

**Healthy Start Baby Love Plus Evaluation Update Northeastern Region 2011-12**  
**Prepared by the Sheps Center Baby Love Plus Evaluation Team**  
**December 2010**

**Evaluation Update**

Throughout the past year, the UNC Sheps Center evaluation team has collaborated with the Northeastern Baby Love Plus staff in both program design and assessment. Using the local evaluation plan described in the original grant application, the evaluation team continues to focus on multiple levels of program effort by measuring community, health system, and participant indicators. Program tracking provides ongoing monitoring of administrative, consortium, and service delivery activities including emphasis on the new ICC learning collaborative efforts. Tracking of program facets and indicators focuses on MCHB-required elements, while enhanced evaluation activities address concerns raised through the LHSAP and the ICC Learning Collaborative such as addressing healthy weight and improving systems of care in the inter-conceptional period. Baby Love Plus staff are responsible for collection of primary data while the evaluation team focuses on data analysis and producing summaries and reports. Findings are useful for program planning and management and are produced in a variety of formats, targeting a range of audiences. The evaluation team represented the project by participating in and giving presentations at local, state and national meetings.

**Major Activities of Past Year**

As described in previous reports, activities related to each model were tracked and the number of services provided to program participants were recorded and summarized. Local staff entered primary data into the BLP MIS tracking system and then uploaded the files to the Data Coordinator in the central office. The evaluation team summarized descriptive data for each program model and aggregate data for the Region. We reported on the following indicators: outreach to potential clients; referrals made for preconception, maternal and child health services; enrollment in and use of prenatal and post-partum case management; education and training activities; the extent to which trainings are effective; and key indicators related to Regional Consortium priorities.

- A. *Most Basic level:*** the evaluation team provided program staff with feedback on the administration and operation of the program. In this capacity, it served as a tracking tool, answering the following questions: does the program happen as proposed? Are program activities and number of services provided to program participants being implemented as planned? See below for findings.
- B. *Regional/Systems level:*** the evaluation team provided feedback on the quality of care, client satisfaction with service delivery, perceived barriers to care, and suggestions for improving the systems of care. In this capacity, it served as a planning and management tool, answering the following questions: how are we progressing? Which objectives are being reached and which ones look like they are falling behind? What gaps need to be addressed? See below for findings.
- C. *Program level:*** the local evaluation provided measurement for the overall program portfolio using process, outcome, and impact measures. In this capacity, it served as an assessment tool answering the following questions: Are we reaching our goals and what impact are we

having? Do we see declines in disparities and improved birth outcomes? How do these trends compare with areas that do not have our program? See below for findings.

The evaluation team provided Baby Love Plus staff with feedback from program data and use of services and made suggestions about identifying program participants and tracking during the interconception period. We recommended shifting case management efforts more on women likely to be at risk for: depression, lack of social support, or short interpregnancy interval. Ensuring that needs are being identified, appropriate referrals made, and referral services completed remains an important activity for staff and an on-going focus of evaluation. A new emphasis in Northeastern BLP over the past year has been focusing on healthy weight and nutrition and identifying appropriate risk factors and opportunities for effective education. This project year there were a number of synergies in the Region with New Parent Initiative, a HRSA SPRANS grant providing community awareness, training, and improved services for reproductive life planning. The Sheps team was the evaluator for both programs, leading to economy of scale with data collection, surveys, and listening sessions for consumers and providers in the project counties. As has been customary, the evaluation team provided reports on population and local clinic level data to inform decisions and help in the design of new policies and procedures. These data are intended to provide the foundation for effective and continuous quality improvement in the project's partnerships with local providers.

To aid in program management, the evaluation team continued to summarize information from administrative data collected on various components of the project. At the most basic level, the evaluation team provided Baby Love Plus program managers and field staff with informal feedback regarding program operation and periodic formal reports on progress toward outreach, case management, education and training, interconceptional health and Consortium goals. In addition to providing ongoing and periodic reviews for tracking and managing the program's progress, the local evaluation assessed program outcomes and impact measures especially linked to the program objectives. We continued to monitor vital record files and administrative clinic data to assess changes in service utilization and health outcomes for program participants.

### **Evaluation and Data Reports / Products Produced**

The local evaluation of the Northeastern BLP program assessed each of three program components, Case Management, Outreach, and Health Education and Training — as well as the Regional Consortium. The primary focus of the program continues to be reduction of Minority infant mortality and morbidity, and improved perinatal health for those women most at risk. Therefore, the evaluation assessed percent change in racial disparity for infant mortality rates and preterm deliveries. The evaluation team produced maternal and infant fact sheets detailing risk factors and birth outcomes for the project area that were distributed among BLP and health department staff members, the Regional Consortium, and a number of collaborating community organizations. Finally, the evaluation team assisted with required reporting protocols and other Healthy Start information requests throughout the year, and worked closely with the management team to produce information needed to complete the renewal application. Summary evaluation results were as follows:

#### **A. Regional Services: Annual Numbers**

Outreach: 1,234 groups with attendance of 8,774

- Maternity-related groups: 150 events; 972 attended
- Referrals: 735 referrals; 379 (52%) completed
- Maternity-related referrals: 411 referrals; 143 (35%) completed
  - Follow-up on hard-to-reach clients: few (9) but 5 were reached (56%)
- Trainings: Held as planned — at each Consortium meeting; at Family Development Retreats; educational updates for all staff, clinical and outreach.
- Participants: 848 pregnant women; 80% African American
- Transportation Services: 1,935 services provided to 556 women
- On average, 3-4 transportation services per user

## B. Evidence of Program Impact

Service Utilization: Do women in BLP counties have higher MCC enrollment rates? Yes, despite MCC enrollment declines statewide, from 51% to 32% (2001-09), BLP county rates remain on a par with the State's rates — and continue to be above those of the comparison counties which have dropped from 40% to 25% over this time period.

Adequacy of Prenatal Care (APNC): Better for Healthy Start BLP participants?

- Yes, over life of project, 9.4% *increase* in adequacy of prenatal care
- Statewide, NC minorities 2x more likely to have late or no PNC
- Despite state trends, BLP-county participants have *improved* early PNC rate (by 17%), while rates for state-wide early entry into PNC *declined*
- BLP counties show 85% decrease (improvement) *in racial disparity* of APNC
- Before BLP: rate of inadequate care was 25%; now rate: < 18% ... improved 34%
- Disparity in APNC rates for MCC clients in *comparison counties worsened* by 7% over time
- Overall, program shows improvement in BLP counties, despite higher risk profile of BLP clients compared to NC state overall

Low Birth Weight: Has Healthy Start project impacted disparities in LBW rates?

- Consistently high LBW rates: NC as well as BLP-county Minorities
- In NC generally, rates not improved; and disparity in LBW rates *worsened*
- In Northeastern BLP counties, we see this same trend, and it is an area of concern

Infant Death: Are Healthy Start program infants more likely to survive?

- Rates for AA (target) in Northeastern BLP counties did not show improvement over the past year in rates of infant death: (13.9 per 1,000 with increase in disparity)
- However, the rates were better than those for the comparison counties that did not have the BLP program services (25% lower increase) suggesting the beneficial supports of Healthy Start in times of severe economic challenges

Issues of Concern for Monitoring Going Forward

- Erosion of progress re: gains in LBW and infant mortality rates
- Increasing needs and demand for services as economy declines
- Staffing and service availability to meet need
- Breastfeeding by participants

- Pregnancy intendedness
- Short birth interval among participants
- Declining number of consumer members and consistent attendance at Consortium

### C. Selected Evaluation Products

#### Routine Reports and Special Data Requests

- Advocacy Factsheets (Regional stakeholders, Congressional Representatives)
- Annual Hospital Discharge Reports (costs/charges of/for preterm deliveries)
- Regional Progress Report for Continuing Applications
- Early PNC, LBW and Medical Home Report
- Infant Mortality in BLP Program and Comparison Regions, HRSA Request

#### Consumer and Community Partner Surveys

- Feedback Survey, New Parent Booklet and Media Spots
- Survey of Target Population on Reproductive Life Planning
- Systems Survey on Incorporating Reproductive Life Planning into Group and Clinical Encounters

#### Selected Presentations

- NHTSA Spring Conference: A Stimulus Package You Can Use

### **Plans for the Coming Year**

Once full data for the 2011 program activities become available, we will update our analyses of the impact of outreach and case management on service utilization for program participants and specific outcome measures such as disparity reduction in use of prenatal care, identification of interconceptional risk factors, and trends in improving birth outcomes since the inception of the program. The range of indicators includes all of the required demographic, performance, and outcome measures stipulated by the MCHB Healthy Start Initiative. Additionally, we plan to introduce a new survey of eligible women who choose *not* to participate in program activities to document reasons for non-use, reasons for discontinued use, and barriers to participation.

During the current program cycle (2008-2012), the project emphasis has shifted from broadly implemented community outreach strategies to targeting access to and use of services for maternity clients during the interconceptional period. We will plan and pilot a survey of clients, both those who were in family care coordination for a number of months after their delivery and those who declined postpartum care coordination or used it only for a short time. Client sessions will provide information about where women are going for their post-partum and interconception care, their satisfaction with services, barriers to utilization and specifics such as whether they were supported in their decisions about breastfeeding, family planning, and maternal and infant medical homes. Clients will also be asked whether coordinators were helpful to them in formulating personal goals and designing plans to achieve them, an indicator of successful staff training through the ICC Learning Collaborative. Client goals may include smoking cessation, control of chronic disease, weight management, nutrition and physical activity as well as job, financial and education goals and having a reproductive life plan.

We will continue our series of analyses of demographic, risk factor, service utilization and birth outcome data in the upcoming year. The annual monitoring will describe the target population,

the program's penetration of that population, their healthcare and psychosocial needs and service utilization. Program monitoring questions continue to be: 1) which women in the targeted communities eligible for services and program participation are *not* reached by project efforts? 2) what are their characteristics (race, age, education, parity, county of residence, smoking during pregnancy, history of LBW or PTB and Medicaid delivery)? and 3) what characterizes women *not* receiving early PNC, adequate PNC or who have short birth intervals? A second series of analyses will continue to assess program impact in the community by comparing data from pre-program (1993-1997), program implementation (2002-2006), and program expansion (2007-2011, as they become available) periods. Program impact questions are: 1) has the project made a difference in reducing disparities in the use of perinatal services and health outcomes? 2) have birth outcomes improved and risk factors lessened more than changes in the comparison counties? and 3) are there improvements in the use of health services and birth outcomes and reduction of risk factors in the target population, over time?

In addition, in preparation for a new, five-year program cycle (2012-2016), the evaluation staff will conduct further assessment of the Title V agency capacity for community collaboration, as described in the original application. The assessment consists of a rating tool covering 20 elements that demonstrate collaborative capacity (previously submitted). It will be distributed to local health department and other medical directors, key leadership of the local Consortium, and staff at local community-based organizations who have been involved in the region's perinatal efforts over time. We will also provide feedback on Consortium leadership including the Family Development, Education and Training programs and on Fatherhood-focused Initiatives. The evaluation team will conduct surveys and/or group listening sessions to provide quantitative and qualitative data to the Regional Manager and the Consortium. We will design these in collaboration with local and State staff to ensure the most effective strategies of reaching consumer members in the program. The goal of this survey work is to help inform deliberations and decisions of program staff and Consortium members, especially around issues of fatherhood and better serving male partners. We will work with the Regional Consumer Advocate to identify consumers who have participated in the Family Development Program, Education and Training sessions and Fatherhood Support activities in order to include the "Consumer Voice" in summaries of Consortium activities.

We will provide requested data to the Consortium committees' workgroups and help members of these groups to identify and use data resources. Our goal is to increase the ability of the local Consortium committees to find, understand, and utilize quantitative and qualitative data to ground the action steps and measure the impact of the program over time. The evaluation team will provide fact sheets as needed for advocacy and community education as well as fact summaries for Consortium members to use when meeting with elected officials locally and nationally, upon request. We will represent the project at local, regional, state and national meetings, as requested and supported by the program.

With the goal of program stability, the evaluation team will collaborate with the Consortium to assess the sustainability of networks and leadership and to identify the community and system-level projects that are still in formative stages and in need of continued support by Healthy Start. Areas to be evaluated include the degree to which committed members of the Consortium are prepared to take on leadership roles (such as being a lay health advisor or participant in a

Speakers' Bureau) and the capacity of local partners to maintain levels of program activity such as outreach and care coordination beyond the life of the grant.



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