Healthy Start

Coalition of Flagler & Volusia Counties, Inc.

Strengthening Our Future

2017 – 2021 Service Delivery Plan

Healthy Start Coalition of Flagler & Volusia Counties, Inc
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Children of the Village

It takes a whole village to raise a child
I am a child of the village

I am mothered by village mothers
And fathered by village fathers
I am fed by village cooks
And clothed by the village weavers

I am protected by village keepers
I learn from the village warriors
And charm the village maids

I dance to the village drum
And chant the village song
I worship at village alters and weep at village pain

I hear stories from the village griots
And honor the village elders
I am loved by the village – ALL

And every breath and heartbeat
Echoes praise to my village
I am a valued gift
Made so by village love

Adapted from Judith Boswell Griffie, 1994

The Healthy Start Coalition of Flagler & Volusia Counties, Inc.
2017 – 2021 Service Delivery Plan

EXECUTIVE SUMMARY

The Healthy Start Coalition of Flagler and Volusia Counties is pleased to present this 2017-2021 Five Year Service Delivery Plan as we enter our 25th Anniversary. This plan is the culmination of assessment of need, analysis of resources and gaps, review of challenges, barriers and strengths, and setting of priorities and corresponding action planning.

We have enjoyed many accomplishments since the last five year plan was completed. Our maternal and child health system of care has adapted to the changing needs of our families and the implementation of Managed Care in the state of Florida. We have worked with local policy makers to leverage financial resources to fill critical service gaps, especially for the most vulnerable pregnant women, babies and families.

Throughout the last year, our Coalition convened multiple meetings to review available quantitative and qualitative data associated with maternal and child health including service data in order to identify the top priorities of our work for the next five year period. Once priorities were established, strategic planning of activities among our participant stakeholders enabled us to establish key strategies and action steps to guide our important work as we move forward.

Since the last planning cycle our infant mortality rate area declined among white and black babies in both of our county service areas, while the low birth weight rate remained unchanged. Racial disparities in infant mortality, fetal loss, low birth weight and access to care continue to be significant. Moreover, related indicators such as access to early prenatal care, planning of pregnancy, substance and tobacco use during pregnancy, and maternal mental health were key areas of our analysis and strategic planning.

The Consideration of social determinants of health has become integral to our ongoing work. Inevitably challenges faced by our families in the areas of income, housing, education, community and domestic violence and nutrition were sources of vibrant discussions and data review, which aided in the development of our plan of action for the next five years. We worked toward the development of consensus and unified under a common truth – there is much for us to do!

We arrived at five key priorities to impact the chosen indicators which include activities associated with: 1) increasing awareness about maternal and child health services; 2) sustaining a comprehensive staff training and development plan; 3) implementation of strategies from the local Fetal Infant Mortality Review/Case Review process and recommendations; 4)utilizing the Strengthening Families Protective Factors as a framework for family and community engagement and; 5) supporting a system of care to respond to the growing number of babies being born with neonatal abstinence syndrome as a result of drug use during pregnancy.

The development of this plan would not be possible without the dedication of professionals and stakeholders from the public and private sectors who devoted their time and expertise to the service delivery planning process. Our service delivery planning members include representation from health, human services, education, policy, consumer and the business sectors. This plan was designed to be a living document and will serve as a guide for our service area toward the well-being of our families and the future of our “village.”

The Healthy Start Coalition of Flagler & Volusia Counties, Inc.
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I. INTRODUCTION

A. Healthy Start Initiative

In 1991, the Florida Legislature launched the Florida Healthy Start Initiative (s.282.2161, F.S.) to ensure that all babies born in the state of Florida be given the opportunity to have a healthy start in life. The goals of Healthy Start are to reduce infant mortality, reduce the incidence of low birth weight and improve the overall health of Florida's children. The key components of the statute mandated **(1) universal screening of pregnant women and newborn infants to identify those at risk of poor birth, health and developmental outcomes; (2) increased access to comprehensive, risk-appropriate maternity and well-child care and support services; (3) state-wide implementation of community-based care coordination systems; (4) expansion of Medicaid funding and expanded eligibility for pregnant women; and (5) formation of local coalitions to spearhead system change through public-private partnerships at the community level and leverage additional resources.** The statute ultimately vested these coalitions with the authority to allocate state and federal dollars to purchase and oversee services for families in their communities. It is now evident that the wisdom of those legislators has contributed to saving the lives of thousands of children during the twenty years.

Healthy Start Coalitions are non-profit organizations dedicated to improving the health of pregnant women, babies, and families in their community. The state's 32 Coalitions mobilize partnerships comprised of professionals and volunteers from all segments of the community who work together to ensure that key services are in place for this important target population. Together, the leadership of these Coalitions participates in statewide activities as members of the Florida Association of Healthy Start Coalitions, or FAHSC. Members include local, public and private medical professionals, representatives of local hospitals, school districts and social service agencies, faith-based representatives, local business men and women, consumers of maternal and child health services and other interested community members. The comprehensive diversity and inclusion of coalition membership provides the venue for communities to come together to identify and address local health problems and implement coordinated systems of care through which the unique needs of that particular community may be met. The legislative mandated responsibilities of each Coalition include: increasing public awareness of the issues related to infant mortality; building and maintaining broad community support; selecting and contracting with local providers for the delivery of Healthy Start services; performing on-going monitoring and evaluation of contracted services; and, conducting short and long range planning for the local maternal and infant populations.

Since the last service delivery planning cycle, there have been significant changes to the way Healthy Starts operate in relation to our legislation. As Florida's Medicaid Managed Care was implemented in the last two years, new legislation was enacted that charges us to interact deliberately and collaboratively with the governmental and private aspects of Medicaid Managed Care, specifically, with the Florida Agency for Health

Care Administration and the private Managed Care Plans in each of our regions. As a result of this, our state association was directed to form an Administrative Services Organization (ASO) which is now known as the Healthy Start Mom Care Network. This entity is the contracting agent with the Agency for Health Care Administration and subsequently subcontracts with each Coalition to serve women and babies on Medicaid. Collectively, we are working with all of the states Managed Care entities to coordinate services for their participants and align our efforts to meet outcome performance measures related to maternal and child health.

B. The Healthy Start Coalition of Flagler and Volusia Counties

The Healthy Start Coalition of Flagler and Volusia Counties was founded in 1992 as the result of a collaborative effort among many local individuals, organizations, and governmental entities. The founding organizations included the Constituency for Children of Volusia and Flagler Counties, the Volusia County Children & Families Advisory Board (formerly the Volusia County Children's Services Council), Volusia County Health Department, Flagler County Health Department, Halifax Medical Center and the United Way of Volusia and Flagler Counties.

The Coalition's membership has expanded significantly since inception, as has the scope and depth of its responsibilities as defined through its contracts with multiple funding entities. The Coalition's primary objective is to work with the community through fund leveraging and allocation, strategic planning, and service delivery to improve the health of our community's maternal and infant population.

At present, our Coalition has structured governance with components designed to ensure quality oversight in the areas of business and financial management, service delivery, community collaboration, resource allocation, marketing, leadership, and fund development.

C. Major Accomplishments of the Past Five Years

There have been numerous accomplishments toward the improvement of maternal, child and family health in our two county service area of which Healthy Start has been a leader or contributor. These are described below in Community Partnerships, Healthy Start Initiatives, Outcomes, and Staff Development.

1. Community Partnerships and Initiatives

There are multiple services and systems that intersect in maternal and child health in our two county service areas. The Healthy Start Coalition is a convener of partners where focused collaboration is needed to achieve desired results. We also participate in initiatives in our community that address the well-being of families through health and human services, academic support, and workforce development. We list those below that have been particularly instrumental in promoting improvements for our pregnant and postpartum women, infants and young children, and their families.

a. One Voice for Volusia

The Healthy Start Coalition participates in a broader coalition building initiative known as One Voice for Volusia. One Voice for Volusia advocates for efficient use of resources and data-driven outcomes and promotes system and community improvements by fostering diverse partnerships in the health and human services field. One Voice for Volusia is a neutral convener engaging leaders, organizations, and individuals to develop strategies to improve the community. One Voice for Volusia has been a more global umbrella under which we have been able to garner support and momentum.

1) **Community Agenda Snapshot** - This annual report is the result of hundreds of volunteers committed to making Volusia and Flagler Counties a better place to live, work, and play. The motivation behind this work is to create a data-based picture of health and social service trends and conditions that are updated every year. This initiative is a long term process, community-shaped and community driven, designed to engage the community by examining data and establishing priorities to improve local health and human services.

2) **Thrive by Five** - One Voice for Volusia convenes stakeholders among its coalition who serve families with children prenatal through age five. Through strategic planning stakeholders are able to align our efforts and increase collective impact through partnership building, information sharing and integration of services. This has resulted in networking and partnerships that have contributed to leveraging of significant resources through Healthy Start.

b. Behavioral Health Consortium

The Volusia and Flagler County Behavioral Health Consortium convene to review the service delivery system for those experiencing problems with substance abuse or mental health. The Healthy Start Coalition is a valuable member of this consortium, and we strive to increase awareness through our behavioral health partners about perinatal mood disorders/maternal mental health and infant mental health as well as the challenges and needs associated with substance and alcohol use during pregnancy that can result in fetal alcohol spectrum disorders, neonatal abstinence syndrome, and higher risk for developmental, neurobiological, and physical health challenges for our babies. This consortium was instrumental in encouraging our coalition to apply for and receive funds to develop a high risk team specializing in serving our families with young children who are experiencing behavioral health problems that might impact their ability to provide positive parenting or support the developmental needs of their children.

c. Help Me Grow

Florida became a *Help Me Grow* replication state in 2012, with the simultaneous launching of the initiative in Hillsborough (Tampa) and Miami-Dade counties. On a state-wide level, what originally started as the Florida Developmental Disabilities Council taskforce, has since, adopted the broader mission of the *Help Me Grow* initiative which has expanded throughout Florida. *Help Me Grow* promotes the Ages and Stages Developmental Screening through multiple venues to ensure parents are able to screen their children and link to services if their child(ren) are not developmentally on task. The Healthy Start Coalition has been an active partner and provides screening at our Family Place ACCESS locations and promotes the program to our participants during intake, assessment, and home visiting. We recently used our Lifesong initiative to provide information to our 115 participating African American Faith Community partnerships.

d. Northeast Central Infant Mental Health Chapter

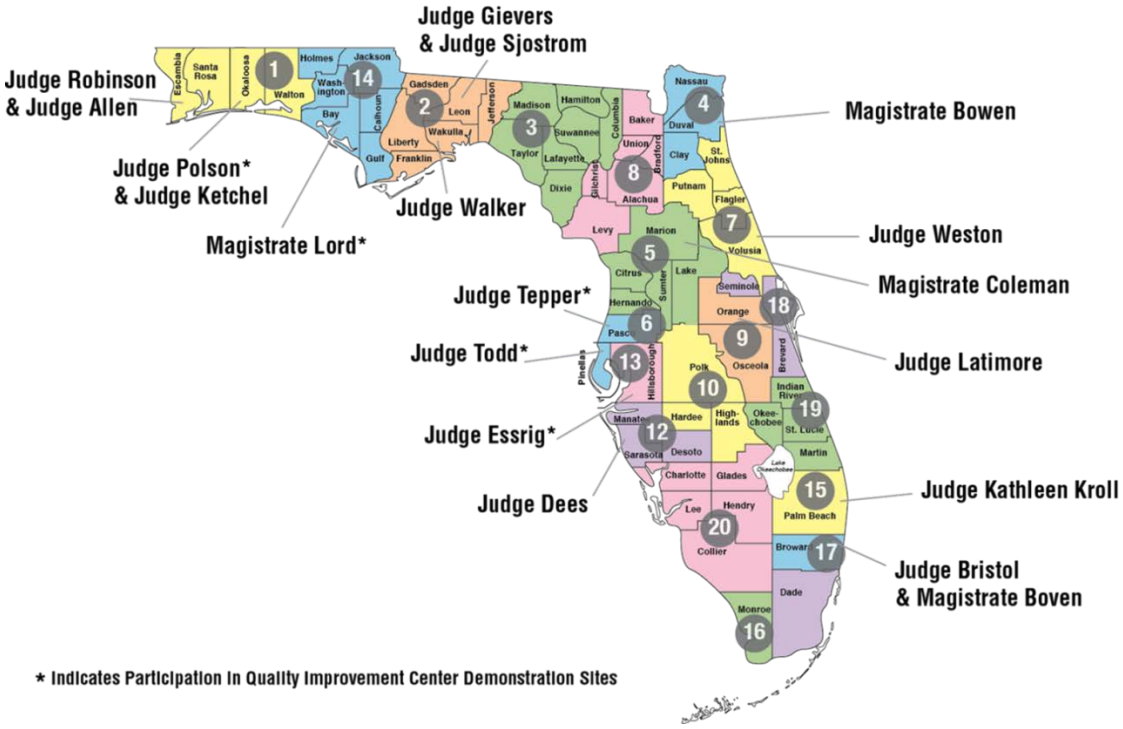
The Healthy Start Coalition co-chairs this initiative, which encompasses the 7th Judicial Circuit and promotes access to tier 1, 2, and 3 infant mental health services for children ages 0-5 years old.

Our activities include educating staff about infant mental health and positive attachment, coordinating with child welfare and behavioral health agencies to ensure information and referral processes are utilized and updated, and providing a forum for service providers to gain clinical expertise from Infant Mental Health experts on managing difficult cases. One of the accomplishments of this group was the collaboration with our 7th Judicial Circuit with focus to implement the Early Childhood Court Team and ensure that the level of trauma to the family is reduced through trauma-informed practice, expedient permanent placement for the child, and ongoing support to respond to the impact of removal with qualified infant mental health support.

e. Early Childhood Court Team

The 7th Judicial Circuit is one of several pilot projects that hold a special court for families with very young children (under age 5). The Healthy Start Coalition has participated in this project since its inception and has recruited and trained Parent Partners that are appointed to cases, so that, families have a mentor to help them navigate with their babies through the child welfare system. This program gives hope to families that they can successfully reunify with their children, or can support them as they courageously make a deliberate decision to surrender their rights and help their children find a permanent home. The science of early childhood development is the common ground for this program and seeks to give babies the best chance at growing up with stable and loving caregivers. The figure below shows the ECC sites by judicial circuit as of July 2016.

Figure 1. Early Childhood Court Sites by Judicial Circuit 2016



f. Flagler CARES

Though Flagler County is a smaller county with less than 1,000 births annually, they have very active leaders and seek to improve the service delivery system for their residents and families. The Flagler CARES group focuses on access to health care for residents and developing a continuity of care for all. The commitment of this group resulted in the successful implementation of a Federally Qualified Health Center, which was awarded to Azalea Health. The Healthy Start Coalition participates in this group and contributes to the knowledge bases' and access concerns for pregnant women and young children. The very low number of clinical prenatal health services in Flagler County makes this group a valuable one to participate in, as prenatal care access is a primary objective of our Service Delivery Plan.

g. Community Health Needs Assessment (CHNA)

The Healthy Start Coalition actively participates in the Community Health Needs assessment process (CHNA) in both Flagler and Volusia Counties and ensures the alignment of strategies with our health centers as it relates to maternal and child health. This work is reflected in this plan where appropriate.

h. Child Abuse Prevention and Permanency Plan (CAPP)

The Healthy Start Coalition has been a leading participant in the Circuit 7 Child Abuse Prevention and Permanency Plan and has worked with stakeholders to ensure a focus on safety issues affecting young children to include safe sleep, safe caregivers, drowning prevention, shaken baby, and hot car abandonment. This has helped align efforts in infant safety and reduce duplication of effort. We have identified substance use by parents and caregivers as a major factor impacting the outcomes in these cases, and we work as a collaborative group to employ effective strategies to improve outcomes for our most vulnerable children.

i. Healthy Volusia

Our Florida Department of Health in Volusia convenes the Healthy Volusia group monthly to address issues impacting the general health of the residents in Volusia County to include healthy weight and social determinants of health. This group has taken the lead in developing objectives outlined in the Florida's Healthy Babies Initiative, and the Healthy Start Coalition is a relevant and active partner in their efforts.

2. Healthy Start Initiatives

The Healthy Start Coalition of Flagler and Volusia Counties has worked diligently to be a trusted voice and leader in our service area in all areas related to pregnant women and the well-being of families with young children. This role and the confidence we have earned from our stakeholders has enabled us to mobilize partners and leverage the in-kind and monetary resources needed to better serve our families. The following initiatives have contributed to this success:

a. Lifesong

The origins of this initiative began in 2007, during our first SIDS Sunday event, when we printed and distributed over 5,000 church fans to over 80 churches in Volusia and Flagler Counties. We have continued this event each year and connected to groups such as, the Black Clergy Alliance and Bethune-Cookman University (a historically Black College, located in Daytona Beach). Our connection to these groups led to a more meaningful dialogue about the need for a more concerted effort, to educate the Faith Community about the nature and scope of the extreme disparities in infant mortality.

Lifesong is a partnership initiative with the African American Faith Community to address the significant disparities in fetal and infant mortality, other health indicators, and health access. This project incorporates music, song, narrative, art, and dance to engage the faith community and inspire empowerment and

organization toward supporting better health outcomes. The dialogue toward improved awareness about the nature and scope of black infant mortality and health disparities, is gaining momentum.

Our Coalition was chosen to present a poster at the 2014 CityMatch Conference in Phoenix, Arizona. The Black Infant Mortality rate in our service area has showed a steady decline since the inception of this program. During the last five years, our coalition has targeted service delivery to the most impacted zip codes.

b. Beds for Babies and Practical Support for Participants

This initiative garners community support for leveraging of financial assistance to purchase safe sleep environments for families who cannot afford one, as well as, materials to distribute to all families about the importance of safe sleep and how to ensure babies remain safe while they sleep. In the last 5 years, over $40,000, in cash and in kind support, has been leveraged to purchase thousands of safe sleep environments and provide baby showers and transportation support for families in our community. Funds have been leveraged from Junior League, Rotary, and fundraising by private donors. We will continue to support safe sleep for our babies.

c. Managed Care Task Force

Our region was the first to implement the new Medicaid Managed Care program. Concerned about the impact of Medicaid changes for our women and babies, we were encouraged to convene an *ad hoc* taskforce, to keep consumers and providers informed, and collaborating, to ensure continuity of services and access to care. We convened members of the Agency for Health Care Administration, the Department of Children and Families, the Florida Department of Health in Volusia and Flagler Counties, Choice Counseling, Halifax Health, Florida Hospital, all participating Managed Care organizations (Staywell, Molina Health Care, Magellan Complete Care, United Health Care, and Sunshine Health Care), private clinical prenatal providers, consumers, and the media to make sure the public was informed, and identified challenges to access and navigation that occurred as the changes were implemented. In addition, we were able to keep the provider network engaged by addressing problems they encountered with billing, authorization approvals, and communication.

d. Substance Exposed Newborn Task Force

As a response to the significant increase in the number of babies born with Neonatal Abstinence Syndrome, as a result of drug use during the mother's pregnancy, we took the lead in convening key stakeholders to address the needs of these mothers, babies, and their families.

Members of this group include the Department of Children and Families, Children's Medical Services, Early Steps, Florida Hospital, Stewart-Marchman-Act Behavioral Healthcare, Community Partnership for Children, Halifax Health Neonatal Intensive Care Unit, University of Florida, private OB/GYN's, Pathfinders, Children's Home Society, Healthy Communities, Chrysalis Recovery, Darryl Strawberry Recovery Center, 7th Judicial Circuit, and parent consumers.

The impact of this group has been significant and has contributed to a best practice model for our families and providers. We have leveraged over $300,000 in addition to Healthy Start funds for intervention, case management, medical support and family planning, behavioral health care, and practical support for women and babies impacted by substance use.

We have worked steadily toward best practice integrated services model that focuses on staff development, participant engagement, peer support, trauma counseling, coordination with opioid prescribers and OB/GYN's, and interconception support after the birth of the baby. As we enter the new fiscal year, we have been approved for additional funding to sustain this model and we are working toward aligning our efforts with the Healthy Start's proposed redesign of services (2.5 Redesign).

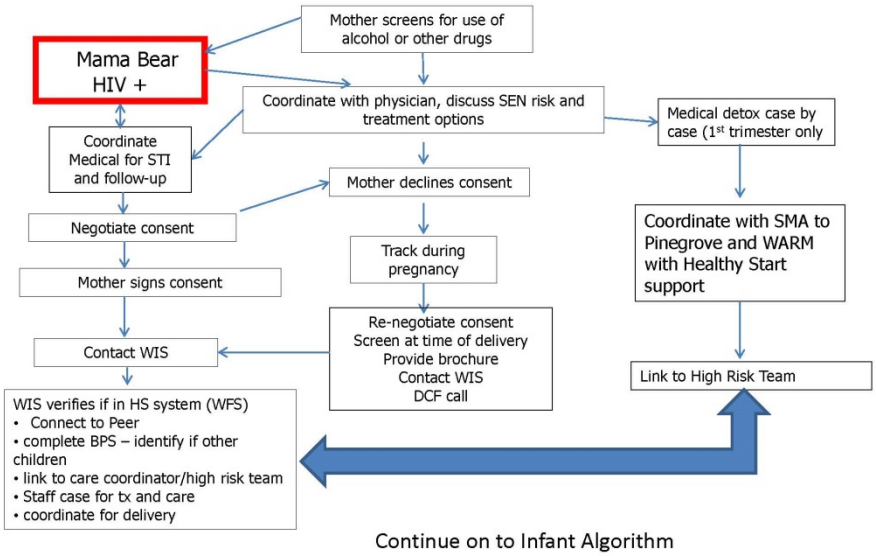
Since the last planning cycle, the capacity for residential treatment has expanded from 16 beds to 78 beds for pregnant and postpartum women and their babies at WARM (Women Assisting Recovering Mothers) at the Stewart-Marchman-Act Center. Healthy Start funds two care coordinators at this residential facility.

However, women on opioid management have few resources for housing and residential services and our community is challenged with ways to coordinate services for all the women who come into our system.

Figures 2 and 3 show the algorithms that have been developed to guide us in our intake and triage processes.

PREGNANCY SUBSTANCE EXPOSED NEWBORN (SEN) ALGORITHMS

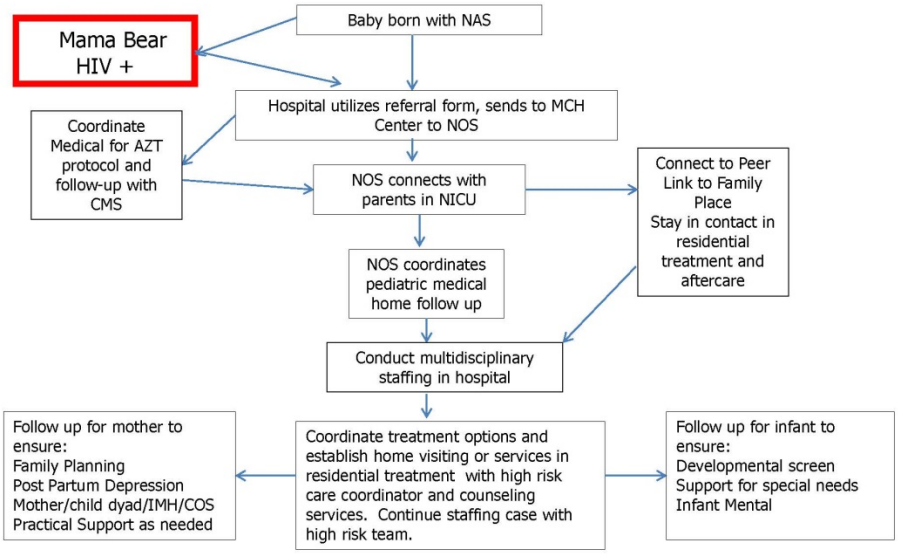
Figure 2 : Process & Resources – Pregnancy SEN Algorithm



Continue on to Infant Algorithm

NEONATE SUBSTANCE EXPOSED NEWORBORN (SEN) ALGORITHMS

Figure 3: Process & Resources – SEN Algorithm



e. Family Engagement and Advisory Board

Family Engagement has been identified as a core value of our service delivery and cannot be accomplished without a consistent process designed for hearing the family voice. With funds leveraged from the Community Partnership for Children, this group is regularly convened and parents are in leadership roles to train and advise the service system about family needs, trauma, family case planning challenges, and ways to engage families who are struggling in the system. Policy recommendations have been presented by this group, and the Chair of this board has been asked to participate in the Casey Family Foundation's Birth Parent Network and has testified before the Senate Ways and Means committee about issues impacting family well-being.

f. Maternal, Infant, Early Childhood Home Visiting Initiative

In 2015, the Healthy Start Coalition of Flagler and Volusia Counties submitted a grant proposal to the Florida Association of Healthy Start Coalitions (FAHSC) Maternal Infant and Early Childhood Home Visiting (MIECHV) Project to expand upon our Centralized Intake and Referral Center to better utilize capacity and more effectively match families to available services.

This project has resulted in activities that can align some of the many initiatives we participate in to centralize referrals from key points of entry for families. One major accomplishment of this effort is the development of a local data tab in our Well Family data system that will enable us to review data, identify families within our multiple service systems, and evaluate outcomes for families touching many services.

g. FIMR Project

The Fetal Infant Mortality Review (FIMR) approach was developed by the American College of Obstetrics and Gynecology (ACOG) and includes an abstraction of information from birth, death, medical, hospital, autopsy, and social service records. Whenever possible, family interviews are also conducted. All information is "de-identified" to ensure that the focus is on systemic strengths, challenges, and recommendations and not on individual providers. Confidentiality is a key component to the process and is strictly maintained in accordance with Florida Statutes 766.101.

The Case Review Team (CRT) is a multidisciplinary team of professionals who volunteer their time and expertise to this process. These members are representative of the public and private sector and include physicians, nurses, midwives, medical examiners, public health officials, law enforcement, academic institutions, clinical staff from various health and human services fields, and hospital administration.

During the last five years, the FIMR process has resulted in activities and publications designed to increase community and provider awareness about infant and fetal loss. FIMR now convenes a data workgroup regularly to review information related to causes of death and strengths and weaknesses in the system in order to better coordinate with service delivery staff to address areas of need. In addition, the Coalition conducts a pre-FIMR meeting to review initial abstraction data, to ensure information is properly de-identified and information is comprehensive and has been properly entered into the BASINET (Baby Abstracting System and Information Network) data system.

The ultimate goal of the FIMR project is to translate what we learn into action intended to reduce the incidence of infant mortality and fetal loss, inform and improve the system of care, and better support our providers and families.

3. Improvements in Healthy Start Service Delivery

In addition to performance measures established through our contract with the Florida Department of Health, we have seen improvements in Healthy Start service delivery for measures we hold ourselves to thorough our contracts with other funding entities. This commitment has enabled us to continuously expand the maternal and child health system of care in our two county service area.

We have been able to meet or exceed all core outcome and performance measures in our Florida Department of Health Contract as narrated below.

a. Core Outcome and Performance Measures

As reflected in our 2015/2016 Year End Report, our Coalition continues to achieve goals set forth in our Core Outcomes and Performance Measures.

Since the last service delivery cycle, our Coalition has continued to maintain high prenatal and postnatal screening rates. Though our goal for screening rates was 78%, our achieved percentage for 2015/2016 was 94.66%. We consistently have exceeded our goal annually over the last five years. We continue to be higher than the state rate which was at 74.15% last fiscal year.

The percentage of women consenting to the prenatal screen also exceeded the objective, which was 80%. The state rate was 88.84% and our coalition rate was 90.54% The percentage of women who were eligible and the consented to participate in the Healthy Start program was 96.01% , which exceeded the goal of 95%.

For the last five years, 100% of Healthy Start participants received an Initial Contact or attempt to contact within five days of the screen. In 2015/2016 100% of Healthy Start participants, determined to be in need of an Initial Assessment, received an Initial Assessment, or an attempt to assess, within 10 working days of an Initial Contact.

Also in FY2015/2016, 100% of Healthy Start records contained documentation that status of Initial Contact has been sent to the healthcare provider within 30 calendar days from first attempt to contact (the goal was 95%).

Also at 100% was the percentage of Healthy Start records with a documented Initial Contact that contained documentation of an Individualized Plan of Care at the time of Initial Contact. The contractual goal was 95%.

4. Staff Development

Our Coalition has developed a comprehensive training plan for our service delivery staff. This is a systemic way to ensure that all field staff has the knowledge, skills, and competencies required to navigate an often complicated system of care. As part of the training plan requirements, we integrated cultural competence into all aspects of clinical training components. As the service needs have changed, our continuous updating of this plan empowers us to adapt to improvements in science and evidence, as well as to recommendations that emerge from our FIMR CRT and Community Action Group (CAG), our data, and our consumer and provider feedback.

As a result of our commitment to staff development and alignment with community needs, our staff has completed core training activities that improve their efficacy and support quality services to our families. These include but are not limited to:

- Certification as Community Health Workers
- Community Outreach and Perinatal Educator certification (COPE)
- Trauma Informed Care
- SCRIPT Smoking Cessation Certification
- Maternal Mental Health – Post Partum Depression & Perinatal Mood Disorders
- Protective Factors and the Community Café
- Partners for a Healthy Baby – FSU Curriculum
- Motivational Interviewing and Stages of Change
- Special Needs of Substance Exposed Newborns & their Families
- Mandated Reporting
- Safe Sleep and Infant Safety
- Risk Appropriate Care
- Family Engagement

II. DESCRIPTION OF PROCESS AND MODEL USED TO UPDATE THE NEEDS ASSESSMENT, RESOURCE INVENTORY AND ACTION PLAN

The Healthy Start Coalition of Volusia and Flagler Counties continually strives to identify and meet the emerging needs of the communities it serves. Information relating to local population characteristics, current and past birth outcomes, and health indicator data related to birth outcomes, reported service needs, perinatal services utilization, and local area resources was compiled from multiple sources to serve as the basis for the most current Healthy Start needs assessment

The Service Delivery Planning process has been improved through systemic review of data and action planning objectives using the MAPP process (Mobilization for Action through Planning and Partnerships). The Coalition adjusted its timeline for Coalition meetings to ensure that quarterly reports can be reviewed publicly after the 25th of the month following a quarter. In this way, core performance measures are reviewed in relation to our action plan objectives with stakeholders convened to determine which strategies are effective and which strategies may require modification. This promotes an open evaluative process where stakeholders can openly discuss the need for programmatic or systemic change in order to meet objectives. This follows the MAPP process of Evaluation, Planning, Implementation and Action.

This provides for ongoing planning and a more informed and mobilized Coalition who participates more fully in the five year planning process because they are an active part of action planning throughout the year. This also allows our action plan to be a living guide that stakeholders are familiar with and feel empowered to change when needed.

Healthy Start participant feedback and information relating to specific health status and service delivery indicators are collected and compiled regularly by the Coalition's staff and management team each year. The organization periodically conducts a full comprehensive needs assessment during each service delivery planning cycle, which then serves as the foundation for the next Service Delivery Plan. The full assessment incorporates additional consumer and provider surveys, more detailed indicator and service data, and active community input and feedback, which is organized into a detailed analysis of local maternal and child health needs.

Upon completion of the analysis of the Needs Assessment findings, the Coalition identified priority areas for Action Plan development. In addition to the MAPP process (Mobilizing for Action through Planning and Partnership), we have developed a visual model which aligns data, assessment findings, priorities, strategies, and anticipated outcomes.

A. Summary of Data Sources

1. Florida CHARTS, Vital Statistics and US Census Data

The health status indicator and demographic data utilized in the assessment process was obtained from accessible Florida Vital Statistics databases, Florida CHARTS,

the Florida Department of Health's website, special data reports generated upon request by the Department of Health, and the U.S. Census Bureau. All of the data and information that was considered during the needs assessment and subsequent planning processes is available for review as a supplement to this document.

2. Healthy Start Screen and Service Data

In addition to serving as the entry point to the Healthy Start system of care, Healthy Start prenatal and infant screens also serve as a vital source of data that, when combined with other sources, help to create a vivid illustration of the circumstances and conditions that local consumers face each day. Data from completed Healthy Start screens is recorded daily into a statewide database. Summary reports generated by geographic location, race, ethnicity, etc. allow researchers to identify community-specific issues and trends among expecting mothers and their babies. The screening instruments address a wide variety of topics to identify potential risk factors for poor perinatal outcomes, and are often the only available documentation of specific risks, behaviors, and circumstances that occur within a particular community. It is important to note however, that the screening data is based on client self-report and reflects only what was documented and processed by the individuals who administer the screen. Therefore, the information may be affected by such issues as: fear among consumers about disclosing specific behaviors, staff turnover, and inconsistent reporting methodologies. For this reason, the data generated and collected from these tools are considered as minimum estimates of the actual occurrence of each factor and/or behavior.

Healthy Start services provided throughout the state, are available through Florida Department of Health CHARTS, Executive Summary Reports, and the Well Family Data system. De-identified, aggregate reports regarding the number and type of Healthy Start services provided in each county are updated by the Department of Health on a monthly basis and are available through the Department's website. These reports are invaluable tools in implementing effective quality management of Healthy Start services and systems of care, and for identifying and monitoring various trends in service provision.

3. Fetal and Infant Mortality Review (FIMR) Data

The findings of this committee relating to the leading causes of death and relevant associated risks were compiled and discussed among the Service Delivery Plan Committee members as an integral part of the needs assessment process. FIMR data is reported from the BASINET (Baby Abstracting System and Information Network) database; hence, FIMR data does not have epidemiological significance due to the small population size and geographical area investigated. Fetal and infant death cases are individually presented and examined to determine what systemic changes may have prevented the death or better responded to prevent future loss.

4. Participant and Provider and Coalition Feedback

In addition to utilizing data from public health and other electronic sources, Healthy Start conducts periodic surveys among local consumers, Healthy Start participants, and area medical service providers. Healthy Start participant satisfaction surveys are conducted semi-annually, while separate surveys pertaining to local participants needs are distributed to both consumers and medical providers during each full needs assessment cycle. The surveys are intended to solicit feedback regarding quality and value of existing services and needs. The survey process is an invaluable component to the comprehensive assessment in that it allows for qualitative data collection and provides an avenue for both participants and providers to express their needs and opinions regarding local programs and services.

5. Community Agenda Snapshot

The Coalition's active role in the development of the Community Agenda Snapshot and the finalized document itself proved invaluable to the gathering of information about related indicators and data trends in our community. The original core of indicators was identified and recommended by nearly 200 community members prior to its first publication. Selected data sets from the Snapshot were used and referenced in the development of the Needs Assessment.

6. Northeast Florida Counts

Northeast Florida Counts is a one-stop source of population data and information about community health in a dashboard design. It is hosted by the Health Planning Council of Northeast Florida, and the Healthy Start Coalition of Flagler and Volusia Counties participated in indicator selection and provided monetary support for its development. The site includes and compares indicators for Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia Counties health with other Florida counties, the nation, and national targets (Healthy People 2020; University of Wisconsin / Robert Wood Johnson's County Health Profiles) using more than 175 health and community sustainability indicators.

7. Well Family Data System

Since the last service delivery planning cycle, our statewide association of coalitions has implemented a new mechanism for capturing service delivery data known as, the Well Family Data system. This system allows us to track unique client identifiers over time in alignment with established coding and can adapt to the changing reporting needs as we consider new designs in our service system.

Though this is a relatively new system, we are still able to utilize some of the data we have garnered through its use.

8. Data Limitations

Overall, it is important to note that all data comes with limitations. Data sets have been compiled from numerous sources and may not be perfectly aligned with one another. Some data are presented in rolling averages and others by single year with the most current data available. Any conflicting data has been verified to provide for the most accurate accounts available. Furthermore, many data sets in the Service Delivery Plan are illustrated in graph form and their sources are referenced for further review, if desired.

Data that is presented by service area must also be reviewed in their proper context. Flagler County consistently has less than 1,000 births annually and therefore may seem to show severe fluctuations, even though it may be the result of two or less incidents of an outcome indicator, such as infant mortality. This is an important factor to consider when identifying trends for analysis and viewing data in chart form.

Through the process of conducting needs assessment activities, we were able to identify data sets that need to be developed and analyzed more thoroughly in the future. Development of new data sets requires that initial baselines be established and that multi-year averages be determined before the data can be validated. These are described further in our Action Plan. One example is in the area of substance exposed newborns. Wherever possible, we have coordinated with local and state partners to identify sources of data that can be obtained to gain a better understanding of the nature and scope of a particular issue impacting maternal and child health and well-being.

B. The Planning Process

The Service Delivery Planning process is an ongoing activity that takes place each quarter with reports of outcomes presented by all providers and stakeholders. The focus on the five year service delivery plan began in October 2015. A timeline of the Service Delivery Planning process is provided in Appendix I. Our timeline was designed to mobilize key stakeholders for specific tasks required to complete the five year plan. The phases of the timeline are described as follows:

1. Needs Assessment

a. **Phase I** - The Comprehensive Needs Assessment began with convening of the Healthy Start provider agencies to review Healthy Start Service Delivery data in relation to core performance measures and outcomes and the ongoing action planning of the Coalition.

b. **Phase II** - The second phase of the Needs Assessment process brought all community stakeholders together to review the findings of the provider agency group and begin to review related indicator data.

c. Phase III - The large group divided into groups and reviewed on specific indicators and conducted an assessment of the indicator data in their related area. Healthy Start staff responded to requests for data and meeting support as needed. The large group convened one final time to share their findings and build consensus about action plan strategies.

Based on the preliminary needs assessment data, the following areas were determined to be indicators for ongoing strategy development and action:

1) Infant Mortality
2) Black Infant Mortality
3) Low Birth Weight
4) Entry into Prenatal Care
5) Screening - prenatal and postnatal
6) Substance Exposed Pregnant Women and their Babies

d. Phase IV – The Service Delivery Planning group came together for two final meetings and made recommendations about the included priorities and strategies.

2. Resource and Gap Analysis

The Healthy Start Coalition works throughout the year to maintain a directory of available resources for pregnant and postpartum women and their families. In addition, we update our website monthly to ensure that resources are available to families and community based providers as well as health care providers. The committee conducted a review of the Resource Guide and also conducted a systemic overview of identified gaps in the system utilizing resources such as United Way's "211" system. This information was considered carefully as the Service Delivery Plan was developed and priorities and activities were determined.

3. Priorities and Strategies

Priorities were established based on extensive review of the data and resources and gaps. Throughout the planning period members reviewed the existing strategies in their indicator area and determined which strategies should be expanded upon and which new strategies should be developed based upon available data.

C. Model Utilized

It is important to ensure that the findings of the Needs Assessment translate into priorities and strategies that aim to improve outcomes. Accordingly, the Coalition utilized a model which provides a logical process for aligning data, assessment, priorities, strategies, and outcomes into a table format for easy viewing and action planning as illustrated on the next page. Our model is based on components of the MAPP model shown below in Figure 4.

Figure 4. MAPP Model

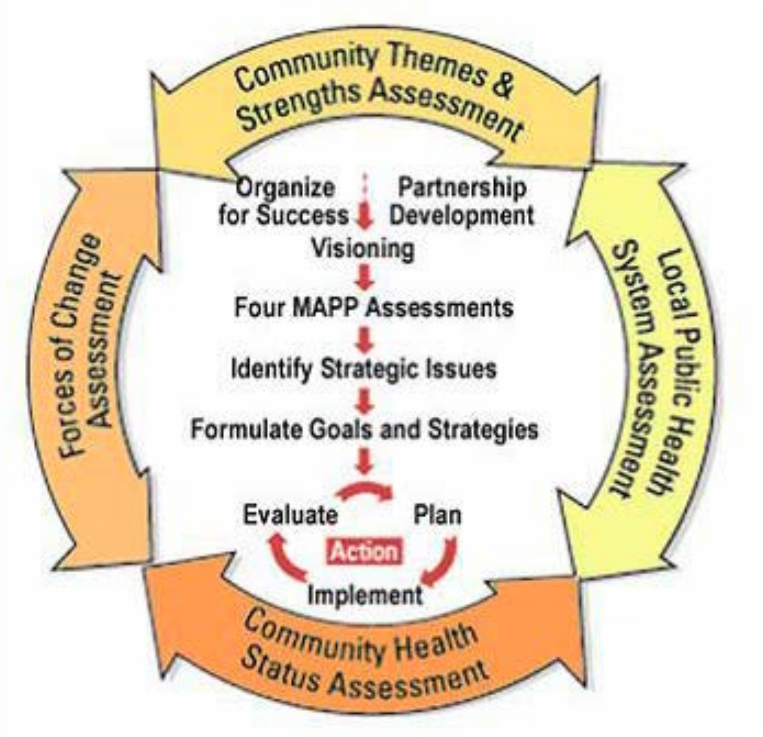
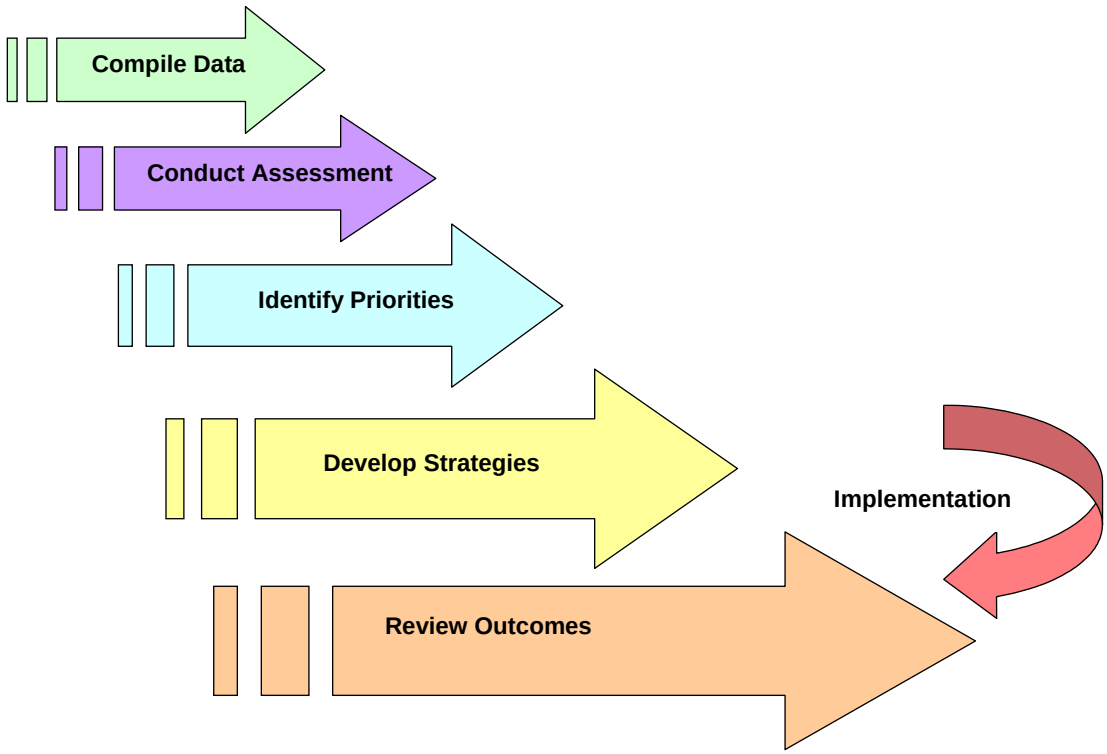


Figure 5. Methodology for Service Delivery Plan Outcome Objective Development and Implementation



The model shown in Figure 5 guides us in action plan development. Each *Core Outcome Indicator* (as discussed in *Section III. Summary of Needs Assessment Findings*) is isolated into an individual table which provides the framework for strategy development. Data and assessment findings are referenced in the first two columns to ensure that priorities and strategies are logically developed. Service Delivery Committee members initiated the tables and strategies which support the allocation plan. The service delivery workforce was then consulted to provide input about the feasibility of identified strategies. See Appendix D.

Once aligned, anticipated outcomes are established as a means for ongoing evaluation of the strategies incorporated into the Action Plan. This model serves to assist the Healthy Start Coalition accomplish the following objectives:

- Needs Assessment summaries link with proposed activities
- Provide Coalition Members with a simple format for Service Delivery Plan updates and future strategic planning that takes the elements of MAPP - Evaluate, Plan, Implement a step further.
- Provide key stakeholders with the rationale for allocation decisions and future funding requests.
- Address service gaps with targeted strategies and outcomes.
- Provide a framework for Continuous Quality Improvement that is data-driven.

III. SUMMARY OF NEEDS ASSESSMENT FINDINGS

A. Core Outcome Indicators

There are multiple ways to measure maternal and child health. The health outcome indicators that were reviewed during this planning process were selected based on contractually required outcomes as well as commonly referenced state and national measures (for comparisons). For example, Infant Mortality is widely accepted throughout the United States and Florida as not only a primary indicator of maternal and child health, but also a primary indicator of the overall health of a community. Additional indicators have been part of our ongoing service delivery planning activities and continuity of this process was determined to be valuable for our service area, with variations on the strategies and action steps we would employ to address them.

Data related to overall births, fetal mortality and infant mortality/morbidity are from the Florida Department of Health, Office of Vital Statistics. Included are data sets by year and in rolling averages from 2010 to 2014.

Figure 6. Birth Data Comparison by State and Service Area Counties 2010-2014

Total Births					
	2010	2011	2012	2013	2014
Florida	214,519	213,237	212,954	215,194	219,905
Flagler County	875	787	802	783	833
Volusia County	4,714	4,654	4,706	4,632	4,767
Service Area	5,589	5,441	5,508	5,415	5,600

Data Note: The state total for the denominator in this calculation may be greater than the sum of county totals due to an unknown county of residence on some records. Data Source: Florida Department of Health, Bureau of Vital Statistics

In Florida the number of births annually has increased each year since 2012. Our service area had 5,600 births in 2014 which was an increase from the previous year.

1. Fetal and Infant Mortality

Infant mortality rate continues to be one of the most widely used indicators of the overall health status of a community. The leading causes of death among infants are birth defects, pre-term delivery, low birth weight, Sudden Infant Death Syndrome (SIDS), and maternal complications during pregnancy. These account for about 57% of all infant deaths in the U.S. Outcomes of this nature may serve as indicators for many factors surrounding birth, including but not limited to: the health of the mother, prenatal care, and quality of the health services delivered to the mother and infant care. In addition, some causes of infant mortality rates are preventable and thus can

be influenced by various education and care programs. *(Source: http://www.cdc.gov/reproductivehealth/maternalinfanthealth)*

a. Fetal Mortality

Fetal deaths are reported by Florida Vital Statistics as those that occur beyond 20 weeks of gestation. As seen in Figure 7, Volusia and Flagler Counties fetal mortality rate has continued to increase since 2008 and is now above the state rate. Flagler shows variation due to their low number of births annually and declined in the period from 2012 – 2014.

Figure 7. Fetal Death by County and State in Rolling Rates from 2005-2014

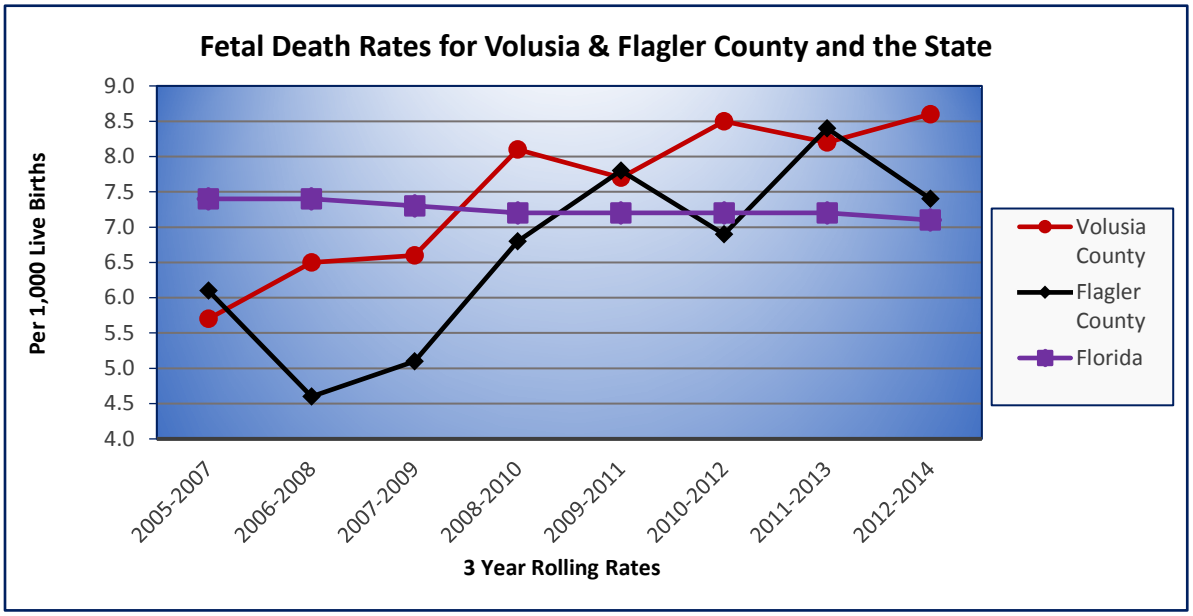
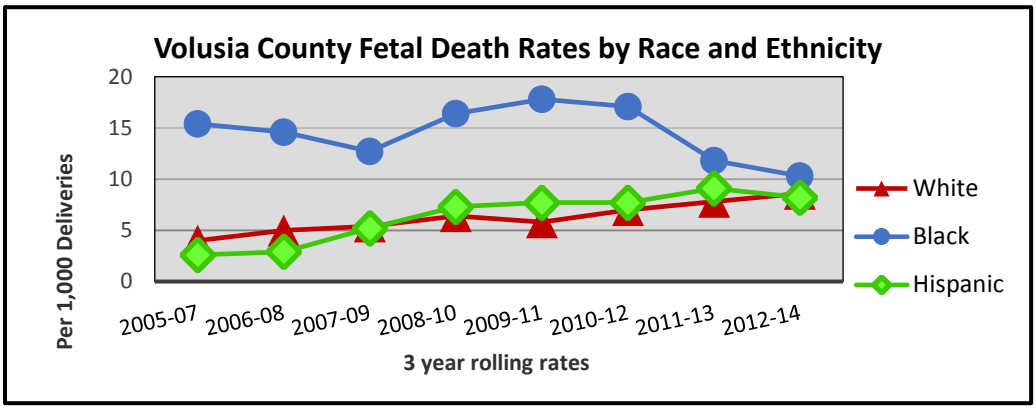
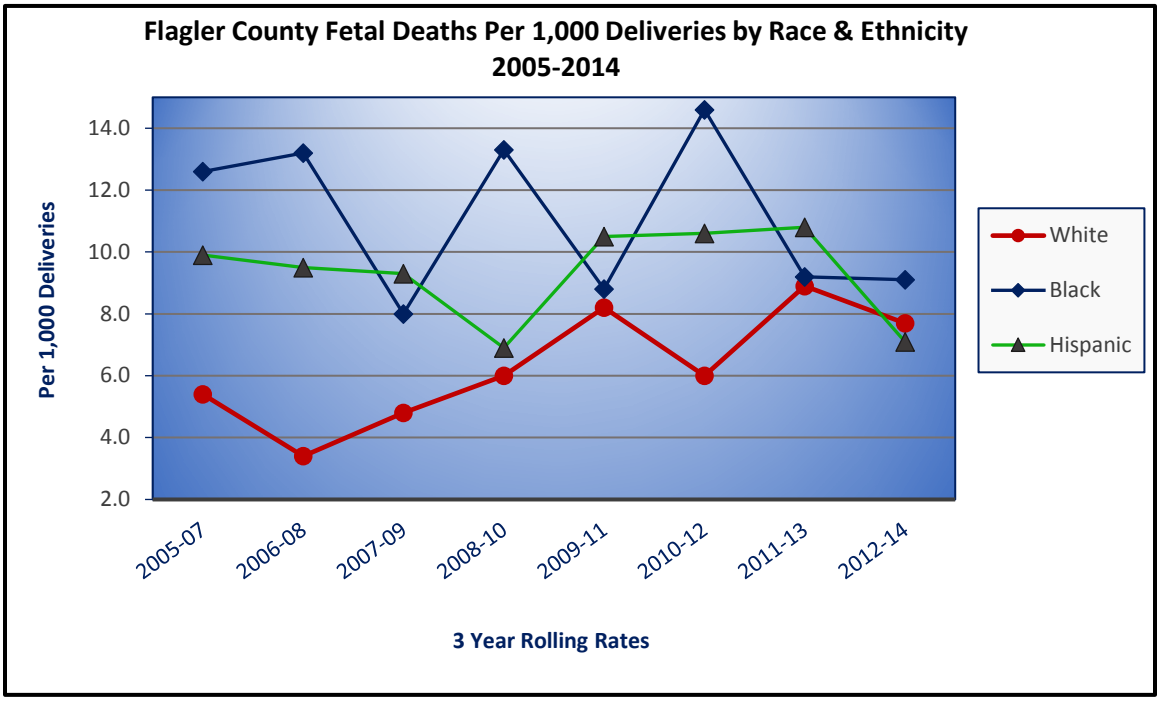


Figure 7a. Volusia County Rate of Fetal Deaths by Race and Ethnicity, 2005-2014



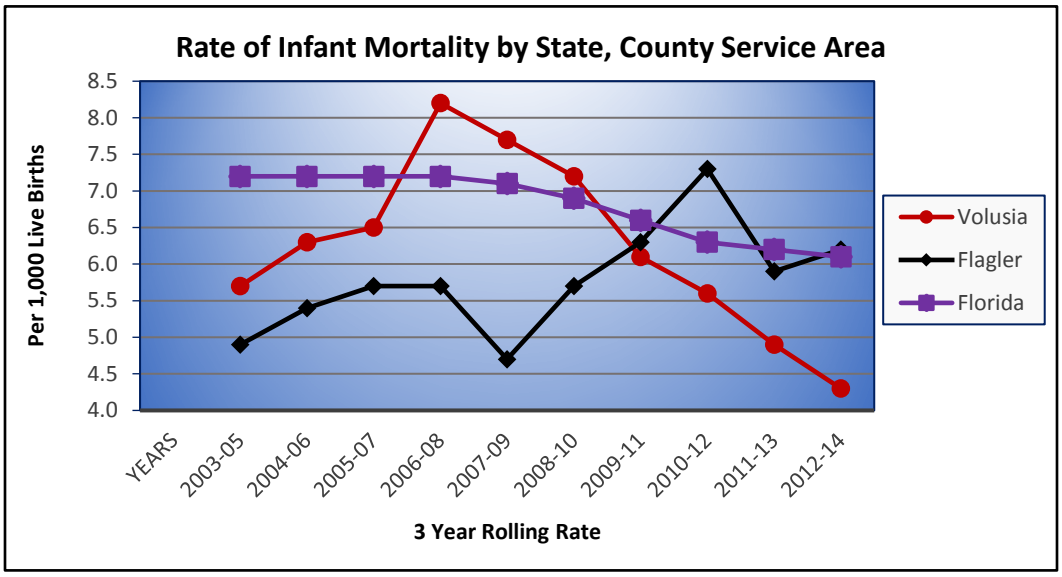
Volusia County shows a steady narrowing of racial disparity in fetal death, though the white and Hispanic rates have experienced a steady increase over the last decade. Flagler shows a graduating increase in white fetal death.

Figure 7b. Flagler County Fetal Deaths by Race per 1,000 Deliveries, 3 Year Rolling Rates



b. Infant Mortality

Figure 8. Rate of Infant Mortality by State, Service Area & County, 2003-2014



Infant mortality has continued to decline in Volusia County since 2008 and the last rolling averages show it below 4.5 per 1,000 live births in the rolling average 2012-2014, which is significantly lower than the state rate. Flagler County has had greater variance.

Figure 8a. Volusia County Rolling Rates of Infant Mortality by Race and Ethnicity 2005-2014

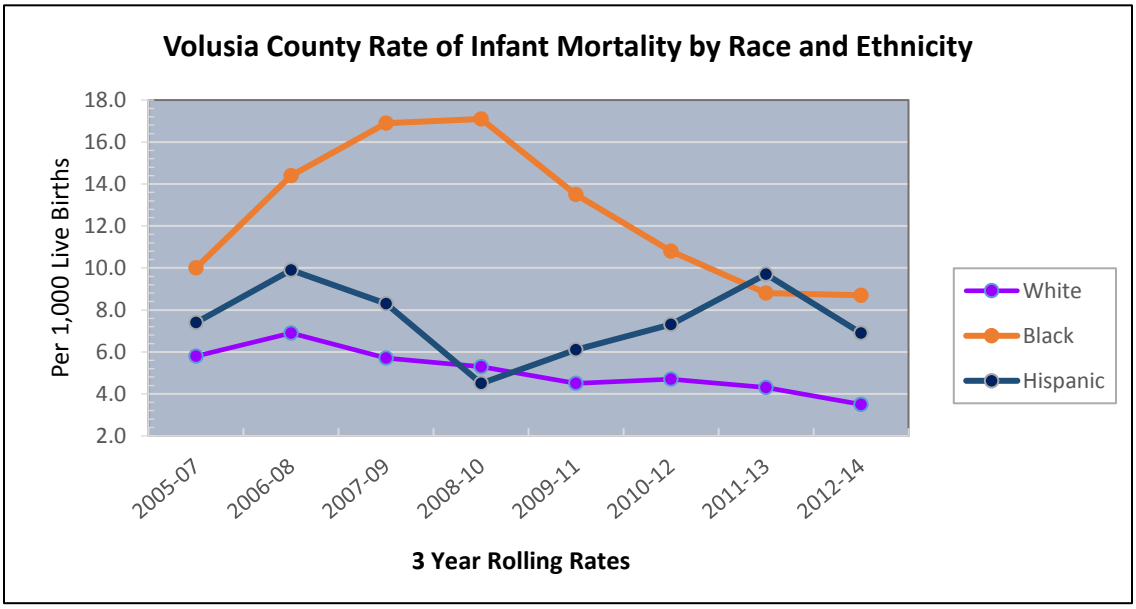
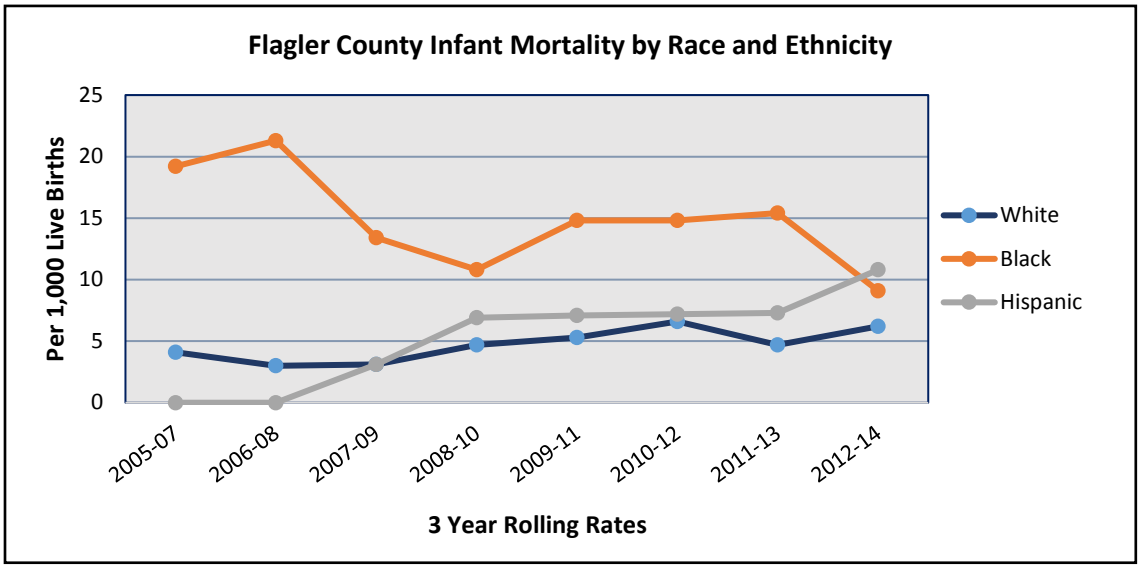


Figure 8b. Flagler County Rolling Rates of Infant Mortality by Race and Ethnicity 2005-2014

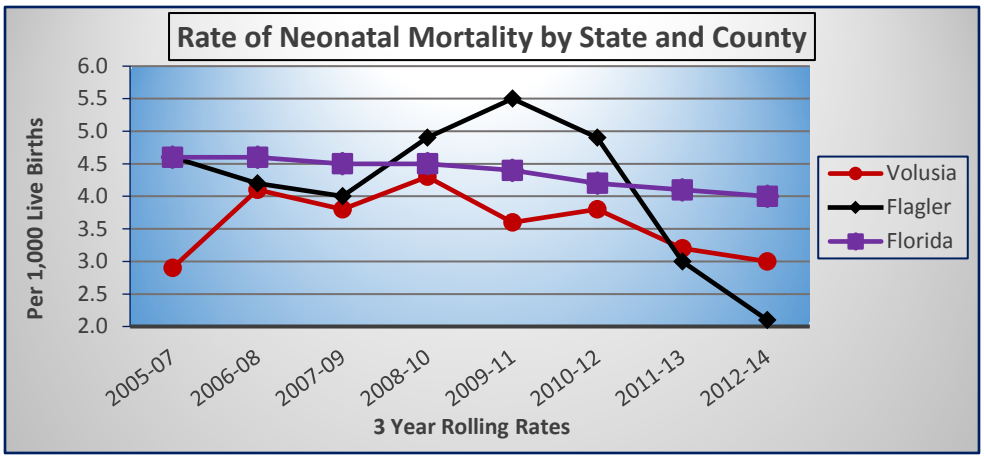


Figures 8a and 8b show the reduction in black infant mortality since the last service delivery planning cycle. The rate for black and Hispanic infant mortality continues to show disparity from the white infant mortality rate in both counties.

c. Neonatal Mortality

Of the babies that died before their first birthday, neonatal deaths are defined as those that died between birth and the first 28 days of life.

Figure 9. Rate of Neonatal Mortality by State & County, 2005-2014 by Rolling Average



Both Volusia and Flagler counties are currently below the state rate for neonatal mortality.

d. Low Birth Weight

Figure 10. Rate of Low Birth Weight by State & County, 2005-2014 by Rolling Average

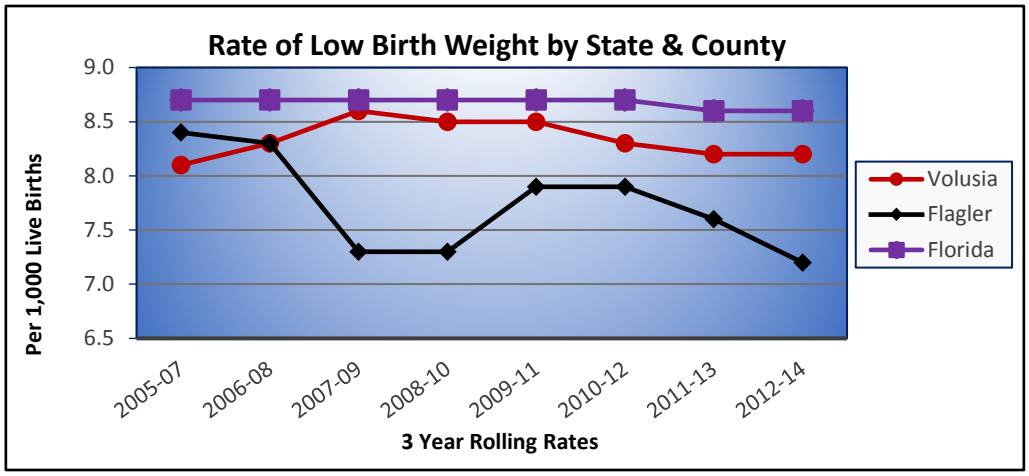


Figure 10 shows rates of Low Birth Weight (LBW) in three year rolling averages from 2005-2014 show our service area below the state rate. Flagler County has shown a steady decline since 2010.

Figure 10a. Volusia County Low Birth Weight by Race & Ethnicity, Rolling Rates from 2004-2014

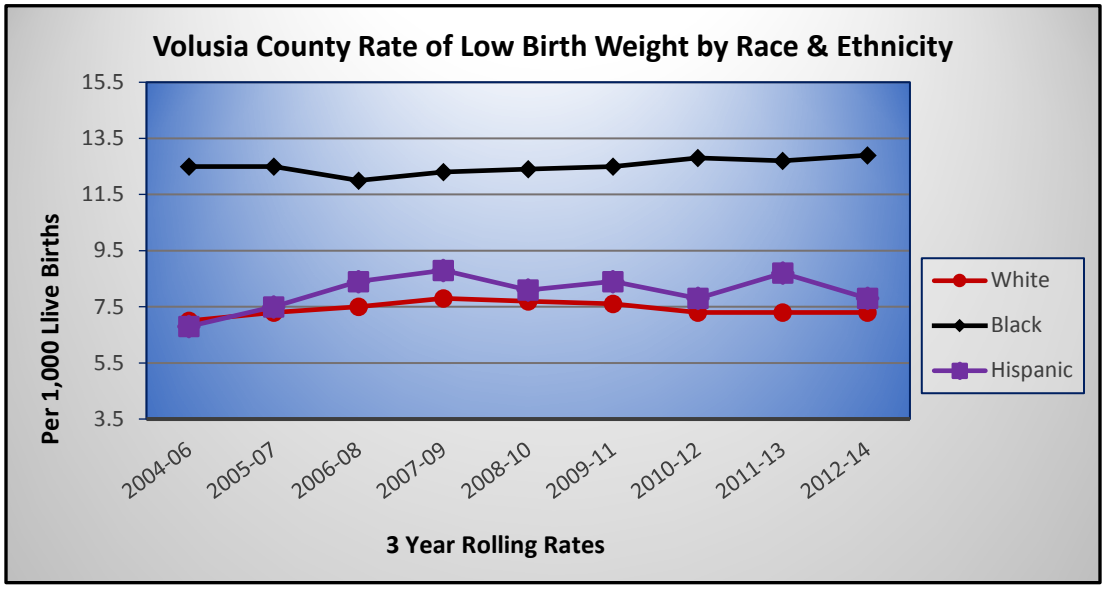


Figure 10b. Flagler County Low Birth Weight by Race & Ethnicity, Rolling Rates from 2004-2014

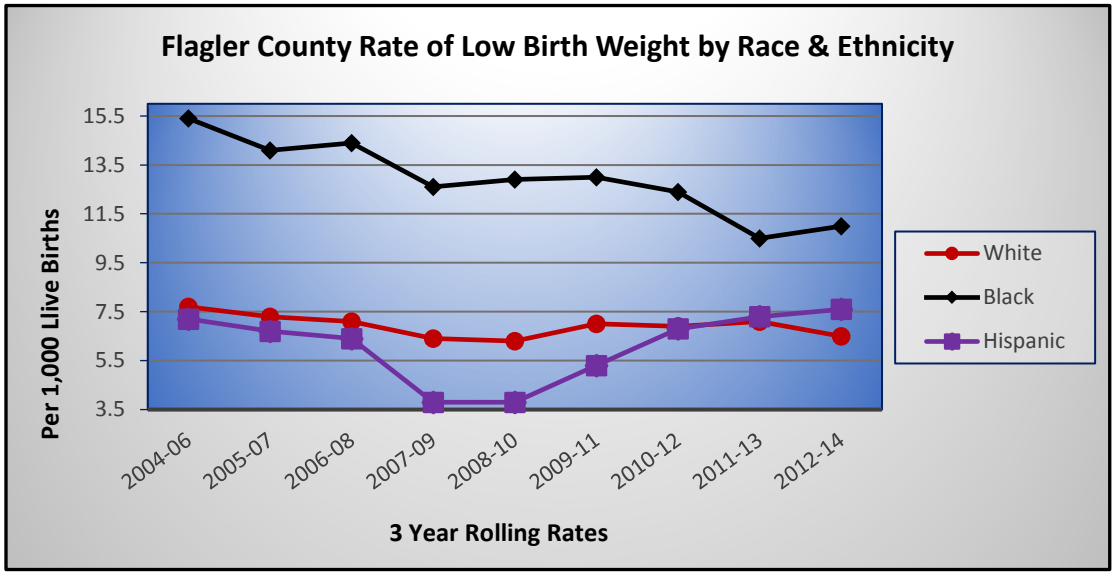


Figure 10a, shown above, reflects a continued disparity between Low Birth Weight amongst babies born to Black mothers in Volusia County compared to babies born to Hispanic and White mothers.

Figure 10b indicates that the Flagler County rate of Low Birth Weight amongst babies born to Black mothers is disproportionate to those born to White and Hispanic mothers.

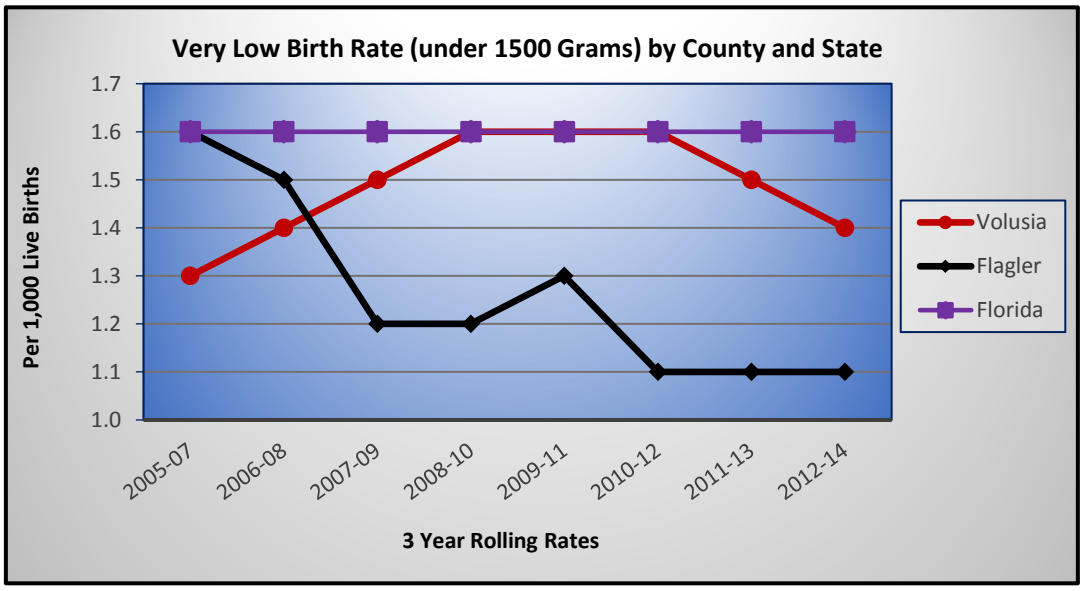
e. Very Low Birth Weight

The category of very low birth weight (VLBW), that is infants born at less than 1,500 grams, is well recognized to represent a population of infants, primarily premature infants, who are at increased risk for acute and chronic impairments related to their immaturity. *(Source: AHRQ www.ncbi.nlm.nih.gov).*

Prematurity is defined both by gestational age and by birth weight criteria. The World Health Organization (WHO) defines prematurity as less than 37 weeks gestation. Birth weight has been and continues to be used as a surrogate definition of prematurity because birth weight and gestational age are closely correlated and birth weight data are readily available. Generally, the lower the birth weight, the more immature is an infant.

Volusia and Flagler counties have been below the state rate for VLBW since the last planning cycle.

Figure 11. Rate of Very Low Birth Weight by State & County, 2005-2014



Flagler County shows a steady decline from 2009 to 2012 and a continued stabilization from 2012-2014. Volusia County showed a steady increase from 2005-2010 with a stabilization from 2010-2012 followed by a steady decline.

Figure 11a. Flagler County VLBW Rates by Race & Ethnicity, 2005-2014

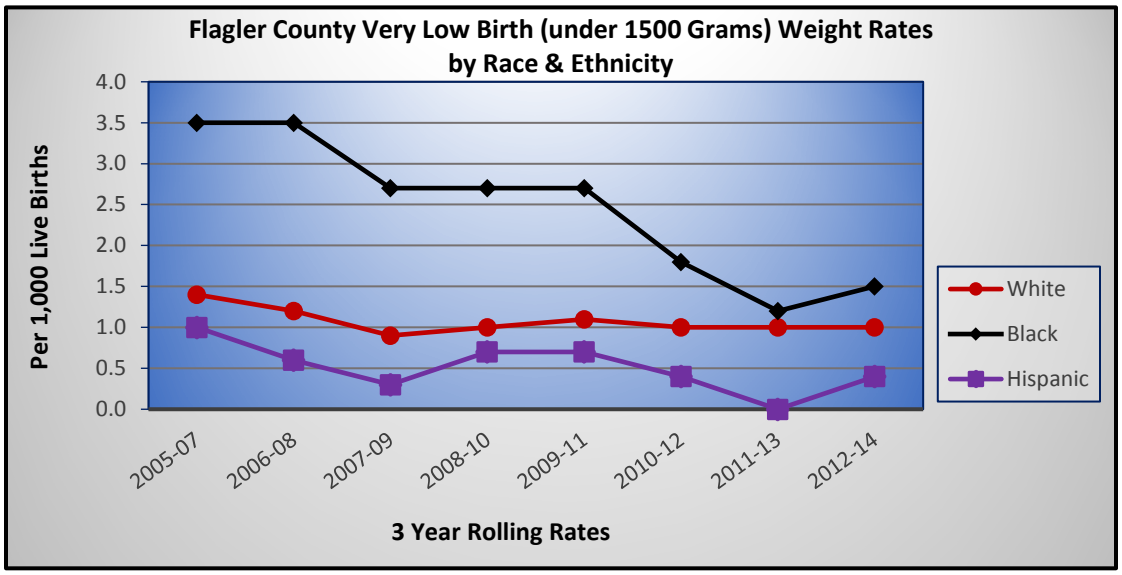
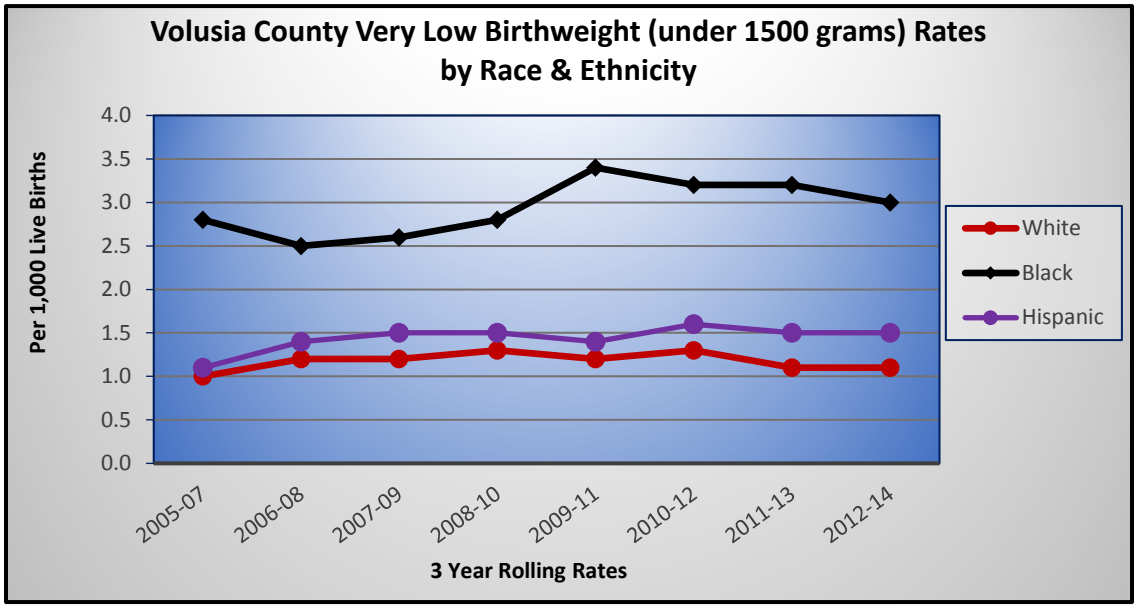


Figure 11a, above, shows 3 year rolling averages of VLBW for Flagler County by Race & Ethnicity. This data reflects a narrowing of disparity for VLBW over the long term with an increase in the last reporting period.

Figure 11b. Volusia County VLBW Rates by Race & Ethnicity, 2005-2014



Volusia County shows a wide racial disparity in VLBW between black and white with a slight decline in incidence of black VLBW since the last planning cycle.

2. Entry into Prenatal Care

Our service area has identified access to prenatal care as an indicator to work on for the last ten years. Though Flagler County has maintained a rate consistently higher than the state with a single point of entry through their health department, Volusia County had struggled to improve. In 2007 we saw a decline to below the state rate in Volusia County and worked with our provider network on assisting in the enrollment of pregnant women into the PEPW (Presumptive Eligibility for Pregnant Women) for Medicaid. We started making progress and developed a "one stop" system with the health department in Volusia until they discontinued clinical prenatal services and Managed Care was implemented. We have continued to work with the provider community but as the landscape has shifted, our strategies have had to adapt to keep everyone informed about access, navigation, and the importance of early and consistent prenatal care.

a. First Trimester Entry into Prenatal Care

During the last planning cycle we have been able to improve our first trimester into prenatal care rates despite changes in policy and loss of four prenatal clinics when the health department in Volusia County discontinued services.

Flagler County continues to have a higher rate than Volusia and the state, and Volusia has steadily improved.

Figure 12. 1st Trimester Entry into Prenatal Care by State & County, 2005- 2014 by Rolling Average

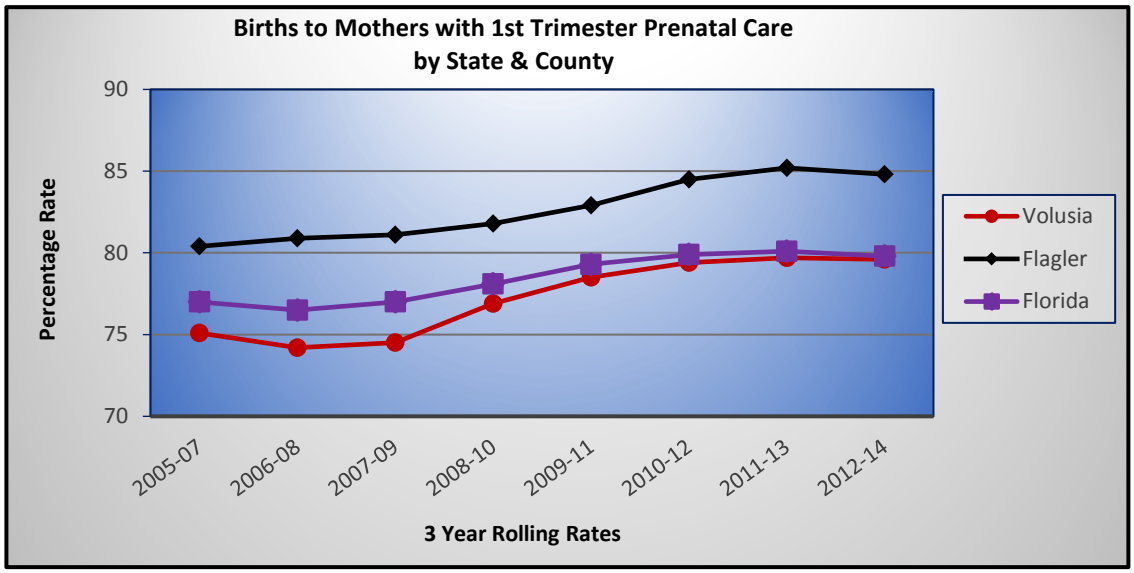


Figure 12 shows the percentage of mothers entering prenatal care in the first trimester by state and county for the time period of 2005-2014. Trends indicate a steady increase from 2006-2013 in entry in prenatal care for the State of Florida, Flagler and Volusia Counties.

Figure 12a. Volusia County 1st Trimester Entry into Prenatal Care by Race & Ethnicity, 2005-2014 by Rolling Average

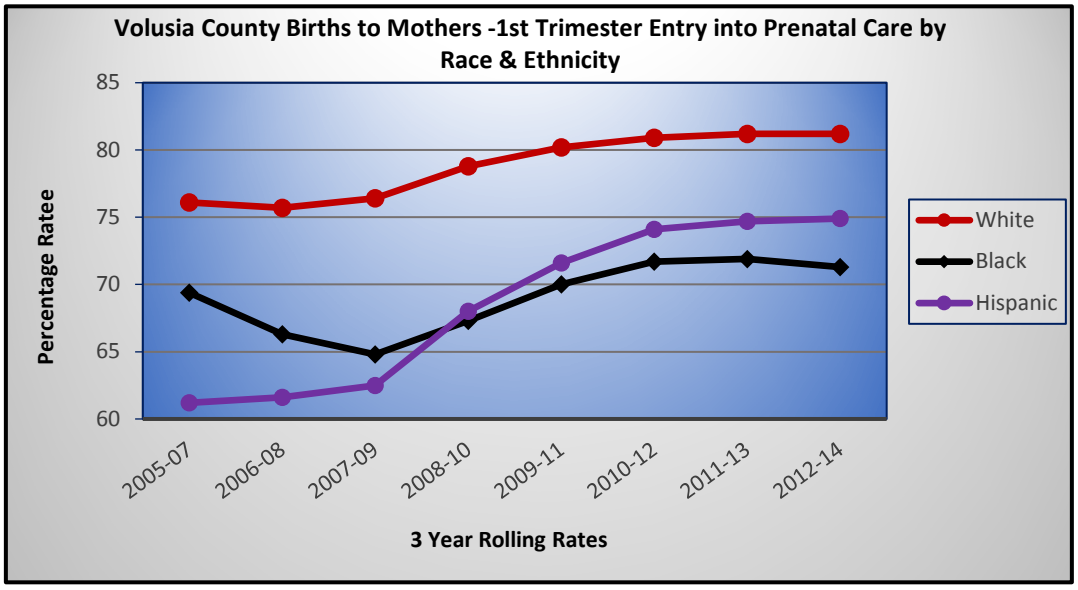


Figure 12a shows three year rolling averages of first trimester entry into prenatal care by percentage by Race and Ethnicity for the time period of 2005 to 2014. The Hispanic rate shows an increasing trend from 2005-2014, while the Black rate reached its highest level during the 2011-2013 periods with a slight decline during the 2012-2014 period average. It is interesting to note that the Federally Qualified Health Center was implemented in West Volusia in 2008, where our highest numbers of Hispanic births are from, even though they did not have a prenatal expansion. There has been a steady increase in the Hispanic rate since that time.

Navigation efforts and public awareness must be directed to reduce racial disparities in first trimester entry rates.

Figure 12b. Flagler County 1st Trimester Entry into Prenatal Care by Race & Ethnicity, 2005-2014

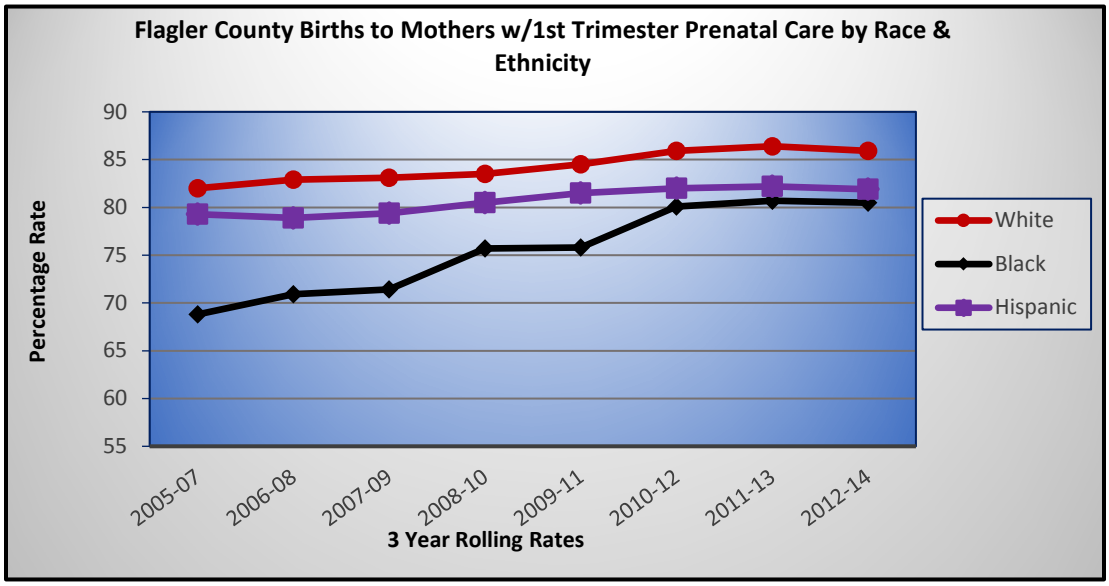


Figure 12b, above, shows Flagler County rates for first trimester prenatal entry. While White and Hispanic mothers are representative of the highest rate of entry into 1st Trimester Prenatal Care, the increase overall from 2005-2014 has been for Black mothers. As stated previously, the Health Department in Flagler County is the sole entry for prenatal care for deliveries in our service area. There has been a narrowing of the racial disparity for first trimester access since 2011.

b. Late or No Entry into Prenatal Care

Women who do not access care until the third trimester or not at all are a focal point of our efforts. Though as a service area we are slightly below the state rate, we consider this population some of our highest risk. As with most indicators the racial disparity is significant for both counties though Hispanic and black rates have declined in Flagler county since the last planning cycle.

Figure 13. Late or No Entry into Prenatal Care by State & County, 2005-2014

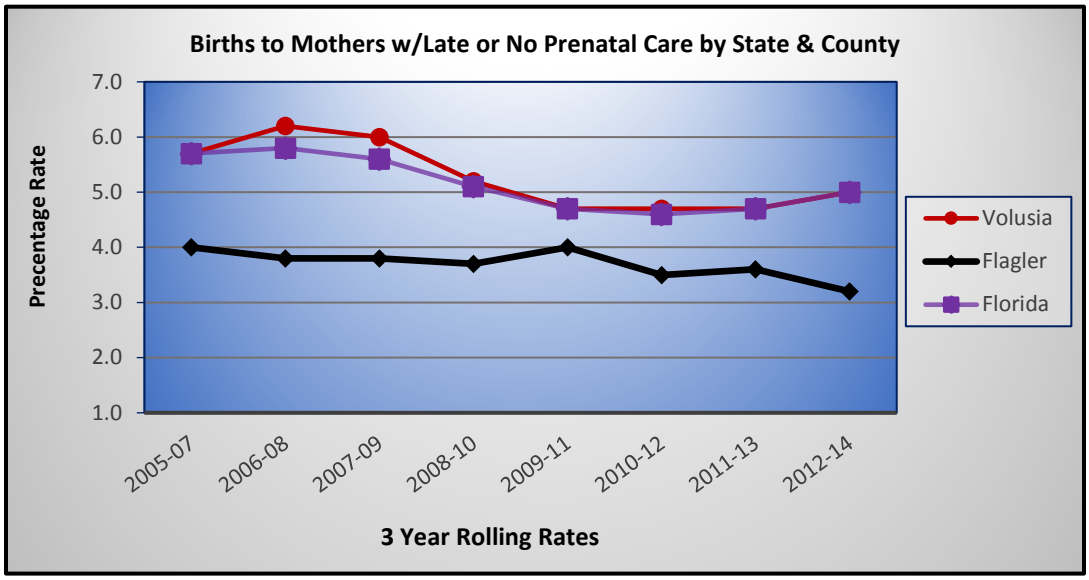


Figure 13, shown above, reflects data of mothers entering prenatal care in the third trimester or not at all, by state and county for the time period of 2005-2014.

Figure 13a. Volusia County Late or No Prenatal Care By Race & Ethnicity, 2005-2014

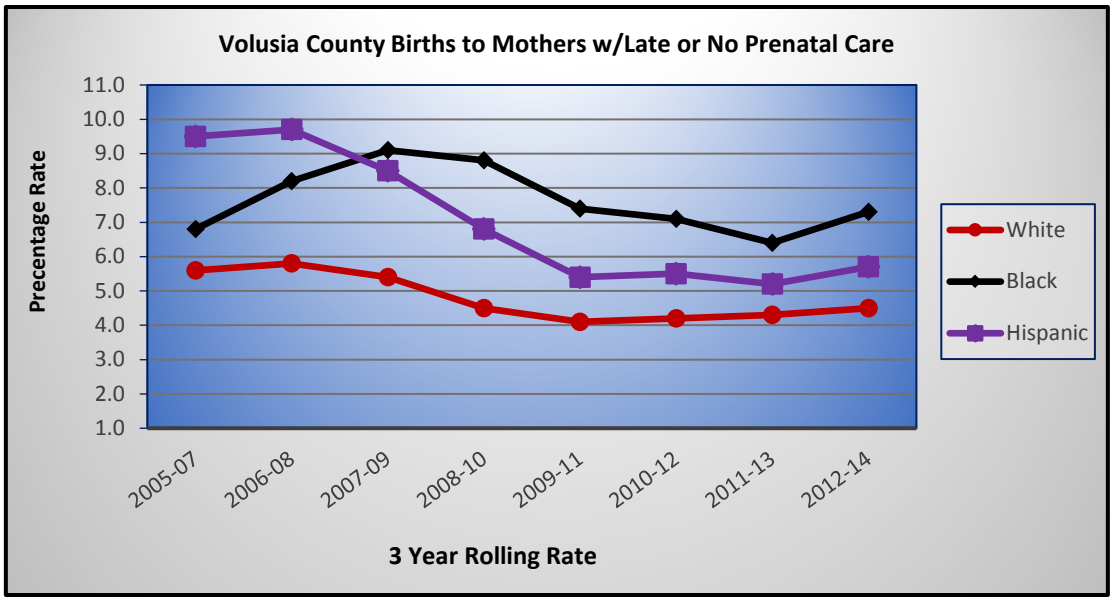


Figure 13a. above represents Volusia County's three year rolling averages of late or no prenatal care by Race & Ethnicity, for the time period of 2005 to 2014. From 2007 to 2009, the rate of Black women with late or no prenatal care increased and exceeded the Hispanic rate and continues to be the highest rate of

incidence. While the Hispanic rates show a decrease from 2007 to 2011, it continues to exceed that of White mothers.

Figure 13b. Flagler County Late or No Prenatal Care By Race & Ethnicity, 2005-2014

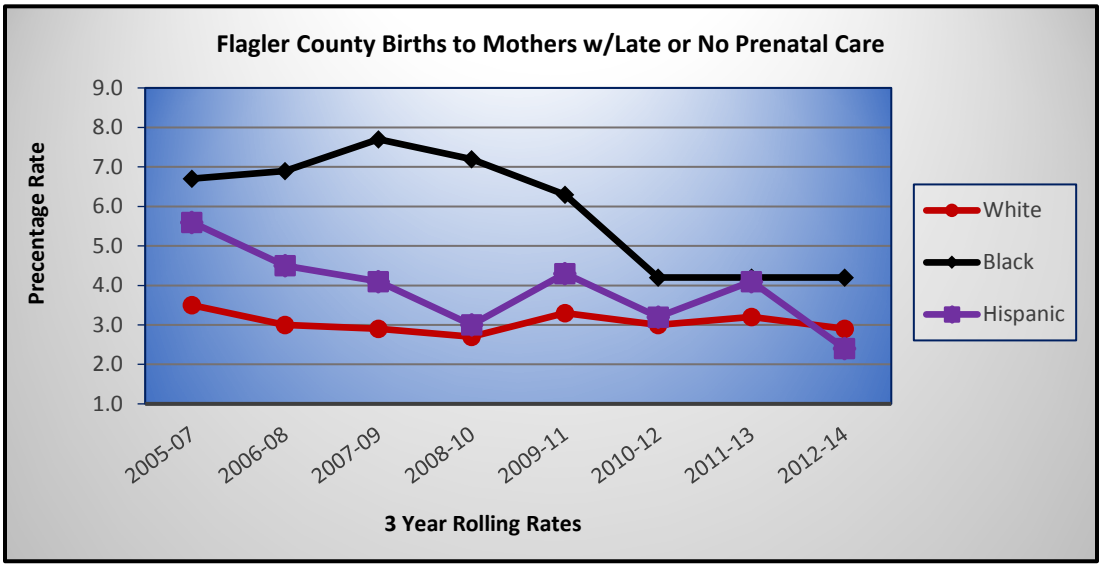


Figure 13b shows Flagler County's three year rolling rates of late or no prenatal care for by race & ethnicity from 2005-2014. Although the rate of incidence for Black mothers continues to lead those of Hispanic and White mothers, there has been a decline in the rate from 2008-2012, closing the gap considerably. Additionally, the rate for Hispanic mothers has declined since 2005 and for the first time has fallen below that of White mothers during the 2012-2014 year cycles.

B. Contributing Risk Factors

Multiple studies have indicated that the health of an infant can be affected by any combination of behavioral and social risk factors that may include the mother's age, marital status, the family's poverty status, whether or not the pregnancy was intended, the presence of HIV or STDs, poor education, poor nutrition, and even some cultural or religious norms and practices. The planning committee members chose supplemental indicators for this needs assessment through the Perinatal Periods of Risk* concept model for fetal and infant mortality, which employed a corresponding table of primary risk factors in Volusia/Flagler for each of the defined perinatal periods. *(*Source: Centers for Disease Control and Prevention and the World Health Organization)* The table assisted the members in differentiating between physical risk factors which are often un-changeable and behavioral risk factors which can typically be influenced through education and support. The tools then also allowed the members to trace core risk factors back to the time periods where they can most impact a pregnancy, in order to develop effective intervention strategies. The risk factor table is available as Appendix E in this publication.

1. Teen Pregnancy

Pregnancies among adolescents (ages 10-17 years) are a strong indicator for both current and projected healthcare and social service needs within a region. The United States has one of the highest rates of teen pregnancy and births in the western industrialized world.

Figure 14. Live Births to Teenagers (Ages 10-14 years) by State & Service Area, 2012-2014

Mothers 10-14 years old	2012			2013			2014		
	Flagler	*Volusia*	*State*	*Flagler*	*Volusia*	*State*	*Flagler*	*Volusia*	*State*
Number	0	5	192	1	1	164	0	1	142
Rate per 1,000	***0***	***.04***	***.03***	***.04***	***.01***	***.03***	***0***	***.01***	***.03***

Figure 14, above, shows the total number of live births to teenagers in our Service Area compared to the State of Florida for the period of 2012-2014. The number of live births to young women between the ages of 10-14 years of age is currently below the State rate.

Figure 14a. Live Births to Teenagers (Ages 15-19 years) by Service Area (Flagler & Volusia Counties) & State, 2012-2014

Mothers 15-19 years old	2012			2013			2014		
	Flagler	*Volusia*	*State*	*Flagler*	*Volusia*	*State*	*Flagler*	*Volusia*	*State*
Number	74	389	15,950	56	360	13,956	56	313	12,811
Rate per 1,000	***27.8***	***27.1***	***27.2***	***21.0***	***25.4***	***23.8***	***20.8***	***22.6***	***21.9***

Figure 14a represents the rate of live births to teenagers ages 15-19 for the service area and the state for the period of 2012-2014. Although the service area and the state all show a steady decline throughout the reporting period, Volusia County exceeds the state's rate.

Figure 14b. Percentage of Repeat Births (Mothers Ages 15-19 years) by Service Area (Flagler & Volusia Counties) & State, 2012-2014

Mothers 15-19 years old	2012			2013			2014		
	Flagler	*Volusia*	*State*	*Flagler*	*Volusia*	*State*	*Flagler*	*Volusia*	*State*
Percentage	***16.2***	***12.3***	***16.9***	***14.3***	***16.9***	***16.4***	***10.7***	***13.1***	***16.5***

Figures 14b. represents the percentage of repeat births to mothers ages 15-19 for the service area and the state from 2012 to 2014. Flagler County shows a consistent decline in subsequent teen births throughout this reporting period while Volusia County experienced a fluctuation peaking in 2013, where it exceed state levels before declining in 2014 to fall below state levels. *(Source: Florida Department of Health, Bureau of Vital Statistics)*

2. Poverty

Poverty is a major contributing factor to poor health outcomes, reduced educational attainment, and child abuse and neglect. Poverty is defined by the U.S. Office of Management and Budget as the number/percent of individuals who live below the U.S. poverty threshold, which is $24,300 for a family of two adults and two children as of January 2016. According to KIDS COUNT Data Center's most current data, Florida ranks 40th for children living in poverty. That's down three places from last year. In the state of Florida in 2014, there were 1.6 million children living in poverty. *(Source: https://aspe.hhs.gov/poverty and http://www.floridakidscount.org/)*

Both counties in our service area seem to mirror Florida in poverty rate trends though Flagler seems to be showing gains in the recent year for children and adults living in poverty.

Figure 15. Percentage of All Persons Living Below Poverty Level in Volusia and Flagler Counties and State 2010-2014

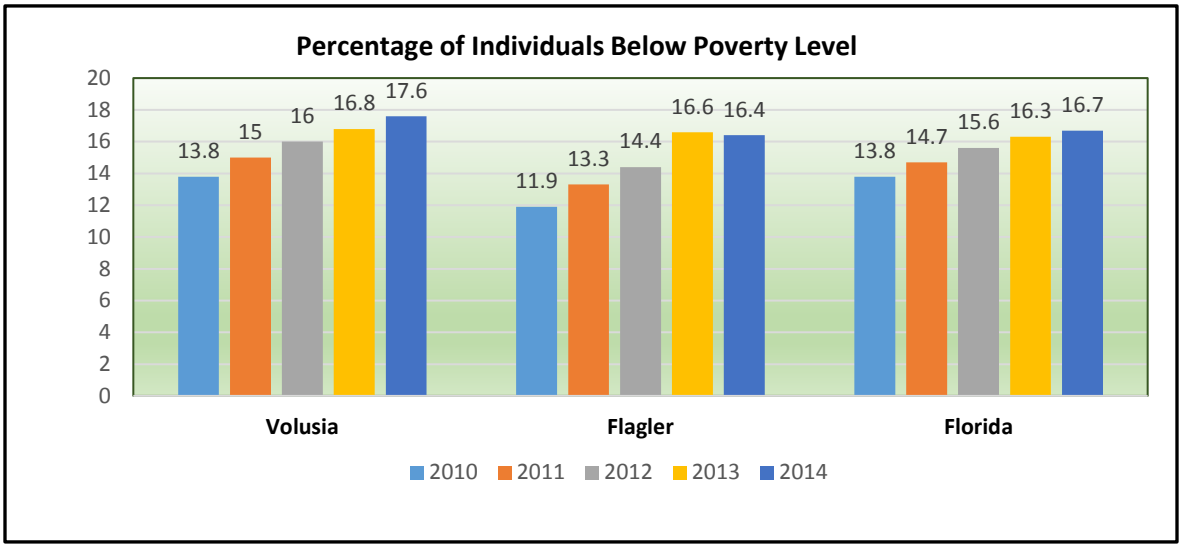
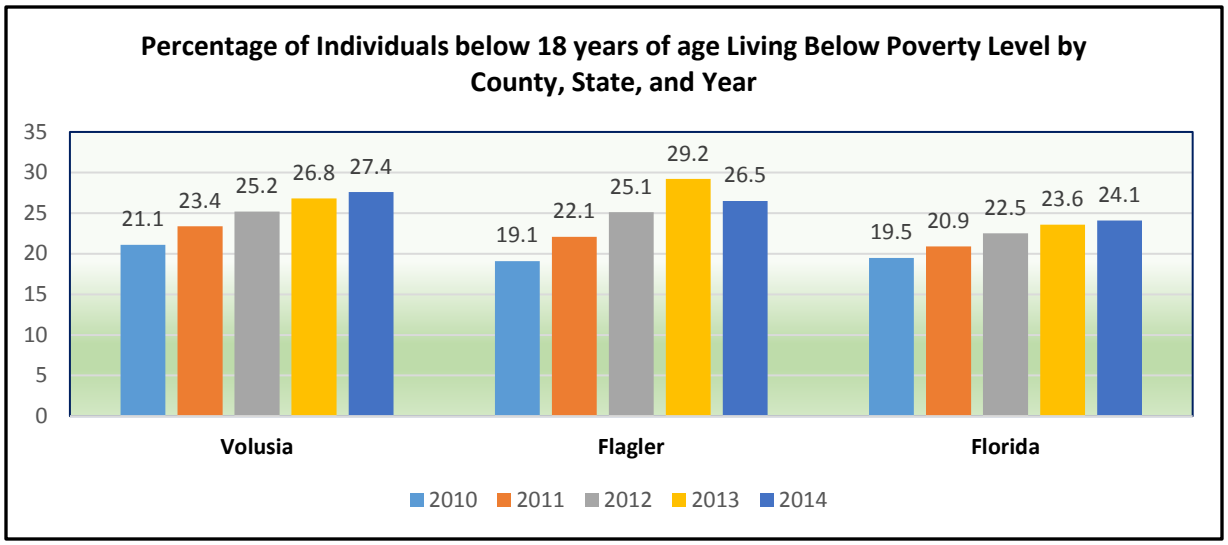


Figure 15a. Percentage of Children under 18 years old Living Below Poverty Level in Volusia and Flagler Counties and State 2010-2014

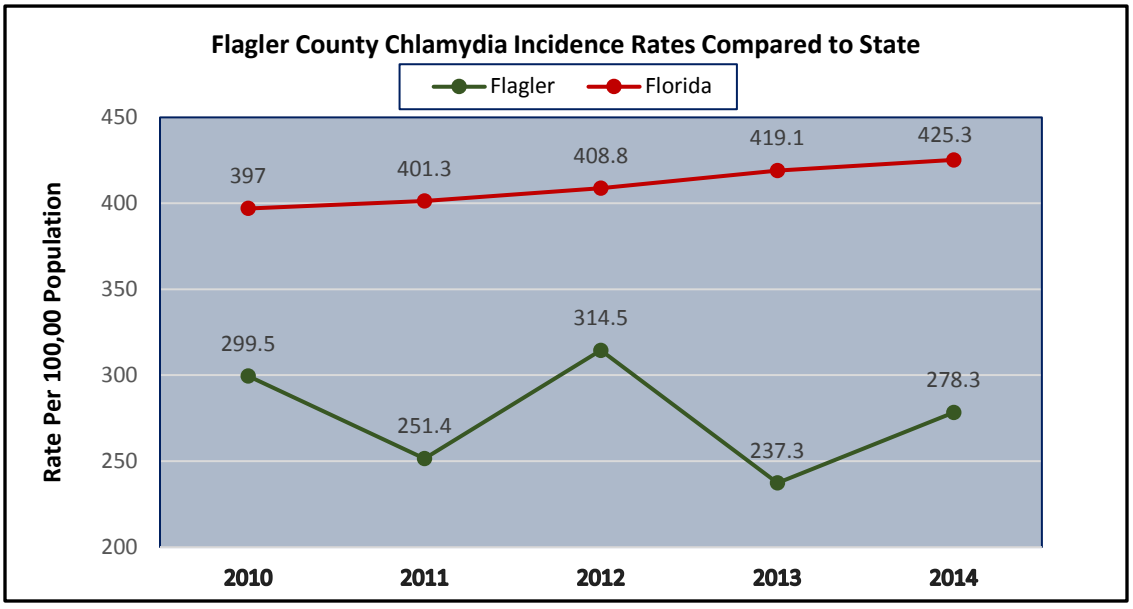


According to the US Census Bureau, 27.4% of Volusia children under 18 years of age were below the poverty level and that number almost doubles for female head of households with children under 5 in 2014.

3. Sexually Transmitted Diseases (STDs)

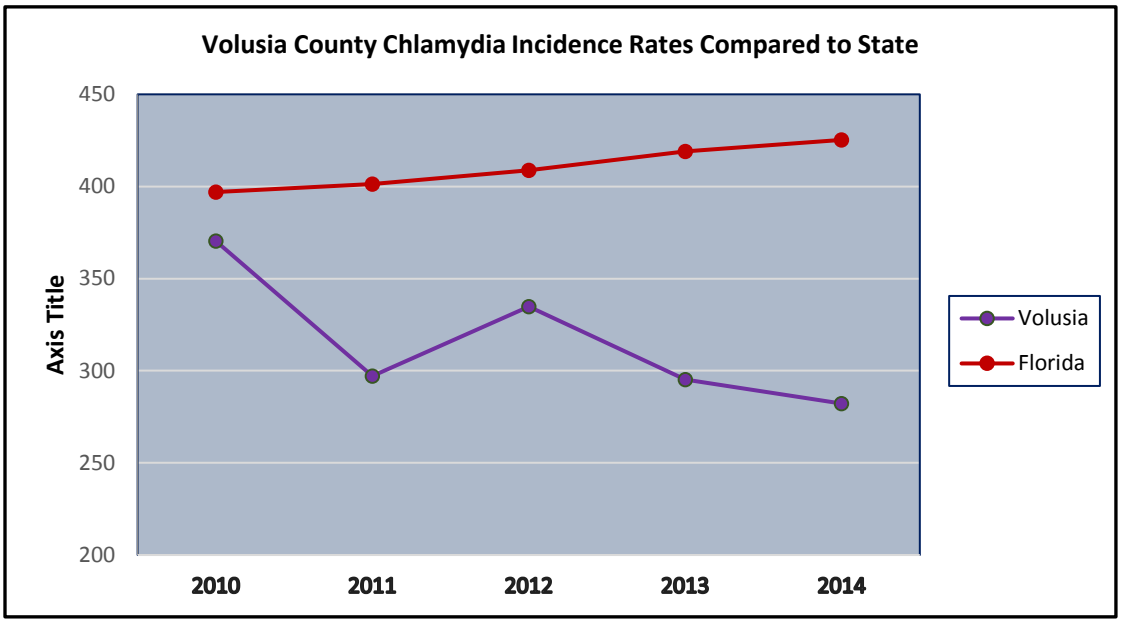
The occurrence of sexually transmitted diseases (STDs) is a strong indicator for unsafe sexual practices, and can be studied among specific population groups. STDs such as Chlamydia and Gonorrhea have been proven to disproportionately affect the poor, under-educated, and minority communities when compared to the general population. Chlamydia rates have increased in Flagler and decreased in Volusia County. Both counties in our service area have less incidence than Florida.

Figure 16. Flagler County and Florida Rates of Chlamydia by single year 2010 - 2014



Florida's Chlamydia Incidence Rates have experienced a steady increase in Florida from 2010-2014. Flagler County rates have fluctuated during the same time period. In 2012, Flagler County experienced its highest rate of incidence during this five-year period followed by its lowest of incidence the following year. The most current trend shows an increase though well below that of Florida.

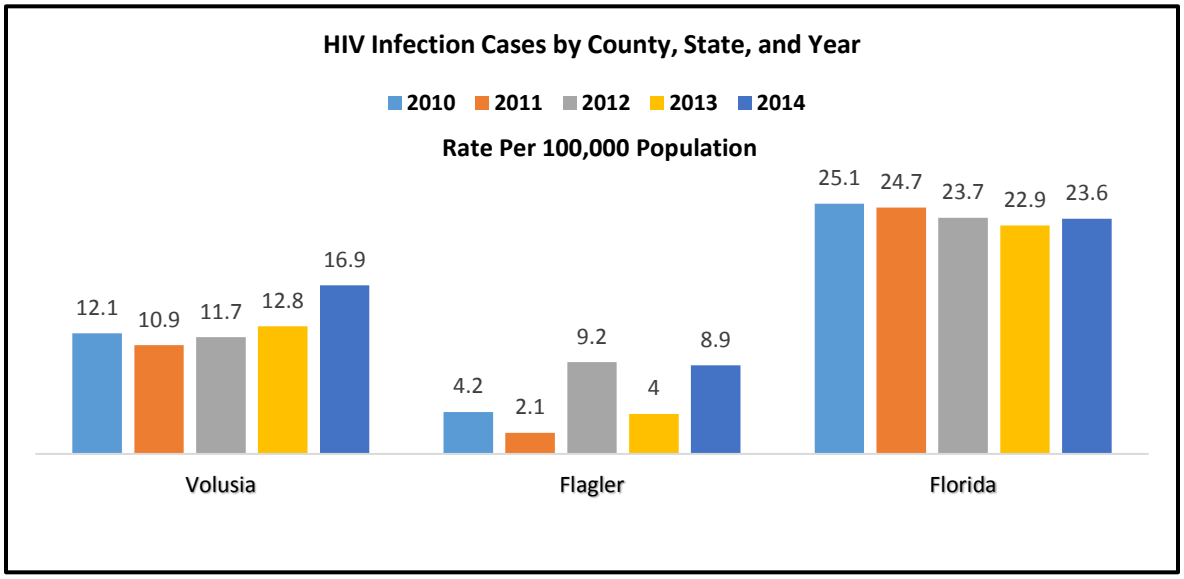
Figure 16a. Volusia County Chlamydia Incidence Rates compared to State 2010-2014



Volusia County data shows the most remarkable decline within this five-year reporting period. Starting in 2010 with its highest rate of incidence it was followed by a decline in 2011. Similar to Flagler County, Volusia incidence rate increased in 2012 before continuing a steady downward trend in subsequent years. *(Source: Florida CHARTS Reportable and Infectious Diseases Data, http://www.floridacharts.com/charts/CommunicableDiseases/default.aspx)*

4. HIV Cases

Figure 17. Comparison Rate of New HIV Cases for Florida, Volusia and Flagler Counties, Per 100,000 Population, for Single Years from 2010 - 2014



The rate of new HIV cases in Volusia and Flagler Counties during this five-year reporting period are below the State rate. Volusia County rates far exceed those of Flagler County and have shown a steady increase between 2011 and 2013 before making a remarkable increase in 2014. While Flagler County experienced a wider fluctuation in rate from year to year, the County rate of incidence more than doubled in 2014. Fortunately, our service area has not seen a perinatal transmission case from mother to infant in over seven years.

C. Analysis of Healthy Start Screening Data

1. Overview of Significance of Screening

Healthy Start Prenatal Screening is intended to be available to all pregnant women and babies through their health care provider and was developed to assist providers and Healthy Start staff in determining the mother's eligibility for Healthy Start services. The tool was designed as an objective first step toward identifying any relevant risk factors or existing needs relating to the health of a woman's pregnancy.

This pre-screening for Healthy Start services has been identified as a priority opportunity for improvement in Volusia and Flagler Counties.

2. Screening Data

a. Prenatal and Postnatal Screening

As shown on the next figures, prenatal screening rates increased steadily throughout the last planning cycle. Prenatal screening rates are based on estimated births so the accuracy of the rate is not exact.

Figure 18. Prenatal Screening Rate Comparisons from State Fiscal Year 2002 to 2016

SFY	Goal	Actual	State Rate
2002	44.79%	43.21%	49.88%
2003	44.00%	45.72%	55.02%
2004-05	48.57%	50.36%	65.40%
2005-06	50.14%	60.01%	67.67%
2006-07	60.58%	61.57%	64.61%
2007-08	65.00%	80.85%	70.28%
2008-09	78.00%	86.12%	77.22%
2009-10	78.00%	86.90%	83.54%
2010-11	78.00%	100.00%	85.42%
2011-12	78.00%	101.43%	81.98%
2012-13	78.00%	100.80%	81.45%
2013-14	78.00%	100.65%	80.29%
2014-15	78.00%	101.09%	78.90%
2015-2016	**78.00%**	**94.66%**	**74.15%**

Figure 18a. Postnatal Screening Rate Comparisons from State Fiscal Year 2002 to 2016

SFY	Goal	Actual	State Rate
2002	47.11%	52.49%	71.82%
2003	49.00%	55.73%	71.69%
2004-05	60.47%	44.75%	69.85%
2005-06	53.00%	54.00%	77.40%
2006-07	68.78%	65.05%	81.14%
2007-08	77.00%	83.28%	83.59%
2008-09	84.00%	86.93%	87.96%
2009-10	84.00%	84.10%	86.92%
2010-11	84.00%	81.46%	89.58%
2011-12	84.00%	84.85%	91.08%
2012-13	84.00%	89.79%	93.44%
2013-14	84.00%	89.18%	94.89%
2014-15	84.00%	90.02%	94.32%
2015-2016	**84.00%**	**90.77%**	**93.46%**

Increasing and maintaining high screening rates is important because the higher the rate, the more significant the risk factor data is that we can gather from it. At the time of this report, 2015-2016 screening data was available so it was included. When the percentage rate exceeds 100% it is because rates and percentages were based on anticipated number of births.

3. Risk Factor Findings from Screening Data (See Appendix C)

a. Prenatal Care

Entry into prenatal care is an important indicator for our service area and our Coalition has conducted several studies surrounding our rates for 1st Trimester Entry to Care and Late or No Entry to Care. As with many other indicators and as evidenced by all available data, there is a disparity in prenatal care access between Black and White women.

Another analysis of prenatal screening information for entry into prenatal services was done on the Southeast quadrant of Volusia County, which includes New Smyrna, Edgewater, and Oak Hill. Although there is a Health Department office there, other prenatal services to this area are extremely limited and there is no birthing center at their hospital.

Figure 19. 1st Trimester Entry to Care by County of Residence 2013-2015

	Flagler	NE Volusia	NW Volusia	SE Volusia	SW Volusia	**Grand Total**
2013	72% (375/521)	70% (1200/1708)	61% (356/579)	69% (218/314)	72% (673/930)	**70% (2822/4052)**
2014	71% (397/558)	70% (1272/1810)	69% (390/564)	71% (252/355)	73% (649/885)	**71% (2960/4172)**
2015	70% (374/532)	69% (1114/1621)	64% (369/573)	62% (201/323)	71% (626/887)	**68% (2684/3936)**
Grand Total	**71% (1146/1611)**	**70% (3586/5139)**	**65% (1115/1716)**	**68% (671/992)**	**72% (1948/2702)**	**70% (8466/12160)**

Our Coalition will work to increase awareness about the importance and availability of care and conduct outreach activities to identify and link potential participants to prenatal services.

b. Unintended Pregnancies

Regardless of a mother's health and socioeconomic circumstances, whether or not she had any prior intentions of becoming pregnant may play a large role in

her health during her pregnancy and ultimately her baby's birth outcomes and developmental outcomes.

Defining "unintended pregnancy" when reviewing screening data for the Service Area below includes responses to the screening questions regarding the timing of the pregnancy. Women who responded that they preferred to be pregnant 'later' or 'not at all' were both included in the analysis of "unintended pregnancy" below by zip code. This is an important distinction and is meant to illustrate the areas where pre- and inter-conception education service is most needed.

Figure 20. Unintended Pregnancies by County of Residence 2013-2015

	Flagler	NE Volusia	NW Volusia	SE Volusia	SW Volusia	**Grand Total**
2013	55% (285/521)	56% (952/1708)	53% (306/579)	51% (159/314)	52% (487/930)	**54% (2189/4052)**
2014	53% (295/558)	55% (1002/1810)	51% (286/564)	50% (178/355)	49% (434/885)	**53% (2195/4172)**
2015	49% (261/532)	53% (859/1621)	51% (290/573)	50% (162/323)	46% (404/887)	**50% (1976/3936)**
Grand Total	**52% (841/1611)**	**55% (2813/5139)**	**51% (882/1716)**	**50% (499/992)**	**49% (1325/2702)**	**52% (6360/12160)**

While the percentage of unintended pregnancies has slightly declined in each county over time, the overall rate remains relatively high in that nearly half of all women screened reported that they preferred to be pregnant 'later' or 'not at all.'

Figure 20a. Women that Preferred Not to Be Pregnant by County of Residence 2013-2015

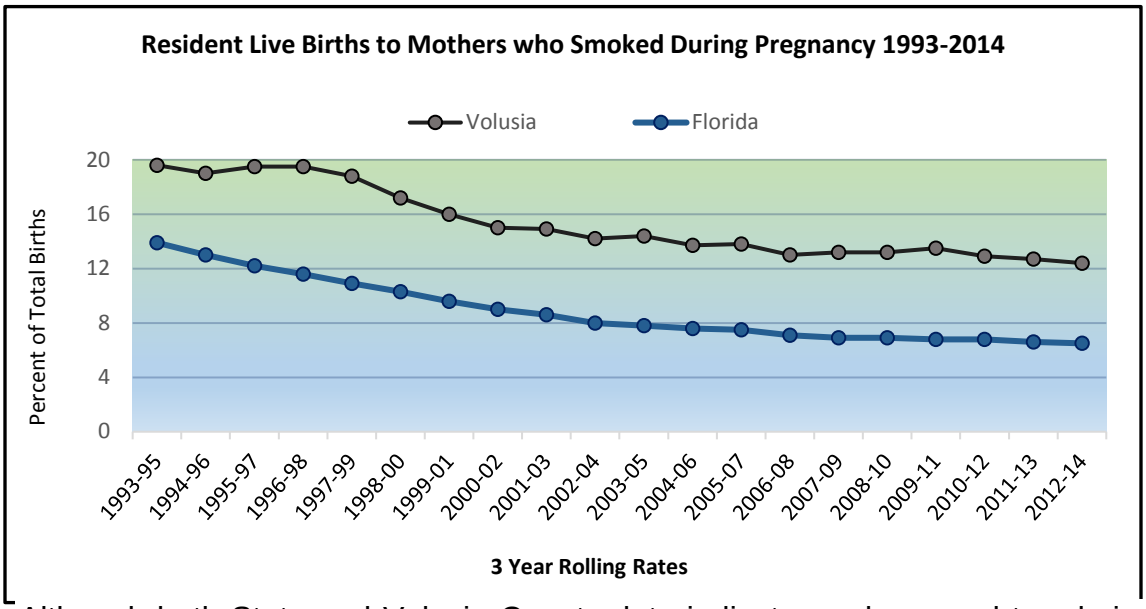
	Flagler	NE Volusia	NW Volusia	SE Volusia	SW Volusia	**Grand Total**
2013	13% (69/521)	12% (211/1708)	10% (60/579)	10% (30/314)	13% (120/930)	**12% (490/4052)**
2014	12% (66/558)	14% (259/1810)	16% (88/564)	14% (51/355)	11% (96/885)	**13% (560/4172)**
2015	12% (63/532)	12% (202/1621)	13% (75/573)	14% (44/323)	12% (107/887)	**12% (491/3936)**
Grand Total	**12% (198/1611)**	**13% (672/5139)**	**13% (223/1716)**	**13% (125/992)**	**12% (323/2702)**	**13% (1541/12160)**

Figure 20a shows the percentage of women that preferred not to be pregnant at the time of screening. This percentage has remained steady over the past three years, and it indicates the opportunity to address the continued need for interconceptional education and family planning services.

c. Tobacco Use during Pregnancy

Tobacco use during pregnancy has been a major concern in Volusia and Flagler Counties. Smoking during pregnancy can negatively influence multiple birth outcomes and has been proven to be especially associated with low birth weight. The rate of mothers who smoke during pregnancy in Volusia/Flagler has consistently exceeded the statewide average.

Figure 21. Resident Live Births to Mothers Who Smoked during Pregnancy Rolling 3 Year Percentage of Live Births



Although both State and Volusia County data indicates a downward trend since the late 1990's, there is still a disproportionate number of women who smoke during pregnancy in Volusia County compared to the State as a whole.

Figure 21a. Smoking during Pregnancy 2013-2015

	Flagler	NE Volusia	NW Volusia	SE Volusia	SW Volusia	**Grand Total**
2013	21% (112/521)	20% (347/1708)	14% (82/579)	23% (72/314)	13% (117/930)	**18% (730/4052)**
2014	20% (110/558)	21% (382/1810)	14% (77/564)	21% (74/355)	13% (115/885)	**18% (758/4172)**
2015	15% (78/532)	17% (280/1621)	12% (68/573)	20% (66/323)	13% (114/887)	**15% (606/3936)**
Grand Total	**19% (300/1611)**	**20% (1009/5139)**	**13% (227/1716)**	**21% (212/992)**	**13% (346/2702)**	**17% (2094/12160)**

Although the percentage of mothers who reported smoking during pregnancy has slightly declined or remained the same in each county over time, the decline has been minimal.

d. Mental Health

Maternal mental health is an important factor that can contribute significantly to child well-being. According to the World Health Organization, worldwide about 10% of pregnant women and 13% of women who have just given birth experience a mental disorder, primarily depression. In developing countries this is even higher, i.e. 15.6% during pregnancy and 19.8% after child birth. In severe cases mothers' suffering might be so severe that they may even commit suicide. In addition, the affected mothers cannot function properly. As a result, the children's growth and development may be negatively affected as well. Maternal mental disorders are treatable. *(Source: http://www.who.int/mental_health/maternalchild/maternal_mental_health/en/)*

The prenatal screening instrument allows the mother to report "feeling down or depressed", "feeling alone," and/or having a diagnosed mental illness. Mothers may also be referred for services based on other factors, such as a medical provider reporting a mental health concern for the mother. Women who indicated any one of these responses, including those referred based on other factors, were included in the analysis of mental health indicators.

Figure 22 shows that in all sectors of our community, anywhere from 28% - 32% of women completing the screen had one or more indicators associated with mental health. Northeast Volusia, our most urban area, showed the highest rate at 32%.

Figure 22. Mental Health Indicators during Pregnancy 2013-2015

	Flagler	NE Volusia	NW Volusia	SE Volusia	SW Volusia	**Grand Total**
2013	30% (154/521)	30% (511/1708)	29% (166/579)	27% (84/314)	30% (275/930)	**29% (1190/4052)**
2014	29% (163/558)	33% (601/1810)	28% (156/564)	28% (99/355)	30% (264/885)	**31% (1283/4172)**
2015	26% (136/532)	32% (516/1621)	28% (161/573)	28% (92/323)	29% (255/887)	**29% (1160/3936)**
Grand Total	**28% (453/1611)**	**32% (1628/5139)**	**28% (483/1716)**	**28% (275/992)**	**29% (794/2702)**	**30% (3633/12160)**

e. Education

Figure 23. Rate of Births to Mothers with Less than High School Education or GED, by Service Delivery Area and State 2010-2014

Births to Mothers With Less Than High School Education, Single Year Rates

	Volusia		Flagler		Florida	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
2010	771	16.4%	77	8.8%	36,712	17.1%
2011	824	17.7%	96	12.2%	34,088	16%
2012	736	15.6%	90	11.2%	32,409	15.2%
2013	711	15.3%	65	8.3%	30,766	14.3%
2014	640	13.4%	87	10.4%	29,097	13.2%

Figure 23 represents the incidence of Births to Mothers with Less than High School Education from 2010 to 2014 in Volusia and Flagler Counties as well as the state of Florida. While both Volusia County and the State rate has declined steadily since 2011, Flagler County experienced an increase in 2014.

Figure 23a. Percentage of Births to Mothers with Less than HS Education or GED by Service Delivery Area County and State from 2010-2014

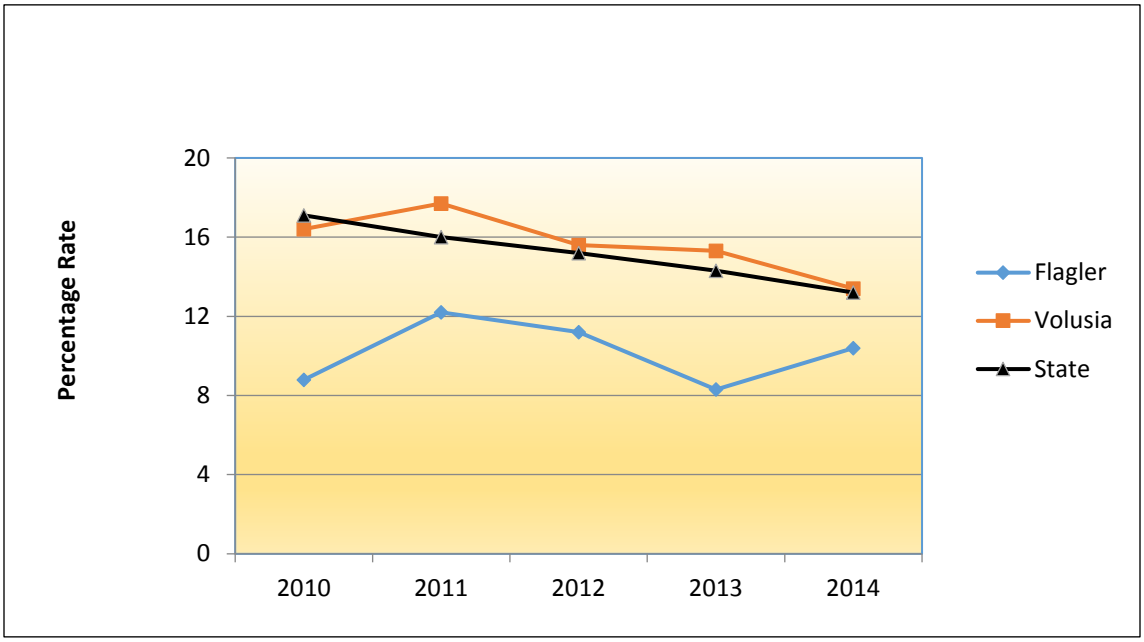


Figure 23b. Birth Mothers Educational Attainment for 2014

Birth Mothers Educational Attainment for year 2014	Volusia	Flagler	Total
< High School	**640**	**87**	**727**
High School Graduate or Higher	**4,064**	**739**	**4,803**
Unknown	**63**	**7**	**70**
Total	**4,767**	**833**	**5,600**

(Source: Office of Vital Statistics, Florida Department of Health, Jacksonville, FL)

Figure 23b shows education attainment of mothers in Volusia and Flagler Counties who gave birth in 2014. Of these, 13.4% of mothers residing in Volusia County did not have a high school diploma compared to 10.4% of mothers residing in Flagler County for the same period.

The children of parents who have not graduated high school or earned an equivalent degree face much higher rates of poverty, poor nutrition, inadequate healthcare, and being uninsured. Studies also indicate that babies born to mothers who have less than a high school education are more likely to be born at low or very low birth weight.

D. Healthy Start Services

Healthy Start services have changed remarkably over the last five years. In 2015/2016, we could see the result of our expansion and leveraging of other funds to serve our

highest risk families in the decrease in the number of level 3 participants receiving Healthy Start services funded through the Florida Department of Health or the Healthy Start MomCare Network.

Our role as the lead entity for the Healthy Families program and the Intensive High Risk Team has enabled us to link our most at risk families to services that are mare able to provide the intensity and duration to have an impact on outcomes. Families experiencing severe mental health problems, substance abuse problems, or evaluated to be at very high risk for child maltreatment are assessed and triaged in our Healthy Start system and linked for case management and coordination to these other services in our system of care.

During fiscal year 2015/2016, 4,740 participants received an initial contact from Healthy Start and an Individualized Plan of Care (IPC). Of those, 3,473 received ongoing direct encounters with Healthy Start and 917 were either in Level II or Level III services.

Analysis of service data is critical to assist in planning for the future and determining what the greatest needs of our participants are. The table below shows unique client identifiers who received specific services or referrals as part of their Healthy Start experience.

Figure 24. Healthy Start Enhanced Services for the Period 2013-2015

Wraparound/Enhanced Services 2013-2015	Unique Participants Served
Tobacco Education and Smoking Cessation Counseling	2,401
Interconception Education and Counseling	1,796
Breastfeeding Education and Support	3,044
Parenting Education and Support	2,065
Total with any wraparound service*	3,790

Participants receive the majority of enhanced services for breastfeeding and support but in the last three years, the second highest volume of services was for tobacco education and counseling.

Figure 25. Tobacco, Alcohol, and Substance Designation Coding for the Period 2013-2015

Tobacco, Alcohol and Substance Designation Coding	Unique Participants Served
Total # Tobacco & Alcohol Use Designation	**1,442**
Total # Tobacco & Substance Use Designation	**1,541**
Total # Alcohol & Substance Use Designation	**894**
Total # Alcohol Designation only	**380**
Total # Substance Use Designation only	**660**

The above numbers represent some of our very high risk participants who require intensive engagement, coordination of services, and skill of the workforce serving them. The duration and intensity of the services provided to participants with tobacco, alcohol, and substance use is significant. During the time period between 2013 – 3015 there were 1,164 referrals for psychosocial or mental health services and 142 for domestic violence. *(Source: HSCFV Well Family Data System as entered into FDOH 2013-2015)*

E. Provider, Participant, and Staff Feedback

As part of our Continuous Quality Improvement process, we regularly survey providers and participants to gain feedback about their satisfaction with services provided by our staff and subcontractors. Direct service staff is also surveyed during monitoring by the Coalition as part of our site review process. The leadership within the Coalition review responses and develop strategies to support the workforce toward improvement.

1. Provider Surveys

Providers from the medical community who receive screening education are surveyed one time annually. Provider surveys are conducted by the Healthy Start Marketing and Education Director to gain feedback about the quality and effectiveness of screening education and information about programs and services for their patients. Of 45 physician offices surveyed, there were 15 respondents. Respondents could be one of a number of staff members that utilize the screen and deal directly with patients. Of the 15 respondents, the following feedback was received:

- 93.3% strongly agreed and 6.7% agreed that the trainer is courteous and informative
- 93.3% strongly agreed and 6.7% agreed that they are able to contact the Marketing and Education Director when needed

- 93.3% strongly agreed and 6.7% agreed that they receive services, screens, and brochures in a timely manner
- 93.3% strongly agreed that if they had an issue or complaint it was handled in a timely manner. (6.6%, or {1} respondent, stated this question was not applicable)
- 93.3% strongly agreed that they are provided with other services or information that they need for their patients (6.6%, or {1} respondent, stated this question was not applicable)
- 93.3% strongly agreed that screening education was presented in a manner that the staff could understand. (6.6%, or {1} respondent, stated this question was not applicable)
- 93.3% strongly agreed and 6.7% agreed that the staff was provided with the education needed to accurately fill out the prenatal screen
- 100% agreed that they are contacted by us on a regular basis
- 100% stated that they are satisfied with the services provided
- Comments were made about the presentation ad services and all were positive. The only response received about additional information needed was a request to provide more information for patients in Spanish. We are continuing to work on ensuring that all materials we provide are available in Spanish and English.

2. Participant Surveys

Participants are surveyed quarterly during the fiscal year. During the 2015-2016 period, there were 206 respondents to our participant satisfaction survey which is collected and compiled in Survey Monkey. Of those surveyed:

- 59% self-identified as White, 23% as Black, 14% Hispanic, and 3% as multiracial. Three respondents skipped the question.
- One respondent was male, 205/206 were female

At the time they responded to the survey:

- 29% (59/206) were pregnant
- 98.5% (203/206) were enrolled in Healthy Start services
- 38% had been in the program less than 3 months
- 35% had been in the program between 3 and 6 months
- 23% had been in the program more between 6 months and 1 year
- 4% had been in the program 1 year or more

Responses to questions related to engagement and quality:

- 98.5% responded their worker treats them with courtesy and respect
- 98.5% said they were able to talk to their worker
- 97% said their worker spends quality time with them

- 97% said they would recommend their worker to a friend
- 98.5 % said they receive help when they need it
- 98% said their worker helps them find other services when needed
- 96.5% said their worker helps them accomplish their goals
- When asked for comments about their worker there were hundreds of very positive responses such as “She’s positive, like a mom,” She’s always helpful,” “I got help with breastfeeding,” “She helped me quit smoking!”

Responses about overall satisfaction:

- 97.5% were overall satisfied with the program (201/206) – 3/206 said Not Applicable and 1/206 respondent disagreed
- 92% stated that their overall ability to cope was improved (190/206); 11/206 were Not Applicable)
- 98.9% said that if they had a complaint or grievance it was handled well

3. Direct Staff Responses to Question and Answer Session

During the FY 2015-2016 annual onsite monitoring, nine (9) direct service staff members participated in a question and answer session. Though the process and the survey questions are not scientific, they provide qualitative information that is beneficial to our planning activities. These responses tell us about their satisfaction with their role as employees in the Healthy Start system of care and inform us so that we can develop strategies and staff development activities to better support them. The goal is to maintain engagement and retention of employees.

Questions are open-ended and each answer is unique.

Question #2.

What are the benefits of Healthy Start?

- 4/9 indicated they benefited from training
- 2/9 indicated that employment and financial stability was the benefit
- 2/9 indicated that they get to help people in the community

Question #3.

What areas of the program do you feel could be improved?

- We need more funding for better resources for the families
- Salary
- Less paperwork
- Enough capacity for no waiting lists

- Better access to technology such as tablets. “It will save money and time and we could be more effective and productive; We could educate the parents better.”
- Resources to provide the intensity needed
- Staff to client ratio – not having care coordinators driving all over the county
- Better pay. Gas Cards. Company vehicles.
- “More resources that actually help. We provide resource numbers, but when the moms call there’s no help. We need more care coordinators in the field. We also need our own educators to teach classes to groups of moms…”

Question #6. Please describe the barriers to meeting program goals.

- Substance using women of childbearing age, pregnant, substance exposed infants and limitations in offering them adequate support
- Families stop opening the door when their needs are so great and they don’t feel you can help them with the basics
- Too much paperwork – does not allow the time needed to really help people
- Not enough human or financial resources needed to do the job
- Too many issues in the home
- Not enough money and not enough workforce
- Not enough centers to house pregnant women with substance abuse problems

Question #7.

Please list any areas of training you would like offered.

- New substances of abuse – Flakka, etc.
- Domestic Violence
- Computer basics
- Periods of Purple Crying
- Assessing infant mental health
- Trauma Informed Care
- Newborn care
- Life skills
- Employee team building

Question #10.

What do you find most satisfying about your job and your role in the local Healthy Start system of care?

- Support, flexibility and it’s a team player program from top to bottom
- Being able to help a family knowing they will be better off as a result of the help
- Educating new mothers
- Seeing a positive change in families

- Helping empower women
- Meeting families to provide education resources, hope, and support
- Being able to help families with tangible resources and witnessing small changes
- I like the freedom of being out in the community connecting with people who desire to improve their quality of life through helping themselves with Healthy Start support
- I am most satisfied if I helped a mom or dad understand something, learn something, or provide support when they have no-one else that will listen and not judge them.

Additional responses that helped to inform us this period related to the challenges with car maintenance for the home visitors and burnout. We are working to address these in team building efforts, subcontracting, and the Comprehensive Training Plan.

IV. SERVICE AREA RESOURCE ASSESSMENT AND INVENTORY

A. Resource Inventory

In order to ensure that our target population has access to the services they need to ensure their health and well-being, it is important to regularly inventory the available resources in the community. The Coalition's resource inventory is updated on a regular basis. To remain apprised of funding and program changes throughout the community's social service and medical system that impact available services, Healthy Start is involved with United Way, One Voice for Volusia, Healthy Volusia, the Behavioral Health Consortium, and the Northeast Florida Infant Mental Health Chapter. Our Marketing and Education Director regularly reviews our Resource Directory, which is provided to women who apply for Medicaid upon enrollment and is available to all of our participant, providers, and the community at large on our website.

1. Medical Providers

The Healthy Start Coalition of Flagler and Volusia Counties, Inc. has made progress in engaging the medical community in planning and service delivery efforts. This has resulted in an increase in referrals to Healthy Start services, regardless of screening score, when a physician or health care provider interacts with a patient and recognizes factors that are associated with social determinants of health. This has also resulted in the increase in prenatal screening rates and referral for interconceptional services.

Flagler County has no hospital birth facilities, and the health department is the main resource there for clinical prenatal services. Women who have transportation and private insurance may travel outside of the county for services but the majority of women receive care at the health department clinic. Healthy Start provides funding to the Health Department in Flagler County for unfunded prenatal patients and a full time Healthy Start worker is appointed to the health department location. There is one OB/GYN in Flagler County but the delivery privileges for that practice is located in St. Johns County.

Volusia County has three hospitals with birth facilities. Two of these have Level II neonatal intensive care units (NICU) and our only facility on the west side of the county has only a Level I nursery. There are a total of 45 prenatal providers and most take at least one Medicaid Managed Care plan. The two recently opened clinics take all four plans and serve the highest risk clients. These clinics opened as a result of the closing of the Volusia County prenatal clinic at the Health Department.

2. Overall Resource Update

a. <u>Medical Services for Pregnant Women</u>

Volusia County is divided into three hospital taxing authorities who provide for funding of medical care for the indigent or working poor who are uninsured or

underinsured. On the east side of the county, Halifax Medical Center authorizes the allocation of ad valorem taxes for these services.

The West Volusia Hospital Authority is comprised of an elected Board who allocate ad valorem tax dollars on the west side of the county. This Board provides funds for prenatal services for the Volusia County Health Department, and funding for indigent services for the local hospital, Florida Hospital Deland. Since the last planning cycle, the west side of the county has received funding for and implemented a Federally Qualified Health Center Our Coalition has successfully obtained funding from the West Volusia Hospital Authority to serve high risk women in approved zip codes within the authority. The only hospital with birth facilities located in the West Volusia Hospital Authority's zip codes is located in DeLand. This is a Florida Hospital community hospital designation with a Level I Newborn Nursery.

The two authorities on the east side are integral to the hospital systems there and do not offer grant programs to the public at large, but must utilize the tax revenue to serve the health needs of the indigent. The Southeast authority area does not have a hospital with a birth facility and the number of prenatal providers in that quadrant of the county is minimal. This area covers Oak Hill, Edgewater, and New Smyrna Beach.

Florida Hospital delivery services have recently upgraded their neonatal intensive care unit from a Level I to a Level II. Our service area does not have a Level III NICU. The only hospital available for delivery on the west side of Volusia County is approximately 25 miles away from our most vulnerable migrant populations of women (in the town of Pierson), who must travel far distances for care. Transportation and language barriers for this population are significant.

Flagler County has no private OB/GYN services but provides for prenatal care at the Flagler County Health Department. Flagler County has no hospital or delivery sites.

In the local jail system, Armor Health Services is contracted to provide for the health of inmates who are locally incarcerated in the Volusia County Branch Jail and "11-29" unit. This is a change from the last service delivery planning cycle, as the health services in the Volusia County Branch Jail were contracted through Prison Health Services. The change in health providers resulted in the need to re-establish relationships with the key personnel delivering medical care and ensure we can coordinate on behalf of pregnant women when they are released. This was critical since these are some of our most high risk pregnancies and they are not given their medical records upon release. OB/Gyn's are reluctant to take them into care because their Medicaid stops when they are incarcerated and they are often trying to enter the private sector very late into their pregnancy. We have developed a continuum of care for pregnant women who are incarcerated. Pregnant inmates receive Healthy Start screening and assessment and are assigned a care coordinator while they are incarcerated. Healthy Start

successfully negotiated a Memorandum of Understanding with the Volusia County Branch Jail to ensure that our entities work together to support the most positive outcomes through effective coordination of services.

HIV positive women have few resources for specialty OB/GYN services. Because of this, we participate in a program called "MAMA BEAR". This collaborative effort provides a coordinated multi-disciplinary staffing of pregnant women who are HIV positive or have other STDs. This staffing is conducted with the Health Department in Volusia County surveillance and related staff, Children's Medical Services, Ryan White Case Management, and Healthy Start. This group works to ensure that pregnant women receive consistent prenatal care under Ryan White Title II and Title IV and ensure that recommended protocols are followed. This process has proved effective. We have had no reported perinatal transmission of HIV in the last 7 years despite the overall increase in HIV incidence..

Children's Medical Services (CMS) provides medical services for children with special medical needs. Healthy Start refers for these services upon birth of the infant if there are special medical needs. Various gatekeepers, including Healthy Start assessment workers and home visitors work with families to determine eligibility or payment of these services. Since implementation of Florida's Medicaid Managed Care the CMS system has experienced some changes. CMS is considered a Managed Care plan and nurse case managers are assigned to families once they are referred. They have a network of pediatric specialty providers and assist patients in navigating their network and obtaining the medical services needed for their children.

b. Basic Needs Services (Food Banks, Housing, Etc.)

There are many social service networks in Volusia County, most of which are available on the east side of the county. The West Volusia area has limited social services, and Flagler County relies predominantly on the East Volusia Area for social services. Most social services that are available in Flagler County are funded through the County.

The Homeless Coalition of Volusia/Flagler County provides for a consolidated plan to address homelessness and ensures that funding be allocated for shelter and transitional services to women and children. These include the Domestic Abuse Council Shelter and Transitional Housing, Family Renew (transitional housing for women and children as well as in-tact families), Palmetto Place Advocates, the newly created STAR Shelter, and the Salvation Army. Halifax Urban Ministries provides for food and shelter vouchers; furthermore, additional aid is provided through many church ministries in the area.

The Neighborhood Center of Deland, Halifax Urban Ministries, and Salvation Army provide services to the homeless on the west side of Volusia County.

WARM (Women Assisting Recovering Mothers), of Stewart Marchman ACT Behavioral Health provides shelter and substance abuse treatment for pregnant and parenting women who need a residential setting. In conjunction with Healthy Start, Project WARM ensures that transitional living arrangements are secured as women and their children leave the treatment setting.

HIV positive women are eligible for HOPWA (Housing Opportunities for People Living with AIDS), which can provide funding for shelter and transitional housing on a temporary basis. HIV positive women are enrolled in Ryan White Title II case management services through the Health Department in Volusia County. This has changed since the last planning cycle since they successfully regained the funding through the local RFP process.

c. Substance Abuse Treatment Services

The state of Florida has seen a steady increase in the number of babies born with Neonatal Abstinence Syndrome as a result of use of substances by a woman when she is pregnant. The challenge of prescription drug availability and use is impacting capacity and protocol for pregnant addicted women, particularly in the second and third trimester of pregnancy.

Opioid management and opiate addiction continues to increase. Women on Medicaid have limited local resources for opioid maintenance during pregnancy unless they can self-pay. This often results in physicians who cannot follow medical guidelines during pregnancy when the mother is impoverished. Residential settings for pregnant addicted women in our community can only admit women when they have gone through detoxification. If the medical recommendation is to maintain a course of opioid management during pregnancy, this creates a gap in services, placing the physician in a challenging position.

Babies born to women addicted to drugs require linkage to a complicated maze of services and require careful assessment and a multi-disciplinary approach to manage effectively. Hospitals frequently interact with the Department of Children and Families, Healthy Start, and the substance abuse treatment community to work toward ensuring a baby's safety and care. In addition, referral to Children's Medical Services, Early Steps, Community Partnership for Children (Foster Care and specialized parenting), and Early Learning Coalition may be required. For this reason, the Healthy Start Coalition allocated resources for a Women's Intervention Specialist to respond to these cases and coordinate with these multiple service providers and the family to support the well-being of the baby and the hopeful recovery of the family. This important position is working with providers and the hospital system to develop community-wide protocols designed to address this growing epidemic.

There is one centralized addictions receiving facility in the service area. (Stewart Marchman ACT Behavioral Health Care). This provider is also the major

subcontractor for Healthy Start services, which is beneficial in coordinating the mental health and substance abuse service needs of Healthy Start families.

Healthy Start periodically utilizes other substance abuse services outside the service area depending on the needs of the woman or the limited capacity of the local service system.

d. Other Community Based Services

Healthy Start workers coordinate with numerous community-based organizations on behalf of their participants. Each family presents its unique set of circumstances that pose both risk and resilience as they care for a newborn or young child.

As we worked in committees to conduct needs assessment activities and review community capacity for needed resources, several themes emerged which should be mentioned as part of the resource inventory and gap analysis.

- Single mothers who live in poverty must often return to work shortly after the birth of their baby and need to be connected to workforce development, child care, and basic needs.

- Transportation is costly and not available to many women who need to get to medical appointments, work, and child care.

- Often women cannot get services because they lack basic identification. Our workers link to I-Dignity, which is an event held regularly throughout areas in the two county areas to help people get their birth certificates or other forms of identification to remove these barriers. While this is very helpful, it still impacts access to care while a woman waits until the next event.

- The local Domestic Abuse shelter has reported capacity limitations for sheltering women who come forward to escape domestic violence.

- Community mental health services often lack expertise in perinatal mood disorders and infant mental health. Women report following up on referrals for mental health services and not engaging even when the capacity is there.

3. Resources Gained

The following is a highlight summary of services gained since the last service delivery plan update. Healthy Start has worked with partners to reduce barriers to access and focus on provision of support for our most vulnerable families.

Though the Medicaid Managed care changes resulted in the prenatal clinical services discontinuing at our health department in Volusia County, the Federally Qualified Health Center (FQHC) expanded services in both counties in our service area.

The Community Health Needs Assessment process provided forums for our Health and Human service providers to come together and review our assets for meeting the needs of our residents. This was a very good exercise and revealed potential for additional partnership building for the maternal and child health system.

Our Coalition has continued to work with our Board of Directors, Coalition members, the Substance Exposed Newborn Task Force, and Service Delivery Planning Committee to identify the gaps in our system of care. As reflected in the responses from direct service staff, challenges with capacity, caseload size, and inadequate resources for very high risk families makes the job of care coordination and home visiting extremely difficult.

Several grants were identified to align with the service needs and our community partners unified to submit proposals to significantly enhance our ability to increase capacity and serve our highest risk families. These projects are being fully implemented in the beginning of the 2016-2017 fiscal year and are described below.

a. Healthy Start Coalition Resources Gained

The Healthy Start Coalition of Flagler and Volusia Counties gained significant resources to support the maternal and child health system of care since the last planning cycle. The majority of these resources were from local municipalities, child welfare, and substance abuse and mental health funding.

Figure 26 shows six new revenue sources that are funding service needs since the last planning cycle. These new funds have enabled us to expand our service capacity and establish an intensive high risk team to respond to our most vulnerable families as well as working toward better utilization of capacity through the MIECHV Centralized Intake and Referral. These funds include incidentals to provide practical support such as transportation, medication, emergency housing, and child care. We continue to work on a community model that includes Family Place Resource sites, Peer Support and Family Engagement, and improved coordination and continuity of care. We have adopted the Strengthening Families Protective Factors as the framework by which to integrate these various services and positions.

Figure 26. New Healthy Start Coalition Funding by Source and Type 2015/2016

Funding Source	Type of Funding	Description
County of Volusia	Children and Families Advisory Board	Women's Intervention, Neonatal Intervention, and Assessment services
City of Deltona	Community Development Block Grant/HUD	Family Place ACCESS site
West Volusia Hospital Taxing Authority	Ad valorem taxes for specific zip codes	Women's Intervention, Women's Health Advisor
FAHSC/MIECHV	HRSA	Centralized Intake and Referral
Lutheran Services	Substance Abuse/Mental Health	Intensive High Risk Team
Community Partnership for Children	Department of Children and Families	Family Engagement and Parent Partner support

b. <u>Prenatal Services at the Northeast Florida Health Services Family Health Source (NEFS)</u>

This is the Federally Qualitied Health Center on the west side of our county and is now offering prenatal services 2 days weekly in DeLand and Pierson. Their OB/GYN has been certified to use Subutex/Suboxone.

c. <u>Family Place ACCESS sites</u>

These resource centers assist families in applying for food stamps, Medicaid, refugee services, TANF, employment and resources their family may need. There are two sites, one on the east and one on the west side of Volusia County.

d. <u>Halifax Health Hospitalists</u>

These are OB/GYN's that are available at the hospital so that any pregnant woman entering the hospital to deliver her baby will have a highly qualified physician available.

e. Women's Care

A clinic operated by Florida Hospital for women who are considered high risk or have difficulty paying for services.

f. Women's Care Now

A clinic operated by Halifax Health for high risk women who are considered high risk or have difficulty paying for services.

g. Halifax Ob/GYN Associates

This practice has a physician on the East side of Volusia County who is now certified to use Subutex/Suboxone.

h. Tree of Life Birth and Gynecology and DeLand Birth Center

Licensed midwives recently opened a practice located on the west side of our county.

i. Darryl Strawberry Recovery Center

This is a private residential center that recently opened in the center of Volusia County and they have provided pro bono support for Healthy Start women who do not need to enter treatment with their baby.

j. A Helping Hand, Inc.

Provides parent-child psychotherapy to promote infant health through tier 3 services.

k. Easter Seals Early Steps

Links with Children's Medical services for children with special health needs. After the closing of Children's Advocacy Center, Early Steps moved to Easter Seals and shortly thereafter, Medicaid Managed care changed the landscape for CMS. Capacity has increased since these two changes occurred.

l. Children's Medical Services

Provides access and care for children with special health care needs.

m. Infant Mental Health

Provides early identification and intervention for infants and toddlers that may exhibit difficult behaviors due to adverse experiences, developmental challenges or medical problems and ensures that parents and caregivers have access to the right kind of support.

n. Chrysalis Health

Provides mental health and substance abuse services in an outpatient modality through home visiting.

o. Help Me Grow

This is a partnership with United Way, Early Learning Coalition, and Florida Disabilities Council designed to improve access to developmental screening for children through age 8.

4. Resources Lost

Since the last Service Delivery Plan, Volusia and Flagler Counties have lost the following social and medical services:

a. Prenatal Clinical services in the Florida Department of Health in Volusia County

The closing of the prenatal clinic at our health department in 2015 was a challenge since the majority of our high risk women obtained services there and we had successfully worked with a private OB/GYN to serve patients there. This provided a central location with wrap around services to include WIC, Healthy Start, HIV and STI testing and Family Planning.

b. Haven Recovery

Previously known as Serenity House – this agency provided residential treatment and outpatient treatment for pregnant women and postpartum women with babies who were on opioid maintenance. The agency was closed in 2015.

c. Children's Advocacy Center

This agency was the location of our Early Steps program and also provided services for families who had experienced trauma to include sexual and physical abuse. This agency closed in 2014.

d. Outreach Community Care Network

This AIDS service organization lost the contract for Ryan White Title II services and as a grass roots organization they were able to link peers to positive clients. The Health Department in Volusia were awarded the RFP so Ryan White services are still being provided but the peer system is now fragmented.

5. Service Gaps

There are several major service gaps in Volusia and Flagler Counties which impact the health and wellbeing of our pregnant women and infants, such as:

- **Dental** - Dental services for uninsured pregnant women are minimally available but for woman with postpartum or interconception health statuses, they are very difficult to access.

- **Prenatal** - Pregnant women residing in the rural areas around Pierson and Seville (Northwest Volusia County) do not have prenatal providers within a 25 mile radius.

- **Affordable Housing** - The number of families who find themselves evicted from their homes or apartments continues to be high. Families who are unemployed or underemployed on a very limited income, or who have a poor credit history or criminal background have an extremely difficult time finding affordable housing.

- **Substance Abuse Treatment for Opioid/Opiate Addiction** – The opiate/opioid drug abuse epidemic has created a gap in services for those who are addicted to heroin, prescription drugs and methadone. For pregnant women, there is a lack of available services for appropriate medical intervention in the second and third trimester of pregnancy if they cannot afford "cash up front" for methadone, buprenorphine, or other opiates or opioids that may be required for them to prevent fetal loss or kindling to the baby. Our community lacks adequate Medicaid resources for proper management of addiction until a pregnant woman delivers her baby. Even after delivery, there is a lack of resources available for transition and detox from opiates/opioids for people with low income.

  Residential services have a capacity for pregnant postpartum women and their babies of 78. There is typically a 3 month waiting list and the treatment center only takes women who have been successfully detoxed.

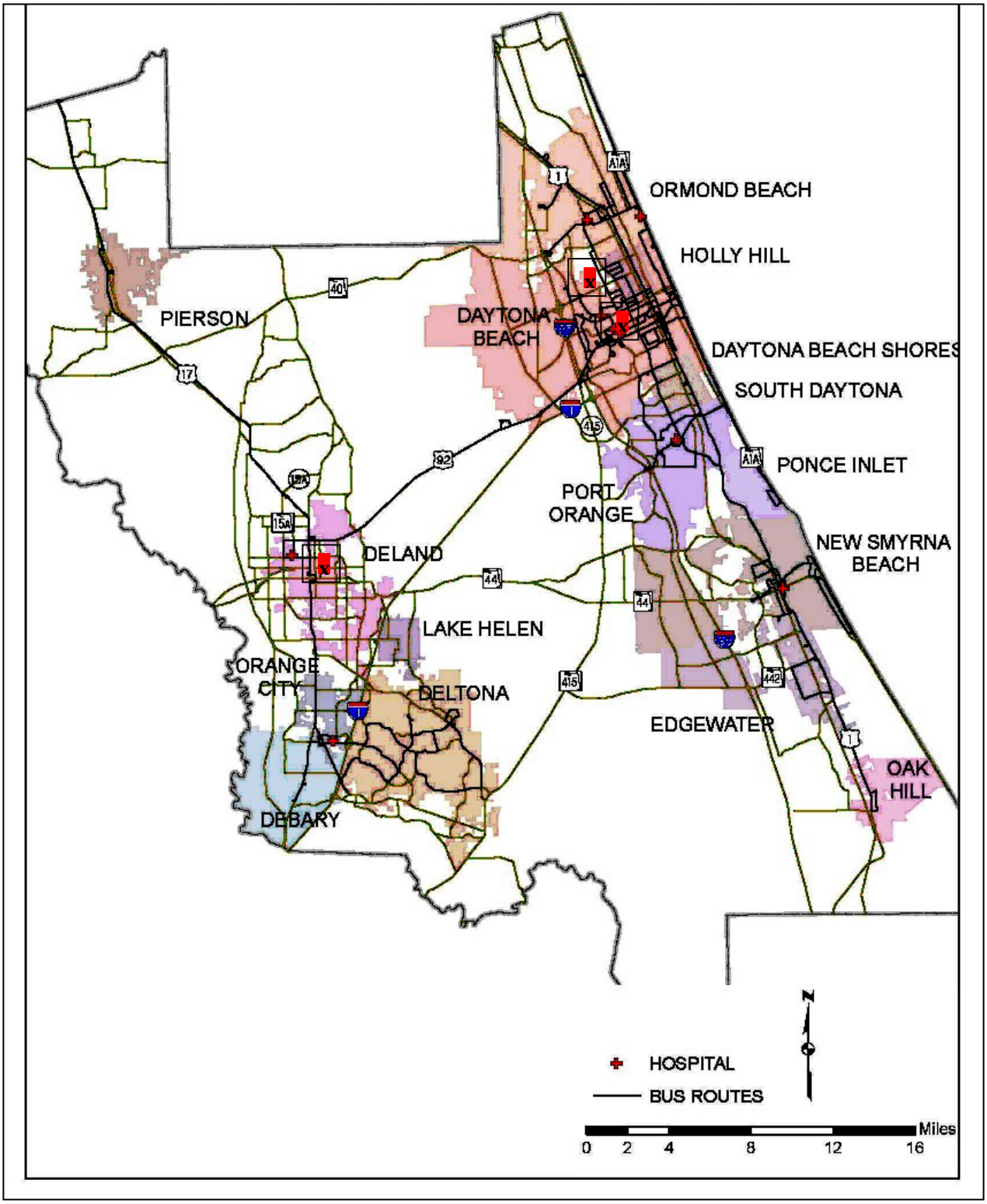
- **Transitional and Emergency Shelter** - Our Healthy Start workers have difficulty working with families who find themselves homeless. The Star Family Shelter typically has a waiting list and there are few other options available. This becomes more challenging when women are pregnant and close to their delivery date. Our community has been working with the County of Volusia to explore options for addressing the growing homeless problem in our area because we are failing to meet the need of homeless families.

- **Geographic/Access** - In the central Daytona Beach area there are multiple health and human service resources. The Deland area on the west side of the County also has available and accessible resources to families. However, our most populous city of Deltona has significant service gaps to include lack of prenatal services, birthing services, and other basic human services such as counseling, substance abuse treatment, basic needs and recently Department of

Children and Families access. In addition, the Southeast quadrant of our county, which includes New Smyrna, Edgewater, and Oak Hill, has significant resource gaps. The Volusia County Health Department has limited prenatal services in this area, but as in Deltona, access to basic needs services are lacking. And finally, the Northwest quadrant of the County is comprised of many migrant farm working populations in an isolated rural setting.

The map in Figure 27 illustrates the Volusia County area in relation to hospitals with birthing centers (red box with an "x") and the distance women residing in Pierson, Deltona, and New Smyrna must travel to reach a birthing facility. These areas tend to be lacking in resources and create transportation and other barriers for families. (Flagler County is to the north and has no hospitals or birthing centers.)

Figure 27. Map of Volusia County with Identifiers for Birth Center Hospitals



V. TARGET POPULATION, INDICATORS, STRATEGIES & FIVE YEAR GOALS

A. Target Population

1. General Population Characteristics

As of 2015, Volusia County was home to 508,744 residents, a steady increase since 2010. The majority (85%) is White, 12% are Hispanic and 11% are Black. Approximately 4% are reported as Other.

Figure 28. Population Volusia County

Total County Population By Year (Number)					
2010	*2011*	*2012*	*2013*	*2014*	*2015*
494,617	**495,758**	**496,832**	**500,343**	**503,179**	**508,744**

Figure 28a. Population Volusia County by Race and Ethnicity

Total Population by Race and Ethnicity By Year (Number)					
Race	*2011*	*2012*	*2013*	*2014*	*2015*
White	422,265	422,971	425,480	427,703	431,133
Black	54,129	54,455	55,145	55,643	57,082
Hispanic	56,842	57,060	58,476	60,533	62,931
Other	19,364	19,406	19,718	19,833	20,529

Figure 28b. Volusia Population under Age 18 and under Age 4

Population Under Age 18 (Number)				
2011	*2012*	*2013*	*2014*	*2015*
17,397	**17,124**	**16,718**	**16,244**	**17,546**

Population Age 0 to 4 (Number)				
2011	*2012*	*2013*	*2014*	*2015*
23,932	**24,203**	**24,361**	**24,544**	**24,556**

(Source: Population estimates are provided by the Department of Health, Office of Health Statistics and Assessment in consultation with the Florida Legislature's Office of Economic)

Flagler County population rates have steadily increased since 2005, and as of 2015, is home to 102,738 residents. The majority of Flagler residents (83%) are White, (13%) are Black, (10%) are Hispanic and (5%) are reported as Other.

Figure 29. Population Flagler County

Total County Population by Year (Number)				
2011	*2012*	*2013*	*2014*	*2015*
96,640	**98,252**	**100,305**	**101,680**	**102,738**

Figure 29a. Flagler County Population by Race and Ethnicity

Total Population by Race and Ethnicity By Year (Number)					
Race	*2011*	*2012*	*2013*	*2014*	*2015*
White	80,952	81,817	83,392	84,169	84,858
Black	11,307	11,852	12,199	12,652	12,879
Hispanic	8,690	9,114	9,410	10,277	10,555
Other	4,381	4,583	4,714	4,859	5,001

Figure 29b. Flagler County Population under Age 18 and Under Age 4

Population Under Age 18 (Number)				
2011	*2012*	*2013*	*2014*	*2015*
3,661	**3,689**	**3,718**	**3,726**	**3,360**

Population Age 0 to 4 (Number)				
2011	*2012*	*2013*	*2014*	*2015*
4,661	**4,758**	**4,857**	**4,943**	**4,939**

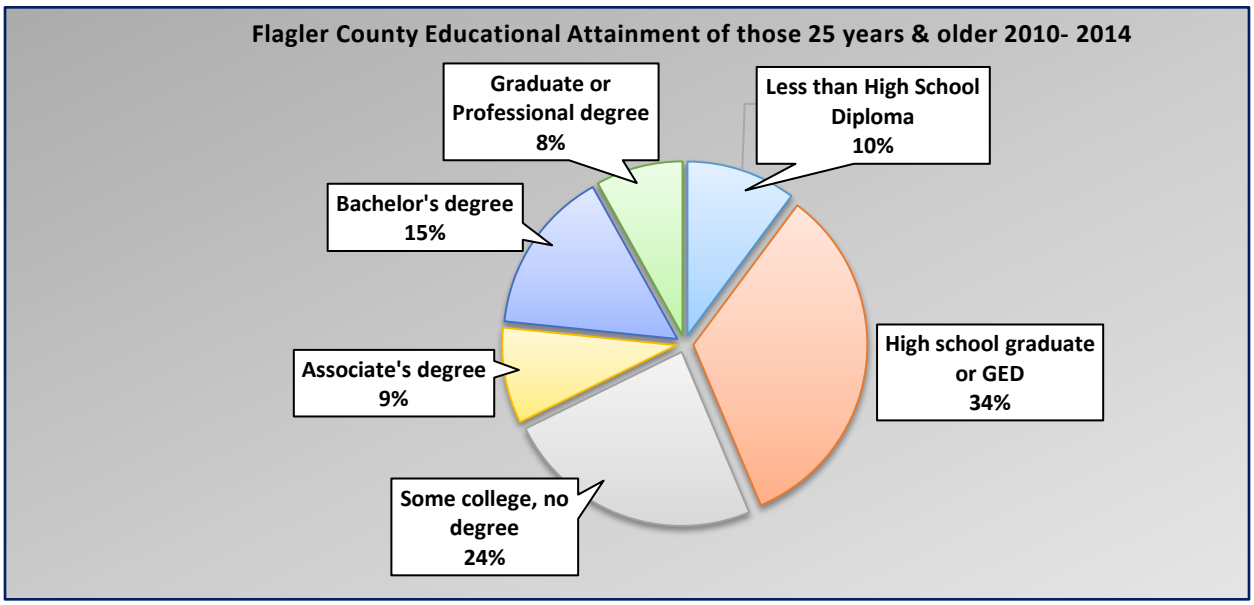
(Source: Population estimates are provided by the Department of Health, Office of Health Statistics and Assessment in consultation with the Florida Legislature's Office of Economic)

The Service Area is comprised of the counties of Volusia and Flagler. As of 2015, the total population of the two counties was 611,482, with Volusia County being the more populous of the two.

2. Educational Attainment

In 2010-2014, 90 percent of people 25 years and over in Flagler County had at least graduated from high school and 23 percent had a bachelor's degree or higher. Ten percent were not enrolled in school and had not graduated from high school.

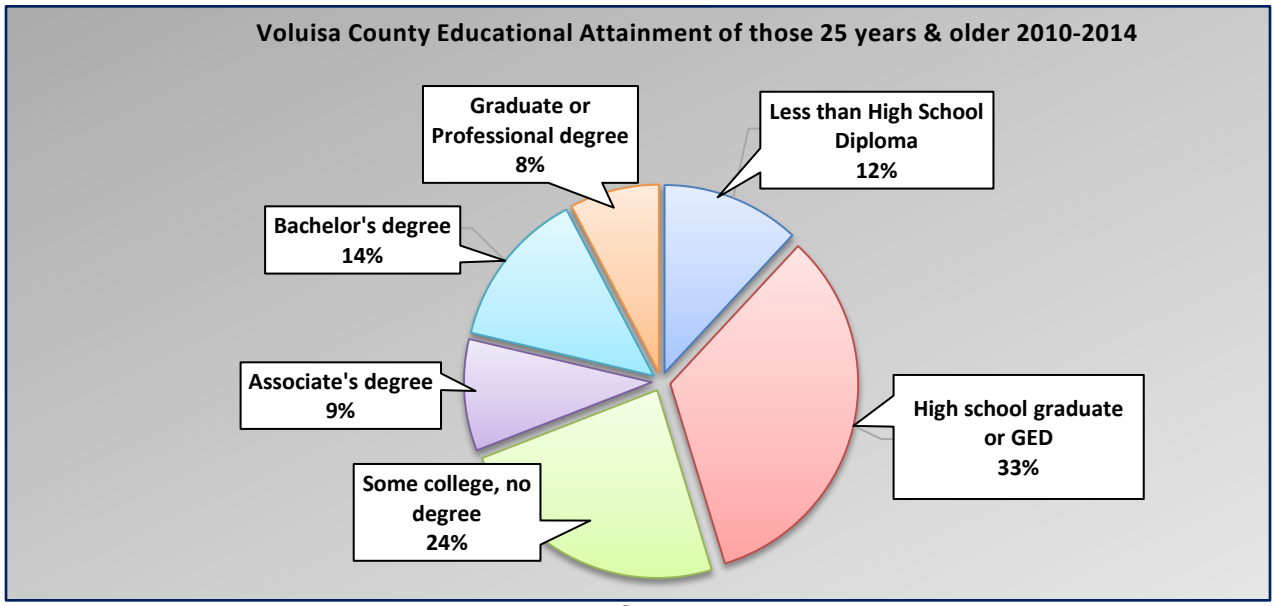
Figure 30. The Educational Attainment of People in Flagler County, Florida in 2010-2014 (5 year estimates)



(Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates)

In 2010-2014, 88 percent of people 25 years and over in Volusia had at least graduated from high school and 22 percent had a bachelor's degree or higher. Twelve percent were not enrolled in school and had not graduated from high school.

Figure 31. The Educational Attainment of People in Volusia County, Florida in 2010-2014 (5 year estimates)



(Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates)

3. Poverty and Income

Figure 32. 2014 Income and Poverty for Volusia, Flagler and Florida

Characteristic	Volusia	Flagler	Florida
Per Capita Personal Income	$36,052	$36,748	$42,737
Median Household Income	$41,714	$47,733	$47,212
Poverty (all ages)	17.7%	11.6%	16.6%
Poverty under 18	27.2%	21.2%	24.2%
Poverty Ages 5-17	25.0%	20.2%	22.9%

(Source: Florida Legislature Office of Economic and Demographic Research http://edr.state.fl.us)

The table above shows 2014 economic characteristics for Volusia and Flagler Counties and Florida. Volusia shows lower income and higher poverty percentages for all ages. Flagler has less children living in poverty and has Median Household Income higher than Volusia County and Florida.

4. Pregnancy and Young Child Profile

Figure 33. Volusia County Pregnancy and Young Child Profile 2014 or 2012 – 2014

Pregnancy and Young Child Profile, Volusia County						
Measure	**Rate Type**	**Year(s)**	**County Quartile 1=most favorable 4=least favorable**	**County Number (Average)**	**County Rate**	**State Comparison**
Community Characteristics						
Median household income (in dollars)	Dollars	2014		$41,714		$47,212
Population below 100% poverty	Percent	2014	2		17.6%	16.7%
Unemployment rate	Percent	2014	2		10.5%	10.9%
Individuals living in owner-occupied housing	Percent	2014	3		71.0%	66.1%
Domestic violence offenses	Per 100,000 population	2012-14	4	4,106	821.1	557.7
Population 5+ that speak English less than very well	Percent	2014	3		4.4%	11.7%
Births covered by emergency Medicaid	Percent of births	2012-14	3	103	2.2%	4.7%
Women of Childbearing Age						
Socio-Demographic Characteristics						
Total female population ages 15-44	Count	2014		82,469		3,622,709
White female population ages 15-44	Count	2014		65,543		2,667,277
Black female population ages 15-44	Count	2014		12,803		730,788
Other female population ages 15-44	Count	2014		4,123		224,644
Hispanic female population ages 15-44	Count	2014		12,684		1,019,513
Birth Family Characteristics						

Births to mothers ages 15-19	Per 1,000 females 15-19	2012-14	2	354	25.0	24.3
Repeat births to mothers ages 15-19	Percent of births 15-19	2012-14	1	50	14.1%	16.6%
Births to mothers >35	Per 1,000 females > 35	2012-14	2	440	2.7	4.6
Total births to unwed mothers	Percent of births	2012-14	3	2,543	54.1%	47.9%
Births among unwed mothers ages 15-19	Percent of births 15-19	2012-14	3	324	91.5%	91.2%
Births among unwed mothers ages 20-54	Percent of births 20-54	2012-14	3	2,216	51.0%	44.8%
Births with father acknowledged on birth certificate	Percent of births	2012-14	2	3,996	85.0%	85.8%
Births to mothers >18 without high school education	Percent of births > 18	2012-14	2	571	12.7%	12.3%
Births to mothers born in other countries	Percent of births	2012-14	2	615	13.1%	30.3%

Volusia County has approximately 82,469 women of reproductive age, with the majority 79% (65,543) White, 16% (12,803) Black, and 15% (12,684) Hispanic.

Women of reproductive age (15-44) represents 16% of the Volusia County population. Several indicators are worthy of note in Volusia County to include births to unwed mothers, as stated previously, the unemployment rate among women and domestic violence offenses rate at 821.1 per 100,000, which is higher than Florida's rate at 557.7 per 100,000 cases.

Figure 34. Flagler County Pregnancy and Young Child Profile 2014 or 2012-2014

Pregnancy and Young Child Profile - Flagler County

Measure	Rate Type	Year(s)	County Quartile 1=most favorable 4=least favorable	County Number (Average)	County Rate	State Comparison
Community Characteristics						
Median household income (in dollars)	Dollars	2014		$47,733		$47,212
Population below 100% poverty	Percent	2014	2		16.4%	16.7%
Unemployment rate	Percent	2014	2		10.4%	10.9%
Individuals living in owner-occupied housing	Percent	2014	1		79.8%	66.1%
Domestic violence offenses	Per 100,000 population	2012-14	3	576	575.9	557.7
Population 5+ that speak English less than very well	Percent	2014	3		7.3%	11.7%
Births covered by emergency Medicaid	Percent of births	2012-14	2	10	1.2%	4.7%
Women of Childbearing Age						
Socio-Demographic Characteristics						
Total female population ages 15-44	Count	2014		16,004		3,622,709
White female population ages 15-44	Count	2014		12,735		2,667,277
Black female population ages 15-44	Count	2014		2,346		730,788
Other female population ages 15-44	Count	2014		923		224,644
Hispanic female population ages 15-44	Count	2014		1,989		1,019,513

Non-Hispanic female population ages 15-44	Count	2014		14,015		2,603,196
Birth Family Characteristics						
Births to mothers ages 15-19	Per 1,000 females 15-19	2012-14	1	62	23.2	24.3
Repeat births to mothers ages 15-19	Percent of births 15-19	2012-14	1	9	14.0%	16.6%
Births to mothers >35	Per 1,000 females > 35	2012-14	2	89	2.6	4.6
Total births to unwed mothers	Percent of births	2012-14	2	385	47.8%	47.9%
Births among unwed mothers ages 15-19	Percent of births 15-19	2012-14	4	59	95.2%	91.2%
Births among unwed mothers ages 20-54	Percent of births 20-54	2012-14	2	326	43.8%	44.8%
Births with father acknowledged on birth certificate	Percent of births	2012-14	1	706	87.6%	85.8%
Births to mothers >18 without high school education	Percent of births > 18	2012-14	1	60	7.8%	12.3%
Births to mothers born in other countries	Percent of births	2012-14	2	115	14.3%	30.3%

Females of reproductive age in Flagler County represent 16% of the total population. Flagler County's unemployment rate for women (14.8%) is higher than Florida's (10.2%) or Volusia County's at 11.4%. Cases of domestic violence offenses, while less than Volusia County, are still high at a rate of 575.9 per population of 100,000 and have surpassed the comparative State rate of 557.5.

B. Needs Assessment Summary

Review of the data shows a decline in infant mortality including Black infant mortality, though disparity is still present. Low birth weight has not decreased and there is also a notable disparity between black and white in the number of low birth weight and very low birth weight incidence. Numbers of Hispanic cases overall have increased, though not significantly. In addition:

- Almost half of the pregnancies in our service area are unintended.
- Domestic Violence occurrences are significantly higher than the state rate in Volusia County.
- Drug use continues to be high among pregnant women and is significantly higher among white women than among black women.
- Mental health is a major risk identified on the Healthy Start prenatal screening instrument.
- Women who smoke during pregnancy has seen a minimal decline but is still higher in our service area than in Florida.
- Sleep related death and SIDS are major causes of death among our infants.
- Transportation and housing impact women of reproductive age who live in poverty.
- Approximately half of the pregnancies in our service area are to women on Medicaid.
- Racial disparities continue to present between black and white populations in almost all significant indicators.
- Access to prenatal care continues to be an area for improvement in our service area.

- Neonatal mortality has declined since the inception of the Neonatal Outreach Specialist and should be a continued strategy.
- Direct service staffs express challenges associated with capacity, resources, and caseload size as well as frustration trying to serve the increasing number of substance involved families.
- Recently gained resources and success with strategies from our last planning cycle suggest continuing on and expanding on the priorities and strategies from the last action planning period.

The assessment information has been incorporated into related strategies in the Coalition Action Plan that will guide our activities for the next five years, with evaluation quarterly and updates annually.

C. Changes from Previous Service Delivery Plan

Since the Coalition's last Service Delivery Plan, the health indicators our community has chosen have not changed, though we have condensed our priority focus and adopted several new strategies.

Infant Mortality, Black Infant Mortality, and Low Birth Weight will remain indicators we will use as the “dashboard” designated to measure our success as a community. Since the previous planning period we have made significant strides in reducing Black infant mortality and infant mortality as a whole. The data used in the previous plan was from 2009, and the rates for our service area for infant mortality were 7.2 per 1,000 live births and black infant mortality was 13.8. The 2014 data shows our local infant mortality rate at 4.5 per 1,000 live births and our black infant mortality rate at 6.7. We have set the new goal for infant mortality for both black and overall at 4.5 per 1,000 live births. This was determined by consensus of our Service Delivery Planning Committee.

Low birth weight and entry to prenatal care are areas where we did not quite meet our stated goal set for the 2011-2016 period though the trend is going in the right direction. New action steps have been included for the new planning period.

Prenatal and Infant Screening rate goals were achieved but the changing landscape of our health care system was a major factor in our Service Delivery Planning Committee’s decision to continue prioritizing strategies associated with provider education and awareness, and participant awareness, and community awareness about accessing services.

D. Selected Indicators and Five-Year Goals

The following indicators have been selected for the Coalition's goals for the next five year planning cycle.

Figure 35. Selected Indicators by Current Status and Previous and Proposed Goals by Planning Cycle

SELECTED INDICATORS	CURRENT STATUS*		SERVICE AREA 5-YEAR GOALS	SERVICE AREA 5-YEAR GOALS	SERVICE AREA 5-YEAR GOALS
	State	Local	2006-2011	2011-2016	2017-2021
1. Infant Mortality Rate	6.1	4.5	6.0	6.0	4.5
2. Black Infant Mortality Rate	10.0	6.7	6.0	12.0	4.5
3. Low Birth Weight	8.6%	8.1%	7.5%	8.0%	7.2%
4. 1st Trimester Entry into Prenatal Care	79.8%	72.3%	>87.50%	>85.0%	>85.0%
5. Late or No Prenatal Care	5.0%	4.2%	<3.31%	<3.6%	<3.6%
6. Infant Screening**	93.4%	90.7%	77.0%	90.0%	90.0%
7a. Prenatal Screening Rates (Offer)**	74.15%	94.66%	67.0%	100%	97%
7b. Prenatal Screening Rates (Consent)**	88.4%	90.54%	78.0%	91.0%	>93.0%

*Current Status is based upon most current data available
**Indicates that 2015-2016 data was used

E. Strategies to Address Five-Year Goals

Indicators/5-Year Goals	Adopted Strategies
1. Infant Mortality Rate ***(Reduce to 4.5)***	• Continue to concentrate on marketing and training on the Healthy Start prenatal screen to better identify risk and support provider linkage to Healthy Start. • Work with hospitals to improve infant screening rate to better identify infants at risk and improve linkages. • Provide leadership support to Infant Mental Health Chapter. • Continue neonatal outreach coordination. • Support educational opportunities for staff to include COPE Training, Lifesong training, Safe Sleep, Compassion Fatigue/Mental Health First Aid, Family Engagement, Interconceptional Care Curriculum, Strengthening Families Protective Factors, maternal mental health • **Explore implementation of a "Call-in line" to use before a prenatal clinic appointment to speak with a "coach" or mentor.** • Continue preconception/interconception care. • Encourage hospital birthing centers to continue to ask "Where will your baby sleep?" and link to crib distribution when needed. • Support assessment services at the three birthing centers. • Provide designated staff, specialized training, and protocols regarding opioid dependence and neonatal abstinence syndrome. • Promote and explore options for enhancing father involvement. • Disseminate the Bereavement Guide to providers for support and follow up when women have experienced a fetal loss/infant loss to support bereavement and health access in between pregnancies. • Increase public awareness about access to prenatal services and other resources.

Indicators/5-Year Goals	Adopted Strategies
2. Black Infant Mortality Rate ***(Reduce to 4.5)***	• Continue FIMR project and increase participation by Faith Community. • Continue Lifesong Health Disparities Reduction program in the African American community, particularly in the 32114, 32117, and 32118 zip code areas. • Continue to provide training to MomCare staff about identifying barriers to health access. • Continue development of the Family Place ACCESS sites and Community Café Dialogues. • Promote and support culturally competent breastfeeding and childbirth education for all women. (COPE Training for staff) • **Work with the Florida's Healthy Babies Initiative to address social determinants of health and provide Circle of Parent/Community Café Dialogues to engage families,** • Continue interconception education. • Continue to promote Safe Sleep initiative, crib/pack and play distribution and educate mothers, fathers, and related caregivers about safe sleep practices. • Continue Neonatal Outreach services and educate mothers regarding importance of pediatric follow-up and a permanent medical home. • **Address risk factors such as hypertension, obesity, stress, and social determinants of health in partnership with the Florida's Healthy Babies Initiative.** • Continue to review data associated with fetal and infant loss through the FIMR process and act on recommendations from the action group. • Increase public awareness through media messaging about safe sleep that can be targeted to participants, caregivers, providers, and the community at large. • Continue Integrate cultural competence into Comprehensive Training Plan for home visiting and enhanced services. • Continue to participate in the Mama Bear Program • Work with the African American Faith Community to increase awareness and education about preventable causes of death and interconception support,

Indicators/5-Year Goals	Adopted Strategies
3. Low Birth Weight ***(Reduce to 7.2%)***	• Continue interconception education services. • Introduce interconceptional risk assessment tool to primary care providers and facilitate implementation. • Continue smoking cessation education services for pregnant women. • Continue to fund Care Coordination services at WARM (Women Assisting Recovering Mothers) to support pregnant recovering women. • Continue marketing and education to patients, providers, and the community about infant mortality, low birth weight and healthy pregnancy. • **Promote APPs that support prenatal education and support such as VROOM and text4baby.** • **Link women to WIC services** • **Provide screening and support for maternal mental health and link to services and resources that can support stress reduction.** • **Support comprehensive training to Healthy Start staff and include additional training about preeclampsia, kick counts, SUID and SIDS, and other causes of prematurity and LBW.**

Indicators/5-Year Goals	Adopted Strategies
4 & 5. Entry to Prenatal Care First Trimester Entry into Prenatal Care ***(Increase to >85.0%)*** Late or No Prenatal Care ***(Decrease to <3.6%)***	• Continue to operate Family Place DCF ACCESS sites to assist pregnant women in application for Medicaid, food stamps, WIC, TANF and other needed services. • Promote broad-based awareness/media campaign focused on early entry to prenatal care (in Spanish and English). • Increase collaboration with community partners serving high risk populations to increase number and scope of consumers receiving educational information on the importance of early prenatal care. • Continue to review data on ineligible prenatal cases. • **Develop stronger partnership with the Domestic Abuse Council to coordinate on behalf of women who enter the shelter and need prenatal services.** • **Provide support for transportation disadvantaged pregnant women.** • **Conduct provider, participant, and community awareness activities to increase access to prenatal services.** • **Develop ongoing strategies associated with serving women and babies adversely impacted by the use of opiates/opioids, alcohol, tobacco and other drugs.** • **Increase the number of peers who work with at risk families in our service system.** • Continue collaboration with community partners serving high risk populations to increase number and scope of consumers receiving educational information on the importance of early prenatal care. • Continue safety net options for the provision of clinical prenatal services for uninsured women (working poor) to include funding prenatal clients with no payer source through the Florida Department of Health in Flagler County. • Continue to survey providers about screening education.
6. Infant Screening Rate ***(Increase to 90.0%)***	• Coordinate with all birth centers in the service area to ensure rates are reviewed and strategies for improvement are developed in partnership. • Continue to implement public education and awareness campaign to promote Healthy Start screening. • Continue to implement provider and consumer incentive programs to increase screening rates.

Indicators/5-Year Goals	Adopted Strategies
7. Prenatal Screening Rates (Offer & Consent to Screen) ***(Offer rate at 97%) (Increase consent rate to 93.0%)***	• Continue to contract with Healthy Communities for liaison services by the Marketing and Education Director to work with prenatal health providers on screening education and implementation. • Continue Health Provider Corner on the website. • Continue to maintain OB/GYN participation on the Healthy Start Coalition and Board of Directors. • Distribute educational materials to Medical providers to promote screening and acceptance of Healthy Start screen/services. • Continue to implement public education and awareness campaign to promote Healthy Start screening. • Implement provider and consumer incentive programs to increase screening rates. • Invite OB/GYN providers to take a more active role in the FIMR process. • Continue to review screening data and coordinate with providers to accurately and consistently conduct Healthy Start Screening.

VI. ACTION PLAN IN CATEGORY A, B, C FORMAT

Coalition Priorities: There are five main priorities we have established that direct our action planning for the next service delivery planning period.

Coalition Priorities: What particular priorities, target groups, or geographic areas are targeted in your Service Delivery Plan?

1. **Strategy: Increase awareness about prenatal and infant services for families in the service delivery area.**

   A. **Provider Education and Awareness** - provide information and education to providers to engage them in assisting our mutual participants and coordinating with Healthy Start for service linkage.

   B. **Participant Education and Awareness –** ensuring information is available through website, media, health events, and parent engagement.

   C. **Community Awareness** – educates the community and policymakers about the importance of maternal and child health, promotes access through the Family Place locations, and promotes tobacco cessation and prevention awareness in partnership with the local health department.

   D. **Convene community stakeholders –** continue to build partnerships with providers and stakeholders to keep apprised of services and coordinate service delivery with new funding resources.

2. **Strategy: Continue to Update and Implement a Comprehensive Staff Training Plan** - Healthy Start workers consistently encounter populations at high risk to include women who are homeless, incarcerated, drug addicted, teens, and those living in poverty. Providing a comprehensive training plan to ensure that field staff is prepared and have the competencies necessary to provide outreach and services to vulnerable populations with a high level of cultural competency continues to be a priority in order to reduce low birth weight and infant mortality.

3. **Strategy: Reduce Infant Mortality and continue to implement, monitor and improve the local FIMR case review process and recommended strategies for community action.**

   A. **Infant Safety Messaging**: Marketing campaign for awareness about infant safety to include safe sleep, drowning prevention, shaken baby, and safe caregiver.

   B. **FIMR** - Improve Case Review Team participation

C. Establish and maintain a community liaison to promote awareness about black infant mortality in the faith and academic communities

4. **Strategy: Continue to utilize the Protective Factors as a Framework for the promotion of Family Engagement.**

   A. Family Place Sites: Operate Family Place access sites where families can convene and obtain resources

   B. Protective Factors: Promote Parent and community training in the Protective Factors and Trauma Informed Care

   C. Parent Partner Approach: Utilize the Parent Partner approach for engaging and mentoring high risk families

5. **Strategy: Sustain a system of care to respond to the growing number of babies born with neonatal abstinence syndrome as a result of drug use during pregnancy.**

   A. Provide Assistance to pregnant women identified as using or abusing alcohol or other drugs during or in-between pregnancies

   B. Coordinate services for substance exposed newborns

A. Planning Summary Sheet & Category "A" Activities

Coalition: The Healthy Start Coalition of Flagler & Volusia Counties, Inc.

The following Planning Summary sheet provides a list of the services and providers for the Coalition's 11/12 fiscal year, as well as whether or not the services are being funded with Healthy Start dollars.

PLANNING SUMMARY SHEET FOR THE HEALTHY START SYSTEM.

Indicate Yes "Y" or No "N" in the Y/N column if Healthy Start (Department of Health) funding is being used for the contract.

Healthy Start Service	Provider Name	DOH Y/N $	Begin/End Date Contract
Outreach services for pregnant women	Healthy Communities	Y	7/1/15 – 6/30/16
	Stewart-Marchman- Act Behavioral Healthcare, Inc.	Y	7/1/15 – 6/30/16
Outreach services for children	Healthy Communities	Y	7/1/15 – 6/30/16
	Stewart-Marchman- Act Behavioral Healthcare, Inc.	Y	7/1/15 – 6/30/16
Process for assuring access to Medicaid (PEPW & ongoing)	State of Florida, Department of Health in Flagler County	N	N/A
	State of Florida, Department of Health in Volusia County	N	N/A
Clinical prenatal care for unfunded women	State of Florida, Department of Health in Flagler County	Y	7/1/15 – 6/30/16
Clinical well-child care for unfunded infants	State of Florida, Department of Health in Flagler County	N	N/A
	State of Florida, Department of Health in Volusia County	N	N/A
CHD Vital Statistics Healthy Start screening infrastructure	State of Florida, Department of Health in Volusia County	Y	7/1/15 – 6/30/16
HMS Data entry	State of Florida, Department of Health in Volusia County	Y	7/1/15 – 6/30/16
Ongoing training providers doing screens and referrals	Healthy Communities	Y	7/1/15 – 6/30/16
Initial contact after screening	Stewart-Marchman- Act Behavioral Healthcare, Inc.	Y	7/1/15 – 6/30/16
Initial assessment of service needs	Stewart-Marchman- Act Behavioral Healthcare, Inc.	Y	7/1/15 – 6/30/16
Interconceptional education and counseling	Stewart-Marchman- Act Behavioral Healthcare, Inc.	Y	7/1/15 – 6/30/16
Ongoing care coordination	Stewart-Marchman- Act Behavioral Healthcare, Inc.	Y	7/1/15 – 6/30/16
Childbirth education	Stewart-Marchman- Act Behavioral Healthcare, Inc.	Y	7/1/15 – 6/30/16

Activities required to maintain effective agency operations and to implement and monitor the Healthy Start care coordination system are documented in Category A of the action plan.

AGENCY ACTION STEPS:

Category "A" Activities

Action Step	Person Responsible	Start Date	End Date
1. Maintain an effective and diverse Board of Directors.	Executive Director, Board of Directors	7/16	6/17
2. Provide staffing services and reports for all Board, Committee and Coalition meetings.	Executive Director, Coalition Staff	7/16	6/17
3. Develop funding allocation methodology and cost allocation plans.	Finance & Operations Director, Coalition Staff	7/16	6/17
4. Develop and issue timely contracts for services.	Operations Manager	7/16	6/17
5. Monitor contracted service providers for contract compliance and programmatic quality assurance.	Executive Director, Program Director, HS Program Manager	7/16	6/17
6. Provide technical assistance to contracted service providers as needed.	Executive Director, Program Director, HS Program Manager	7/16	6/17
7. Maintain effective Coalition operations.	Executive Director, Coalition Staff	7/16	6/17
8. Monitor agency's compliance with all funding contracts.	Executive Director, Finance & Operations Director, Operations Manager, Program Director	7/16	6/17
9. Prepare required DOH reports.	Coalition Staff	7/16	6/17
10. Prepare required reports for other funding sources.	Coalition Staff	7/16	6/17
11. Seek additional sources of revenue to benefit service delivery to families.	Executive Director, Program Director	7/16	6/17
12. Conduct organizational planning activities to maximize Coalition human resources.	Executive Director	7/16	6/17
13. Conduct performance planning to ensure competency in the administrative workforce.	Executive Director	7/16	6/17
14. Continue to maintain the Healthy Start website to improve communication to consumers, community partners, and Board members.	Operations Manager, Coalition Staff	7/16	6/17
15. Develop and update agreements with community partners in order to formalize methods of coordinating services on behalf of our clients.	Executive Director, Program Director	7/16	6/17

16. Ensure independent audit is conducted and financial statements are prepared.	Finance & Operations Director, Executive Director	9/16	12/16
17. Develop continuous quality improvement related to self-assessment and general improvement of the Coalition	Board President, Executive Director, Coalition staff	7/16	6/17
18. Conduct comprehensive review of disaster planning and business continuity procedures	Board President, Executive Director, Leadership staff	7/16	12/16

B. Category "B" Activities

PRIORITY AREA I: **INCREASE AWARENESS ABOUT PRENATAL AND INFANT SERVICES FOR FAMILIES IN THE SERVICE DELIVERY AREA**

1. CONTRACT REQUIREMENT OR IDENTIFIED COMMUNITY-WIDE/SYSTEM ISSUE:

a. What is the requirement or system/community-wide problem or need identified to be addressed by a strategy?

The changing system of care requires responsive service delivery particularly to those families at-risk for low birth weight, fetal or infant loss, and other poor birth outcomes. Our community many families at-risk who face difficulties accessing services, particularly since the closing of the four health department prenatal clinics in Volusia County which were previously a prenatal healthcare safety net. Since screening is the primary entry way to Healthy Start services and this occurs at the first prenatal visit, we recognize that promoting education and awareness about accessing services at all levels is critical to supporting healthy pregnancy and child well-being.

b. What health status indicator/coalition administrative activity is being addressed by this strategy?

Reduce Infant Mortality Rate to 4.5

Reduce Black Infant Mortality Rate to 4.5

Reduce Low Birth Weight Rate to 7.2%

Increase 1st Trimester into Prenatal Care to 85.0%

Reduce Late or No Entry into Prenatal Care to 3.60%

Increase Infant Screening Rate to 90%

Maintain Prenatal Screening Consent Rate at 92%

c. What information, if any, was used to identify the issue/problem (i.e. HPA, FIMR, screening, client satisfaction, interviews, QI/QA)?

Issue identified with Compiled Data: DOH reporting data, BASINET data, MIS data, MCH Problem Analysis data, Healthy Start data, WFS data, provider data, medical provider feedback, and participant feedback.

2. PLANNING PHASE QUESTIONS: (All Required)

a. What strategy has been selected to address this?

The strategy that has been selected to address this issue is to continue to improve access to and consistency of prenatal care through improved provider, patient and community education and awareness and convene our stakeholders to evaluate strategies for effectiveness.

1A)Provider Education and Awareness
1B)Patient Education and Awareness
1C)Community Awareness
1D)Convene Community Stakeholders to Improve the System of Care

b. What information will you gather to demonstrate that you have implemented this strategy as intended (who, what, how many, how often, where, etc.)?

In addition to related entry to care and screening data, the following information will be collected to review the success of implementing this strategy:

1A) Provider Education and Awareness – Information obtained will include provider feedback (OB/GYNs, Midwives, Hospital Staff, Office Managers, Medical Assistants, Healthy Start Providers and other Community Based Organization representatives), website tracking on the health care professional's page, Facebook data, committee meeting lists and minutes, annual survey information, publications and informational documents distributed, and screening data.

1B) Patient Education and Awareness – Information will be gathered about participant outreach and identification data, website reports (Mom and Dad's Corner, Resource Page), Facebook data, participant feedback from Healthy Start service staff, and indicator data.

1C) Community Awareness – Information will be gathered from health fairs/community events (numbers attending and numbers of literature distributed, etc.), Community Action Group members and activities, policy recommendations, number of FAHSC meetings attended, survey monkey.

ID) Convene Community Stakeholders – information will be gathered through sign in sheets, strategic planning//action planning changes, and evaluation reports/service data.

c. Where/how will you get the information?

Provider surveys are conducted as a routine part of needs assessment activities. MomCare Maternity Care Advisors will also gather information when possible about how useful patient information was in assisting women in linking to prenatal care and navigating through the system.

- Website hits are reviewed quarterly with the Operations Manager
- Literature distributed is counted for each event
- Provider and Participant surveys
- WFS narrative data reports
- Indicator data
- DOH reporting data

d. What do you expect will be the observed impact of the strategy on the system or community-wide problem/need?

Families will gain access to needed healthcare services. Providers will stay informed and knowledgeable about how to communicate changes to participants. The overall goal is to reduce late or no entry to prenatal care, increase first trimester entry to prenatal care, retain high screening rates, and maintain high participant and provider satisfaction with our services.

AGENCY ACTION STEPS:

STRATEGY 1

Ensure access to prenatal and infant services for families in the service delivery area triaged by risk.

1A) Provider Education and Awareness

Action Steps	Overseer	Start Date	End Date
1. Distribute informational material to medical providers and other key points of entry to prenatal care through the Healthy Start Community Liaison.	HS Community Liaison, HS Program Manager	7/16	6/17
2. Update and maintain the Healthy Start website to include relevant information for providers.	Operations Manager	7/16	6/17
3. Ensure a minimum of **14** medical professionals and/or hospital staff visits each month for the purpose of supporting the overall system of care, providing education regarding universal screening of pregnant women and infants, maternal and child issues and to promote awareness of the Healthy Start Program.	HS Community Liaison, HS Program Manager	7/16	6/17
4. Provide on-site presentations and technical assistance to community providers about HS, MomCare and access to prenatal care services.	HS Community Liaison, HS Program Manager	7/16	6/17
5. Participate in One Voice for Volusia	Executive Director	7/16	6/17

Thrive by Five steering committee and monthly OVV coalition meetings.			
6. Participate in the Infant Mental Health Chapter of Volusia and Flagler Counties.	Executive Director	7/16	6/17
7. Coordinate with FQHC to promote access to Healthy Start services by FQHC prenatal and pediatric patients.	Executive Director, Program Director	7/16	6/17
8. Work in community environments to assist women in navigating to healthcare.	Executive Director, Program Director, HS Program Manager, Lead MomCare Advisor	7/16	6/17
9. Continue to participate in Mama Bear community collaborative for pregnant women and infants who are HIV/STD positive.	HS Program Manager, SMA-HS Program Director	7/16	6/17
10. Continue to monitor the subcontract with the Flagler County Health Department for the provision of clinical prenatal services.	HS Program Manager	7/15	6/17
11. Continue to seek funding sources for expanding outreach, care coordination and support services to the highest risk and most vulnerable maternal and infant populations.	Executive Director, Program Director	7/15	6/17
12. Continue parent engagement and parent-led training of community providers and continued leveraging of new resources related to the Protective Factors framework.	HS Program Manager, Family Engagement Manager	7/15	6/17

1B) <u>Patient Education and Awareness</u>

Action Steps	**Person Responsible**	**Start Date**	**End Date**
1. Update and maintain the Healthy Start website to include relevant information for participants, potential and those in the service system. (i.e., Mom's Corner, Dad's Corner and the Resources Page)	Operations Manager	7/16	6/17
2. Meet with MomCare staff monthly to identify barriers patients encounter.	Executive Director, Program Director, Lead MomCare Advisor	7/16	6/17
3. Continue to support prenatal access in high-risk communities and keep patients informed.	Executive Director, Program Director, HS Program Manager	7/16	6/17
4. Make available and disseminate patient education materials about infant safety.	Program Director, HS Program Manager	7/16	6/17

1C) Community Awareness

Action Steps	Person Responsible	Start Date	End Date
1. Ensure a minimum of **4** community development activities are conducted per month that increases awareness of the program and/or promotes improved birth outcomes for pregnant women and infants.	HS Community Liaison, HS Program Manager	7/16	6/17
2. Continue to coordinate with Managed Care networks to inform them about Healthy Start services.	Executive Director Program Director, HS Program Manager	7/16	6/17
3. Work with the local and state partners to access media and policy maker outlets (such as press conferences, Op Eds, PSA's legislative briefs) aimed at increasing community awareness through news media and updating policy makers on MCH issues.	Executive Director	7/16	6/17
4. Continue to participate in community events aimed at improving leadership awareness of maternal and child health issues.	Executive Director, Program Director	7/16	6/17
5. Operate two community-based family engagement sites where pregnant women and families can obtain face to face assistance and connect with other parents.	Program Director, Family Engagement Manager	7/16	6/17
6. Coordinate with public health and other community partners to promote tobacco cessation	Program Director, HS Program Manager	7/16	6/17

1D) Convene Community Stakeholders to Improve the System of Care

Action Steps	Person Responsible	Start Date	End Date
1. Review service data quarterly at Service Delivery Planning meetings.	Program Director	7/16	6/17
2. Meet regularly with key personnel at Stewart-Marchman-Act Behavioral Healthcare, Inc. to ensure transition to the new system of care.	HS Program Manager	7/16	6/17
3. Continue to review external funding contracts to establish alignment and integration with the changing system of care.	Executive Dir, Finance & Operations Dir, Prog Dir, Ops Mgr,	7/16	10/16

PRIORITY AREA II. CONTINUE TO IMPLEMENT COMPREHENSIVE COMMUNITY TRAINING PLAN

1. CONTRACT REQUIREMENT OR IDENTIFIED COMMUNITY-WIDE/SYSTEM ISSUE:

a. What is the requirement or system/community-wide problem or need identified to be addressed by a strategy?

Our community has multiple providers often addressing complex issues for high risk families and a Healthy Start system working toward implementation of a redesigned approach toward evidence based interventions for the families we serve. Staff can become frustrated if they lack the efficacy to engage and retain participant or support them through stages of change toward better outcomes.

b. What health status indicator/coalition administrative activity is being addressed by this strategy?

Infant mortality, black infant mortality, low birth weight, 1st trimester entry into prenatal care, late or no entry into prenatal care, infant screening, prenatal screening and consent.

c. What information, if any, was used to identify the issue/problem (i.e. HPA, FIMR, screening, client satisfaction, interviews, QI/QA)?

Provider reports and feedback, client feedback, supervisor feedback, direct service staff feedback, parent feedback, and other agency provider feedback

2. PLANNING PHASE QUESTIONS: (All Required)

a. What strategy has been selected to address this?

The strategy that has been selected to address this is to continue to improve Healthy Start services through development and implementation of a comprehensive community training plan.

b. What information will you gather to demonstrate that you have implemented this strategy as intended (who, what, how many, how often, where, etc.)?

The following information will be gathered:

- Comprehensive community training plan
- Individual training learning objectives
- Training sign-in sheets
- Community feedback/Evaluation forms

c. Where/how will you get the information?

Information will be gathered from training participants, supervisors, and presenters at each staff development offering.

d. What do you expect will be the observed impact of the strategy on the system or community-wide problem/need?

- A community that is more knowledgeable about Healthy Start services and maternal and child health
- Less burn out
- Better prepared and trained staff
- Better staff retention
- Improved management of families
- Improved retention of families in Healthy Start services
- Improved perception of Healthy Start services by referring providers
- Smoother transition in implementing the Healthy Start 2.5 Redesign

e. What information will you gather to demonstrate this change on the system?

- Participant feedback
- Staff feedback
- Family retention
- Numbers of women who consent to services
- Reduced number of women "lost to contact"
- Better management of substance involved families
- Staff retention – number of staff retained in direct service for Healthy Start
- Data about interventions and outcomes associated with models staff received training on and implements

f. Where/how will you get the information?

Information will come from agency surveys, client surveys, subcontracted provider surveys, and the local HS (WFS) database.

AGENCY ACTION STEPS:

STRATEGY 2

Continue to implement comprehensive community training plan.

Action Steps	Person Responsible	Start Date	End Date
1. Continue to implement minimum training requirements for all program staff positions to include interconception education, sleep-related infant death and cultural competency.	Program Director	7/16	6/16
2. Obtain provider feedback about ongoing training needs.	Program Director	7/16	6/16
3. Update comprehensive training plan to include community offerings.	Program Director	7/16	6/16
4. Analyze and review evaluation and staff feedback to address the quality of the training activities presented.	Program Director	7/16	6/16
5. Monitor contract compliance with comprehensive community training plan.	Program Director, HS Program Manager	7/16	6/16
6. Integrate issues/concerns identified during contract monitoring into comprehensive community training plan.	Program Director, HS Program Manager	1/17	6/17
7. Update website monthly to include training calendar for community providers.	Operations Manager	7/16	6/17
8. Include parents and consumers as trainers and training participants.	Program Director	7/16	6/17
9. Monitor SMA to ensure training is being translated into direct service to families.	HS Program Manager, SMA-HS Program Director	9/16	6/17
10. Expand training to include increased awareness of staff about preeclampsia, SUID and SIDS, and other primary causes of death and prematurity.	HS Program Manager	12/16	6/17
11. Ensure contract compliance with DOH training requirements.	HS Program Manager, SMA-HS Program Manager	7/16	6/17

PRIORITY AREA III. **REDUCE INFANT MORTALITY AND CONTINUE TO IMPLEMENT, MONITOR AND IMPROVE THE LOCAL FIMR CASE REVIEW PROCESS AND IMPLEMENT RECOMMENDED CRT STRATEGIES**

1. CONTRACT REQUIREMENT OR IDENTIFIED COMMUNITY-WIDE/SYSTEM ISSUE:

a. What is the requirement or system/community-wide problem or need identified to be addressed by a strategy?

Infant mortality and low birth weight continues to impact families throughout Volusia and Flagler Counties.

b. What health status indicator/coalition administrative activity is being addressed by this strategy?

Infant mortality, Black Infant Mortality

c. What information, if any, was used to identify the issue/problem (i.e. HPA, FIMR, screening, client satisfaction, interviews, QI/QA)?

Vital statistics data, supplemental risk data (FIMR, interviews, etc), Survey data, Screening Rates indicators, WFS data, and SMC data

2. PLANNING PHASE QUESTIONS: (All Required)

a. What strategy has been selected to address this?

The strategy that has been selected to address this is to continue to implement, monitor and improve the local FIMR Case Review Process and implement recommended CRT Strategies. This strategy is comprised of the following sub-strategies:

3A) Continue to implement Marketing Campaign for SIDS Awareness and Sleep Related Death

3B) Continue to implement and improve FIMR CRT process

3C) Increase awareness about black infant mortality

b. What information will you gather to demonstrate that you have implemented this strategy as intended (who, what, how many, how often, where, etc.)?

3A) **Continue to implement Marketing Campaign for SIDS Awareness, sleep related death** – information will be gathered from newspaper advertisements, accounting of funds received, website information and number of hits to the page where it is listed, number of safe sleeping information packets distributed.

3B) Continue to implement and improve FIMR CRT process – information will be gathered from FIMR CRT attendance, Abstractor contract and abstraction data, maternal interview information, and CAG minutes.

3C) Increase awareness about black infant mortality – information will be gathered from the number of SIDS fans, Protective Factors data, Lifesong presentations, increased participation by African American leaders in Healthy Start activities.

c. Where/how will you get the information?

3A): Continue to implement Marketing Campaign for SIDS Awareness – Information will be clipped from the newspaper, accounting information will be entered and retrieved from the Coalition's accounting software (QuickBooks).

3B): Continue to implement and improve FIMR CRT process – Information will be obtained from FIMR attendance sheets, BASINET data, and CAG minutes.

3C) Increase awareness about black infant mortality – sign-in sheets, newspaper articles

d. What do you expect will be the observed impact of the strategy on the system or community-wide problem/need?

- FIMR CRT will retain members and identify professionals in the community who should be identified or included.
- FIMR CRT members will become more adept at reviewing fetal and infant death cases and providing valuable input and recommendations for system-wide change.
- The Community will have documented publications to assist them in understanding the nature and scope of Infant Mortality, CRT Activities, and grief and loss.
- Providers will have additional resources to assist women who have experienced a loss and a mechanism to refer them for bereavement support and interconception education and care. (Grief Toolkit)
- Healthy Start Supervisor participation in FIMR will reinforce implementation of recommendations into direct service activities.
- The community and consumers will be more knowledgeable about sleeping infant death (number of SIDS cases and sleeping infant death cases will decrease).
- FIMR recommendations will be more effectively communicated to the direct service staff and other providers of maternal and infant care.
- Ultimately, infant mortality will decrease.

e. What information will you gather to demonstrate this change on the system?

- FIMR recommendations and implemented changes.
- Project INFORM Report
- Provider Feedback
- Training plan illustrating incorporation of recommendations for field staff.
- Infant mortality data

f. Where/how will you get the information?

- CHARTS data
- WFS data
- Vital Statistics (Infant Mortality data)
- BASINET data
- Provider feedback reports from Marketing and Education Director
- Survey Monkey.

AGENCY ACTION STEPS:

STRATEGY 3

Reduce infant mortality and continue to implement, monitor and improve the local FIMR case review process and implement recommended CRT strategies

3A) Continue to Implement Marketing Campaign for SIDS/SUIDS Awareness

Action Steps	Person Responsible	Start Date	End Date
1. Work with Media to enhance community awareness about safe sleep and infant mortality.	Executive Director, HS Marketing Committee	7/16	6/17
2. Conduct a minimum of two (2) presentations at civic groups or policy-maker forums about the importance of safe sleep.	Executive Director	7/16	6/17
3. Continue to distribute practitioner's toolkit on fetal and infant loss to support patient empowerment and practitioner support as well as linkage to mental health support and interconception services for women who have experienced a loss.	HS Community Liaison, HS Marketing Committee	7/16	6/17
4. Maintain information on website about safe sleep practices and SIDS risk reduction.	Operations Manager, Executive Director	7/16	6/17
5. Provide information about Bereavement Peer Support group.	Program Director, HS Program Manager	7/16	6/17
6. Coordinate with stakeholders regarding sleep-related deaths.	Program Director, HS Program Manager	7/16	6/17

3B) Continue to implement and improve FIMR CRT Process

Action Steps	Person Responsible	Start Date	End Date
1. Conduct Data Committee activities for better analysis of FIMR data and to develop a comprehensive report for community presentation.	Program Director	7/16	6/17
2. Continue to distribute Project INFORM to increase community awareness about fetal and infant mortality in our service area, particularly to the provider network. Update biannually as resources allow.	Program Director, HS Program Manager	7/16	6/17
3. Execute two (2) FIMR abstractor contracts to ensure adequate support for FIMR Case Review Team (CRT).	Operations Manager, Program Director	7/16	9/16
4. Continue pre-planning CRT meeting.	Program Director	7/16	6/17
5. Participate in FIMR conference calls.	Program Director	7/16	6/17
6. Continue participation of Faith Based Community in the FIMR CRT.	Program Director	7/16	6/17
7. Continue to include mandatory supervisor participation in a minimum of one (1) FIMR meeting annually in Care Coordination subcontract.	HS Program Manager/ SMA-HS Program Director	7/16	8/16
8. Utilize MomCare advisors to assist with maternal interview process.	Executive Director, Program Director	7/16	6/17

3C) Increase awareness about black infant mortality

Action Steps	Person Responsible	Start Date	End Date
1. Promote cultural and linguistic competency best practices integration into all training events.	Program Director	7/16	6/16
2. Develop marketing strategies toward target audience about accessing available prenatal services.	Program Director	7/16	6/16
3. Coordinate one event annually with the African American Faith Based Community to reduce sleep-related deaths.	Program Director	9/16	11/16
4. Identify specific risk indicators impacting the target population.	Program Director, HS Program Manager/ SMA HS Director	7/16	6/17
5. Establish contract outcomes for Lifesong Liaison to support Florida's Healthy Babies Initiative.	Program Director	7/16	6/17

PRIORITY IV. CONTINUE TO UTILIZE THE PROTECTIVE FACTORS AS A FRAMEWORK FOR THE PROMOTION OF FAMILY ENGAGEMENT

1. CONTRACT REQUIREMENT OR IDENTIFIED COMMUNITY-WIDE/SYSTEM ISSUE:

a. What is the requirement or system/community-wide problem or need identified to be addressed by a strategy?

The local systems for serving pregnant women and families with children who are under the age of five are often fragmented and include a degree of duplication in several components including administration and intake, assessment of service needs and data collection and maintenance. This causes families to have to access multiple service systems to obtain needed resources for themselves and their children. In addition, particular areas in our county are disproportionately impacted by health disparities for key indicators (infant mortality, low birth weight, late or no entry into prenatal care) as well as contributing factors such as rate of STDS, smoking, unplanned pregnancy, child abuse and neglect, poverty, and substance abuse. These communities often lack available health and social services resources or, even though they may be available, are complicated and have cumbersome eligibility criteria or require payment that families cannot afford. Consequently, families become frustrated, lack a voice about the service system, and when capacity is limited, the result is that some families receive no services and other families receiving multiple similar services from multiple agencies.

This system often lacks the ability to capitalize on family strengths and build the protective factors needed for families to make significant progress in reducing their risk. Agencies could benefit from increased training about the Protective Factors and family involvement.

b. What health status indicator/coalition administrative activity is being addressed by this strategy?

This strategy will address infant mortality, black infant mortality, entry to prenatal care, and low birth weight.

c. What information, if any, was used to identify the issue/problem (i.e. HPA, FIMR, screening, client satisfaction, interviews, QI/QA)?

Child Welfare data, CDC Adverse Childhood Experiences data, Data review with Department of Health from Florida's Heathy Babies Initiative related to social determinants of health, Casey Family Foundation, Participant and staff feedback, and Strengthening Families Protective Factors.

2. PLANNING PHASE QUESTIONS: (All Required)

a. What strategy has been selected to address this?

4A) Promote Parent Engagement and social equality

4B) Promote Strengthening Families and Protective Factors training

b. What information will you gather to demonstrate that you have implemented this strategy as intended (who, what, how many, how often, where, etc.)?

4A) **Promote Parent Engagement and social equality** – Protective Factors survey data, dialogue sign-in sheets, Parent Leadership training completion, parent participation in Coalition activities

4B) **Promote Strengthening Families and Protective Factors training** – Advertisement of website, completion certificates, promotion activities

c. Where/how will you get the information?

4A) **Promote Parent Engagement and social equality** – Protective Factors survey data, dialogue sign-in sheets, Parent Leadership training completion, parent participation in Coalition activities

4B) **Promote Strengthening Families and Protective Factors training** – Data from advertisement of website, completion certificates, promotion activities

d. What do you expect will be the observed impact of the strategy on the system or community-wide problem/need?

4A) **Promote Parent Engagement and social equality** – Families that have been lost to contact can be more easily reengaged, ineffective service delivery will be addressed by parent feedback, and parents will become effective trainers of staff

4B) **Promote Strengthening Families and Protective Factors training** – More agencies will understand and implement Protective Factors Framework, other agencies will be more likely to engage consumers in activities, the community will start aligning efforts more effectively

e. What information will you gather to demonstrate this change on the system?

4A) **Promote Parent Engagement and social equality** – The number of agencies who conduct family dialogues and/or Protective Factors trainings

4B) **Promote Strengthening Families and Protective Factors training** – Parent and staff feedback regarding accessibility of services

f. Where/how will you get the information?

Local WFS database; Participant Feedback, Family Engagement Advisory Board data, staff feedback, Community Café/Circle of Parents Dialogue summaries

AGENCY ACTION STEPS:

STRATEGY 4

Implement the protective factors framework.

4A) Promote Parent Engagement and social equality

Action Steps	Person Responsible	Start Date	End Date
1. Hold monthly family dialogues.	Family Engagement Manager, HS Program Manager	7/16	6/17
2. Operate and maintain the Daytona Beach Family Place (formerly known as the Community Café) in Daytona Beach.	Family Engagement Manager, Program Director	7/16	6/17
3. Leverage funding to expand community awareness and participation.	Executive Director, Program Director	7/16	6/17
4. Monitor and report activities to the County of Volusia – outside funding entity.	Program Director	7/16	6/17
5. Involve parents in policy making and training activities.	Program Director, Family Engagement Manager, HS Program Manager	7/16	6/17

4B) Promote Strengthening Families and Protective Factors training

Action Steps	Person Responsible	Start Date	End Date
1. Provide Protective Factors training and Strengthening Families training to Healthy Start leadership.	Executive Director	7/16	6/17
2. Schedule regular trainings for agencies in the community.	Family Engagement Manager,	7/16	6/17
3. Conduct parent training and dialogues in partnership with the Florida's Healthy Babies Initiative	Program Director, Lifesong Liaison		
4. Work with the Thrive by Five collaborative and other community leaders to support their training activities and parent engagement activities.	Executive Director, Family Engagement Manager, Program Director	7/16	6/17
5. Monitor and conduct continuous quality improvement on training activities based on parent and staff feedback.	Executive Director, Program Director, Family Engagement Manager, HS Program Manager,	7/16	6/17

PRIORITY V. **IMPROVE A SYSTEM OF CARE TO RESPOND TO THE GROWING NUMBER OF BABIES BORN WITH NEONATAL ABSTINENCE SYNDROME AS A RESULT OF DRUG USE DURING PREGNANCY.**

C. Category "C" Activities

1. ANNUAL RESPONSIBILITIES FOR THIS POPULATION:

a. The Coalition must submit an action plan for assisting chemically dependent pregnant women and substance-exposed newborns that includes action steps/strategies for multi-agency collaboration, access to evaluations, treatment and services to substance-exposed newborns.
b. The Coalition will submit Progress Reports that shows documentation that action steps of strategies chosen were implemented as planned or rationale as to why they were not.

2. PLANNING PHASE QUESTIONS: (All Required)

a. What do you plan to do for these populations? As part of your action plan how will you make referrals for services needed?

The strategies that have been selected to address these issues are:

1A) Provide Assistance to Pregnant Women Identified as Using or Abusing Alcohol or Other Drugs during or in-between Pregnancies

1B) Coordinate Services for Substance Exposed Newborns

b. Describe how doing this will change the system of care to chemically dependent pregnant women and substance exposed newborns?

Volusia County has had increasing rates of Neonatal Abstinence Syndrome over the last decade. Babies are born with NAS as a result of their mother using drugs prenatally to such a degree that the baby experiences withdrawal symptoms. The workforce expresses frustration at the lack of coordinated resources, housing availability, residential bed capacity and lack of residential services for opioid managed women, and the reluctance of prenatal providers to accept women with a substance abuse problem into their practice.

Having leveraged financial resources will enable us to expand our capacity to provide high risk service coordination but we must work with partners to address these other gaps in services. We have made strides in serving this target population by conducting multidisciplinary staffing and training. Our next steps will be to better leverage practical support for housing, transportation, and health care and continue to work on engagement and retention in services.

c. What information will you gather to demonstrate that you have implemented this strategy as intended? What will you do? (who, what, how many, how often, where, etc.)

Feedback from stakeholders, staffing sheets, meeting minutes and sign-in sheets, service units and birth outcomes of identified participants will be gathered to demonstrate implementation of this strategy as intended.

d. What do you expect to be the immediate EFFECT (measurable objective) of this strategy on the population who receives the intervention/exposed to the strategy? (for example, changes in knowledge, attitude and behaviors stated with baseline information and goal)

- Reduction in length of time to deliver services (Initial Contact and Assessment)to substance involved women who are referred
- Reduction in number of women "lost to contact"
- Increase in number of staff serving high risk
- Increase in number of women who receive intensive services
- Increase in number of women assigned to a Peer for support

5A): Provide Assistance to Pregnant Women Identified as Using or Abusing Alcohol or Other Drugs during or in-between Pregnancies

Action Step	Pers. Responsible	Start Date	End Date
1. Increase staffing pattern for high risk services responsible for serving pregnant substance using women.	HS Program Manager/ SMA-HS Program Director	7/16	6/17
2. Hire Project Manager to oversee new funding for High Risk Team	Program Director	9/16	6/17
3. Continue to develop language in direct service contracts regarding serving substance using pregnant women.	HS Program Manager	7/16	6/17
4. Participate in Behavioral Health System activities to coordinate services effectively.	Executive Director	7/16	6/17
5. Conduct workforce training about identifying and assisting substance involved families.	Executive Director, HS Program Manager	7/16	6/17
6. Leverage funding to conduct outreach for substance exposed pregnant women and infants.	Executive Director	7/16	6/17

5B) Coordinate Services for Substance Exposed Newborns

Action Step	Pers. Responsible	Start Date	End Date
1. Coordinate multi-disciplinary staffing activities when infants are born to support the families and well-being of infants.	HS Program Director/SMA-HS Director	7/16	6/17
2. Conduct regularly scheduled Substance Exposed Newborns (SEN) meetings.	Executive Director	7/16	6/17
3. Implement new form to gather data on service coordination.	HS Program Manager, SMA-HS Program Director	7/16	6/17
4. Develop action plans in alignment with best practices.	Executive Director	7/16	6/17
5. Develop policies and procedures to formalize new service coordination processes.	Program Director, Program Manager	7/16	2/17
6. Provide technical consulting and conduct monitoring of new services.	Program Manager	12/16	6/17
7. Develop committees to address infant safety, aftercare, interconception care, and policy issues.	Executive Director, Program Director	7/17	1/17
8. Integrate knowledge from taskforce to workforce.	Program Director	7/16	6/17

VII. ALLOCATION PLAN FOR SERVICE DOLLARS FOR FY 2017-2021

Each fiscal year, an allocation plan for Healthy Start funds is developed by reviewing priorities established in the Service Delivery Plan, goals and strategies contained in the current annual action plan, progress in meeting the prior year's contract objectives, and the performance of subcontracted providers. Coalition staff develops a proposed allocation plan based upon this information within the parameters established by the availability of resources. The proposed plan is then presented to the Coalition's Finance and Audit Committee for review and recommendations. The committee finalizes a recommendation for consideration by the full Board membership. After the Board of Directors approves a final allocation plan, staff completes contract preparations, conducts contract negotiations and facilitates contract execution. Copies of all executed contracts are provided to the Department of Health. The allocation plan is reviewed on a quarterly basis and modified if necessary in order to maximize the effectiveness with which resources are utilized in order to achieve established goals.

The Healthy Start Coalition of Flagler & Volusia Counties currently contracts with the following entities for the provision of Healthy Start services and the required administrative components of the Healthy Start service delivery process: Florida Department of Health in Volusia County, Florida Department of Health in Flagler County, Stewart-Marchman Act Behavioral Health Care, Inc., Healthy Communities, and Maria Long, M.Ed., Lifesong Liaison. The FY16/17 allocation plan for Healthy Start service delivery includes service dollars from the DOH Base contract, HSMCN Medicaid contract, and other leveraged state and local funds to support critical service gaps not funded by the Base and Medicaid contracts.

Following are the allocations for Healthy Start the period July 1, 2016 through June 30, 2017:

Services Funded	Provider of Services	Funded By		
		DOH-Base	HSMCN-Medicaid	Other
MomCare Program/SOBRA Administration	HS Coalition	$ -	$ 133,000	$ 30,600
Prenatal Care for Uninsured	Department of Health in Flagler County	$ 15,200	$ -	$ -
Screen In-take & Processing; Service Data Import	Department of Health in Volusia County	$ 36,000	$ -	$ -
Medical Provider Screen/Program Education & Outreach	Healthy Communities	$ 78,000	$ -	$ -
Black Infant Mortality/Community Education and Outreach	Long, Maria (Vendor Contract)	$ 34,000	$ -	$ -
Healthy Start Services; Outreach Services; High Risk Services	Stewart-Marchman Act Behavioral Healthcare, Inc.	$ 315,600	$ 857,774	$ 305,460
Training – Direct Service Staff	Multiple contracted trainers	$ 5,000	$ -	$ -
Program Marketing & Public Education	N/A	$ 9,644	$ -	$ -
Healthy Start Program/Contract Management	HS Coalition	$ 54,827	$ -	$ -
TOTAL	**$ 1,875,105**	**$ 548,271**	**$ 990,774**	**$ 336,060**
*** does not include Healthy Families funding**				

VIII. QUALITY ASSURANCE/IMPROVEMENT PLAN

Since the last Service Delivery Plan Update, additional activities have been put in place to improve the Quality Monitoring conducted by the Healthy Start Coalition to support contract compliance and continuous quality improvement (CQI) by agencies subcontracted to provide the range of Healthy Start services. Healthy Start utilizes the Well Family System (WFS) and the Health Management Information System (HMS) to assist administration and direct service supervisory staff in monitoring outcomes and identifying areas for further evaluation. Healthy Start staff are trained in use of HMS and WFS and quality controls have been integrated into the policies and procedures related to our Quality Management Plan.

In addition to adherence to the Healthy Start Standards and Guidelines, local quality indicators are established and monitored quarterly. Results of the monitoring process provide an opportunity to conduct teambuilding activities and outline a course of action and staff development needs that may be required. As stated in the Standards and Guidelines, the "quality improvement process is necessary to assure that services are:

- Provided in a manner that meets the needs of participants
- Accessible and acceptable to the community and the participants
- Delivered in a timely manner.

This section of the Service Delivery Plan outlines the systematic approach that is utilized by the Healthy Start Coalition as a means by which to accomplish the above objectives and work toward Continuous Quality Improvement.

A. Methodology

Monitoring the quality of service delivery and fiscal accountability among sub recipients and vendors is approached from several directions, and utilizes multiple methods. Monitoring tools are regularly reviewed to guide the Contract Manager in determining if the Standards and Guidelines and outcome measures have been met or exceeded. These tools calculate values using an Excel program, which makes the process more accurate and efficient. These tools are utilized during chart reviews and the calculations assist with follow-up performance development. The Healthy Start Coalition also utilizes an observation component to the site review process, which includes: shadowing home visitation, assessment, and supervision activities.

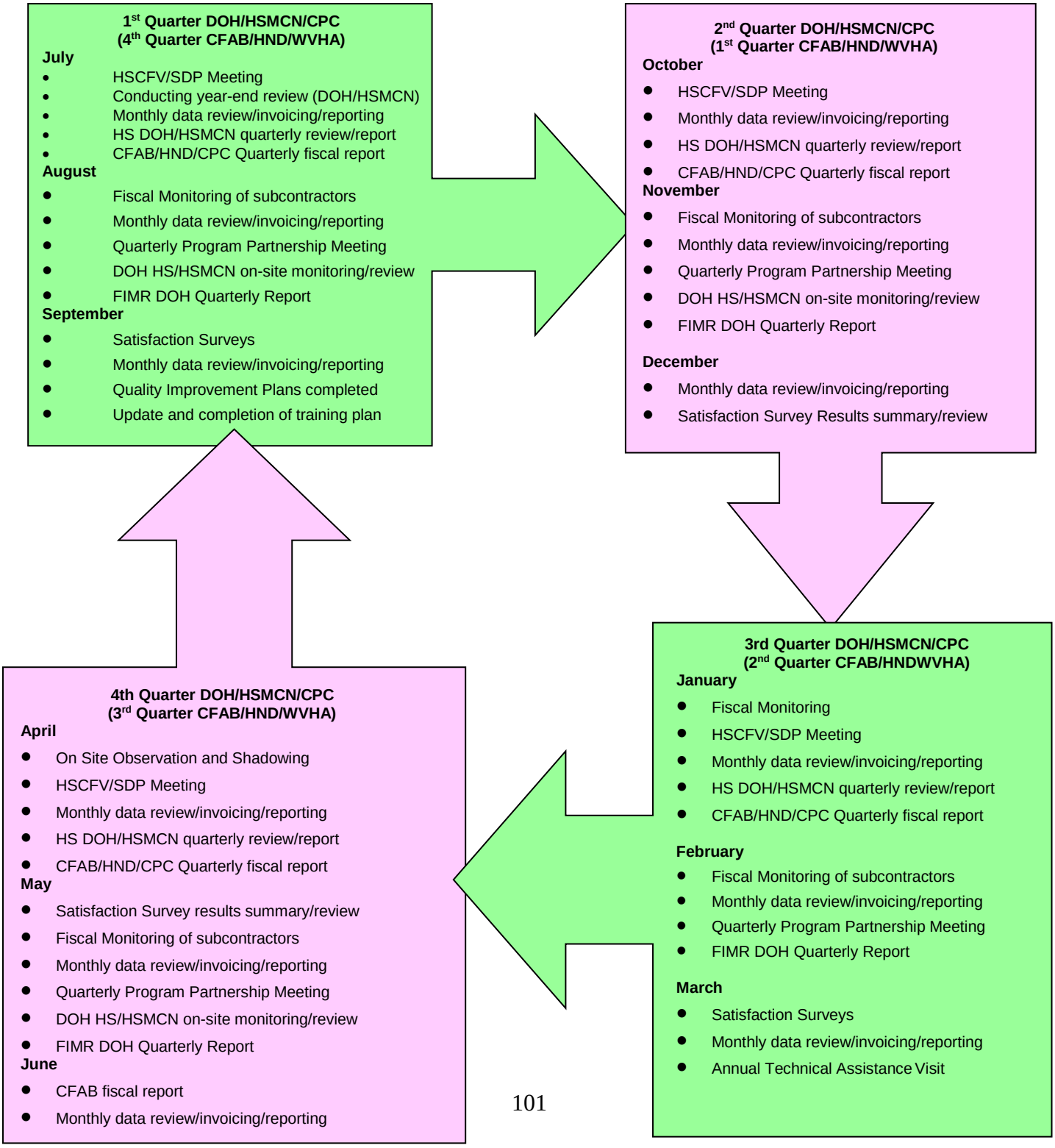
The Healthy Start Contract Manager meets monthly with the supervisors of the programs to provide ongoing technical assistance in between monitoring periods. The Contract Manager is also available for onsite Technical Assistance immediately following a monitoring to provide follow up and support successful accomplishment of the Quality Improvement Plan and implementation of corrective action if necessary. The leadership in each agency is kept apprised of the results of the monitoring activities and participates in active development of strategies for improvement by attending the quarterly Coalition meetings and presenting their quarterly outcomes.

Minimum Training requirements are verified by comparing the program's staff development plan to actual training attended or educational levels achieved by service delivery staff and

supervisors. Feedback and evaluation from training events are reviewed and utilized for continuous quality improvement in staff training activities and outcomes.

B. Healthy Start Quality Monitoring Calendar

The model below illustrates the timelines associated with Coalition Quality Monitoring activities:



X. APPENDICES

Appendix A – Healthy Start Board, Coalition and FIMR Members

The Healthy Start Coalition of Flagler and Volusia Counties, Inc. Coalition Board Members			
Name	**Membership**	**Work Title**	**Representing**
The Honorable Diane Smith	Board Member - President	Commissioner	City of Deltona, District 2
Carly Meek	Board Member – Vice President	Attorney	City of Ormond Beach
Eric Giore	Board Member - Treasurer	Chief of Operations	Museum of Arts and Sciences
Dixie L. Morgese, BA, CAP, ICADC	Secretary	Executive Director	Healthy Start Coalition of Flagler and Volusia Counties, Inc.
Alma Dixon	Board Member	Private Citizen	Flagler County
Amanda K. Hayes	Board Member	Financial Advisor	The Executive Compensation Group
Bonnie Wittman	Board Member	Director	Halifax Center for Women & Infants
Chris Fulton	Board Member	Senior Vice President	Brown & Brown, Inc.
Jessica Fox-Sznapstajler	Board Member		Consolidated Tomoka Land Co.
Joanna Nightingale	Board Member	Administrator	Pediatric Health Choice
John Meyers, MD	Board Member	OB/GYN	OB/GYN Health Center
Kassandra Blissett	Board Member	Private Citizen	City of Port Orange
Loverso Walker	Board Member	Pastor	Faith Temple C.O.G.I.C.
Michele Goeb-Burkett	Board Member	Chief Nursing Officer and VP of Clinical Services	Florida Hospital Memorial Medical Center
Pamela Carbiener, MD	Board Member	OB/GYN, Faculty, FSU School of Medicine	Halifax OB/GYN, Florida State University
Patricia Boswell	Board Member (ex-officio)	Administrator	Florida Department of Health in Volusia County
Ray Salazar	Board Member	Private Citizen	Volusia County
Robert E. Snyder	Board Member (ex-officio)	Administrator	Florida Department of Health in Flagler County
Steven R. Forsyth	Board Member	Senior Private Banker	5/3 Bank
Suzette Cameron	Board Member	Director of Campus Services	Daytona State College
Zenesha Barkley	Board Member	Assistant Professor/Assessment & Program Evaluator	Bethune-Cookman University School of Nursing

The Healthy Start Coalition of Flagler and Volusia Counties, Inc. Coalition General Members	
Name	**Representing**
Amy Velez	Florida Hospital Memorial Medical Center
Ann Bodziak	Florida Department of Health in Volusia County
Ann Wilson	Children's Medical Services
Anne Ferguson	The Chiles Academy
April Leopold	Easter Seals
Bonnie Welter	Florida Department of Health in Flagler County
Brandy Panariello	SMA Behavioral Healthcare, Inc.
Cher Philio	Healthy Communities
Claretha Sabree	The Chiles Academy
Corey Best	The Healthy Start Coalition of Flagler & Volusia Counties, Inc.
Christina Roebling	United Way of Volusia-Flagler
Dawn Murray	SMA Behavioral Healthcare, Inc.
Dixie Morgese	The Healthy Start Coalition of Flagler & Volusia Counties, Inc.
Gail Hallmon	The House Next Door
Hussain Rawji	Florida Department of Health in Volusia County
Ivan Cosimi	SMA Behavioral Healthcare, Inc.
Joanne Roberts	Adoption & Family Support Center, LLC
John Long	Halifax Health Medical Center
Judy Ryan	Children's Medical Services
Karen Kennedy-Tyus	Agape Midwifery
Kathy Diaz	Florida Department of Health in Volusia County
Kimberly Pleasants	Children's Home Society
Larisa Remishevskiy	The Healthy Start Coalition of Flagler & Volusia Counties, Inc.
Laureen Husband	Florida Department of Health in Volusia County
Leighray Wilson	Children's Medical Services
Lisa Funchess	Florida Department of Health in Volusia County
Lisa Benitez	Presbyterian Counseling Center
Lynn Kennedy	One Voice for Volusia
Maria Long	African American Faith Community Liaison
Michelle Morrell	Florida Department of Health in Flagler County, WIC
Nathalie Dunning	Early Learning Coalition of Flagler & Volusia
Nathaniel Loucks	SMA Behavioral Healthcare, Inc.
Pam Martin	SMA Behavioral Healthcare, Inc.
Patricia Boswell	Florida Department of Health in Volusia County
Patrick Miley	SMA Behavioral Healthcare, Inc.
Rebecca Vernon	Florida Hospital Memorial Medical Center
Robert Snyder	Florida Department of Health in Flagler County
Rosha Loach	The Healthy Start Coalition of Flagler & Volusia Counties, Inc.
Shanna Dickson	The Healthy Start Coalition of Flagler & Volusia Counties, Inc.
Sheena A Fegumps	Florida Department of Health in Volusia County
Sheryl Bell	The Chiles Academy

Shirley A. Wilson	Florida Department of Health in Volusia County
Sue Snow	The Healthy Start Coalition of Flagler & Volusia Counties, Inc.
Susan LeBlanc	The Healthy Start Coalition of Flagler & Volusia Counties, Inc.
Susan Monahan	Florida Department of Health in Volusia County
Tegan Graser	Children's Home Society
Thalia V. Smith	The Healthy Start Coalition of Flagler & Volusia Counties, Inc.
Thomas Bryant III	Florida Department of Health in Volusia County
Victoria Camper	The Healthy Start Coalition of Flagler & Volusia Counties, Inc.

The Healthy Start Coalition of Flagler and Volusia Counties, Inc. FIMR Case Review Team (CRT)	
Name	**Representing**
Allison Crowe	University of Florida First Coast Child Protection Team
Amy Velez	Florida Hospital Memorial Medical Center
Ann Bodziak	Florida Department of Health in Volusia County
Arnold Anderson	Department of Children and Families
Bonnie Welter	Florida Department of Health in Flagler County
Bonnie Wittman	Halifax Health Medical Center
Brandy Panariello	SMA Behavioral Healthcare, Inc.
Catherine Luchsinger	Halifax Health Medical Center
Cher Philio	Healthy Communities
Christy Hersey	Agape Midwifery Services
Dewan Raja	Palmer College of Chiropractic Florida
Diana Lee	Bethune-Cookman University
Dianne Reed	FIMR Abstractor
Glynne Pascal	Early Learning Coalition of Flagler and Volusia
Heidi Wright	Halifax Health Labor & Delivery
Hussain Rawji	Florida Department of Health in Volusia County
Janet Elliott	FIMR Abstractor
Jennie Joseph	Commonsense Childbirth, Inc.
Joanna Nightingale	Pediatric Health Choice
John Long	Halifax Health Medical Center
Judy Ryan	Children's Medical Services
Kathy Santi	Halifax Health Medical Center
Kristen Combs	Halifax Health Medical Center
Lorraine Harrigan	Maternity Mentor
Marcela Chiste	Volusia County Medical Examiner's Office
Maria Long	African American Faith Community Liaison
Marie Herrmann	Volusia County Medical Examiner's Office
MaryAnn Ruddy	Florida Department of Health
Megan Bagwell	Volusia OB/GYN
Natalie Eisenhut	The TEARS Foundation
Nathaniel Loucks	SMA Behavioral Healthcare, Inc.
Pam Carbiener	Halifax OB/GYN Associates
Paula Meek	Florida Hospital Memorial Medical Center
Rosha Loach	The Healthy Start Coalition of Flagler & Volusia Counties, Inc.
Susan Monahan	Florida Department of Health
Teri Hanans	Volusia County Medical Examiner's Office
Valarie Urquhart	Halifax Health Center for Women & Infant Health
Vicki Whitfield	University of Florida

Appendix B – Service Delivery Plan Committee Members

Carrie Baird, Executive Director, One Voice for Volusia

Kimberly Beck-Frate, Halifax Health
Laurie Bell, PhD, Certified Nurse-Midwife, Halifax OB/GYN Associates
Pamela Carbiener, MD, Halifax OB/GYN Associates, Faculty, Florida State University
Darlinda Copeland, Chief of Operations, Florida Hospital Memorial
Margaret Crossman, MD, Family Health Services, Halifax Health
Catherine Davis,, Stewart-Marchman ACT Behavioral Health Care
Dr. Alma Dixon, Bethune Cookman University
Anne K, Ferguson, MPH, Director, The Chiles Academy Charter School for Pregnant and Parenting Teens at The Bonner Center Full Service Community School
Lisa Funchess, Volusia County Health Department
Richard Fay, LCSW, Therapist, Infant Mental Health and Developmental Specialist, A Helping Hand, Inc.
Wandrea Grier, Supervisor, Healthy Start, Stewart Marchman ACT Behavioral Health Care
Rhonda Harvey, Stewart Marchman ACT Behavioral Health Care
Marilyn Heck, Circuit 7, Department of Children and Families
Marie Herrmann, MD, Volusia County Medical Examiner
Karen Horzepa, Program Director, Children's Advocacy Center
Don Jones, Chaplain, Volusia County Sheriff's Department
Mark Jones, Executive Director, Community Partnership for Children
Karen Kennedy-Tyus, Licensed Midwife, Owner/Operator, Agape Midwifery
Lynn Kennedy, One Voice for Volusia
W. David Kerr, Department of Juvenile Justice
Patricia Kruse, PhD., Certified Nurse Midwife,
Pastor John Long, Tubman King Community Church, VITAS Innovative Hospice Care
Maria Long, African American Faith-based Bereavement and Lifesong Initiative
Paula Meek, Florida Hospital Memorial
Jeremy Mirabile, MD, Addiction Medicine, Stewart Marchman ACT Behavioral Health Care
Patricia Modad, MD, OB/GYN
Dixie Morgese, Executive Director, Healthy Start Coalition of Flagler & Volusia Counties, Inc.
Leslie Pearce, Contract Manager and FIMR Coordinator, Healthy Start Coalition of Flagler & Volusia Counties, Inc.
Nancy Perkins, Vice President, Outpatient Services, Stewart Marchman ACT Behavioral Health Care
Cher Philio, MPA, Healthy Communities, Halifax Health
Celeste Phillips, MD, Volusia County Health Department
Barbara Preston, Healthy Start Supervisor, Outreach Community Care Network, Inc.
Hussain Rawji, MD, OB/GYN, Volusia County Health Department
Gladys Roman, LPN, Stewart Marchman ACT Behavioral Health Care
Mary Ann Ruddy, WIC Coordinator, Volusia County Health Department
Judy Ryan, Director, Children's Medical Services
Judy Seltz, Healthy Start Program Director, Stewart Marchman ACT Behavioral Health Care
Bonita Sorensen, MD, Director, Volusia County Health Department
Andrea Thorpe, MD, Pediatrician, Keech Street Clinic, Halifax Health
Rebecca Vernon, Birth Center Director Florida Hospital Memorial
Alicia Vincent, Program Director, Project WARM, Stewart Marchman ACT Behavioral Health Care
Jan Wagner, Halifax Health
Sue Wagner, Flagler County Schools
Bonnie Welter, Nursing Director, Flagler County Health Department

Appendix C – Healthy Start Prenatal and Infant Risk Screening Forms

Help your baby have a healthy start in life!

Please answer the following questions to find out if anything in your life could affect your health or your baby's health. Your answers are confidential. You may qualify for free services from the Healthy Start Program or the Healthy Families Program, no matter what your income level is! (Please complete in ink.)*

Today's Date: _____

	YES	NO
1. Have you graduated from high school or received a GED?	☐	☐ 1
2. Are you married now?	☐	☐ 1
3. Are there any children at home younger than 5 years old?	☐	☐
4. Are there any children at home with medical or special needs?	☐	☐
5. Is this a good time for you to be pregnant?	☐	☐
6. In the last month, have you felt down, depressed or hopeless?	☐ 1	☐
7. In the last month, have you felt alone when facing problems?	☐	☐
8. Have you ever received mental health services or counseling?	☐	☐
9. In the last year, has someone you know tried to hurt you or threaten you?	☐	☐
10. Do you have trouble paying your bills?	☐	☐

11. What race are you? Check one or more.
☐ White ☐ 3 Black ☐ Other _____

12. In the last month, how many alcoholic drinks did you have per week?
_____ drinks 1 ☐ did not drink

13. In the last month, how many cigarettes did you smoke a day? ***(a pack has 20 cigarettes)***
_____ cigarettes 1 ☐ did not smoke

14. Thinking back to just before you got pregnant, did you want to be.....?
☐ pregnant now ☐ pregnant later ☐ 1 not pregnant

15. Is this your first pregnancy?
☐ 2 Yes ☐ No If no, give date your last pregnancy ended:
Date: (month/year)_____

16. Please mark any of the following that have happened.
☐ 3 Had a baby that was not born alive
☐ 3 Had a baby born 3 weeks or more before due date
☐ 3 Had a baby that weighed less than 5 pounds, 8 ounces
☐ None of the above

PATIENT INFORMATION

Name: First Last M.I.	Social Security Number:	Date of Birth (mo/day/yr):	17. Age: ☐ 1 <18
Street address (apartment complex name/number):	County:	City: State:	Zip Code:
Prenatal Care covered by: ☐ Medicaid ☐ Private Insurance _____ ☐ No Insurance ☐ Other _____	Best time to contact me:	Phone #1 _____ Phone #2 _____	

I authorize the exchange of my health information between the Healthy Start Program, Healthy Start Providers, Healthy Start Coalitions, Healthy Families Florida, WIC, Florida Department of Health, and my health care providers for the purposes of providing services, paying for services, improving quality of services or program eligibility. This authorization remains in effect until revoked in writing by me.

Patient Signature: _____ **Date:** _____

Please initial: _____ Yes _____ No I also authorize specific health information to be exchanged as described above, which includes any of my mental health, TB, alcohol/drug abuse, STD, or HIV/AIDS information.

** If you do not want to participate in the screening process, please complete the patient information section only and sign below:*

Signature: _____ *Date:* _____

PROVIDER ONLY

LMP (mo/day/yr):	EDD (mo/day/yr):	18. Pre-Pregnancy: Wt: _____lbs. Height: _____ft. _____in. BMI: _____	☐ 1 < 19.8 ☐ 2 > 35.0
Provider's Name:	Provider's ID:	19. Pregnancy Interval Less Than 18 Months? ☐ N/A ☐ No	☐ 1 Yes
		20. Trimester at 1st Prenatal Visit? _____	☐ 1 2nd
Provider's Phone Number:	Provider's County:	21. Does patient have an illness that requires ongoing medical care? Specify illness: _____ ☐ No	☐ 2 Yes
Healthy Start Screening Score: _____	**Check One:** ☐ **Referred to Healthy Start. If score <6, specify:** _____ ☐ **Not Referred to Healthy Start.**		
Provider's/Interviewer's Signature and Title _____ **Date (mo/day/yr)** _____			

DH 3134, 04/08, stock number 5744-100-3134-7 Distribution of copies: WHITE & YELLOW—County Health Department in county where screening occurred PINK—Retained in patient's record GREEN—Patient's Copy

INFANT RISK SCREEN

Use ink. Be certain to check the appropriate boxes at the top of the birth certificate.

Pursuant to § 383.14(1)(b) and 383.011(1)(e), F.S., this form must be completed for each infant and submitted to the local County Health Department, Office of Vital Statistics.

MOTHER

Mother's Name: First Last Maiden

Mother's Date of Birth

INFANT

Infant's Name: First Last | Infant's Date of Birth | Boy | Girl

Name of Infant's Doctor/ HMO or Group: _____ Name of birth hospital/facility: _____

Was the infant transferred? ❑ No ❑ Yes If Yes, enter name of facility transferred to: _____

Was the infant admitted to neonatal intensive care unit for more than 24 hours? ❑ No ❑ Yes ❑ Unknown

SECTION 1: COMPLETED BY PATIENT

Yes_____ **No**_____ **(please initial)** I am interested in having my infant screened for risks that could affect his/her health or development in the first year of life.

Yes_____ **No**_____ **(please initial)** If my infant is referred, Healthy Start may contact me.

I can be reached at (home phone): _____ or (work or contact phone): _____

Street Address: _____
(Give either street address with bldg.#, apt.# or lot# or directions to baby's home)

Mailing Address: _____
(if different from street address)

Yes_____ **No**_____ **(please initial)** By initialing yes, I am giving my written permission on behalf of my infant for release of the confidential information on this form and any information provided during his/her evaluation for service by Healthy Start to Healthy Start care coordination providers, Healthy Start Coalitions, Healthy Families Florida, WIC, and my health care providers for the following purposes: care coordination, payment of claims for services, quality improvement of services, or screening for program eligibility. This includes any medical, mental health, alcohol/drug abuse, sexually transmitted disease, tuberculosis, HIV/AIDS, and adult or child abuse information. This authorization shall remain in effect unless withdrawn in writing.

_____ Signature of parent or guardian

_____ Date (mo/day/yr)

SECTION 2: BY PROVIDER

Item numbers correspond to the numbers on the Birth Certificate. Write the point(s) on the appropriate lines, and add for the total score.

Item 54	⊙____	Abnormal conditions include one or more of the following: Assisted Ventilation (30 min. or more), Assisted Ventilation (6 hrs. or more), NICU admission, newborn given Surfactant Replacement Therapy, Hyaline Membrane Disease/RDS, or seizure or serious neurological dysfunction.
Item 4	⊙____	Birthweight less than 2000 grams or less than 4 pounds, 7 ounces
Item 28b	⊙____	Infant transferred within 24 hours of delivery
Item 15	⊙____	Mother unmarried
Item 26	⊙____	Principal source of payment Medicaid
Item 30	⊙____	Maternal race black
Item 19	⊙____	Father's name not present or unknown
Item 40	⊙____	Mother used tobacco in one or more trimesters
Item 36d	⊙____	Prenatal visits less than 2 or unknown
Item 16	⊙____	Maternal age less than 18 or unknown
	_____	Infant's Healthy Start Screening Score

CHECK ONE

❑ Referred to Healthy Start
If score less than 4 specify reason for referral: _____
❑ Not referred to Healthy Start

BE CERTAIN TO CHECK THE APPROPRIATE BOXES AT THE TOP OF THE BIRTH CERTIFICATE.

I have explained the Healthy Start program, and if screened, the patient's screening score.

_____ Provider's/Interviewer's Signature and Title

_____ Date (mo/day/yr)

NO ATTACHMENTS MAY BE ADDED TO THIS FORM.

DH 3135, 01/15 stock number 5744-100-3135-5 Rule 64C-7.008(3)

Appendix D – Methodology for SDP Outcome Objective Development and Implementation

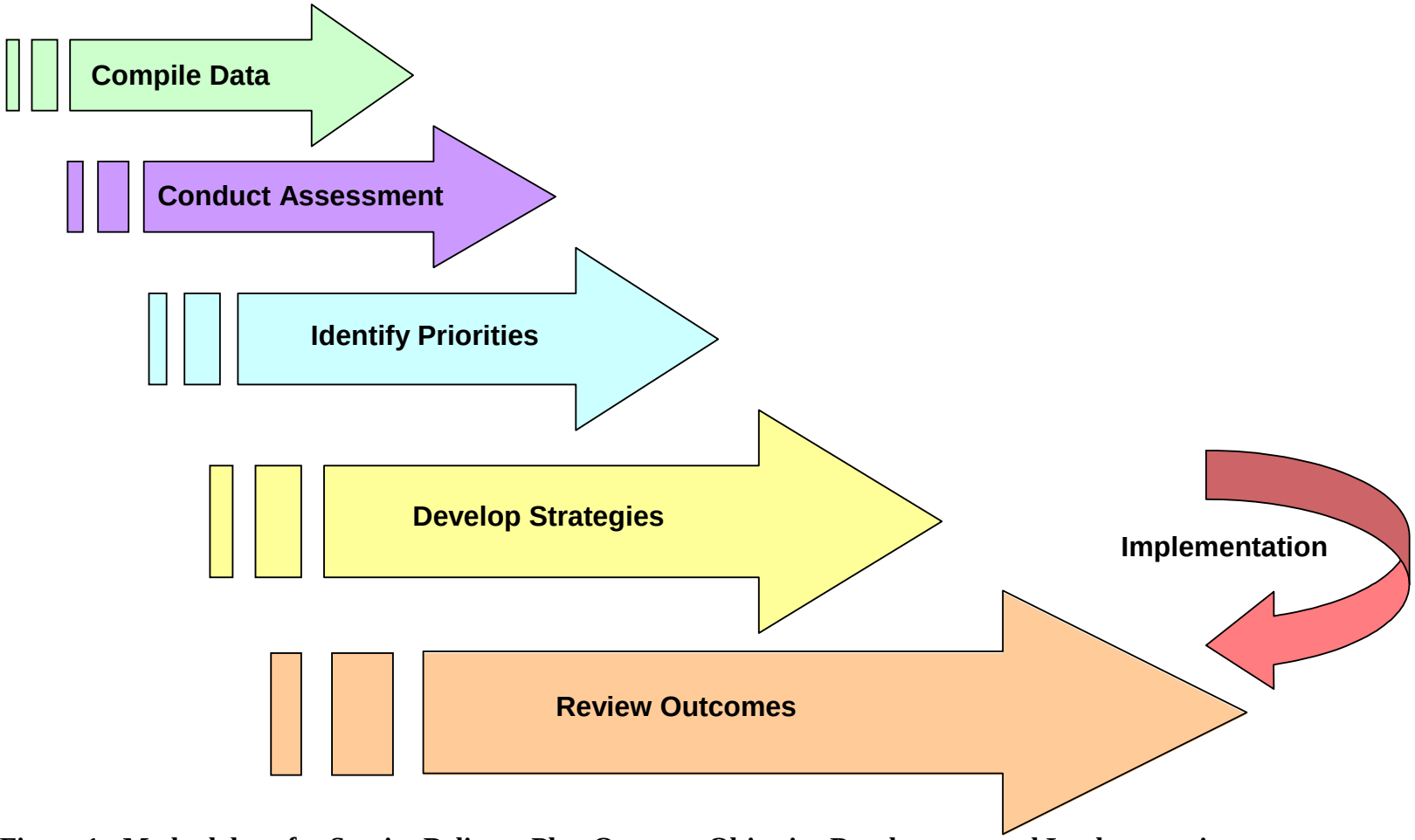


Figure 1 - Methodology for Service Delivery Plan Outcome Objective Development and Implementation

Indicator # 1: Infant Mortality **Goal: 4.50**

Rate as of 2014: Flagler: 6.2 Volusia: 4.3 Florida: 6.1

Data	Assessment	Priorities	Strategies	Outcomes
• DOH CHARTS data by race and zip code • Supplemental risk data (FIMR, interviews, etc.) • Survey data • Screening Rates • Indicators • WFS	• Volusia infant death rates have decreased to 4.3; however, there are still disparities in race • Flagler & Volusia Neonatal death rate decreased and neonatal outreach worker implemented and seems to be effective • Infant screening rates are lower than the State's	• Comprehensive training plan for workforce • Increase infant screening rates • Increase awareness about prenatal and infant services for families • Increase Healthy Start initial contact rates and enrollment services • Improve access for Medical care for the uninsured, underinsured and Medicaid • Increase knowledge about Preconceptional and continue Interconceptional Care and Education • Increase services for targeted zip codes • SIDS Education Safe Sleep Campaigns • Capture information on substance exposure for all women in treatment or other venues where substance/alcohol use is disclosed	• Continue to concentrate on marketing and training on the Healthy Start Screen • Encourage hospitals to improve infant screening rate • Continue Neonatal Outreach Coordinator to provide services to newborns • Encourage breastfeeding education and continue to provide as a service delivered by the field staff • Provide Preconceptional and Interconceptional education • Hospitals continue to ask "where will your baby sleep?" • Continue to educate the community on safe sleep practices and provide cribs to financially challenged families • Continue to distribute cribs or pack n' plays • Monitor Healthy Start Services at WIC to increase number of participants served • Review data sets with front line Supervisors • Conduct a minimum of three (3) safe-sleep "Train the "Trainer" programs annually • Increase Interconceptional services to women who have experienced a loss • Explore implementation of "Call-in line" to use before prenatal clinic appointment to speak with a "coach" • Provide designated staff to coordinate services for opioid and opiate addicted women and NAS babies • Enhance father involvement	• Reduction in Infant Mortality • Increase local infant screening rate • Maintain prenatal screening rate • Increase initial contact rates to 95% • Increase Hospital based FAWs to successfully enroll 80% of IC's in HS/HF services • Neonatal outreach attempt within 5 days of discharge for high risk • Continue Breastfeeding education by Healthy Start FAWs and Care Coordinators • Increase maternal interviews of women for FIMR • Increased capacity to serve high risk women

Indicator #2: Black Infant Mortality **Goal: 4.50**

Rate as of 2014: Flagler 6.3 Volusia 7.0 Florida 10.0

Data	Assessment	Priorities	Strategies	Outcomes
• DOH data by race and zip code • Survey data • Indicators • Screening data by zip code • FIMR data/interviews • Census data	• Black infant mortality has significantly declined in the last 3 years • Northwest quadrant has higher rate of Infant Mortality • Black women comprise higher percent of women with late entry or no entry into prenatal care • Black women disproportionately report unplanned and/or unwanted pregnancy • Black women disproportionately access prenatal care late in pregnancy • Infant mortality disproportionately occurs with unmarried Black women • Black women have disproportionate incidence of chronic medical conditions and infection during pregnancy	• Continue to improve FIMR CRT and incorporate recommended strategies • Community engagement through an organized programming with churches and community organizations • Access to health services for families • Safe sleep environments and information to families before they are discharged from the hospital • Engage African American Churches and other community venues to increase awareness about the extreme disparities in health outcomes and infant mortality • Continue training plan/staff development	• Continue Lifesong initiative in targeted zip codes 32114, 32117, 32118 • MomCare/SOBRA – ask about potential barriers to health care & social services • Coordinate with Community Cafés in Deltona, DeLand, Daytona Beach, and Flagler to support preconception and interconception support and parent involvement in partnership with Florida's Healthy Babies Initiative • Continue to increase Interconceptional care/education in and around the 32114 zip code • Preconceptional: increase planned parenthood & baby spacing education (baseline) • Media campaigns (bus displays, church fans) • Enhanced data sets for FIMR of Black deaths/causes • Continue to participate in MAMA BEAR program • Continue to implement culturally sensitive enhanced services models to include breastfeeding support and in-home childbirth education (doula services in non-traditional settings) through JJ Way model • Culturally sensitive SIDS and safe sleeping educational programs and materials including media campaign • Prioritization of Black families for crib distribution • Provide training efforts to incorporate educational and economic development goals in the FSP • Provide in-home services within 72 hours for families with significant risk and ensure home safety, adequate support, safe sleep and linkage to pediatric services according to AAP guidelines	• Increased number of churches and civic groups who are aware of and support initiatives that improve health outcomes • Quarterly review with front line supervisors - increased knowledge and competency of field staff • Increased number of culturally sensitive educational materials at key distribution points and to Black HS participants • Continued increase of Black participants who receive Childbirth Education, Interconception Care and Breastfeeding Support • Increased number of women with access to health services before, during, and after pregnancy • Increased number of women and caregivers receiving information about safe sleep and safe sleep environments when needed • Continued reduction of infant mortality rates • Continued zero rate in HIV perinatal transmission • Increased engaged parents conducting community dialogues

Indicator #3: Low Birth Weight **Goal: 7.2%%**

Rate as of 2014: Flagler 7.2 Volusia 8.2 Florida 8.6%

Data	Assessment	Priorities	Strategies	Outcomes
• Vital Statistics • Florida DOH • Healthy Start Pre-natal, Post-natal, & Infant Risk Screens • Field staff reports • FIMR	• The rate of infants born at a Low Birth Rate (LBW) per 1000 live births decreased to 8.1 in Service Area but goal was not attained from last planning period • White LBW declined to 7.3 but Black LBW increased to 12.7. Hispanic decreased to 7.3 • Highest rates in Northeast and Southeast quadrants, 32114, 32127, 32168 and 32759 • STDs are a contributing factor to Low Birth Weight • Very Low Birth Weight decreased in both Volusia (1.5 per 1000 live births) and Flagler (1.2 per 1000 live births), which is lower than the state rate of 1.6 • Poor oral hygiene contributing factor to preterm labor • Late Entry into Prenatal Care: 4.2% and 1st trimester to care 72.3% • Pregnancy smoking rates are declining but still higher than the state rate	• Provide accessible places where women can gain information about reproductive health and family planning • Increase awareness about prenatal and infant services/Healthy Start services • Access for medical care for the uninsured, underinsured and Medicaid • Services for High Risk Case Management • Increase family involvement in Healthy Start • Continue to implement comprehensive training plan – increase staff understanding of causes of LBW and ensure they can deliver smoking cessation services	• Continue to provide Interconceptional /preconceptional care education services • Continue to provide smoking cessation education or referrals • Improve Access for medical care for the uninsured, underinsured and Medicaid • Continue to fund the Women's Intervention Specialist • Continue to maintain website with information focused on physicians and health care professionals • Encourage the medical community to provide Preconception Education services • Continue marketing and education related to the Healthy Start prenatal screen • Dental referral services for pregnant women • Continue to support Family Place ACCESS sites • Support WIC referrals • Inform women about kick counts, preeclampsia, signs of preterm labor	• Increase number of women receiving Interconceptional education services • Increase number of clients receiving smoking cessation education or referrals • Increase ICC with teen population • Reduce smoking rates • Increase WIC rates • Increased community awareness

Indicator #4: 1st Trimester Entry into Prenatal Care

Goal: >85.0%

Rate as of 2014: Flagler 84.8% Volusia 79.6% Area 72.3% Florida 79.8%

Data	Assessment	Priorities	Strategies	Outcomes
• Vital Statistics • Florida DOH • Healthy Start Pre/Post-natal Screens • FIMR data • Field staff reports	• Area lower than state rate – goal not achieved from last planning period • Lower rate of early entry among minorities (African American lower than Hispanic) • Lowest rates in zip codes 32114 and 32118 • Prenatal service provider in VCBJ changed • Transportation barriers and closing of health department prenatal services created more barriers to care • Providers do not want to take pregnant women with substance problems or those who are released from jail	• Provider Engagement • Use Protective Factors Framework for participant engagement • Black and Hispanic women, especially SOBRA-eligible • Eligible pregnant women via MomCare/SOBRA lists • Identify pregnant women in the jail and screen for HS • Identify pregnant and post-partum women in substance abuse treatment, homeless shelters, and high risk neighborhoods • Family Place ACCESS Centers • Provider, Participant, and Community Awareness	• Media campaigns (broad-based) about the importance of early prenatal care (in Spanish and English) • Prevention on the Move-screening of pregnant women "on the streets" • LifeSong Liaison providing health outreach and education in high risk zip codes. • Promote pre/interconceptional education minority women • Interagency coordination with providers of substance abuse and homeless services and other social services to women for early identification of pregnancy (also jail) • Coordinate Prenatal Services with providers to develop strategies for meeting the needs of the most vulnerable populations • Consumer and provider education regarding Medicaid eligibility and available services (media campaign, provider education, website) • Continue MomCare and SOBRA efforts • Train new medical provider at VCBJ (Armor Health Services) on use of the prenatal screen • Implement High Risk Team • Engage providers and support coordination to accept high risk into clinical care • Coordinate with FQHC's new prenatal services	• Reduce the number of undocumented women who are turned away for diagnostic services • Meet all outcome standards (and exceed where possible) for MomCare contacts and follow-up • Better coordination with provider network • Increase in 1st trimester entry • Increase number of women in the jail who receive a HS screen and follow-up contact

Indicator #5 : Late or No Entry into Prenatal Care **Goal: <3.6%**

Rate as of 2014: Flagler 3.2% Volusia 5% Florida 5%

Data	Assessment	Priorities	Strategies	Outcomes
• Vital Statistics • Florida CHARTS • Healthy Start Pre/Post-natal Screens • FIMR data • Field staff reports	• Area lower than state average but the same in Volusia • Substance abuse and domestic violence are barriers to care • Undocumented have barriers to care • Gap in Medicaid SOBRA coverage for undocumented Hispanic mothers preventing mothers from accessing prenatal care • Prenatal services are now available in the VCBJ	• Pregnant women in Flagler County • Eligible pregnant women via MomCare/SOBRA lists • Identify pregnant women in the jail and screen for HS • Identify pregnant and post-partum women in substance abuse treatment, homeless shelters, and high risk neighborhoods • Family Place ACCESS Centers – bilingual staff on site	• Media campaigns (broad-based) about the importance of early prenatal care (in Spanish and English) • Prevention on the Move-screening of pregnant women "on the streets" • Promote Long Acting Reversible Contraception • Florida's Healthy Babies Initiative – coordinate for community dialogues • Interagency coordination with providers of substance abuse and homeless services and other social services to women for early identification of pregnancy (also jail) • Implementation of High Risk Team • Coordinate Prenatal Services with providers to develop strategies for meeting the needs of the most vulnerable populations • Consumer and provider awareness (education regarding Medicaid eligibility) and available services (media campaign, provider education, website) • Continue MomCare and SOBRA efforts • Train VCBJ (Armor Health Services) on use of the prenatal screen	• Decrease in Late or No Entry • # of MOUs established with FQHC • MOU with Domestic Abuse Council • Reduce the number of undocumented women who are turned away for diagnostic services • Meet all outcome standards (and exceed where possible) for MomCare contacts and follow-up • Increase by 100% the number

Indicator # 6: Infant Screening Rates

Goal: 90.0%

Rate as of 2014: Flagler 83.5% Volusia 90.8% Florida 94.6%

Data	Assessment	Priorities	Strategies	Outcomes
• Screening Rate data • FIMR BASINET data • Vital Statistics • WFS Data .	• Infant screening rates have increased slightly since all providers are on Electronic Birth Registration (EBR) • Screening rates have significantly increased when providers present the screen in person • Consent rates have shown a slight increase when an Assessment Worker coordinates with the hospital	• Provider understands the Healthy Start program and can present it positively to patients • Provider understands the screening process and presents the screen in manner that encourages consent • Provide incentive to hospital staff to give patients if they consent to the screen • Review process used for entering screen information in the Electronic Birth Registration (EBR) database • Increase awareness about prenatal and infant services for families in service area: Provider, Participant and Community awareness	• Fund contract with Healthy Communities for Liaison services • Review data monthly and follow-up with providers that are below 80% • Invite hospital personnel to take a more active role in the FIMR process • Continue to review and educate hospital personnel on how to properly administer the screen and discuss the program benefits with the mother • Assessment workers will coordinate with Hospitals/Birth Care Centers • Review screening data at Board and Coalition meetings	• Increase infant screening rates • Better coordination with service area birth centers • More women needing services will be linked to the MCH Assessment Center • Increased community awareness about HS services

Indicator #7: Prenatal Screening Rates (offer and consent) **Goals: 92.0% (offer) & 91.0% (consent)**

***Rate as of 2015: 94.6% (offer) & 90.54% (consent) Florida 74.15% (offer) 88.84 (consent)**

Data	Assessment	Priorities	Strategies	Outcomes
• DOH Screening Data • MomCare employee feedback * 2015 data available.	• Prenatal screening rates are above the state average • All providers are offering the prenatal screen to their patients • Most providers are receptive to feedback regarding improving their screening rates • Most providers are proactive in searching for information Healthy Start may have in order to help their client • Positive relationships have either developed or maintained between Healthy Start and providers	• OB/GYNs with the largest percent of OB patients • Identify offices with new staff and set up in-services to train on Healthy Start program and screening tool • Continue marketing through the website and social network (Facebook)	• Fund contract with Healthy Communities for Liaison services • Review data monthly and follow-up with providers that are below 80% • Determine next steps regarding feedback from the Prenatal Summit • Invite OB/GYN providers to take a more active role in the FIMR process • Continue to review and educate providers on how to properly administer the screen and discuss the program benefits with the mother • Provide technical assistance to prison health services • Coordinate with medical providers regarding referrals of screens for pregnant teens • Review screening data at Board and Coalition meetings	• Increase/maintain prenatal screening rates • Better transition for pregnant women leaving the jail • Early identification of pregnant teens • Better coordination with are prenatal service providers • Better linkage of high risk pregnant women to available services

Appendix E – Prenatal and Postnatal Risk Factors

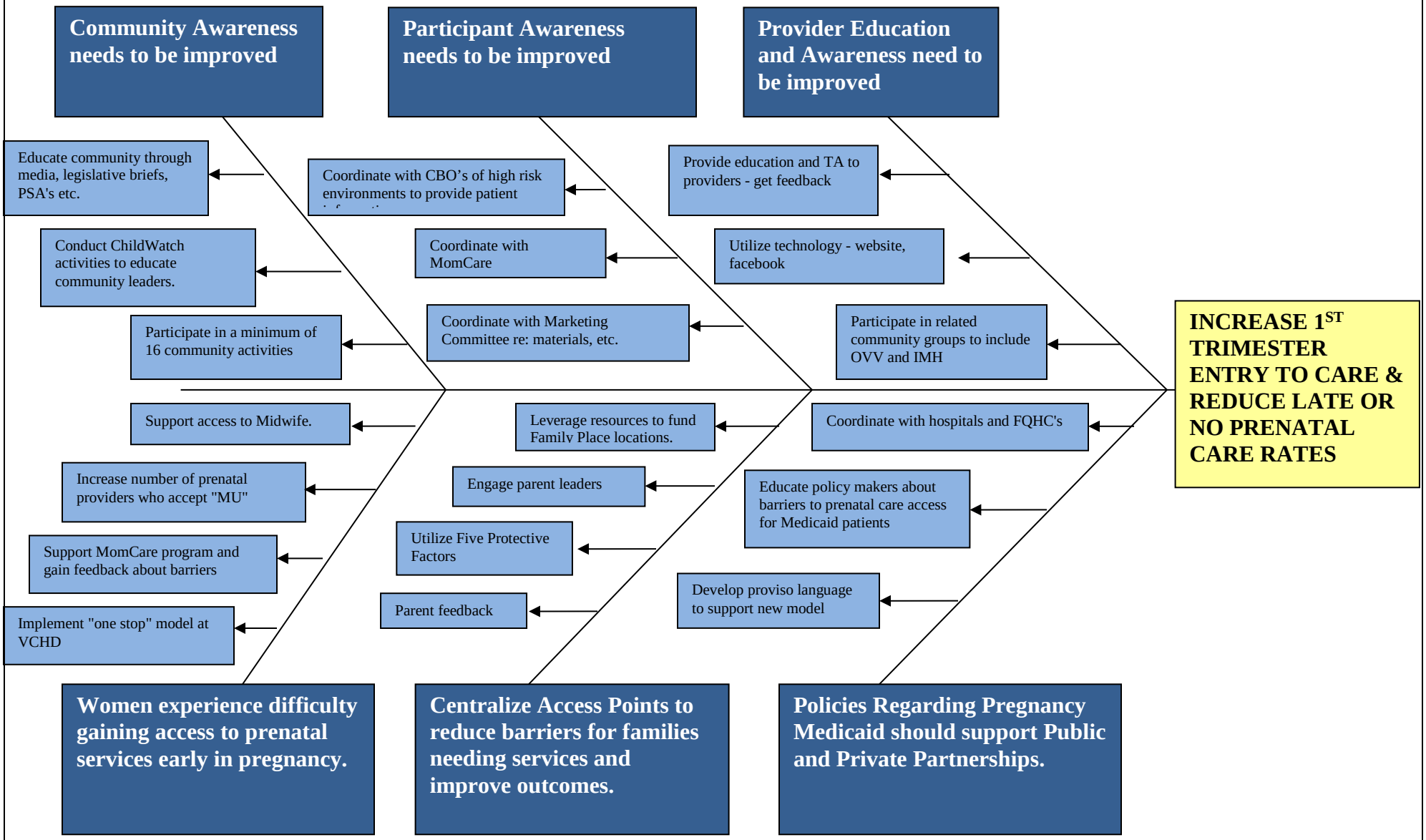
Healthy Start of Flagler & Volusia Counties Service Area Prenatal and Postnatal Factors Table							
Pre-Conception		**Pregnancy**		**Labor & Delivery**		**Postnatal**	
Physical Risk Factors	**Behavioral Risk Factors**	**Physical Risk Factors**	**Behavioral Risk Factors**	**Risk Factors**	**Behavioral Risk Factors**	**Infant Physical Risk Factors**	**Parental Physical and Behavioral Risk Factors**
Multi-parity	Poor Nutrition	Prima-parity	Poor nutrition	Distance to hospital	HIV/STDs	Low Birth Weight	Prima-parity
Age Under 18	Smoking	Plurality	Smoking	Delivery mode	Cultural Practices	Very Low Birth Weight	Lack of parenting skills
Age Over 30	Alcohol	Age Under 18	Alcohol	Delivery complications	Family Mobility = Lack of Continuity of Care	Prematurely	Abusive Environment
Poverty	Drug Abuse	Age Over 30	Drug Abuse		Self-induced labor	Congenital anomalies	Stress
Single Parent	HIV/STD	Poverty	HIV/STD			Other infant health conditions	Depression
History of poor birth outcomes	Cultural Practices	Single Parent	Late or No Prenatal Care				Lack of medical insurance
Chronic Health Problems	Family Mobility = Lack of Continuity of Care	Weight gain	Cultural Practices				Low Education
Contraceptive Use	Low Education	Health Conditions Caused by the Pregnancy	Family Mobility = Lack of Continuity of Care				Poverty
		Chronic Health Problems	Low Education				Single parent
		Abusive Environment	Poor Dental Health				Parent(s) under 18
		Stress					Smoking
		Depression					Alcohol
							Drug Abuse
							HIV/STD
							Cultural Practices
							Family Mobility = Lack of Continuity of Care

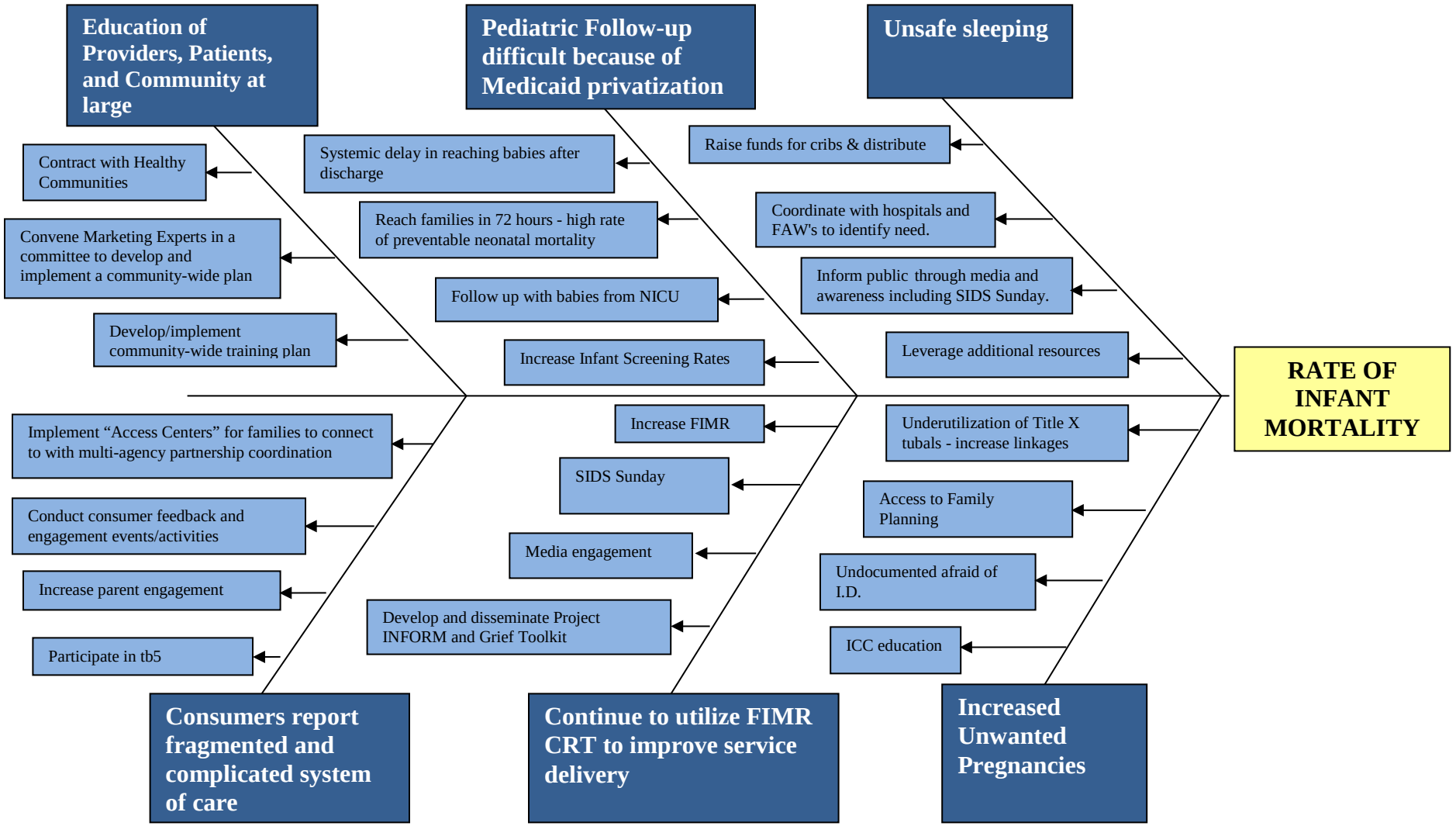
Appendix F – Local Resource Inventory for Pregnant Women

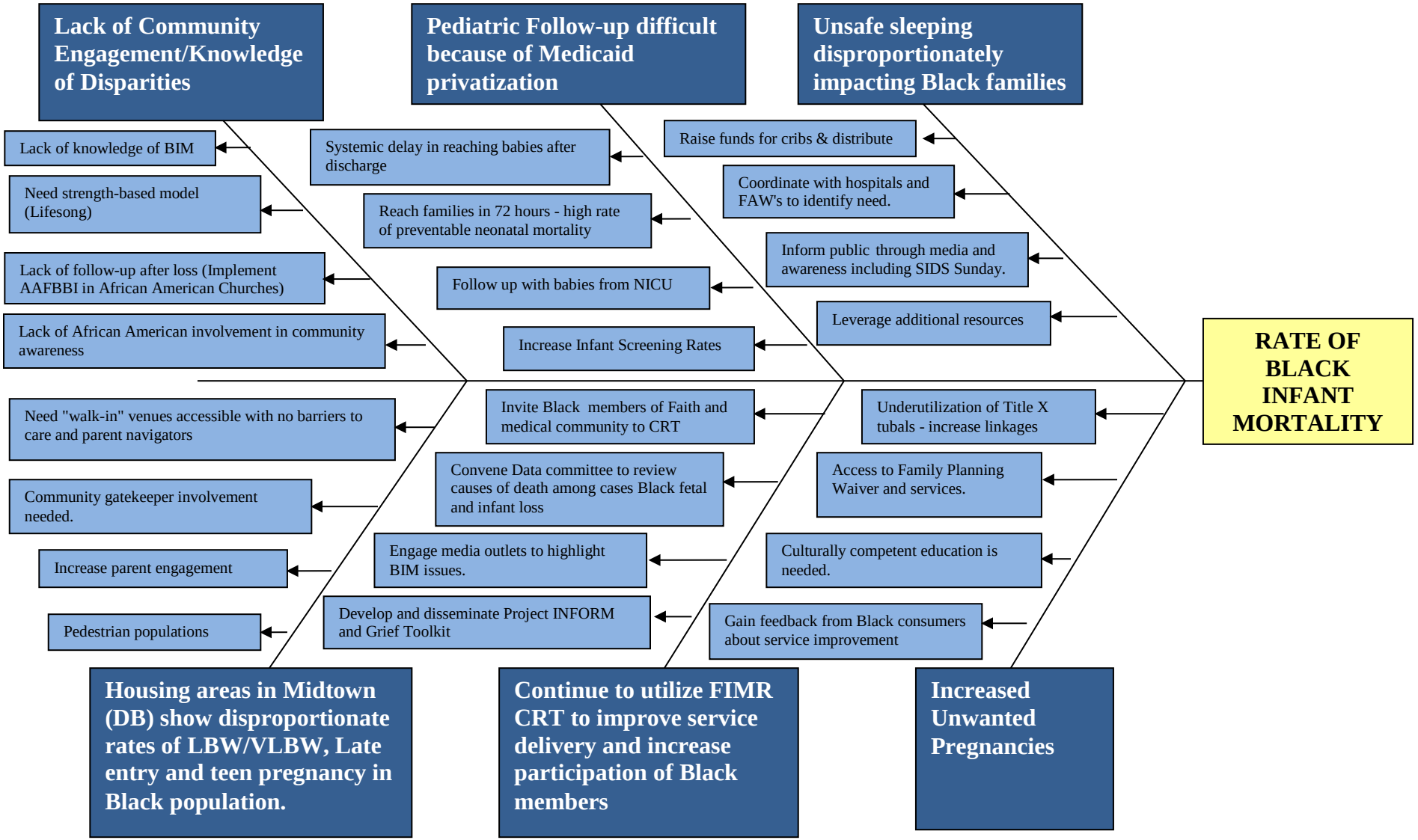
Please refer to our website at: www.healthystartfv.org

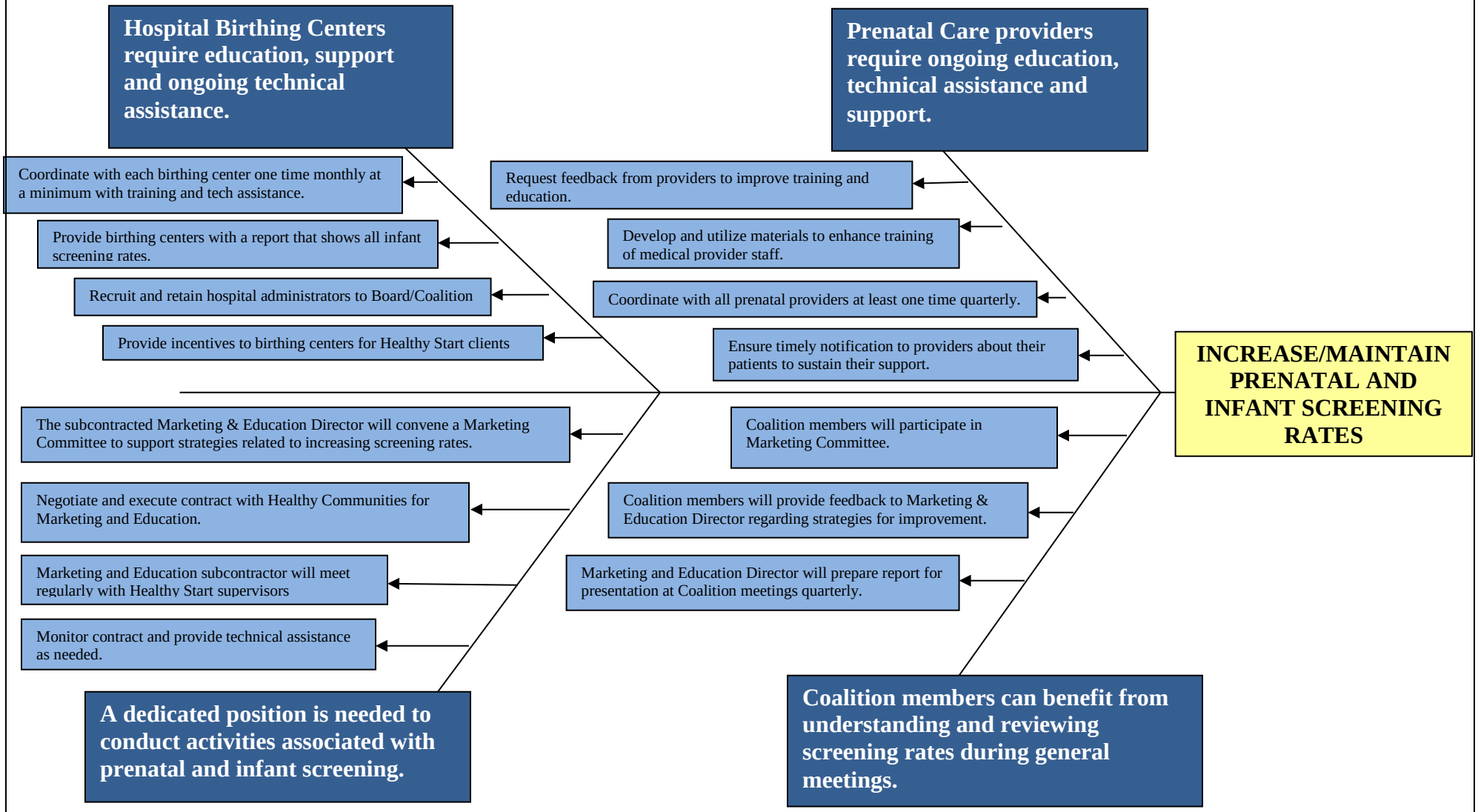
Resource Guide is updated regularly and changes frequently.

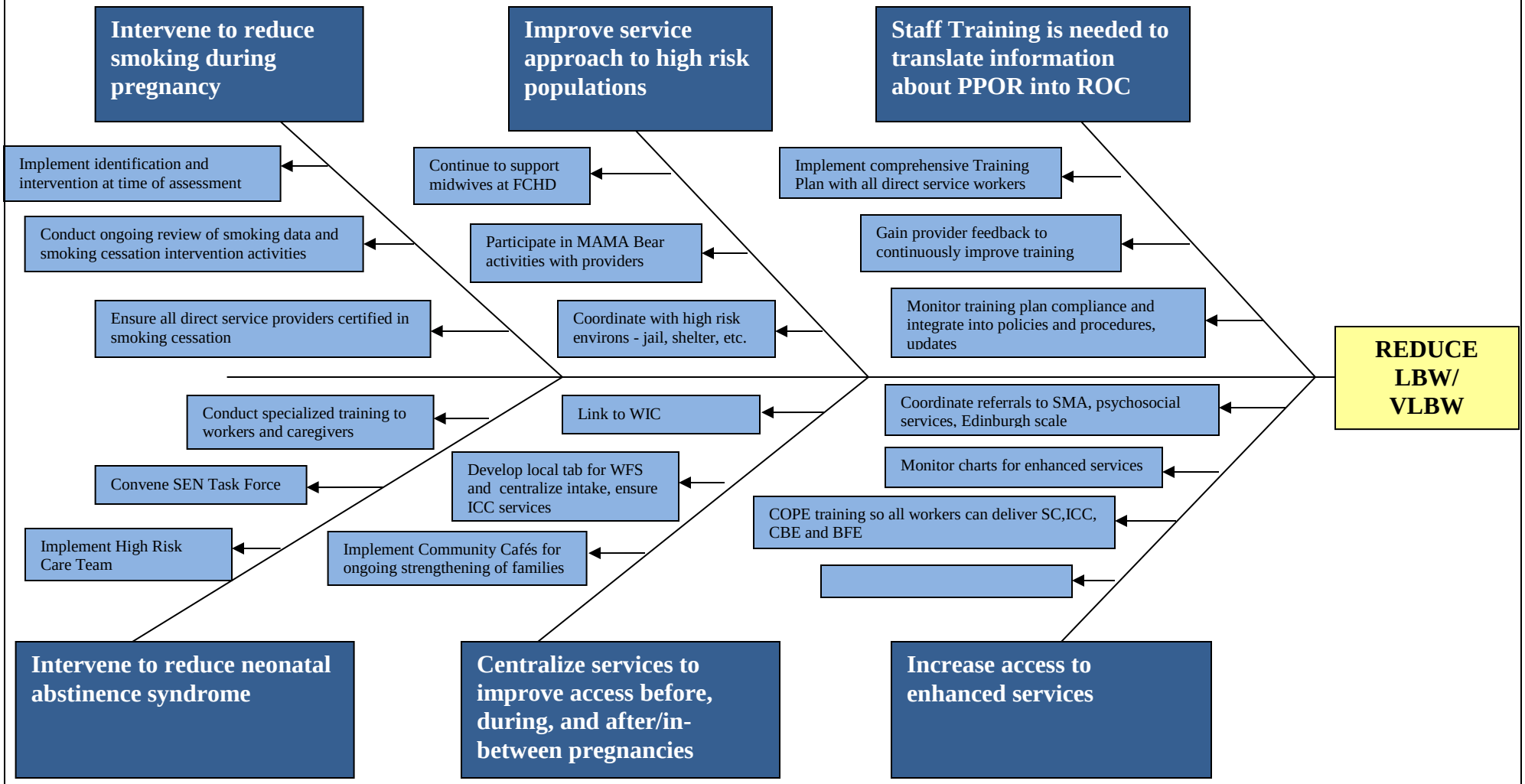
Appendix G – Fishbone Analysis




Education of Providers, Patients, and Community at large
Contract with Healthy Communities
Convene Marketing Experts in a committee to develop and implement a community-wide plan
Develop/implement community-wide training plan
Implement "Access Centers" for families to connect to with multi-agency partnership coordination
Conduct consumer feedback and engagement events/activities
Increase parent engagement
Participate in tb5
Consumers report fragmented and complicated system of care
Pediatric Follow-up difficult because of Medicaid privatization
Systemic delay in reaching babies after discharge
Reach families in 72 hours - high rate of preventable neonatal mortality
Follow up with babies from NICU
Increase Infant Screening Rates
Increase FIMR
SIDS Sunday
Media engagement
Develop and disseminate Project INFORM and Grief Toolkit
Continue to utilize FIMR CRT to improve service delivery
Unsafe sleeping
Raise funds for cribs & distribute
Coordinate with hospitals and FAW's to identify need.
Inform public through media and awareness including SIDS Sunday.
Leverage additional resources
Underutilization of Title X tubals - increase linkages
Access to Family Planning
Undocumented afraid of I.D.
ICC education
Increased Unwanted Pregnancies
RATE OF INFANT MORTALITY


Lack of Community Engagement/Knowledge of Disparities
Pediatric Follow-up difficult because of Medicaid privatization
Unsafe sleeping disproportionately impacting Black families
Lack of knowledge of BIM
Need strength-based model (Lifesong)
Lack of follow-up after loss (Implement AAFBBI in African American Churches)
Lack of African American involvement in community awareness
Systemic delay in reaching babies after discharge
Reach families in 72 hours - high rate of preventable neonatal mortality
Follow up with babies from NICU
Increase Infant Screening Rates
Raise funds for cribs & distribute
Coordinate with hospitals and FAW's to identify need.
Inform public through media and awareness including SIDS Sunday.
Leverage additional resources
RATE OF BLACK INFANT MORTALITY
Need "walk-in" venues accessible with no barriers to care and parent navigators
Community gatekeeper involvement needed.
Increase parent engagement
Pedestrian populations
Invite Black members of Faith and medical community to CRT
Convene Data committee to review causes of death among cases Black fetal and infant loss
Engage media outlets to highlight BIM issues.
Develop and disseminate Project INFORM and Grief Toolkit
Underutilization of Title X tubals - increase linkages
Access to Family Planning Waiver and services.
Culturally competent education is needed.
Gain feedback from Black consumers about service improvement
Housing areas in Midtown (DB) show disproportionate rates of LBW/VLBW, Late entry and teen pregnancy in Black population.
Continue to utilize FIMR CRT to improve service delivery and increase participation of Black members
Increased Unwanted Pregnancies


Hospital Birthing Centers require education, support and ongoing technical assistance.
Coordinate with each birthing center one time monthly at a minimum with training and tech assistance.
Provide birthing centers with a report that shows all infant screening rates.
Recruit and retain hospital administrators to Board/Coalition
Provide incentives to birthing centers for Healthy Start clients
Prenatal Care providers require ongoing education, technical assistance and support.
Request feedback from providers to improve training and education.
Develop and utilize materials to enhance training of medical provider staff.
Coordinate with all prenatal providers at least one time quarterly.
Ensure timely notification to providers about their patients to sustain their support.
INCREASE/MAINTAIN PRENATAL AND INFANT SCREENING RATES
The subcontracted Marketing & Education Director will convene a Marketing Committee to support strategies related to increasing screening rates.
Negotiate and execute contract with Healthy Communities for Marketing and Education.
Marketing and Education subcontractor will meet regularly with Healthy Start supervisors
Monitor contract and provide technical assistance as needed.
Coalition members will participate in Marketing Committee.
Coalition members will provide feedback to Marketing & Education Director regarding strategies for improvement.
Marketing and Education Director will prepare report for presentation at Coalition meetings quarterly.
A dedicated position is needed to conduct activities associated with prenatal and infant screening.
Coalition members can benefit from understanding and reviewing screening rates during general meetings.


Intervene to reduce smoking during pregnancy
Improve service approach to high risk populations
Staff Training is needed to translate information about PPOR into ROC
Implement identification and intervention at time of assessment
Continue to support midwives at FCHD
Implement comprehensive Training Plan with all direct service workers
Conduct ongoing review of smoking data and smoking cessation intervention activities
Participate in MAMA Bear activities with providers
Gain provider feedback to continuously improve training
Ensure all direct service providers certified in smoking cessation
Coordinate with high risk environs - jail, shelter, etc.
Monitor training plan compliance and integrate into policies and procedures, updates
REDUCE LBW/ VLBW
Conduct specialized training to workers and caregivers
Link to WIC
Coordinate referrals to SMA, psychosocial services, Edinburgh scale
Convene SEN Task Force
Develop local tab for WFS and centralize intake, ensure ICC services
Monitor charts for enhanced services
Implement High Risk Care Team
Implement Community Cafés for ongoing strengthening of families
COPE training so all workers can deliver SC,ICC, CBE and BFE
Intervene to reduce neonatal abstinence syndrome
Centralize services to improve access before, during, and after/in-between pregnancies
Increase access to enhanced services

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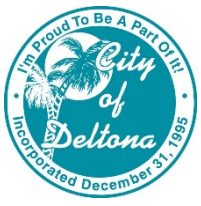

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