Healthy People 2020: Who’s Leading the Leading Health Indicators?
Don Wright, MD, MPH
Deputy Assistant Secretary for Disease Prevention and Health Promotion
Who’s Leading the Leading Health Indicators?

Leading Health Indicators are:

- Critical health issues that, if addressed appropriately, will dramatically reduce the leading causes of preventable deaths and illnesses.
- Linked to specific Healthy People objectives.
- Intended to motivate action to improve the health of the entire population.
Who’s Leading the Leading Health Indicators?

Featured Speakers:

■ **Karen B. DeSalvo, MD, MPH, MSc**, Acting Assistant Secretary for Health, U.S. Department of Health and Human Services

■ **David Willis, MD**, Director, Division of Home Visiting and Early Childhood Systems, Health Resources and Services Administration (HRSA), U.S. Department of Housing and Urban Development

■ **Gina Easterly, PhD, CCC-SLP**, Supportive Services Program Manager, Bureau of Family Health, Office of Public Health, Louisiana Department of Health and Hospitals

■ **Sarah Hinshaw-Fuselier, PhD, LCSW**, Infant Mental Health Specialist Manager, Bureau of Family Health, Office of Public Health, Louisiana Department of Health and Hospitals
Healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and help enable children to reach their full potential.

Despite major advances in medical care, critical threats to maternal, infant, and child health continue to exist in the United States.
Maternal, Infant, and Child Health – Leading Health Indicators

- All infant deaths (MICH-1.3)
- Total preterm live births (MICH-9.1)
Infant Deaths, 2003-2013

Rate per 1,000 live births

HP2020 Baseline

HP2020 Target: 6.0

NOTE: Includes all deaths <1 year.
SOURCE: Linked Birth/Infant Death Data Set, CDC/NCHS.

Obj. MI CH-1.3
Decrease desired
Preterm Births, 2003–2013

NOTE: Preterm births are infants born before 37 completed weeks of gestation.
SOURCE: National Vital Statistics System-Natality (NVSS-N), CDC/NCHS.

Obj. MI CH-9.1
Decrease desired
Preterm Births & Infant Deaths, 2013

NOTE: I = 95% confidence interval. Preterm births are infants born before 37 completed weeks of gestation. Infant deaths include all deaths <1 year. Race/ethnicity for infant deaths is that of mother. American Indian includes Alaska Native. Asian includes Pacific Islander. The categories black and white exclude persons of Hispanic origin. Persons of Hispanic origin may be any race.
SOURCE: Linked Birth/Infant Death Data Set; National Vital Statistics System-Natality (NVSS-N), CDC/NCHS.

HP2020 Target: 11.4%

HP2020 Target: 6.0

NOTE: I = 95% confidence interval. Preterm births are infants born before 37 completed weeks of gestation. Infant deaths include all deaths <1 year. Race/ethnicity for infant deaths is that of mother. American Indian includes Alaska Native. Asian includes Pacific Islander. The categories black and white exclude persons of Hispanic origin. Persons of Hispanic origin may be any race.
SOURCE: Linked Birth/Infant Death Data Set; National Vital Statistics System-Natality (NVSS-N), CDC/NCHS.
Maternal, Infant, and Child Health
Risk Factors

- Maternal risk factors that can lead to complications for both mother and infant during pregnancy:
  - Obesity
  - Smoking
  - Use of alcohol or drugs
  - Failure to take recommended folic acid supplements
  - Depression

- Improving access to quality care before, during, and after pregnancy is critical to reducing pregnancy-related complications and maternal and infant disability and death
Health Resources and Services Administration

Improving health and health equity through access to quality services, a skilled health workforce and innovative programs
FY 2015 MCHB Investments

- Home Visiting: 32%
- MCH Block Grants to States: 44%
- EMSC: 2%
- Healthy Start: 8%
- Autism: 4%
- SPRANS: 6%
Infant Mortality CoIIN

• A state-driven HRSA-coordinated partnership to accelerate improvements in infant mortality

• CoIIN is a platform designed to help states:
  • Innovate and improve their approaches to reducing infant mortality and improving birth outcomes through communication and sharing across state lines;
  • Use the science of quality improvement and collaborative learning to improve birth outcomes.

• Part of a portfolio of Public/Private and MCHB efforts to improve birth outcomes.
Healthy Start

Healthy Start works to prevent infant mortality in high risk communities across our nation where the infant mortality rates are at least 1.5x national average and where there are high rates of low birth weight, preterm birth, maternal mortality and morbidity

Five (5) Key Approaches

- Improve Women’s Health
- Promote Quality Services
- Strengthen Family Resilience
- Achieve Collective Impact
- Increase Accountability via Quality Improvement, Performance Monitoring, & Evaluation
Healthy Start
2015

• Less than a year into implementing a transformed Healthy Start program, the 100 grantees are reporting:
  • Enrolling approximately 5000 participants per month
  • Approximately 1200 births per month
  • Approximately 80 percent of program participants have health insurance (linking participants to Medicaid/ACA navigators is a key activity of community health workers)
The Federal Home Visiting Program (MIECHV)

- **Section 2951 of the Affordable Care Act of 2010 (P.L. 111-148)**
- **Amends Title V of the Social Security Act to add Section 511: Maternal, Infant, and Early Childhood Home Visiting Programs (MIECHV)**
- **$1.5 billion over 5 years**
  - $100M FY2010
  - $250M FY2011
  - $350M FY2012
  - $400M FY2013
  - $400M FY2014
- **Sustainable Growth Rate (“Doc Fix”)**
  - $400M FY2015
- **Medicaid Access and CHIP Reauthorization Act (MACRA) of 2015**
  - $400M FY2016
  - $400M FY2017
The Federal Home Visiting Program

Tiered-evidence grant design

- Focuses grant dollars on approaches backed by strong evidence...evidenced-based practices
- Encourages innovation so new & effective approaches are discovered
- Examples:
  - The Home Visiting Program
  - Teen Pregnancy Prevention
  - Investing in Innovation (i3)
  - Workforce Innovation Fund
  - Social Innovation Fund
The Federal Home Visiting Program

• **Supports Families**
  • Evidence based parent support services to address family needs
  • Partnership between parents and home visitors

• **Voluntary**
  • For families that ask to be empowered with better knowledge, health and parenting

• **Evidence-based**
  • Built on four decades of rigorous research and evaluation
  • Includes a rigorous national randomized controlled trial evaluation and local evaluations
  • HRSA approved Evidence-based HV models
The Federal Home Visiting Program

- **Cost effective**
  - HV prevents child abuse and neglect, encourage positive parenting and promotes child development and school readiness
  - Long term reduction of school drop out, teen pregnancy and crime
  - Every $1.00 invested, yields up to $9.50 ROI to society

- **Locally designed and run**
  - Provides states with maximum flexibility to tailor programs to fit needs of different communities
  - State’s can choose from HRSA”s EB- HV models
  - Programs run by local organizations
The Federal Home Visiting Program
An evidence-based, place-based strategy

- Programs are in all 50 states, DC and five territories and 787 counties (2015)
- In 2014, programs provide services in over 721 communities - urban, rural and frontier
- Programs have provided nearly 1.4M home visits since start of program
- In 2014, states reported serving 115,500 parents and children.
The Federal Home Visiting Program (MIECHV)

Provide voluntary, evidence-based home visiting services to improve

- Prenatal, maternal, and newborn health
- Child health and development, including the prevention of child injuries and maltreatment
- Parenting skills
- School readiness and child academic achievement
- Family economic self-sufficiency
- Referrals for and provision of other community resources and supports
The Federal Home Visiting Program

Who are the families we serve?

Families served by the Home Visiting Program were at risk for poor family and child outcomes:

- 27% of newly enrolled households included pregnant teens.
- 20% of newly enrolled households reported a history of child abuse and maltreatment.
- 12% of newly enrolled households reported substance abuse.
The Federal Home Visiting Program

• Poverty Level
  • 79% of participating families had household incomes at or below the 100% of the Federal Poverty guidelines and 48% were at or below 50%

• Educational attainments
  • 34% of adult participants had less than a high school education and 35% had a high school degree.

• Racial and Ethnic minorities
  • 67% of program participants belonged to a racial/ethnic minority.
# The Home Visiting Program

## State Grantees Selection of Home Visiting Models

03/24/14

<table>
<thead>
<tr>
<th>Evidence Based Model</th>
<th>Number of States Implementing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Families America</td>
<td>41</td>
</tr>
<tr>
<td>Nurse-Family Partnership</td>
<td>40</td>
</tr>
<tr>
<td>Parents as Teachers (PAT)</td>
<td>30</td>
</tr>
<tr>
<td>Early Head Start</td>
<td>26</td>
</tr>
<tr>
<td>Home Instruction for Parents of Preschool Youngsters (HIPPY)</td>
<td>9</td>
</tr>
<tr>
<td>Healthy Steps</td>
<td>3</td>
</tr>
<tr>
<td>Child First</td>
<td>1</td>
</tr>
<tr>
<td>Family Check-Up</td>
<td>1</td>
</tr>
</tbody>
</table>
Resources

Maternal Infant and Early Childhood Home Visiting
http://mchb.hrsa.gov/programs/homevisiting/

Home Visiting Evidence of Effectiveness (HomVEE)
http://homvee.acf.hhs.gov/
Louisiana’s Innovation with Nurse-Family Partnership

Caring, Advocating, and Leading in Maternal and Child Health, One Family at a Time

Gina Easterly, PhD, CCC-SLP
Supportive Services Program Manager

Sarah Hinshaw-Fuselier, PhD, LCSW
Infant Mental Health Specialist Manager

Louisiana Department of Health and Hospitals, Office of Public Health, Bureau of Family Health
Introductions and Purpose

Gina Easterly, PhD, CCC-SLP
Supportive Services Program Manager

Sarah Hinshaw-Fuselier, PhD, LCSW
Infant Mental Health Specialist Manager

Discuss Louisiana’s implementation and innovation of evidence-based maternal, infant and early childhood home visiting
Nurse-Family Partnership (NFP)
Overview

• Evidence-based, community health program

• Home visiting program for first-time mothers from low-income backgrounds and their babies

• Registered nurses provide support from early pregnancy until the child’s second birthday
Goals of NFP

• Improve pregnancy outcomes
  • Helping women engage in good preventive health practices, including thorough prenatal care from their healthcare providers
  • Improving their diets
  • Reducing their use of cigarettes, alcohol and illegal substances

• Improve child health and development by helping families provide nurturing, responsible and competent care

• Improve the economic self-sufficiency of the family
  • Helping families develop a vision for their own educational future
  • Plan future pregnancies
  • Continue their education and find jobs
NFP Program Effects Research Trials

• Three randomized, controlled trials with demographically diverse populations
  • Improved prenatal health
  • Fewer childhood injuries
  • Fewer subsequent pregnancies
  • Increased intervals between births
  • Increased maternal employment
  • Improved school readiness
History of NFP in Louisiana

• Implemented in 1999 to address poor maternal and child health outcomes

• Administered by the Louisiana Department of Health and Hospitals Office of Public Health

• Input from the Tulane School of Medicine’s Department of Psychiatry and Behavioral Sciences
Expansion of NFP in Louisiana

1999: Pilot program with two teams of 8 nurses in 7 parishes

2005: Included in the Governor’s Children's Cabinet

2009: State Early Childhood Advisory Council recommended that NFP be expanded

2011: Capacity to serve 59 of 64 parishes

Partnerships with agencies with shared commitments and goals
• Serve families from low-socioeconomic backgrounds
• Commitment to innovation and evidence-based practices
• Commitment to growing and expanding the program
• Strong relationship with referring agencies
• Flexible and focused on supporting nurse home visitors to succeed
• Collaborative, strong alignment with mission and priorities
• Financially stable
NFP in Louisiana

• Served more than 15,000 families since 1999
• 18% reduction in smoking during pregnancy
• 24% increase in workforce participation among NFP clients 18 or older between intake to completion
• 92% of 24 month olds are fully immunized
Innovation and Augmentation of NFP in Louisiana: Addition of Infant Mental Health Specialists

- Primary goals of augmentation:
  - Reinforce healthy relationships and development
    - Infant’s quality of attachment to primary caregiver is one of the strongest predictors of psychological and social outcomes in middle childhood and adolescence.
    - Attachment security in infancy is considered to be a protective factor for later mental health.
    - Attachment insecurity and disorganization in infancy are considered risk factors for the development of psychopathology.
  - Support healthy parenting in the context of maternal mental health concerns
Innovation and Augmentation of NFP in Louisiana

• Primary Goals of Augmentation
  • Address maternal mental illness
  • Identify and address early childhood emotional, behavioral and relationship concerns
  • Early intervention matters
Development

Protective factors:
- caregiving relationships
- social class
- IQ

Risk factors:
- poverty
- parental mental illness
- parental substance abuse
- abuse/neglect
- teenage parenthood
- low birthweight

Favorable outcome

Unfavorable outcome

Institute of Infant and Early Childhood Mental Health--Tulane University School of Medicine
Early Intervention Effects

Change from a high-risk to a low-risk trajectory

Adaptive behavior

Delinquency
Substance abuse
Psychiatric sequelae
School failure

Intervention
Returns to a Unit Dollar Invested

Source: Heckman (2008)
Need for Mental Health Services

- Need for perinatal mental health and infant/early childhood mental health perceived early on in NFP implementation
  - Limited mental health coverage available through Medicaid
  - Limited number of providers who accept pregnant women
  - Limited number of early childhood mental health providers
Need for Mental Health Services

- Expertise available locally
- Began with two IMHSs in 2000
- Gradually expanded to eight by 2011
Need for Mental Health Services

• 2011 review of clinical depression screens among pregnant NFP mothers found
  • Almost 22% reported clinically significant depression symptoms
  • 25% of mothers identified four or more mental health risk factors that can negatively impact current self-care or parenting functioning
Effects of Depression

- Infants of depressed mothers are less positive and more negative when interacting with their mothers.
- Insecure attachment is more common.
- Young children of depressed mothers tend to be more impulsive and to have more difficult peer interactions.
- Child psychiatric disorders are more prevalent when mothers are depressed.
- Children of depressed mothers are at increased risk for cognitive, language problems.
Infant Mental Health Services in NFP

- IMHSs provide NFP teams with
  - Direct behavioral health services for clients
    - Mothers
    - Parent-child relationships
    - Families
  - Consultation and support to the nursing staff & supervisors
    - Case consultation
    - Individual consultation: Nurses, supervisors
  - Coordinate client care with NHVs
Implementation: IMHSs in NFP

- Part-time to full-time, depending on team
- Licensed mental health providers
- Sub-specialization training required
- Group and individual clinical supervision provided
Implementation: Nurse Home Visitors

- Introduce to Infant Mental Health (IMH): Training
  - Increase awareness of IMH needs
  - Increase awareness of maternal mental health issues
- Implement mental health screening to clients
- Make referrals to IMHS
  - Introductions/joint visits decided case by case
- Coordinate client care with IMHS
Evaluation, Next Steps and Lessons Learned

• Currently evaluating the IMHS augmentation

• Final evaluation results expected within the next six months

• Qualitative and quantitative data

• Preliminary data highlights:
  • Families with IMHS receive more resources of all kinds
  • IMHS augmentation valued by nursing staff, home visitors, supervisors, teams
Evaluation and Lessons Learned

Nurses feel

• More confident

• Better supported in caring for complicated clients

• Better able to focus more on their role with clients
Evaluation: Nurses

• "It used to scare me to have to talk to a client about their mental health issues...since having (IMH-S), she gives us feedback and support, so I'm not as afraid to address it with a client."
  [- Nurse Home Visitor]

• "...doing the introductory visit with (IMH-S) makes clients more aware of the services that we do and helps us provide more comprehensive, holistic care to our clients."
  [- Nurse Home Visitor]
**Evaluation: Team Supervisors**

- "I think her (IMH-S) role has had a huge impact with our team as far as meeting mental health needs of our clients...she has been able to support the nurses in being able to deliver the NFP program more effectively because they don't have to go into a visit and spend 60 minutes dealing with an ongoing mental health issue."
  
  [- Nurse Supervisor]
Evaluation: Clients

- "The best thing is that I'm back on track with my life. Before it was out of control. She helped me see things in a whole other light and look at things in a different way. I've gotten back to being me."

- "My anxiety was really bad and now I barely have any attacks...from talking with her she's helped me to overcome a lot of things. I used to be very shy, she taught me how to open up and speak to people."
Evaluation and Lessons Learned

• Important for relationship between IMHS and nurses to be developed.

• “I feel that I work very closely with the team, we kind of have a cohesive gel that works well for us. I work closely with the nurses when they have difficult cases, whether I'm providing direct care for that client or not.”
  - [IMHS]
Evaluation and Lessons Learned

• Difficult to find qualified mental health providers
• Training and support important
Questions

Gina.Easterly@la.gov
Sarah.Fuselier@la.gov
Roundtable Discussion
Please take a moment to fill out our brief survey.
Stay Connected

Visit healthypeople.gov to learn more about the Healthy People 2020 Leading Health Indicators.

To receive the latest information about Healthy People 2020 and related events, visit our website to:

- Join the Healthy People 2020 Consortium
- Share how your organization is working to achieve Healthy People goals

Follow us on Twitter @gohealthypeople

Join our Healthy People 2020 group on LinkedIn
Join us for the next “Who’s Leading the Leading Health Indicators?” Webinar!

November 19, 2015

Learn more about the Nutrition, Physical Activity, and Obesity LHI Topic.

Registration information coming soon.