developed a consortium, composed of neighborhood residents, clients, medical providers, social service agencies, faith representatives and the business community. This ensures that not just Healthy Start but the whole community is committed to the fight to reduce infant mortality and low birthweight.

Healthy Start communities don't stop helping to build healthy families when a healthy baby is born. They stay with the mother, the baby, the whole family, for two years, monitoring the baby's growth and development, ensuring the mother's safety and health, so that each new

family is assured a “healthy start”. These projects have been forward thinking in their recognition that there can be both physical and psychological threats to a mother’s health before, during, and after pregnancy, and they are particularly focused on identifying and treating perinatal depression. Part of what all Healthy Start projects are funded to do is help their communities build and strengthen the medical, social, and psychosocial resources available to women and their families. These projects are actively engaging mothers, babies, and families through these crucially important first two years of the child’s life. These years are critical because any difficulties in a child’s development can be uncovered and addressed early, and the child’s parents can be most readily engaged in positive parenting techniques that will result in the child’s optimum development and adjustment. Just as important, Healthy Start programs begin with the fundamental precept that it is important to make sure the mother has a medical home, and that she is followed along with her infant to improve her health, through risk reduction and health education. Good interconceptional care for women can make a subsequent pregnancy less risky for both mother and baby.

Throughout the history of the program, it has been monitored by an independent council, known as the Secretary’s Advisory Committee on Infant Mortality, and the initial program design included a rigorous national evaluation. This evaluation, released in 2000, used matched comparison communities (that did not have a Healthy Start site) to the original 15 Healthy Start program communities. The evaluation revealed several statistically significant differences: more than half (eight) of the Healthy Start communities had improved adequacy of prenatal care utilization; four Healthy Start communities had declines in the preterm birth rate; three project areas had reductions in the low birthweight rate; and two Healthy Start communities had declines in the infant mortality rate of greater than 50 percent. The evaluation also found that Healthy

Start projects were more effective in enrolling high risk women into prenatal care, and that the community-based interventions which Healthy Start uses, may have longer term impacts on future health and well being of women and their families, that have not yet been measured.

A major result of the first national evaluation was that using its findings, coupled with recommendations from the Secretary's Advisory Committee, HRSA was able to reshape the Healthy Start program to reflect what had been found to be most effective.

Committed to implementing evidence-based practices and innovative community-driven interventions, Healthy Start works with individual communities to build upon their own local assets to improve the quality of health care for women and infants at both service and system levels. At the service level, beginning with direct outreach from community health workers to women at high risk, Healthy Start projects ensure that the mothers and infants have ongoing sources of primary and preventive health care and that basic needs (housing, psychosocial, nutritional, educational, and job skill building) are met. Following risk assessments and screening for perinatal depression, case management provides linkages with needed services and health education for risk reduction and prevention.

It is significant that the Healthy Start program was forward thinking in the recognition of the profound negative effects of perinatal depression, not only on birth outcomes, but also in the neonatal and post neonatal period. Beginning in 2001, 38 grants were awarded to provide screening for perinatal depression, and to enhance linkages to community-based intervention services for depression that are culturally and age appropriate. At the same time 35 grants were awarded to provide resources for high-risk interconceptional care. These programs ended this past year and we are now compiling the lessons learned from these projects to share with other communities across the nation.

Healthy Start programs are located in and are responsive to the needs of mothers and infants in the poorest neighborhoods in the United States. Healthy Start has been successful at enrolling women with the highest risk of adverse pregnancy outcomes, women who were less likely to receive care in a private medical office, to have less than a high school education and to have lower incomes.

Getting women into prenatal care in the first trimester of pregnancy, or as early as possible, is critical - - since prenatal care is critical to improving birth outcomes. Healthy Start has made proven impacts on participants' access to prenatal care: in 1998, participants' first trimester entry into prenatal care was only 41.8 percent; by 2003, this number had risen to 71.4 percent, an increase of 73 percent in five years.

One of the first 15 sites, Washington, D.C., reported for the year 2000, its lowest infant mortality rate ever, and in that same year, no babies born to Healthy Start clients died. Central Harlem is another example of a Healthy Start success story. The infant mortality rate there has dropped significantly since its project began in 1991, when there were 27.7 infant deaths per 1,000 live births. By FY 2003, the rate had dropped to 7.3 deaths per 1,000 births – a 273 percent decline.

Other locations have had real success in reducing low birth weight. In Baltimore, the percentage of very low birth weight babies was 2.0 percent among participants with single births enrolled in Healthy Start – 99 percent of whom are African-American – compared to a 3.7 percent rate of very low weight births among African-American women throughout the city. President Bush has asked for $101.5 million for Healthy Start in his FY 2007 budget – an amount equal to the FY 2006 appropriation.

I would be happy to respond to your questions.