# Service Delivery Plan 2021-2026

Healthy Start Coalition of Seminole County, Inc.

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# ACKNOWLEDGMENTS

We would like to thank the community leaders who devoted their time and talent to assist the Healthy Start Coalition of Seminole County, Inc. in developing this five-year maternal and child health service delivery plan.

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**Janelle Dunn, MHA, CPME** – CEO True Health

Additionally, thank you to the families who gave of their time and knowledge in this process, as well as the Healthy Start Program. The Program has been a fundamental part of this process, and their continued dedication to improving the outcomes of our families exemplifies the purpose of why we all do this work.

We thank everyone for their tireless efforts and continued work for health equity in Seminole County.

# INTRODUCTION

This plan is the culmination of our community health needs assessment, an analysis of our current resources, examination of our challenges and strengths, and identification of service gaps and barriers to care. The outcomes of these assessments enabled the development of tangible priorities and corresponding action plans designed to improve birth outcomes for all women.

Our coalition consists of many members who together represent every aspect of our county. The task of completing this plan would not have been possible without their dedication of time, expertise, and desire to improve the health outcomes of our families in Seminole County. Our stakeholders are inclusive of the public and private sector, social services, public health, local medical societies, civic organizations, and mental health, hospital, education, consumer, and business sectors.

Seminole County has faced many new challenges in past year related to the COVID-19 pandemic. Amid these new obstacles, we hold steadfast to our commitment to do what is best for our families. We acknowledge that we have still been able to move forward in this new environment but must be realistic that the journey ahead may be longer and more difficult. The dedication of our collaborative community is an invaluable resource as we all work to address the challenges that lie ahead.

## History

Seminole County established its first Healthy Start Coalition in 1992. It operated successfully until 2008. The Florida Department of Health in Seminole County resumed the coalition's duties in-house and assigned a staff person to begin the rebuilding process, with the goal of returning the coalition to community governance. As a result of these actions, the community was reengaged, and reestablishment of the coalition occurred in 2010. The Coalition's proposal for funding was successfully accepted by the Florida Department of Health Program office, and it began its administrative operations in 2011. Unfortunately, due to unforeseen circumstances, the coalition did not execute its full direct services contract and thus the program did not come to fruition until 2 years later. In 2013, The Florida Department of Health in Seminole County hired a Community Program Manager to facilitate the process of engaging community members around the need to reestablish a Healthy Start Coalition. The Community Program Manager identified and met with a variety of community leaders, stakeholders, and key community informants securing their commitment to assist with the process. Several informative community meetings were held to educate the community on maternal and child health issues, including infant morbidity and mortality, low birth weight, and prematurity. Distribution of surveys at community health fairs was designed to gather community member input on their perceived health and social needs. Community members also agreed to support and assist in the establishment of a Healthy Start Coalition. Resulting from a series of follow-up meetings, a core infrastructure was developed, and the coalition was formed.

The Florida Department of Health (FDOH) issued an RFA for the establishment of a Healthy Start Coalition in 2014. Community members joined together to prepare and submit a response to the RFA. The response was reviewed and favorably accepted by FDOH. The coalition then began its administrative planning year. The body of the coalition utilized Mobilizing for Action through Planning and Partnership (MAPP) as the chosen strategic planning process to identify and address the maternal and child health needs in Seminole County. This process allowed for the community to focus on systems while utilizing the data provided from all resources to formulate a

strategic plan. The coalition focused on ensuring that there was diversity throughout the process and that we acknowledged the current collaborations and partnerships that are already work in our community. The coalition has continued with all tasks associated with developing a community-based, data-driven, Service Delivery Plan. This five-year plan, based upon the MAPP process, will assist us in creating a stronger community that will increase positive outcomes within the areas of maternal and child health, health disparities, and social inequities.

We embrace utilizing a life-course "from the cradle to the grave" approach to improve the health of our families in Seminole County; this approach includes a focus on health disparities, particularly in the areas of black infant mortality, low birth weight births, and preconception and inter-conception care. We recognize that much of this work is done within the community and will also influence our prenatal and postnatal screening rates. The life-course model broadens the focus of maternal and child health to include not only health but also social justice. Many factors, highlighted in our fishbone analysis, such as socioeconomic factors, nutrition, and accessibility, are factors that have a disproportionately negative impact on racial and ethnic minorities.

The coalition adopted a new mission, purpose, and vision statement that will guide our activities and commitment to our families. This service-delivery plan outlines our commitment in its entirety. We are confident that this plan will serve as a continuation for our work in the community. We will evolve and grow as we work to improve the lives of all our families, which will ensure that "every baby will blossom."

# PRIMARY DATA COLLECTION

## Connect Program Provider Survey Results

The Connect Program identifies needs and links families to the programs that best serve them. This coordinated intake and referral process ensures the best fit for families and streamlines access to services. It also increases program enrollment and retention rates, reduces duplication of efforts, and builds a broader early childhood system of care in Florida.

Connect helps pregnant women, caregivers, and families with young children by providing a one-stop entry point for needed services, such as education and support in childbirth, newborn care, parenting, child development, food and nutrition, mental health, and financial self-sufficiency.

Services

- Pregnancy education and support
- Childbirth education
- Newborn care instruction
- Breastfeeding education and support
- Parenting education and support
- Counseling services
- Help to quit smoking
- Nutritional education
- School readiness
- Child development education and support
- Family planning education
- Car seat safety
- Infant safety
- Home visiting programs
- Other community resources

Seventeen providers participated in a survey to gather insight on the Connect Program.

Most of the providers who completed the survey were in a private group or single practice. Most patients completed the screen in the office. Over ninety percent of providers accepted self-pay and Medicaid patients. Those accepting high-risk patients accounted for 87.5 percent of providers who completed the survey. Most provider offices had bilingual staff. Of the providers surveyed, 76.5 percent were not aware that they could be a part of the Healthy Start Coalition.

The results of the survey questions are found below.

Figure 1: Which of the following best describes this practice?

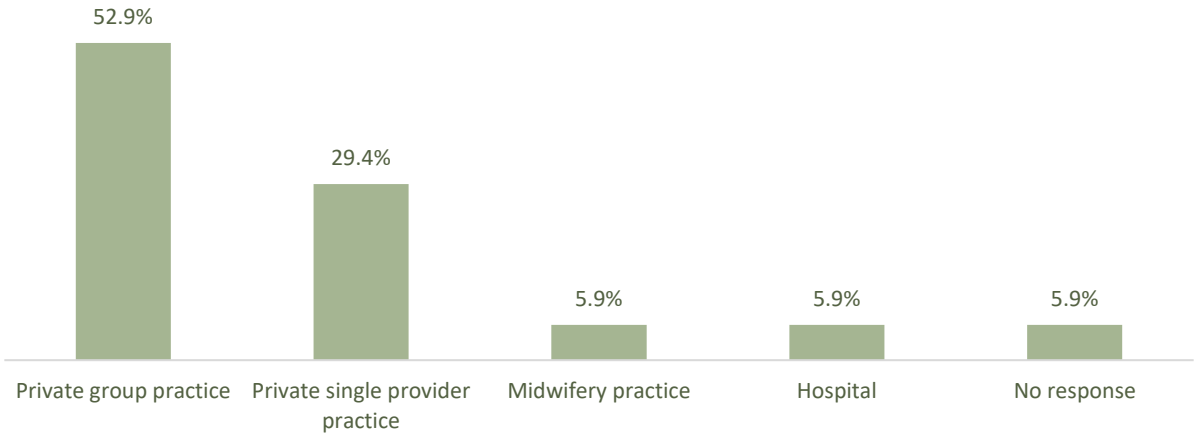



Figure 2: Who is completing this survey?

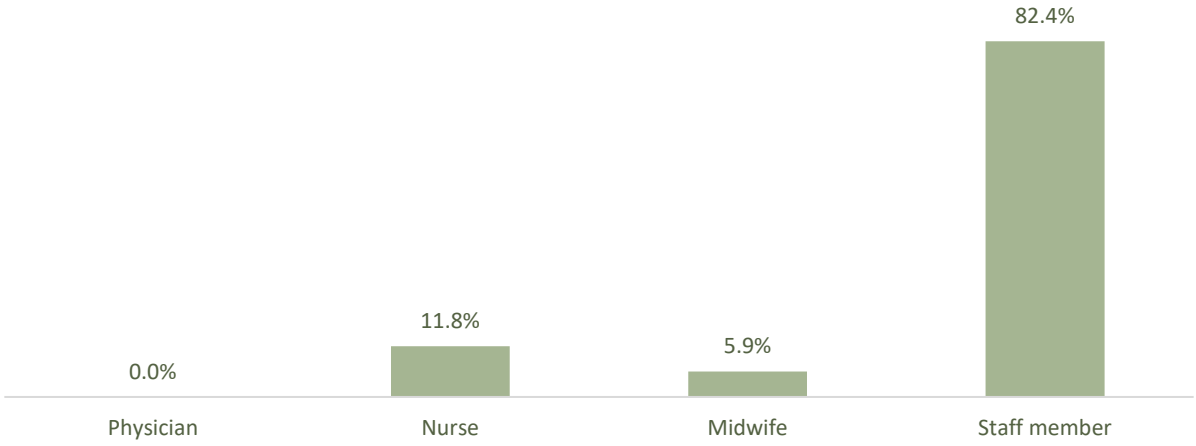



Figure 3: Are you familiar with the Connect program services?

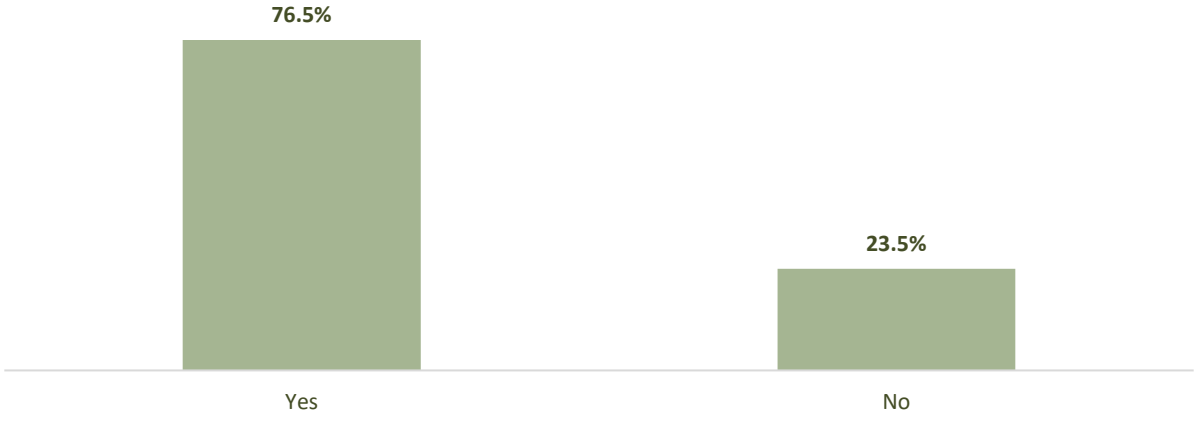
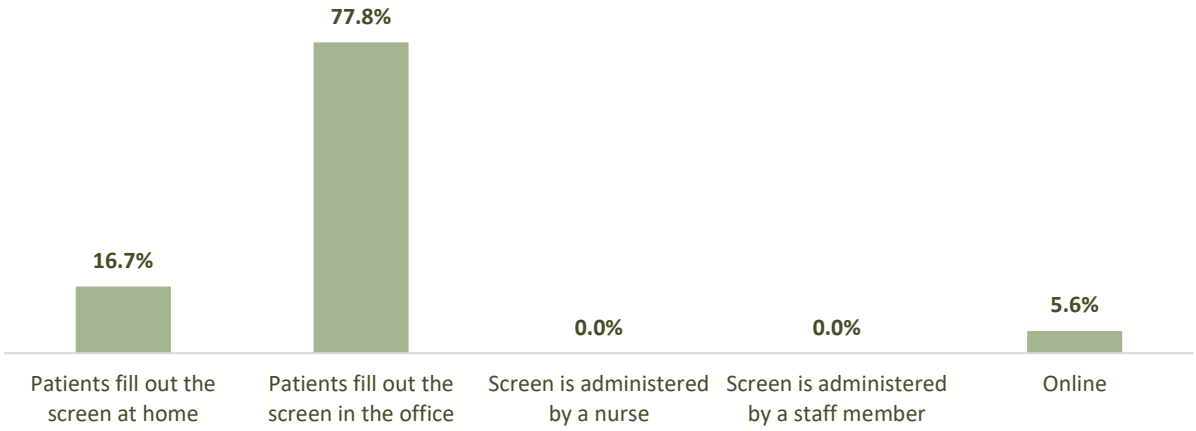


Figure 4: How is the Healthy Start Prenatal/Infant Screen administered?

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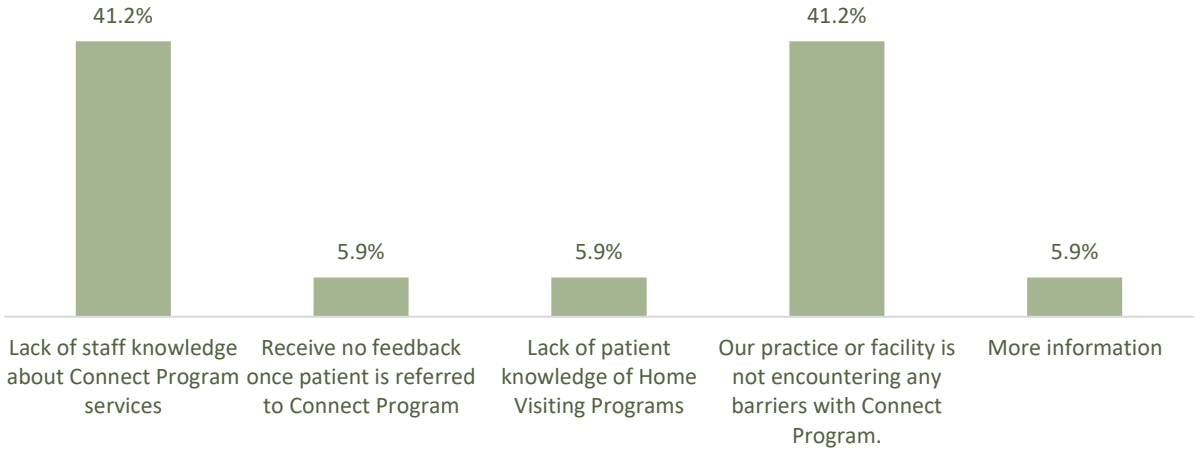



Figure 6: Do you accept self-pay patients?

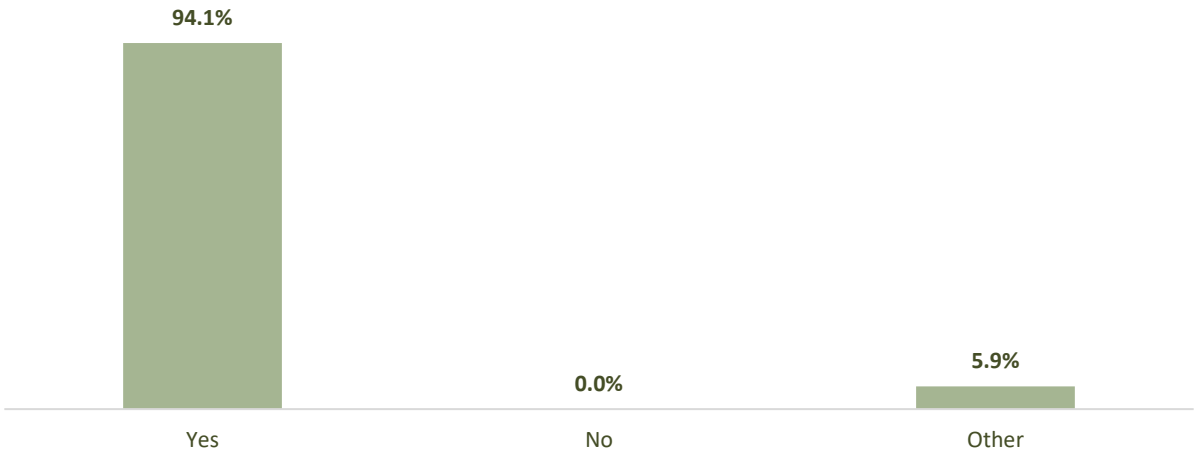


Figure 7: Does this practice or facility accept patients who are experiencing high-risk pregnancies?

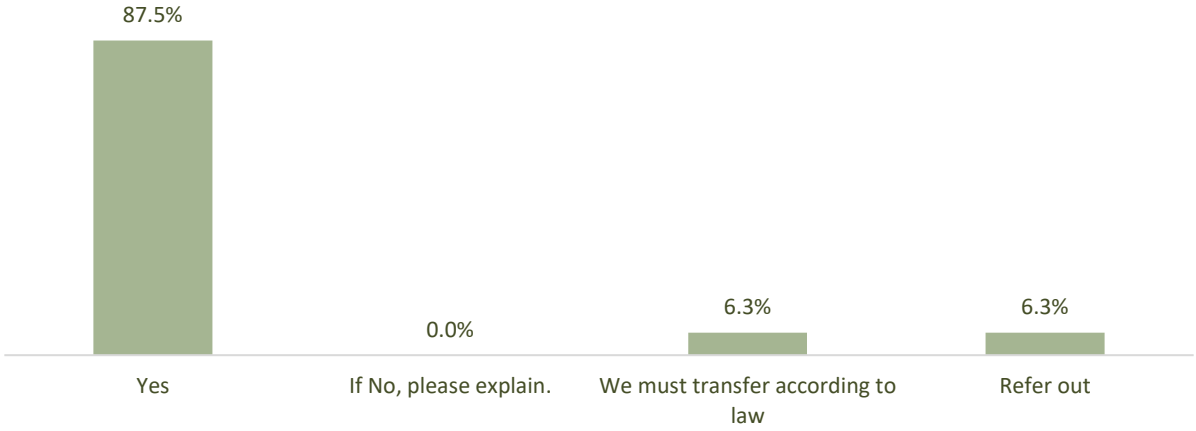
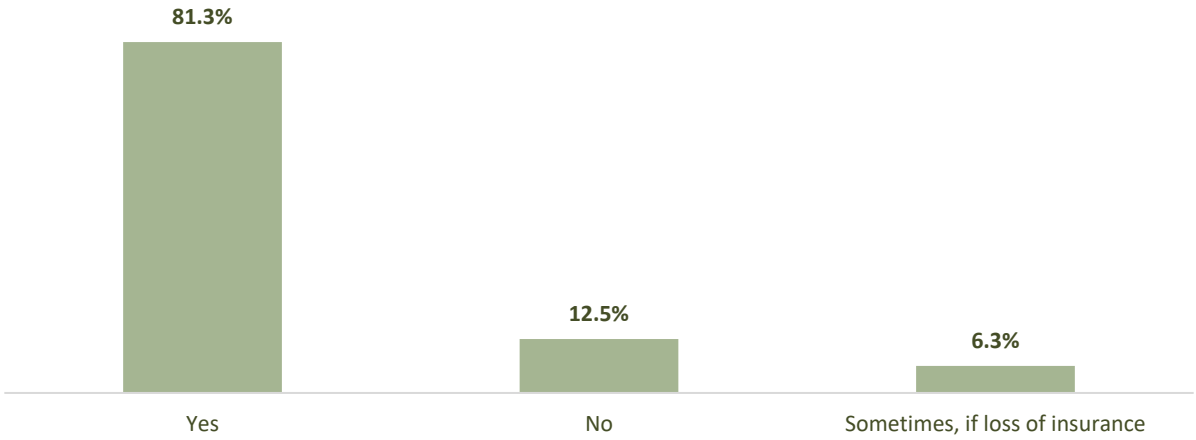



Figure 8: Do you accept patients with Medicaid?

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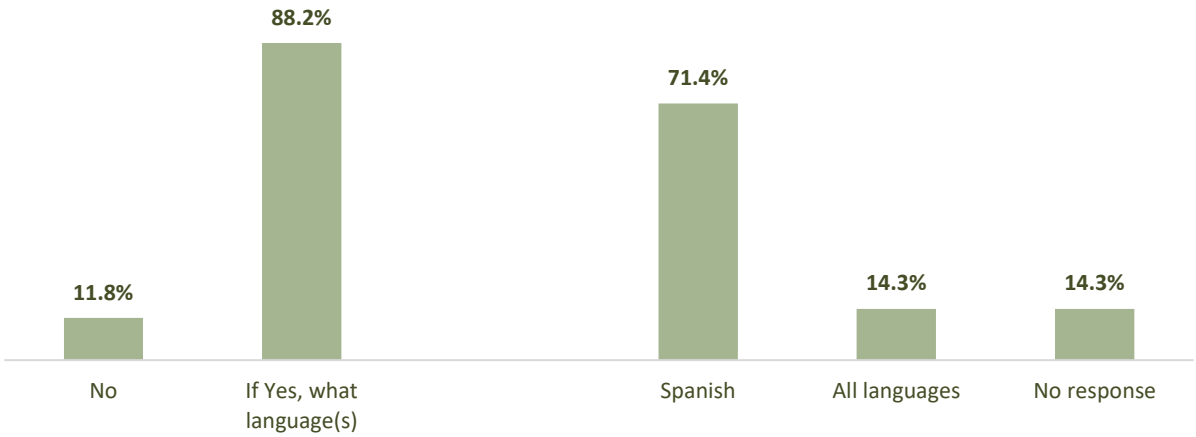


Figure 10: Did you know that you can be part of the Healthy Start Coalition of Seminole County, Inc., by joining our FIMR team, by becoming a general member, or by volunteering with our various program components?

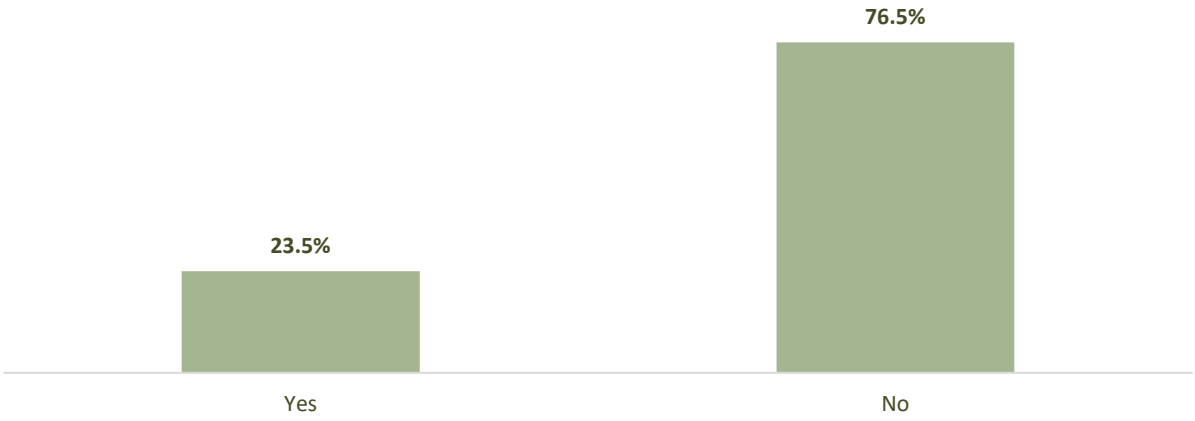
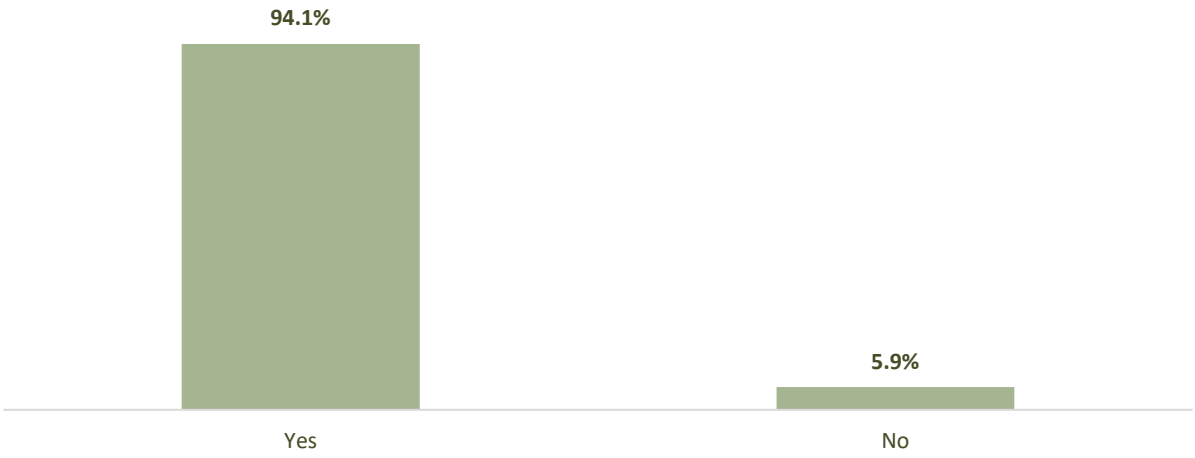



Figure 11: The distribution of additional materials provided by the Community Liaison related to Prenatal and Infant Care has benefitted your patients.




Providers were asked for the top 3 complaints or concerns they hear from clients regarding their pregnancies and or care of their newborn child. Although more than fifty percent of providers responded with n/a, none or nothing, the remaining providers cited transportation, cost, childcare, and nausea as complaints/concerns.

Forty percent of providers responded when asked for the overall reasons for participating in a home visiting program. They listed assistance with baby, extra help, care, and resources.

When asked about some of the misinformation and myths about the home visiting programs in Seminole County, some providers stated that the perceptions were that the program is only for low income and that it is intrusive. Most providers did not offer any information for this question.

Providers were also asked for strategies that would help with enrollment into the home visiting program. One provider suggested explaining in detail helps with enrollment and one provider stated education about the program.

The top 3 health disparities cited by the providers were lack of knowledge/information, finances, and importance of prenatal care.

## Consumer Survey Results

The Healthy Start Coalition of Seminole County, Inc., administered a client survey in 2021. They received responses from 91 community members. The survey was distributed in English and Spanish through an electronic link. Most residents surveyed were familiar with the Healthy Start Coalition. Major barriers to accessing healthcare services for themselves included medical insurance, social support, and hours of services. Other responses to barriers included the lack of available Medicaid providers, cost of care, assistance for formula and diapers, and home health support. Regarding barriers when seeking care for their children, responses were similar with hours of services, medical insurance, and transportation cited as obstacles. Almost sixty percent of respondents did not know if there were gaps in care that pregnant women face. Over eighty-five percent of respondents had not encountered trouble getting an appointment with an obstetrician.

The needs expressed by respondents for what would help the infants and pregnant mothers is summarized below.

- Resources – increased awareness of available educational programs, a focus on the special needs of first-time moms, support groups, and the creation of a centralized data source where information can be easily accessed.
- Support – financial, emotional, physical, postpartum, and supplies for baby.
- Medical care – need more providers who accept Medicaid, offer high-risk care, and expanded hours of service.
- Educational – need educational classes for all aspects of pregnancy that covers the prenatal period up to the child's first birthday.

Figure 12: Are you familiar with Healthy Start Program Services?

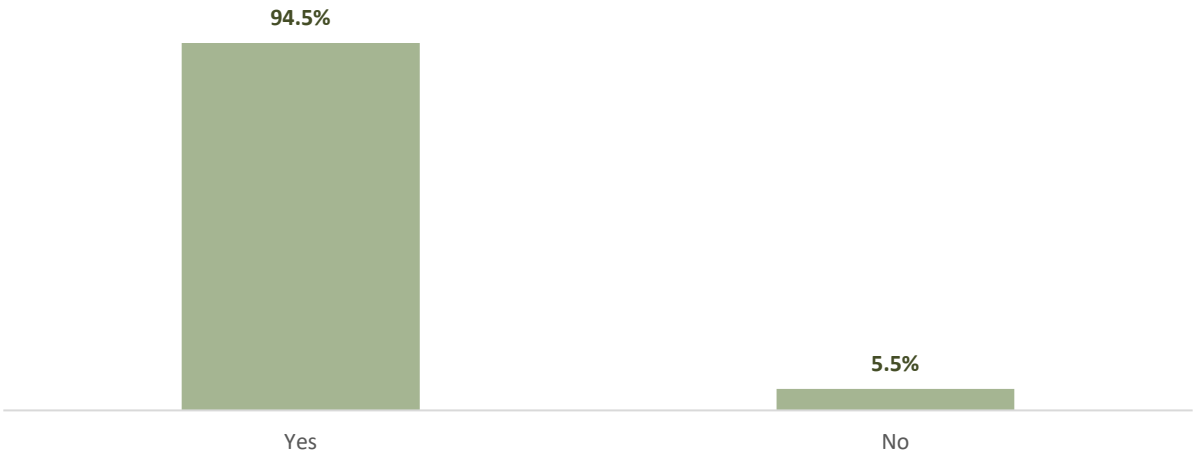


Figure 13: What are the problems that you have had when looking for health care services for yourself?

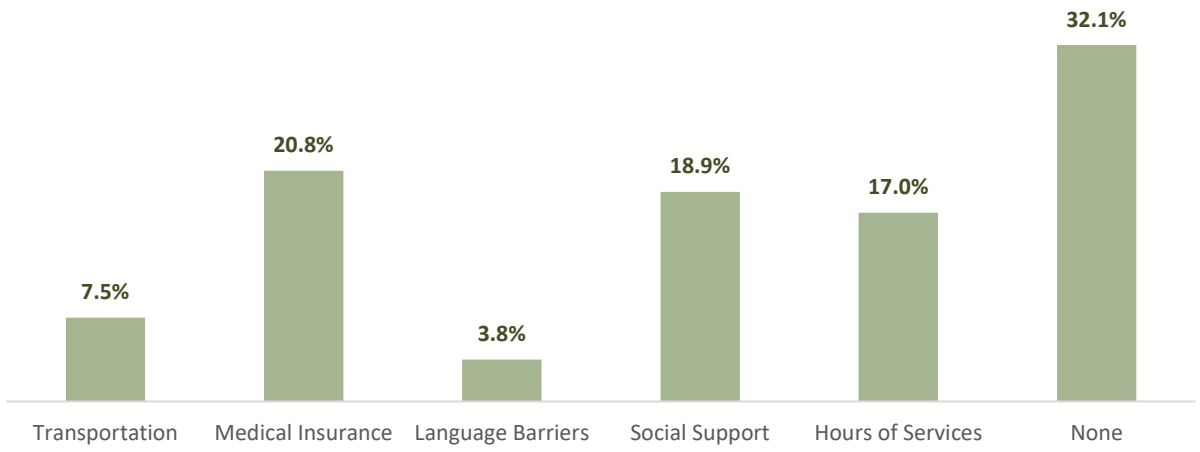



Figure 14: What are the problems you have had when looking for health care services for your children?

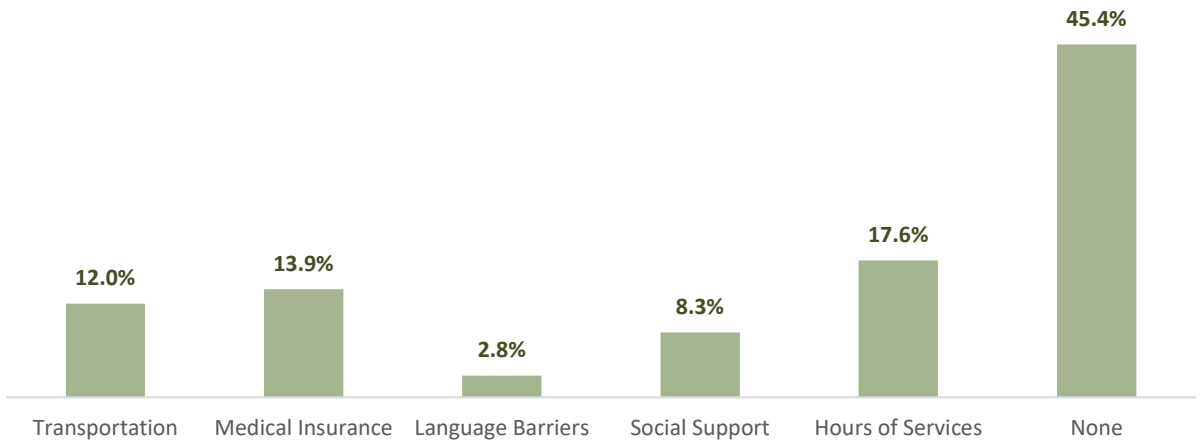



Figure 15: Are there gaps in the care that pregnant women in your community face?

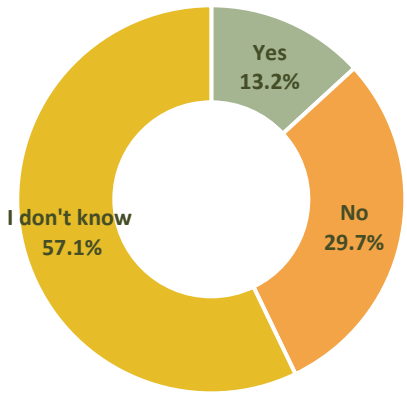


Figure 16: Are you having trouble getting an appointment with an obstetrician?

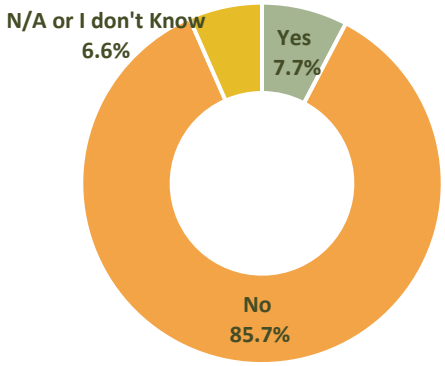



Figure 17: Respondents by Gender

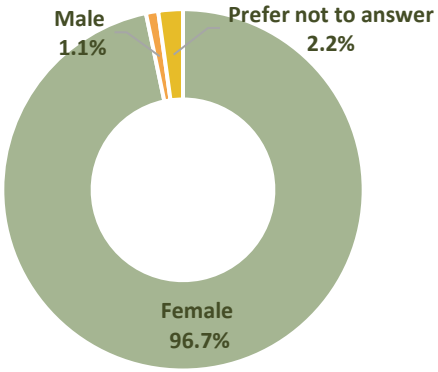



Figure 18: Respondents by Race and Ethnicity

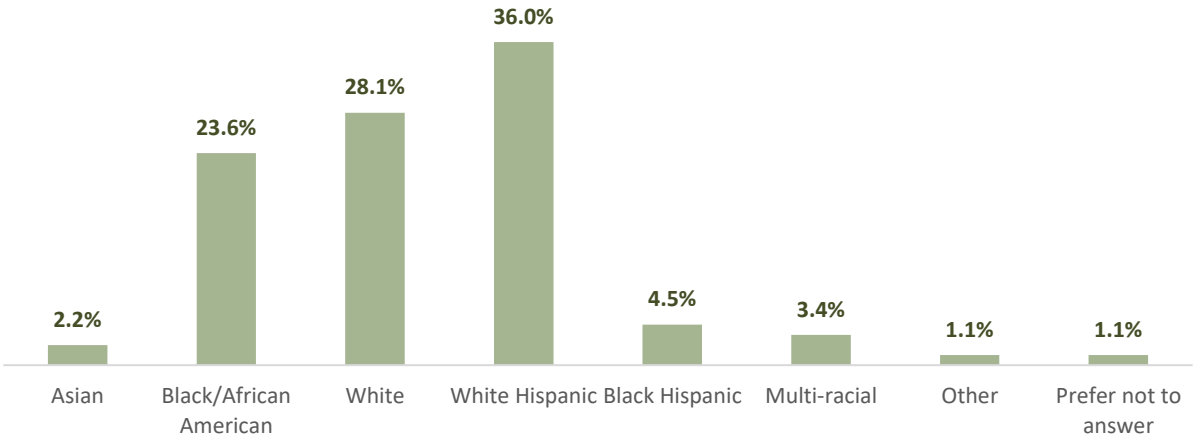


Figure 19: Respondents by Age Range

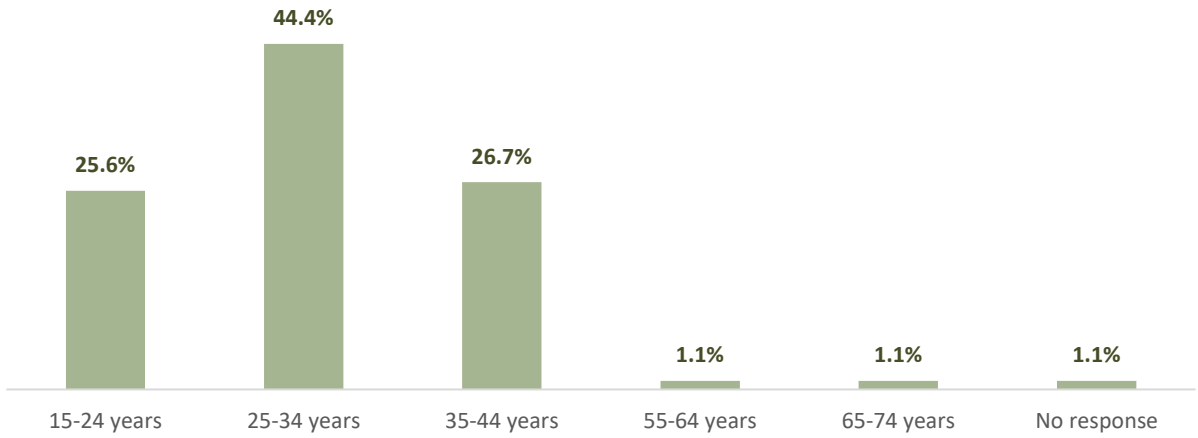



Figure 20: Respondents by Municipality

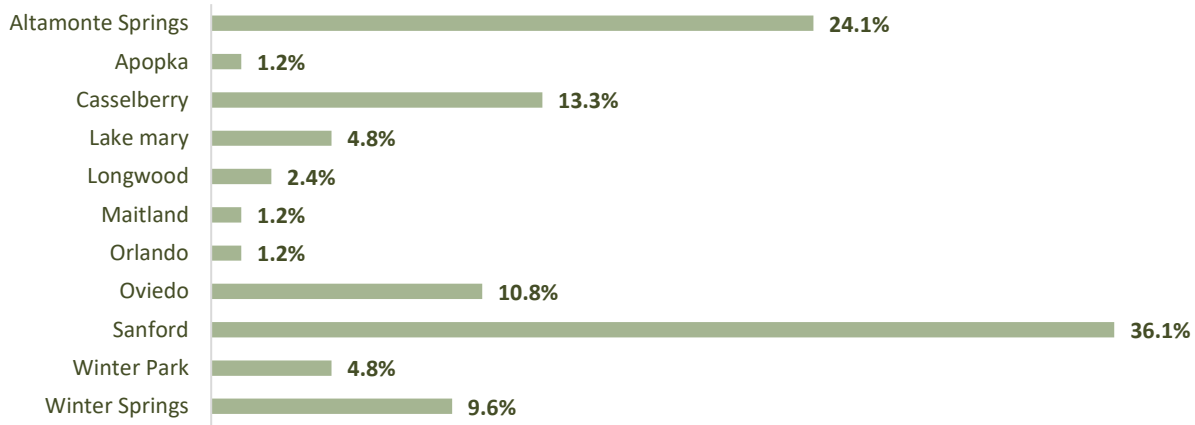
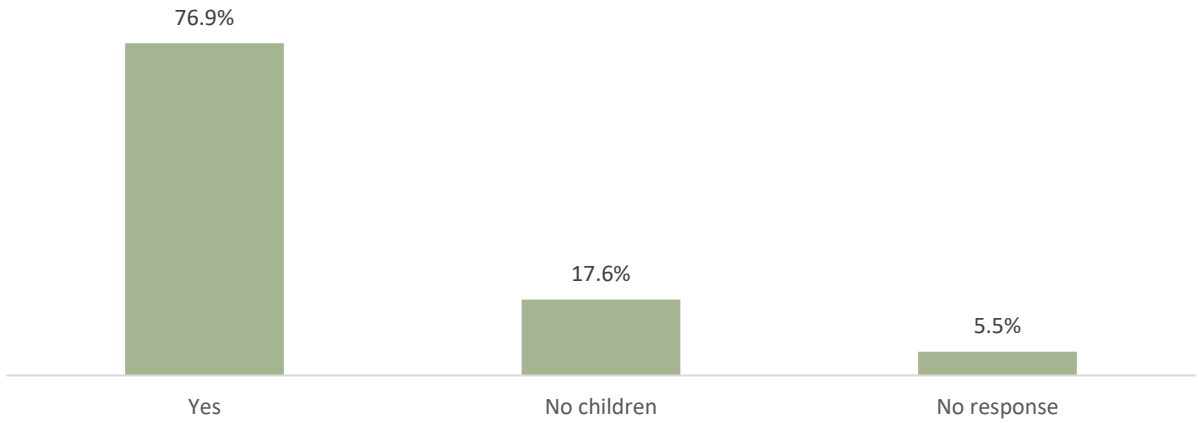



Figure 21: Do you have children ages 0-3 years living in your house?



# SECONDARY DATA COLLECTION

> **“**Research has shown that a web of biological, environmental, economic, social, and psychosocial factors influenced perinatal health outcomes. To effectively understand, address, and affect these potential casual factors, Healthy Start Coalitions should continuously identify and assess the varied factors within the catchment areas that impact systems of perinatal care and perinatal health outcomes.” Healthy Start Standards & Guidelines, Chapter 26.

Social Determinants of Health | Healthy People 2020 (included in our website)

Social Determinants of Health - Healthy People 2030 | health.gov

“Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.” Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed]

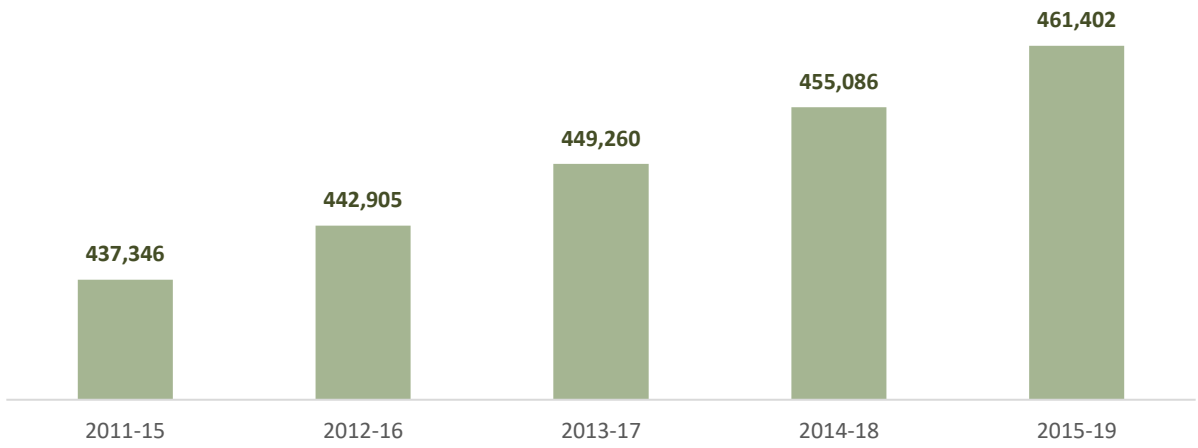
Additional poverty data for Seminole County can be found at: www.unitedforalice.org.

ALICE, is an acronym for **A**sset **L**imited, **I**ncome **C**onstrained, **E**mployed. This data site provides a new way of defining and understanding the struggles of households that earn above the Federal Poverty Level (FPL), but not enough to afford a bare-bones household budget.

## Demographics

The population in Seminole County has increased 5.5 percent in the past five years. A total of 461,402 residents currently live in the county. Gender distribution is almost evenly split between females and males. Racially, 78.6 percent of the population is White; 13.1 percent are Black/African American; 5.0 percent are Asian; 2.9 percent are two or more races and 0.6 percent are Other. The Hispanic population accounts for 22.5 percent of all residents. Seminole County is slightly less diverse racially and ethnically when compared to Florida. Adults, ages 45-64 years of age comprise 26.8 percent of the population. Those below 18 years of age accounted for 21.0 percent as did those 30-44 years of age. Seminole County has a younger population than that of the state.

Figure 22:Seminole County Population, 2011-2015

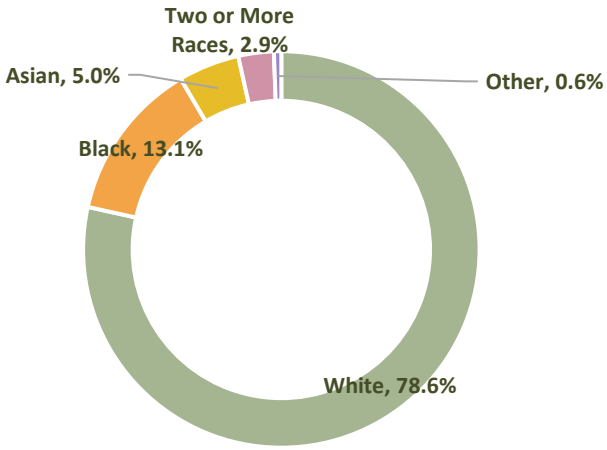



Source: U.S. Census Bureau

Figure 23:Seminole County Population by Gender, 2015-2019

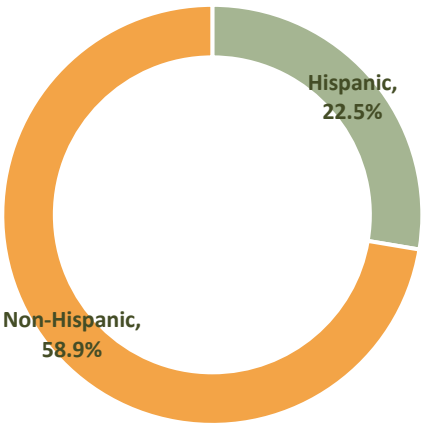

Source: U.S. Census Bureau

Figure 24: Seminole County Population by Race, 2015-2019



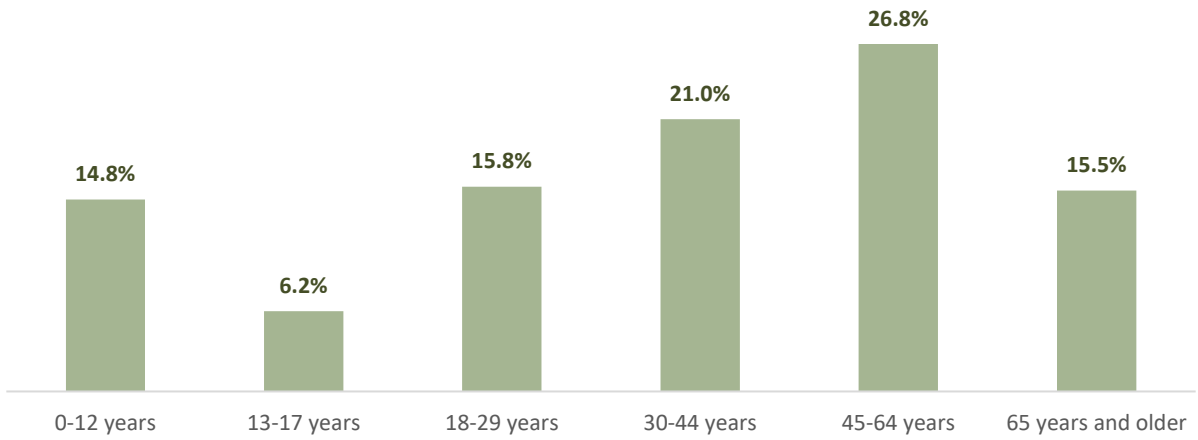

Source: U.S. Census Bureau

Figure 25: Seminole County Population by Ethnicity, 2015-2019




Source: U.S. Census Bureau

Figure 26: Seminole County Population by Age Range, 2015-2019




Source: U.S. Census Bureau

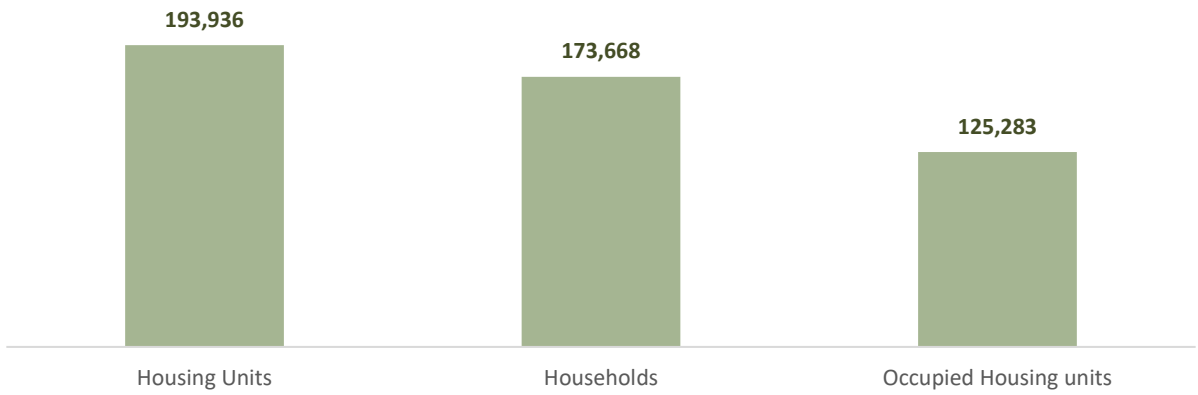
## Social Determinants

### HOUSING

Housing plays a big role in the health of a community population. Healthy and safe homes promote good physical and mental health while decreasing overall health costs. A total of 193,936 housing units were available during 2015-2019. Of these 173,668 were occupied households where 64.6 percent were owner-occupied, and 35.4 percent were rented. The percentage of single parent households in Seminole County decreased from 30.4 percent in 2015 to 29.3 percent in 2019.

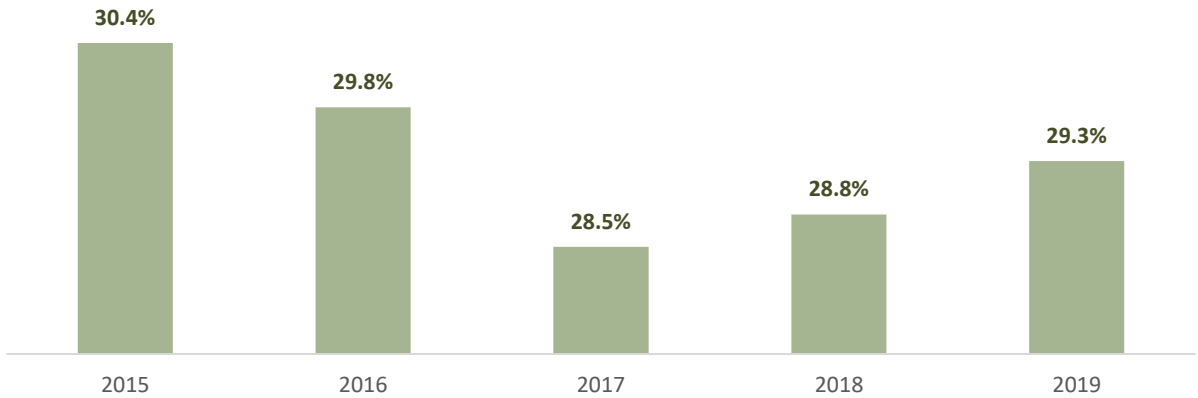
Adults and children in single-parent households are at a higher risk for poor health outcomes including emotional and behavioral issues when compared to those in two-parent homes. Children are more likely to develop depression, use tobacco products, and abuse alcohol and/or other substances. Consequently, these children experience increased risk of morbidity and mortality from all causes. Similarly, single parents suffer from lower perceived health and higher risk of mortality.

Figure 27: Housing Units and Status, 2015-2019




Source: U.S. Census Bureau

Figure 28: Percentage of Single Parent Households, 2015-2019

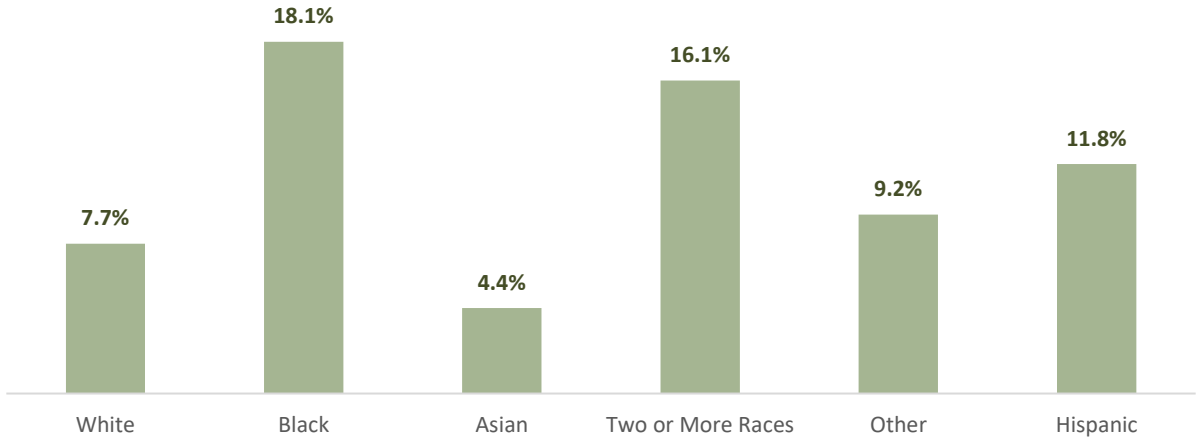



Source: U.S. Census Bureau

## POVERTY

The U.S. Census Bureau determines the federal poverty thresholds each year. These thresholds vary by the size of family and the ages of family members. A high poverty rate is both a cause and a consequence of poor economic conditions. A high poverty rate may indicate that local employment opportunities are not sufficient to provide for the local community. In 2019, poverty status was determined for 9.3 percent of the population in Seminole County. This was lower than the state rate at 12.7 percent. There is a wide gap when comparing poverty rates across racial and ethnic groups. Poverty among the Asian (4.4 percent) and White (7.7 percent) population was much lower when compared to the Black population at 18.1 percent and those with Two or More Races at 16.1 percent. Among the Hispanic population, 11.8 percent were living in poverty. These same trends were noted when comparing the county percentages to those in the state.

Figure 29: Percentage of Poverty Among Population Groups, 2019

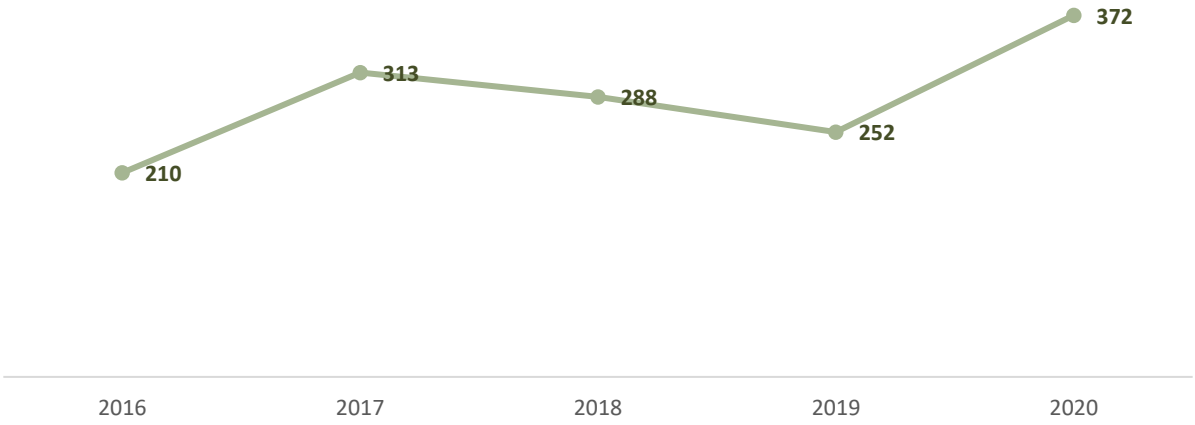



Source: U.S. Census Bureau

## HOMELESSNESS

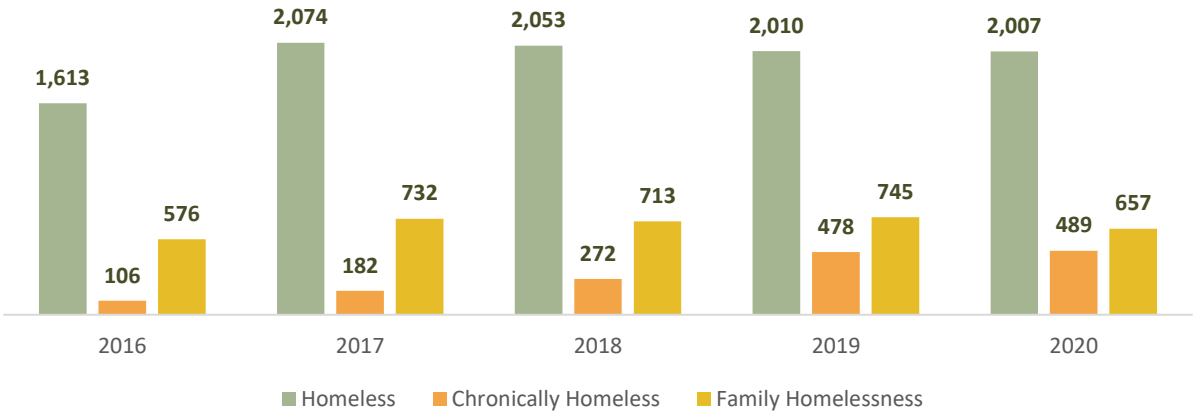
Homelessness is considered a significant public health issue as individuals experience increased rates of morbidity and mortality when compared to the general population. The Florida Department of Children and Families identified 372 homeless residents in the point-of-time county in 2020. This was an increase from count in 2016, where 210 residents were homeless. In the tri-county area of Orange, Osceola and Seminole counties, the number of homeless, chronically homeless and family homelessness has increased over the past five years.

Figure 30: Point-in-Time Homeless County, 2016-2020




Source: Florida Department of Children and Families, Annual Council on Homelessness 2020 Report

Figure 31: Tri-County Homelessness Count, 2016-2020

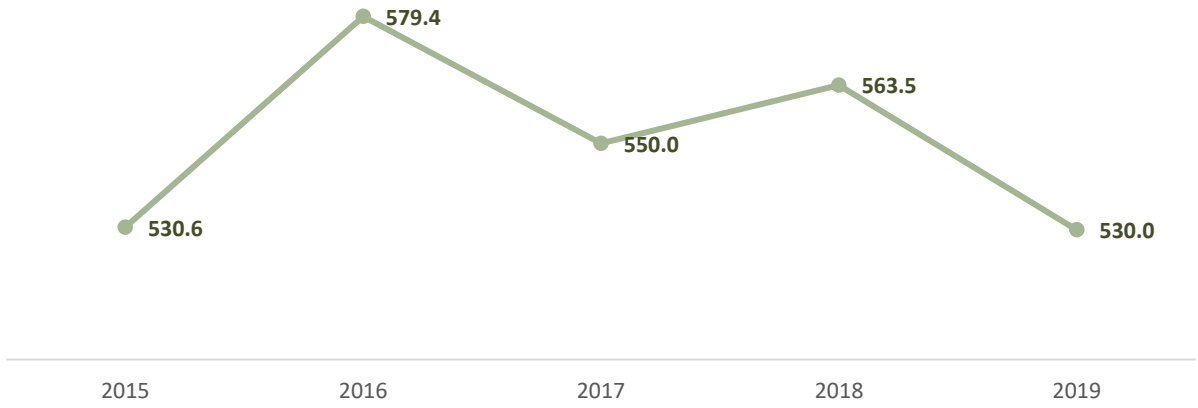



Source: Florida Department of Children and Families, Annual Council on Homelessness 2020 Report

## DOMESTIC VIOLENCE

Domestic violence is any criminal offense resulting in physical injury or death of one family or household member by another family or household member, including assault, battery, sexual assault, sexual battery, stalking, kidnapping, or false imprisonment. Statistics from the Florida Department of Law Enforcement showed the increase and decrease in rates over the past five years. The rates, per 100,000 population, were identical in 2015 and 2019.

Figure 32: Domestic Violence Offence Rate in Seminole County, 2015-2019




Source: Florida Department of Law Enforcement

## Mortality Indicators

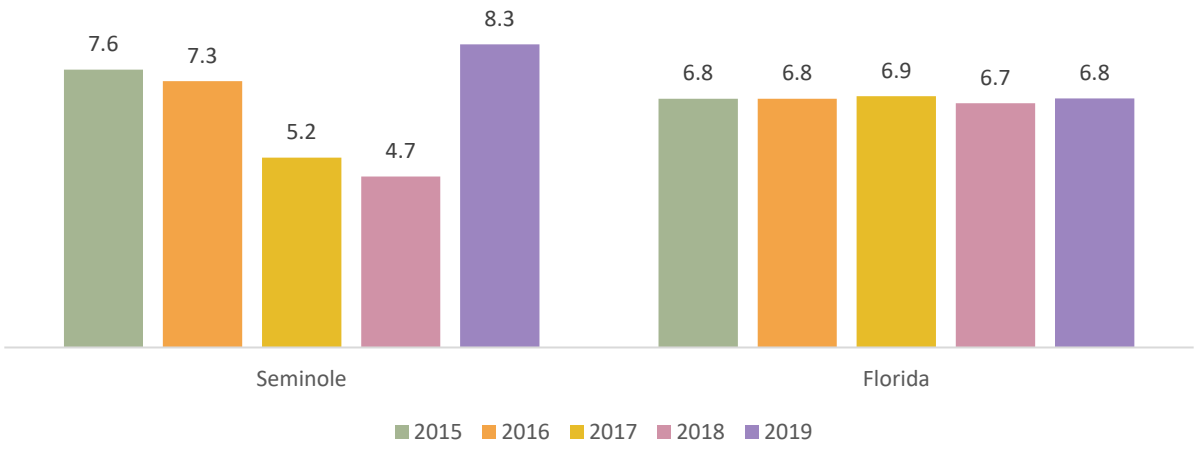
### FETAL DEATHS

Fetal death, fetal mortality or stillbirth is the death of a fetus after 20 weeks of gestation. It results in a baby born without signs of life. The term contrasts with miscarriage (less than 20 weeks of gestation) and live birth (where the baby is born alive, even if it dies shortly after birth). The fetal death rate is the number of fetal deaths per 1,000 live births plus fetal deaths. Fetal mortality and the fetal mortality rate reflect the health and well-being of the population's reproductive age women and their pregnancies as well as the quality of the health care available.

The fetal death rate in Seminole County increased from 7.6/1,000 deliveries in 2015 to 8.3/1,000 deliveries in 2019. The rate among White women increased in the county while remaining stable at the state level. Among Black & Other women, the fetal death rate decreased at the county and state levels. Although the fetal death rate for Hispanic women decreased in Seminole County from 8.9/1,000 deliveries in 2015 to 7.0/1,000 deliveries in 2019, the 2019 rate was up from rates in the previous three years. The Hispanic fetal death rates at the state level have continually increased over the past five years. The fetal death rate among White women increased from the 4.1/1,000 in 2018 to 7.8/1,000 in 2019. Among Black & Other races, the fetal death rate increased from 6.4/1,000 deliveries in 2018 to 9.1/1,000 in 2019. Death counts by race increased for all races when comparing the counts from 2018 to 2019. over the past five years increased from 4.8/1,000 delivers in 2018 to 7.9/1,000 in 2019. In 2019, the highest number of fetal deaths by race and age were among White Non-Hispanic women ages 30-34 years and Black women ages 25-29 years. White Non-Hispanic women living in Casselberry and Black Non-Hispanic women living in Sanford had the highest fetal death counts by ZIP Code. By ZIP Code, Sanford (32771 & 32773) accounted for 30.2 percent of all fetal deaths (26 deaths) in the county. This was followed by Altamonte Springs (32701 & 32714) at 15.1 percent and Casselberry (32707 & 32730) and Winter Springs (32708) each accounting for 10.5 percent of fetal deaths or 9 deaths per city. Lake Mary, Longwood, and Oviedo each accounted for less than ten percent of deaths or less than 9 deaths per city. The remaining 8.1 percent of fetal deaths (7 deaths) were in ZIP Codes 32703 (Apopka), 32751 (Maitland), 32792 (Winter Park) and unknown or out of state.

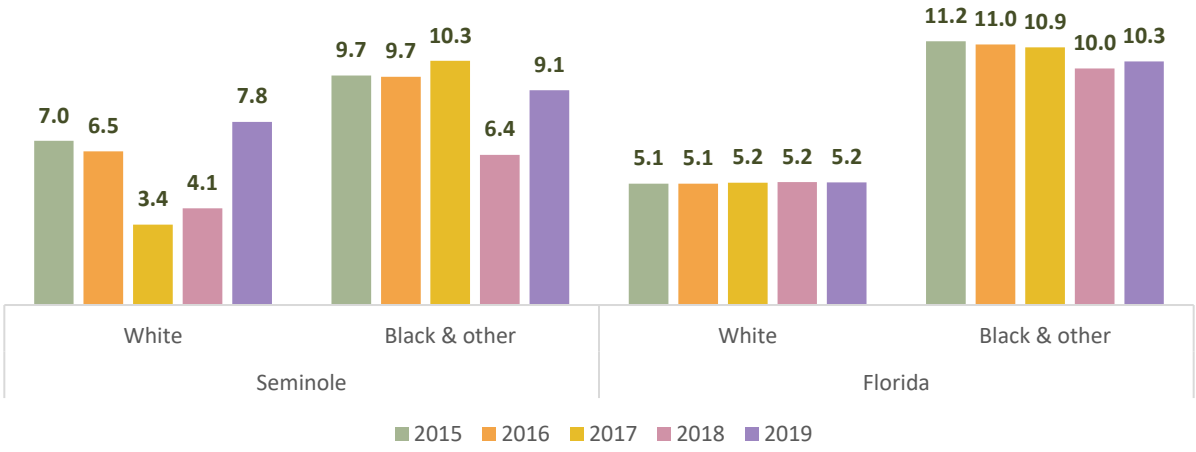
Fetal death certificates revealed complications of the placenta, cord and membranes were the leading cause of death at 3.0/1,000 deliveries in 2019. Maternal complications of pregnancy were cited as the second leading cause of death for 1.3/1,000 deliveries, and the third leading cause of death, congenital malformations, deformations, and chromosomal abnormalities at 1.1/1,000 deliveries.

Figure 33: Fetal Deaths - Rate Per 1,000 Deliveries, 2015-2019



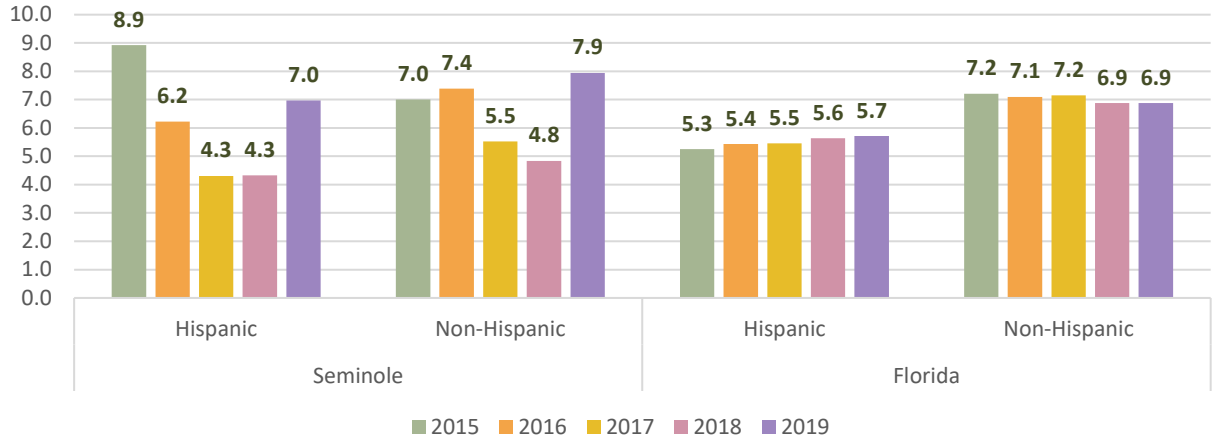

Source: Florida Department of Health, Bureau of Vital Statistics

Figure 34: Fetal Deaths by Race, Rate Per 1,000 Deliveries, 2015-2019



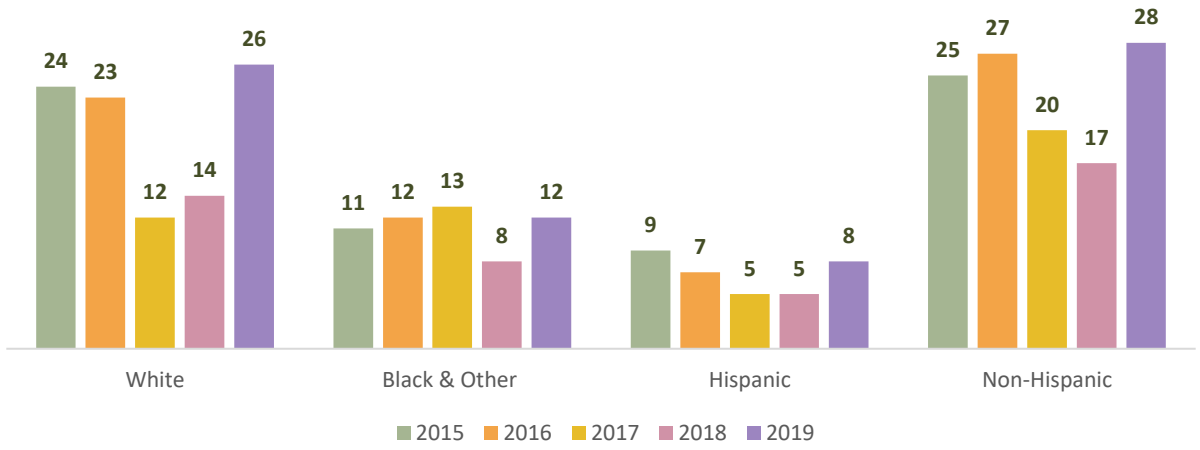

Source: Florida Department of Health, Bureau of Vital Statistics

Figure 35: Fetal Deaths by Ethnicity, Rate Per 1,000 Deliveries, 2015-2019



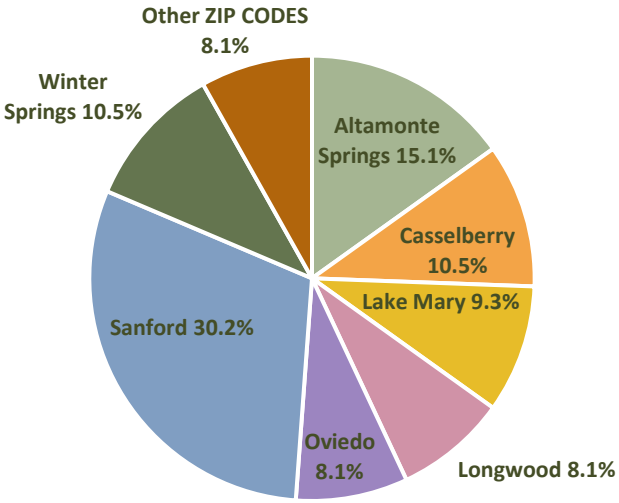

Source: Florida Department of Health, Bureau of Vital Statistics

Figure 36: Fetal Death Counts by Race for Seminole County, 2015-2019




Source: Florida Department of Health, Bureau of Vital Statistics

Figure 37: Fetal Death Counts by ZIP Code for Seminole County, 2017-2019




Source: Florida Department of Health, Bureau of Vital Statistics

Figure 38: Fetal Death Rate Per 1,000 Deliveries by Leading Ranked Causes of Death, Seminole County 2017-2019

| Leading Ranked Causes of Fetal Deaths by Year | 2017 | 2018 | 2019 |
|---|---|---|---|
| In situ neoplasms, benign neoplasms, and neoplasms of uncertain or unknown behavior (D00-D48) | - | .2 | - |
| Fetus affected by maternal conditions which may be unrelated to present pregnancy (P00) | .4 | .2 | .9 |
| Fetus affected by maternal complications of pregnancy (P01.0-P01.9) | .2 | .2 | 1.3 |
| Fetus affected by complications of placenta, cord, and membranes (P02) | **2.3** | **1.7** | **3.0** |
| Fetus affected by noxious influences transmitted via placenta (P04) | - | - | .2 |
| Syndrome of infant of a diabetic mother, and neonatal diabetes mellitus (P70.0-P70.2) | .2 | - | .2 |
| Hydrops fetalis not due to hemolytic disease (P83.2) | .4 | - | .2 |
| Fetal death of unspecified cause (P95) | .6 | .6 | .4 |
| Congenital malformations, deformations, and chromosomal abnormalities (Q00-Q99) | **.8** | **1.3** | **1.1** |
| Unknown | .2 | .4 | 1.1 |

Source: Florida Department of Health, Bureau of Vital Statistics

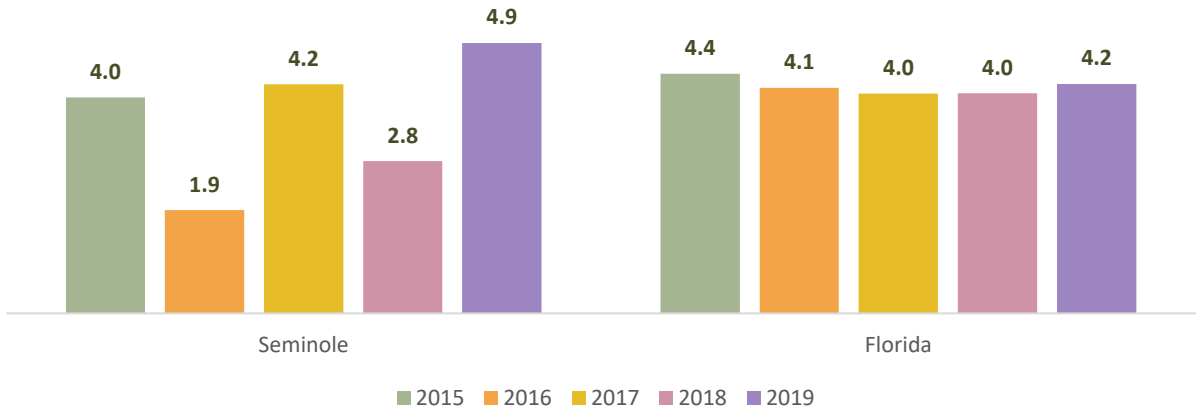
## NEONATAL MORTALITY

Neonatal mortality is the death of a live-born baby prior to the 28th day of life. The rate is the number of deaths to babies through 27 days of life per 1,000 live births. Neonatal mortality and the neonatal mortality rate reflect the health and well-being of the population's women of reproductive age and their infants as well as the quality of the health care available. Neonatal mortality information is generally associated with risk factors and issues related to pregnancy and birth.

Neonatal mortality rates increased in Seminole County from 4.0/1,000 deliveries in 2015 to 4.9/1,000 deliveries in 2019. Rates for Florida decreased slightly. Rates for White women remained stable at the county and state level but increased for Black & Other women in Seminole County. In Florida, the neonatal death rate decreased from 7.7/1,000 deliveries (2015) to 6.8 in 2019 for Black & Other women. Among Hispanic women in Seminole County, neonatal mortality

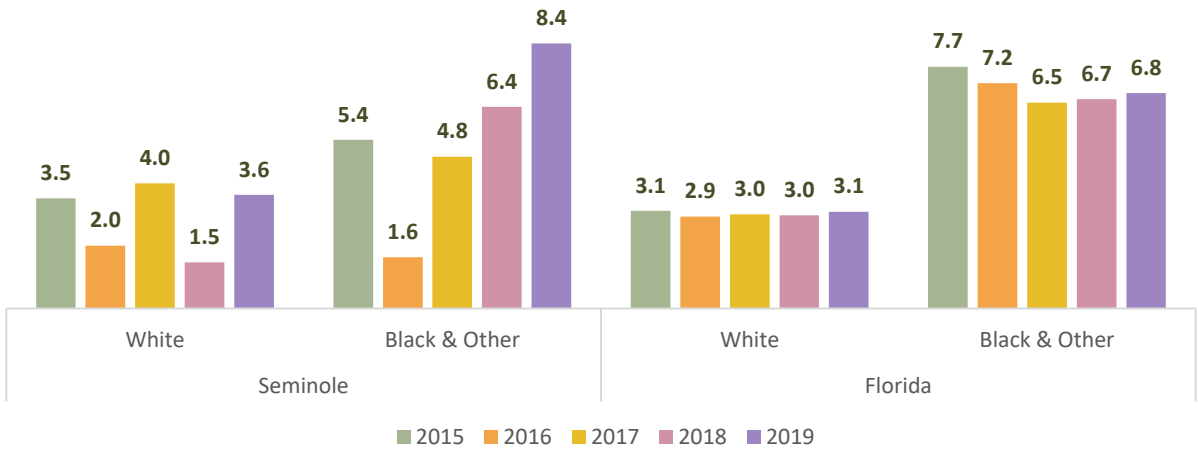
decreased from 4.0/1,000 deliveries in 2015 to 3.5/1,000 deliveries in 2019. The rate for Non-Hispanic women increased in Seminole County while decreasing slightly in the state. Over the past five years, neonatal death counts in Seminole County increased for White, Black & Other, and Non-Hispanic women while remaining stable for Hispanic women.

Figure 39: Neonatal Mortality (0-27 days) - Rate Per 1,000 Deliveries, 2015-2019



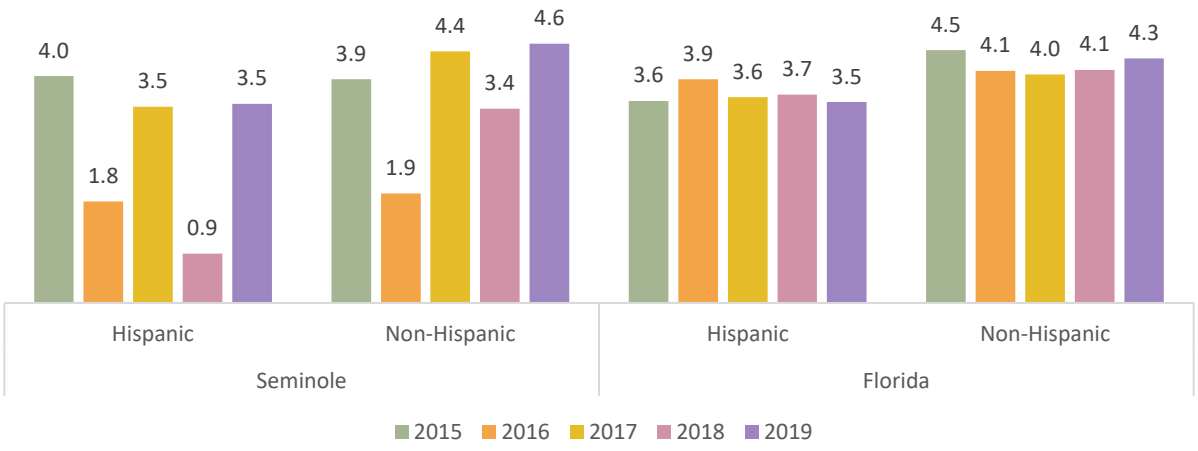

Source: Florida Department of Health, Bureau of Vital Statistics

Figure 40: Neonatal Mortality (0-27 days) by Race - Rate Per 1,000 Deliveries, 2015-2019



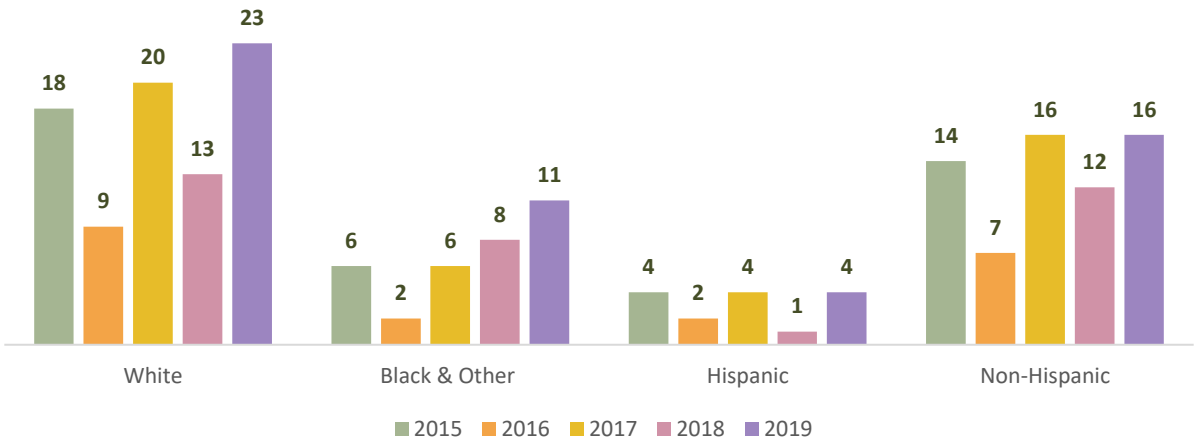

Source: Florida Department of Health, Bureau of Vital Statistics

Figure 41: Neonatal Mortality (0-27 days) by Ethnicity - Rate Per 1,000 Deliveries, 2015-2019




Source: Florida Department of Health, Bureau of Vital Statistics

Figure 42: Neonatal Mortality (0-27 days) Counts for Seminole County, 2015-2019




Source: Florida Department of Health, Bureau of Vital Statistics

## INFANT MORTALITY

Infant mortality is the death of a live-born baby during the first year of life. The rate is the number of infant deaths per 1,000 live births.

The infant mortality rate in Seminole County increased from 4.8/1,000 live births to 6.9/1,000 live births. The rate for Florida decreased slightly from 6.2/1,000 live births in 2015 to 6.0/1,000 live births in 2019. Racially, the infant mortality rate increased for White and Black & Other women. During the past five years, the rate for Black & Other mothers increased from 6.3/1,000 live births to 12.2/1,000 live births. The increase was not as great among White moms where the rate increased from 4.4/1,000 live births to 4.8/1,000 live births. The state infant mortality rates for

White women remained stable while decreasing slightly for Black & Other women. Among Hispanic women, the infant death rate rose from 4.0/1,000 (2015) live births to 7.0/1,000 live births in 2019. The count of infant deaths increased for all racial and ethnic groups. The greatest increase was among Black & Other moms where deaths increased from seven deaths in 2015 to 16 deaths in 2019. Moms living in Sanford, Lake Mary and Casselberry had higher death counts when compared to other municipalities in the county. The city of Sanford (ZIP Codes 32771 & 32773) accounted for almost thirty percent of the infant deaths in the county for the past three cumulative years (2017-2019). Infant deaths in Casselberry (Zip Codes 32707 & 32730) accounted for 17.9 percent while Altamonte Springs (ZIP Codes 32701 & 32714) and Lake Mary (Zip Code 32746) each accounted for 13.1 percent of all infant deaths. Winter Springs (Zip Code 32708) accounted for 11.9 percent of infant deaths, Oviedo (ZIP Code 32765 & 32766) accounted for 8.3 percent and Longwood (Zip Code 32750 & 32779) accounted for 1.2 percent of all infant deaths in the county. The remaining 4.8 percent of infant deaths were in ZIP Codes 32751 (Maitland) and 32792 (Winter Park).

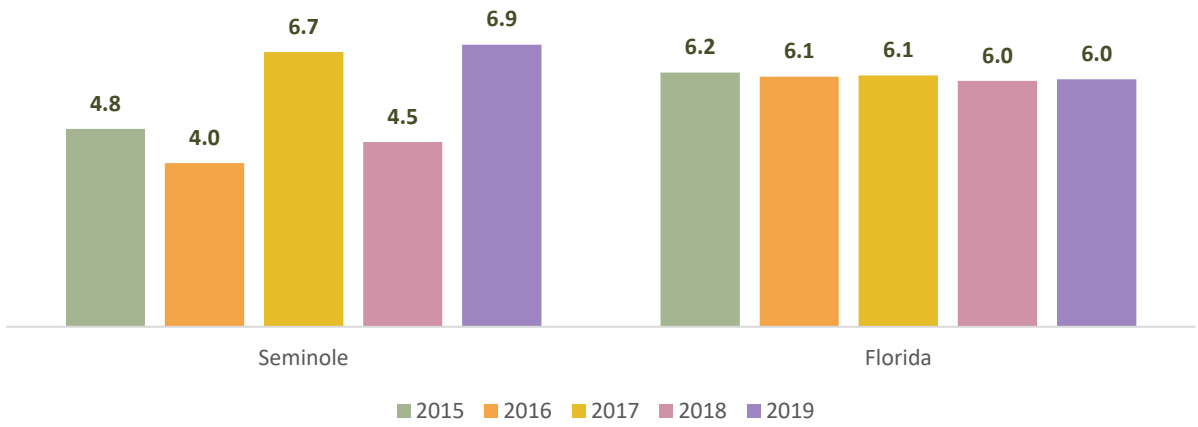
Infant mortality from Sudden Infant Death Syndrome (SIDS) is the death of a live-born baby during the first year of life due to this underlying cause. The rate is the number of infant deaths from Sudden Infant Death Syndrome per 1,000 live births.

Infant mortality from Sudden Infant Death Syndrome and the associated rate reflects the health and well-being of the population's infants. Monitoring death rates from this cause provides information about trends and opportunities to learn more about causes and prevention.

There were no SIDS deaths in Seminole County in 2019. This was a decrease from the rate in 2018 at 1.1/1,000 live births.

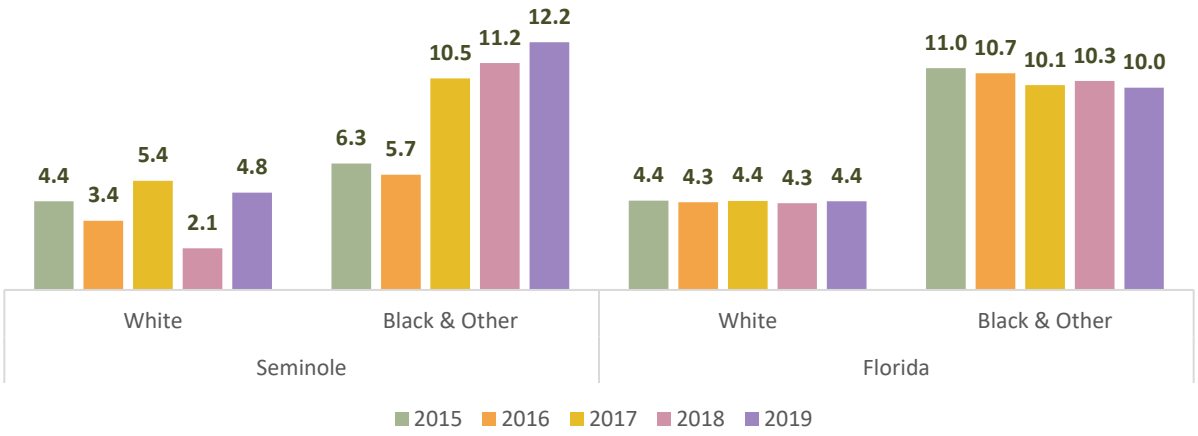
Sudden Unexpected Infant deaths (SUID) for the county increased from 0.9/1,000 live births in 2015 to 1.1/1,000 live births in 2019. SUIDS deaths for Florida remained stable at 0.9/1,000 live births during the same time-period. The SUID rate for White women remained at 0.6/1,000 live births during 2015-2019. Among Black & Other women, the rate increased from 1.8/1,000 live births (2 deaths) to 2.3/1,000 live births (3 deaths). Among Hispanic women the SUID rate increased from zero in 2015 to 1.8/1,000 live births in 2019 (2 deaths). The rate for Non-Hispanic women decreased by one birth from 2015 to 2019.

Figure 43: Infant Mortality (0-365 days) - Rate Per 1,000 Live Births, 2015-2019



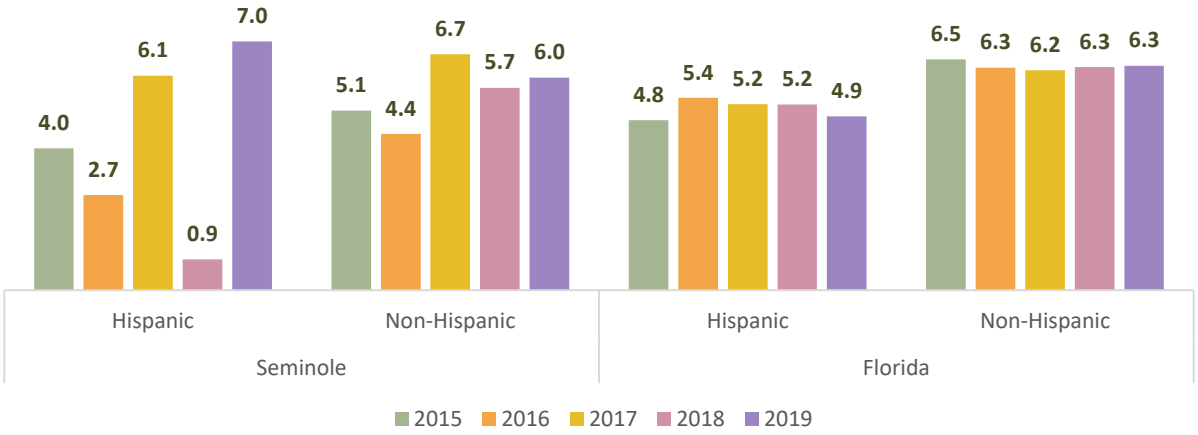

Source: Florida Department of Health, Bureau of Vital Statistics

Figure 44: Infant Mortality (0-365 days) by Race - Rates per 1,000 Live Births, 2015-2019



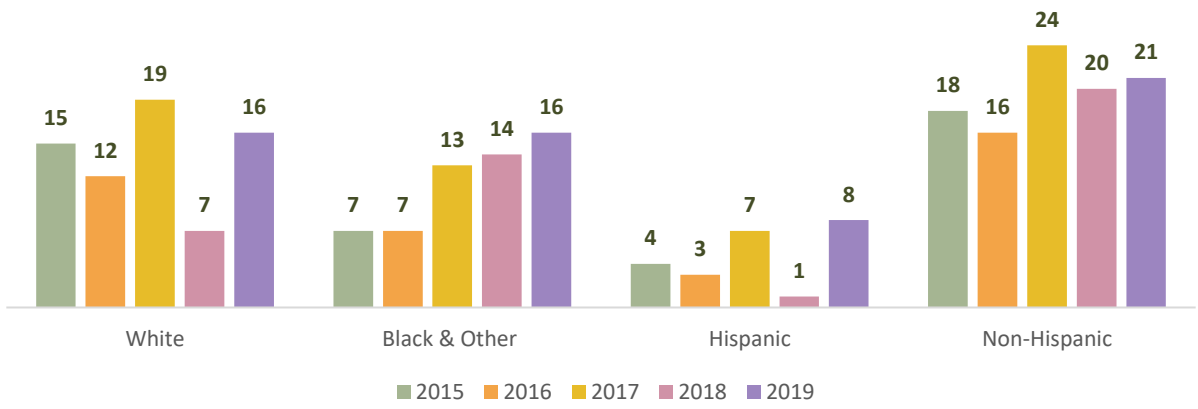

Source: Florida Department of Health, Bureau of Vital Statistics

Figure 45: Infant Mortality (0-365 days) by Ethnicity - Rates Per 1,000 Live Births, 2015-2019



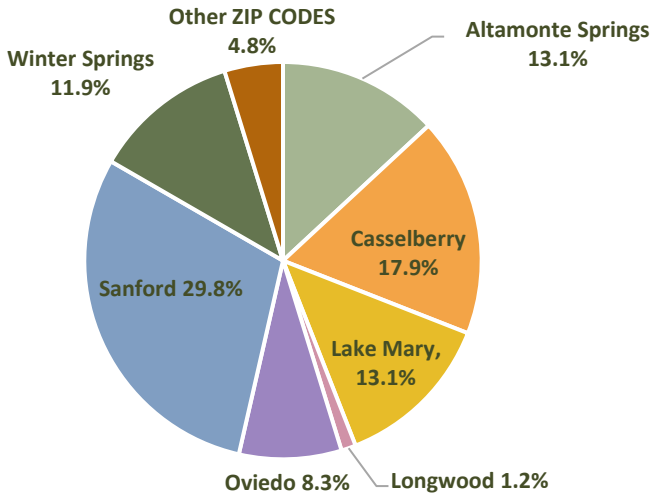

Source: Florida Department of Health, Bureau of Vital Statistics

Figure 46: Infant Mortality (0-365 days) Counts for Seminole County, 2015-2019



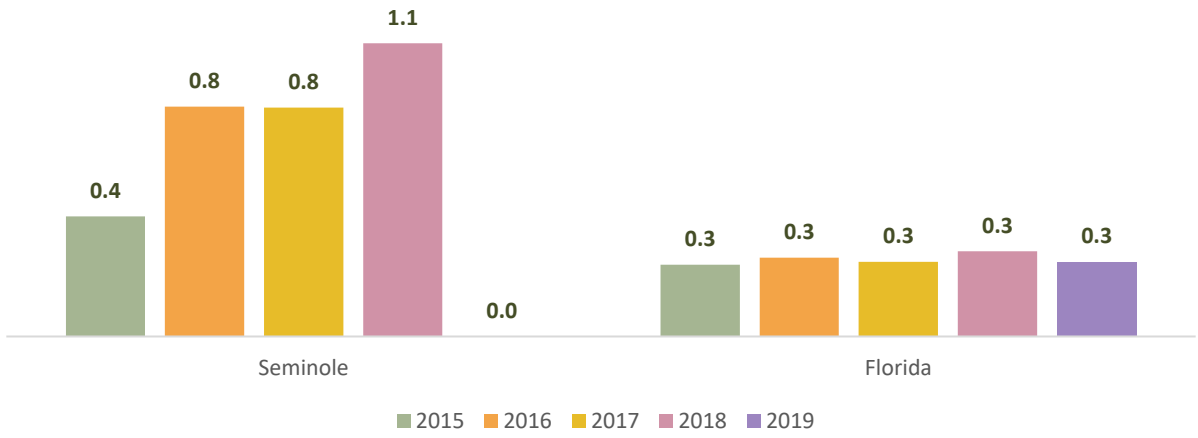

Source: Florida Department of Health, Bureau of Vital Statistics

Figure 47: Percent of Infant Deaths by ZIP Code in Seminole County, 2017-2019




Source: Florida Department of Health, Bureau of Vital Statistics

Figure 48: Sudden Infant Death Syndrome (SIDS) Deaths - Rate Per 1,000 Live Births, 2015-2019



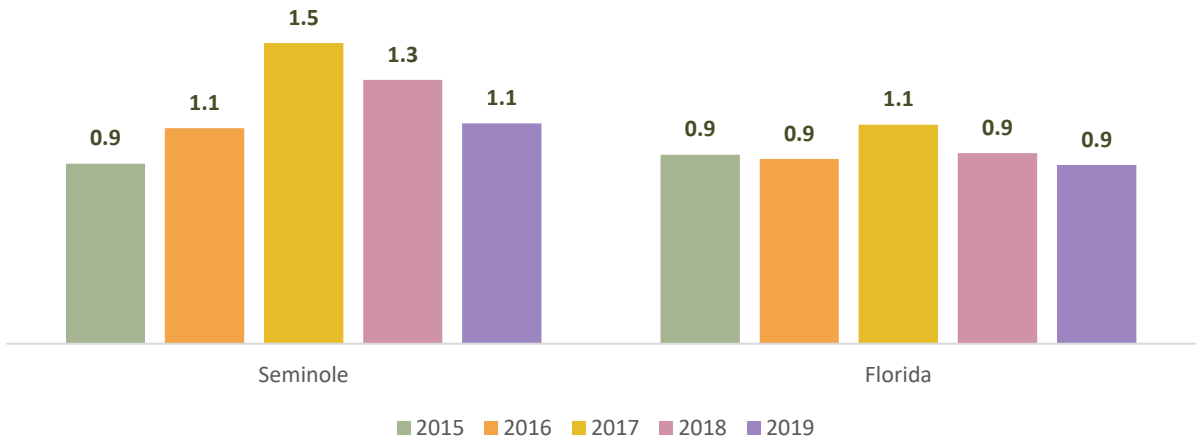

Source: Florida Department of Health, Bureau of Vital Statistics

Figure 49: Seminole County Sudden Infant Death Syndrome (SIDS) Deaths - Counts and Rates by Race and Ethnicity

| Year | White | | Black & Other | | Hispanic | | Non-Hispanic | |
|---|---|---|---|---|---|---|---|---|
| | Count | Rate | Count | Rate | Count | Rate | Count | Rate |
| 2015 | 1 | 0.3 | 1 | 0.9 | 0 | 0.0 | 2.0 | 0.6 |
| 2016 | 1 | 0.3 | 3 | 2.4 | 0 | 0.0 | 4.0 | 1.1 |
| 2017 | 1 | 0.3 | 3 | 2.4 | 2 | 1.7 | 2.0 | 0.6 |
| 2018 | 2 | 0.6 | 3 | 2.4 | 0 | 0.0 | 5.0 | 1.4 |
| 2019 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0.0 | 0.0 |

Source: Florida Department of Health, Bureau of Vital Statistics; Rate Per 1,000 Live Births

Figure 50: Sudden Unexpected Infant Deaths (SUID) - Rate Per 1,000 Live Births, 2015-2019




Source: Florida Department of Health, Bureau of Vital Statistics

Figure 51: Seminole County Sudden Unexpected Infant Deaths Syndrome - Counts and Rates by Race and Ethnicity

| Year | White | | Black & Other | | Hispanic | | Non-Hispanic | |
|---|---|---|---|---|---|---|---|---|
| | Count | Rate | Count | Rate | Count | Rate | Count | Rate |
| 2015 | 2 | 0.6 | 2 | 1.8 | 0 | 0.0 | 4 | 1.1 |
| 2016 | 2 | 0.6 | 3 | 2.4 | 0 | 0.0 | 5 | 1.4 |
| 2017 | 3 | 0.9 | 4 | 3.2 | 2 | 1.7 | 4 | 1.1 |
| 2018 | 2 | 0.6 | 4 | 3.2 | 0 | 0.0 | 6 | 1.7 |
| 2019 | 2 | 0.6 | 3 | 2.3 | 2 | 1.8 | 3 | 0.9 |

Source: Florida Department of Health, Bureau of Vital Statistics; Rate Per 1,000 Live Births

Figure 52: Seminole County Resident Infant Deaths by Cause of Death - Counts and Rates, 2017-2019

| | 2017 | | 2018 | | 2019 | |
|---|---|---|---|---|---|---|
| | Count | Rate | Count | Rate | Count | Rate |
| Other Ill-Defined and Unspecified Causes of Mortality (R99) | 0 | 0.0 | 1 | 0.2 | 2 | 0.4 |
| Sudden Infant Death Syndrome (R95) | 4 | 0.8 | 5 | 1.1 | 0 | 0.0 |
| Unintentional Injury: Suffocation & Strangulation in Bed (W75) | 2 | 0.6 | 0 | 0.0 | 3 | 0.6 |
| **Total** | **7** | **-** | **6** | **-** | **5** | **-** |

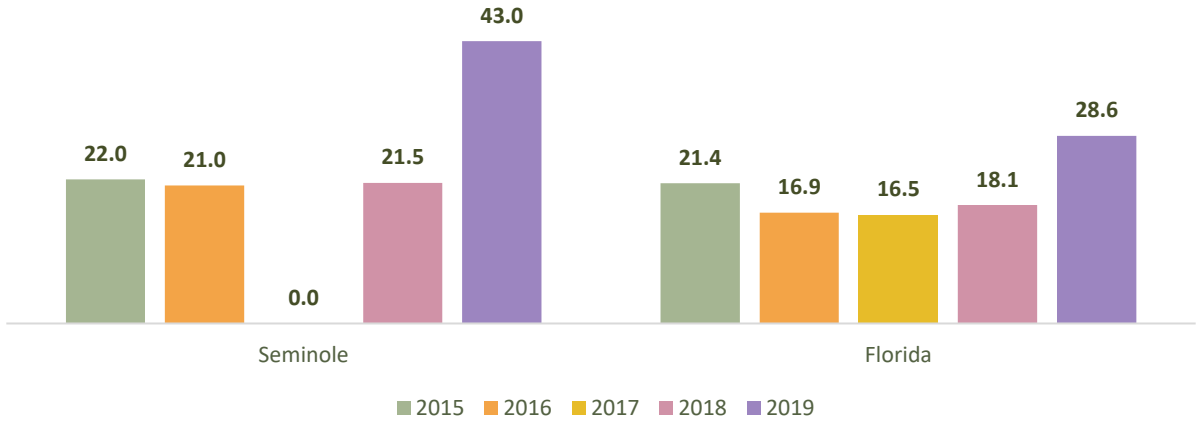
Source: Florida Department of Health, Bureau of Vital Statistics; Rate Per 1,000 Live Births

## MATERNAL MORTALITY

The World Health Organization defines a maternal death as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. Complications during pregnancy and childbirth are a leading cause of death and disability among women of reproductive age in developing countries. Using the World Health Organization definition allows comparison of these data with other states, the United States, and other countries. The maternal deaths per 100,000 live births represents the risk of maternal death associated with each pregnancy.

The maternal death rate increased in Seminole County from 22.0/100,000 live births to 43.0/100,000 live births. There was one maternal death in 2015, zero deaths in 2017, and two deaths in 2019. Over the past five years (2015 -2019), there were two maternal deaths among White women, three maternal deaths among Black & Other women and two maternal deaths among Hispanic women.

Figure 53: Maternal Deaths - Rate Per 100,000 Live Births, 2015-2019




Source: Florida Department of Health, Bureau of Vital Statistics

## Maternal and Child Health Indicators

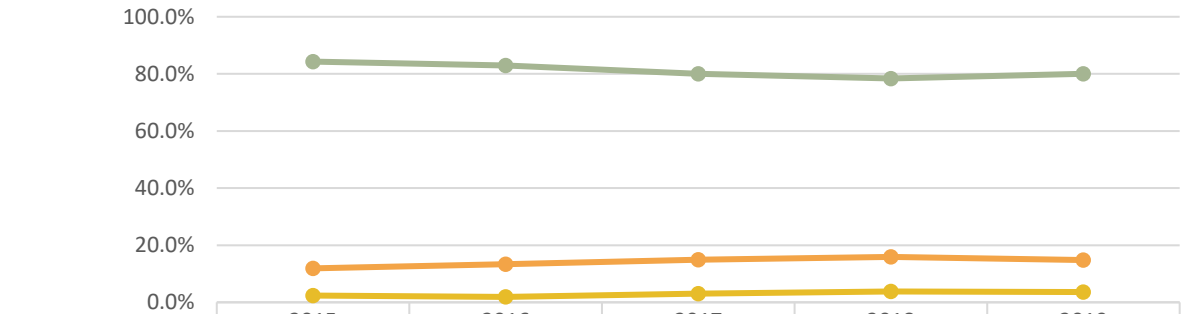
### PRENATAL CARE

Prenatal care is the health care women get when they are pregnant. Women who see a health care provider regularly during pregnancy have healthier babies and are less likely to have pregnancy complications. Mothers with unknown prenatal care are excluded from the denominator in calculating the percentage.

Prenatal care (PNC) visits provide benefits to both the mother and baby and are used to monitor the progress of a pregnancy. To achieve the greatest benefit for both the mother and baby, it is recommended that women begin PNC visits in the first trimester of pregnancy or as soon as pregnancy is suspected or confirmed. Early PNC allows health care providers to identify potential problems as early as possible so they can be prevented or treated before they become serious. Ensuring that all women receive early and adequate PNC is a top maternal and child health priority. Public health programs emphasize access to early PNC services for teens, women with less than a high school education, and Black and Hispanic women.

The trend for mom accessing prenatal care in their first trimester has decreased while the percentages of women waiting until their second or third trimester before seeking care has increased. The counts and percentages of infants born to mothers with no prenatal care increased in Seminole County and Florida during the past five years. In Seminole, the rate increased slightly from 1.4 percent of live births (2015) to 1.6 percent of live births in 2019. The number of infants born in 2015 whose moms did not receive prenatal care increased from 56 births to 63 births in 2019, representing an increase of 12.5 percent. Births to mothers with third trimester or no prenatal care have increased over the past five years among all races and ethnicities.

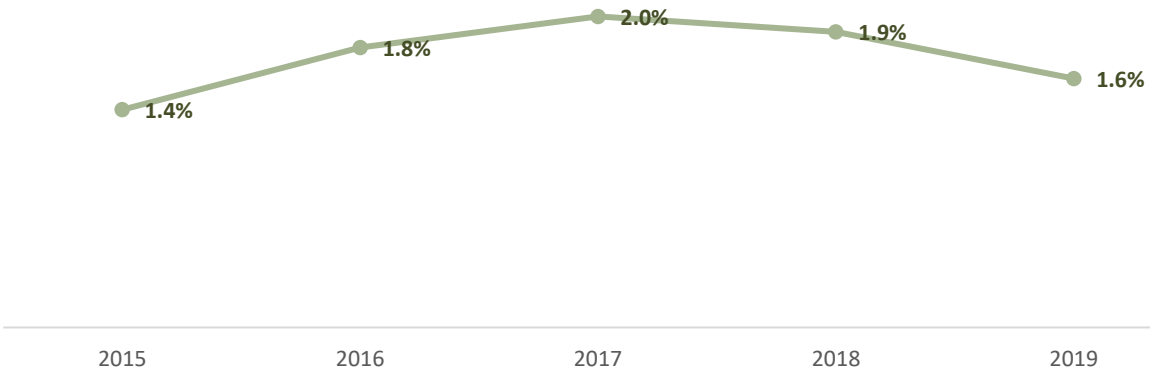
Figure 54: Births to Mother's with Prenatal Care by Trimester - Seminole County, 2015-2019




| | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| 1st Trimester | 84.3% | 82.9% | 80.0% | 78.4% | 80.0% |
| 2nd Trimester | 11.9% | 13.4% | 14.9% | 15.9% | 14.8% |
| 3rd Trimester | 2.4% | 1.9% | 3.1% | 3.8% | 3.6% |

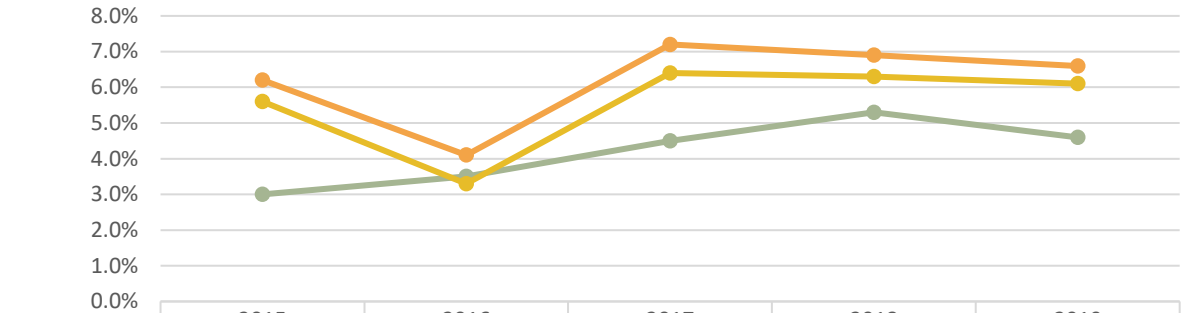
Source: Florida Department of Health, Bureau of Vital Statistics

Figure 55: Births to Mothers with No Prenatal Care – Seminole County, 2015-2019




Source: Florida Department of Health, Bureau of Vital Statistics

Figure 56: Births to Mother's with 3rd Trimester Care or No Prenatal Care by Race, 2015-2019




| | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| White | 3.0% | 3.5% | 4.5% | 5.3% | 4.6% |
| Black | 6.2% | 4.1% | 7.2% | 6.9% | 6.6% |
| Hispanic | 5.6% | 3.3% | 6.4% | 6.3% | 6.1% |

Source: Florida Department of Health, Bureau of Vital Statistics

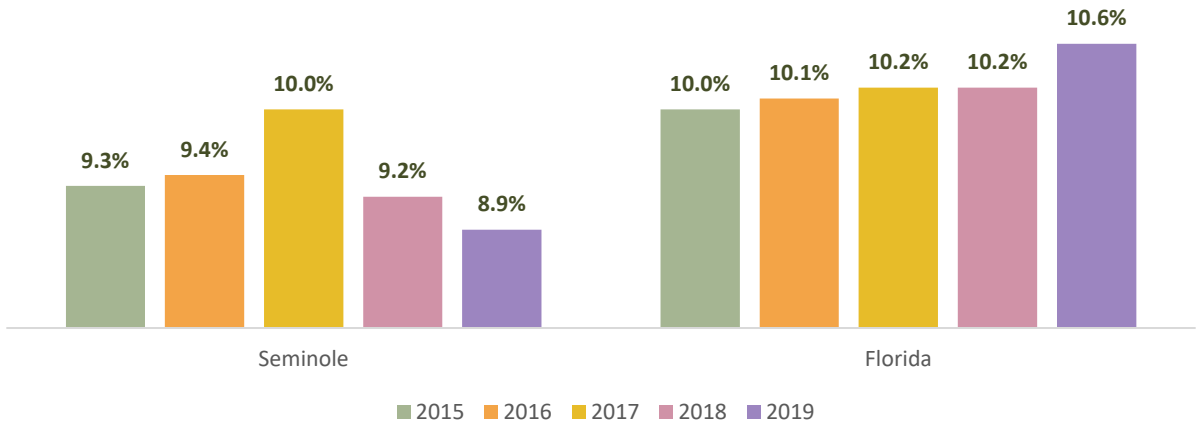
## PRETERM BIRTHS

A preterm birth is the early birth of a live baby. Reaching 37 weeks of gestational age is a measure of success in achieving a full-term pregnancy. Births that occur before 37 weeks gestation (preterm births) have lower chances of survival and higher chances of short and long- term health problems when compared to term births.

The percentage of preterm births (<37 weeks gestation) in 2019, at 8.9 percent, was lower than the rate in 2015 at 9.3 percent. The rate of preterm births increased in the state during the same time-period. There were 97 babies born preterm in 2019.

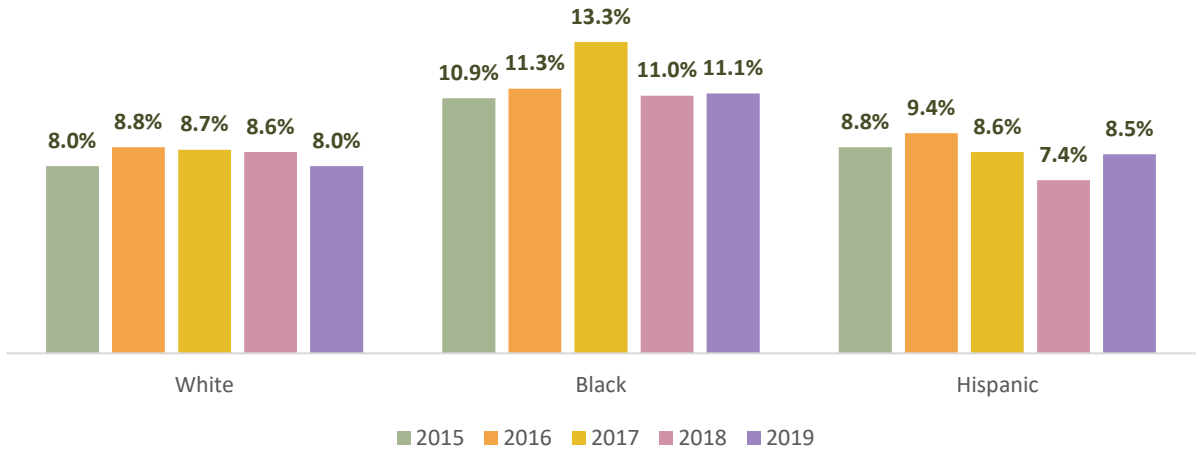
Rates of preterm births among White women have remained relatively stable over the past five years. Among Black & Other women, the rate in 2019, at 11.1 percent was still above the 2015 rate (10.9 percent) but below the highest rate in 2013 at 13.3 percent.

Figure 57: Preterm Births (<37 weeks gestation), 2015-2019




Source: Florida Department of Health, Bureau of Vital Statistics

Figure 58: Preterm Births (<37 weeks gestation) by Race and Ethnicity, 2015-2019



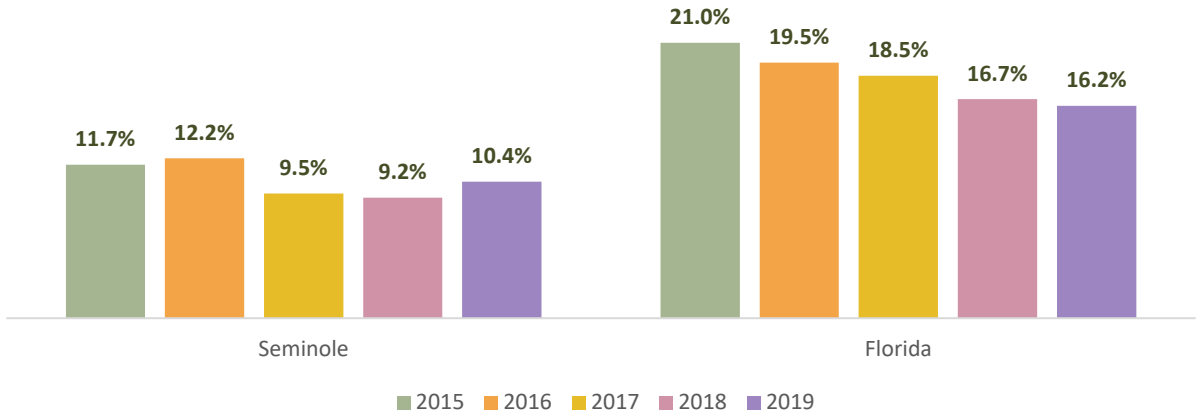

Source: Florida Department of Health, Bureau of Vital Statistics

## TEEN BIRTHS

The percentage of births to teen moms, ages 15-19 years, decreased from 11.7 percent in 2015 to 10.4 percent in 2019. At the state level, rates decreased from 21.0 percent in 2015 to 16.2 percent in 2019. The number of teen births per year fell from 159 (2015) to 143 in 2019.

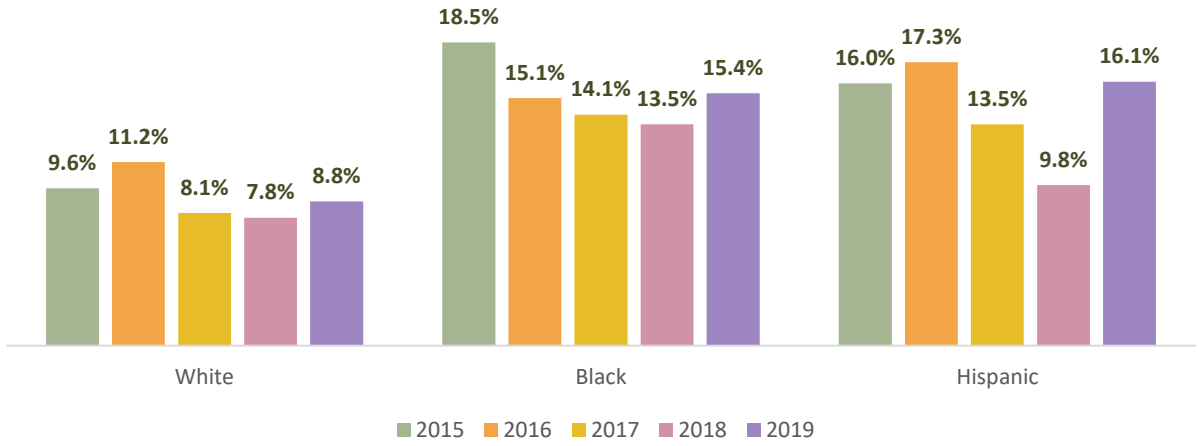
The percentage of teen births was higher among Black and Hispanic women at almost twice the rate for White moms.

Figure 59: Births to Mother's 15-19 Years - Rate Per 1,000 Total Population, 2015-2019




Source: Florida Department of Health, Bureau of Vital Statistics

Figure 60: Births to Mothers 15-19 Years by Race and Ethnicity, 2015-2019




Source: Florida Department of Health, Bureau of Vital Statistics

## PRENATAL SCREENING

Prenatal screening rates have fallen in the past three years. It should be noted that data from 2019-2020 may be skewed due to Covid-19 lockdowns. The number of prenatal forms processed and the number of women consenting to screening decreased from 2017-18 to 2019-20. Among infant screenings, the number of infants who scored 4 or more increased from 570 in 2017-2018 to 646 in 2019-20, while the number of births decreased during the same time-period. The percentages of infants with a positive score also decreased over the past three years.

Figure 61: Seminole County Prenatal Screenings - Counts, Single Fiscal Years

| Prenatal Screening | 2017-18 | 2018-19 | 2019-20 |
|---|---|---|---|
| Forms Processed | 3,703 | 3,606 | 3,129 |
| Consented to Screening | 3,269 | 3,160 | 2,620 |
| Declined Screening | 434 | 446 | 509 |
| Consent Rate | 88.3% | 87.6% | 83.7% |

Source: Florida Healthy Start Prenatal Screening Forms

Figure 62: Seminole County Infant Screening – Counts, Single Fiscal Years

| Infant Screening | 2017-18 | 2018-19 | 2019-20 |
|---|---|---|---|
| Resident Births | 4,736 | 4,634 | 4,692 |
| Consented to Screening | 4,612 | 4,564 | 4,565 |
| Infant Scored 4 or More | 570 | 571 | 646 |
| Infants with a Positive Score | 87.6% | 87.5% | 85.8% |

Source: Florida Healthy Start Infant Screening Forms

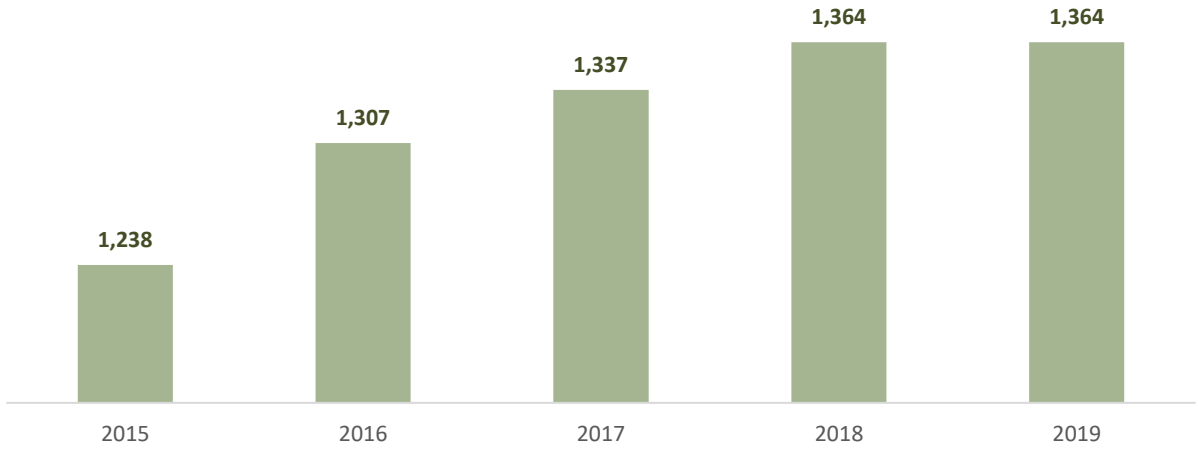
## Health Risk Factors

### HIV/AIDS and BARRIERS TO CARE

The Orlando Eligible Metropolitan Area (EMA) consist of Lake, Orange, Osceola, and Seminole counties. The epidemiological profile developed by the Florida Department of Health revealed that there are 1,364 persons living with HIV in Seminole County in 2019. The number of women of childbearing age (WCBA) living with HIV in the Orlando EMA have continually decreased over the past five year. The number of Black WCBA PWH living in the EMA (670) in 2019 was almost five time higher than that of White WCBA PWH (139) and nearly three times that of Hispanic WCBA PWH (231). In 2019, the number of Black pediatrics (0-12 years of age) PWH was far higher (16) when compared to White pediatric PWH (0) and Hispanic pediatric PWH (5). The numbers of pediatric PWH in the EMA has also decreased over the past five years.

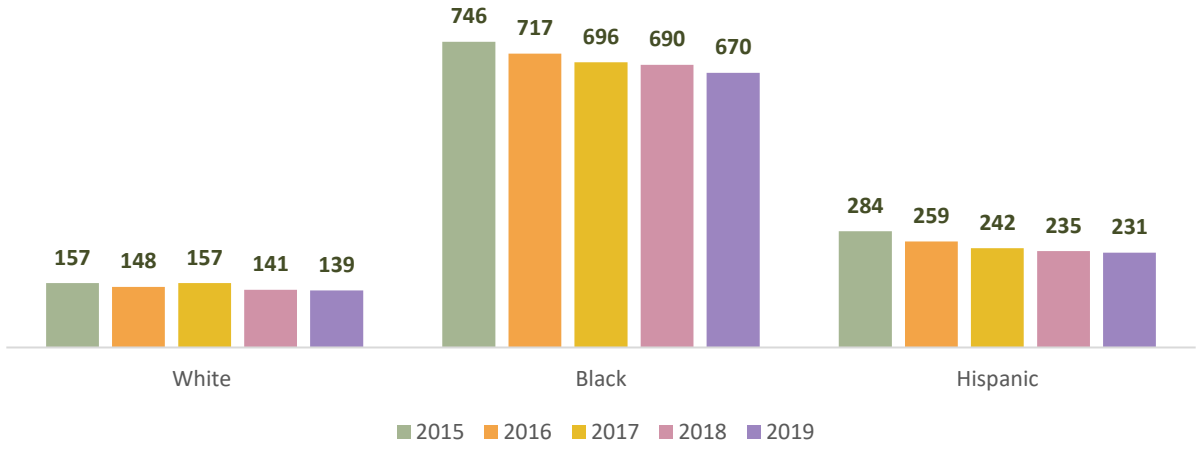
The 2019 community survey revealed that 4.3 percent of women respondents in Seminole County had trouble in accessing prenatal care. Research participants identified several needed services in the region: more high-risk obstetric providers, accessible care for immigrants, and affordable maternal care that is easy to access. Lack of transportation to access health care was cited as a barrier by 9.2 percent of respondents. Additional barriers for Seminole County respondents included access to primary care (26.9 percent) and specialists (35.4 percent) and affordable health care at 45.0 percent. These were lower when compared to other counties in the region. According to the 2019 PRC Child & Adolescent Needs Assessment Report, the percentage of uninsured children was highest in Seminole County at 17.5 percent when compared to Orange and Osceola Counties at 7.0 percent and 5.2 percent, respectively. Difficulty getting an appointment for their child in the past year was experienced by 23.9 percent of respondents.

Figure 63: Number of Persons Living with HIV (PWH), 2015-2019



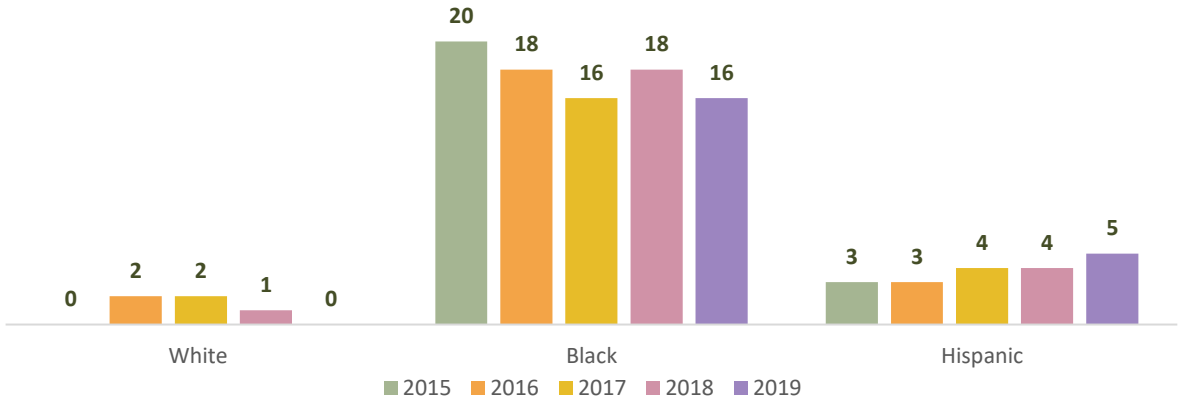

Source: Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section

Figure 64: Orlando EMA Women of Childbearing Age Living with HIV by Race/Ethnicity, 2015-2019



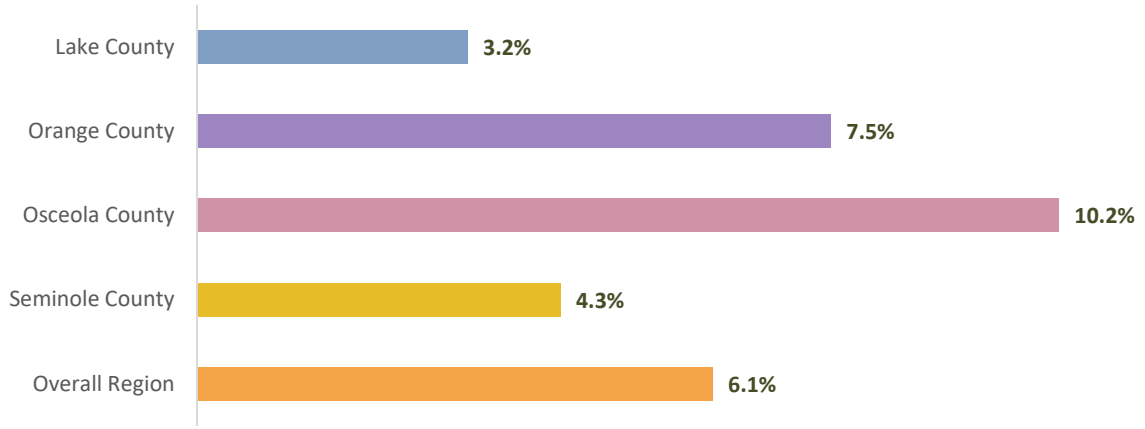

Source: Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section

Figure 65: Orlando EMA Pediatrics (0-12 years of age) Living with HIV by Race/Ethnicity, 2015-2019



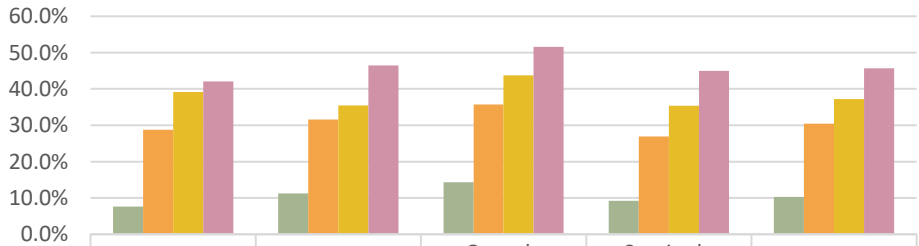

Source: Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section

## Figure 66: Difficult Accessing Prenatal Care, 2019




Source: Central Florida Community Collaborative Community Survey, Strategy Solutions, Inc.

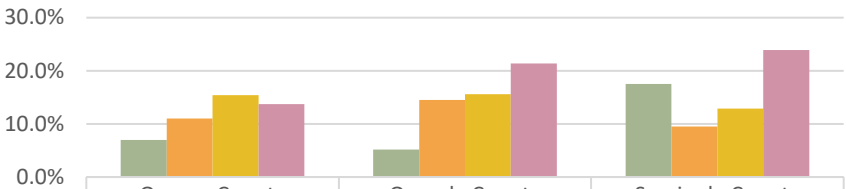
## Figure 67: Barriers to Care, Community Survey 2019




| | Lake County | Orange County | Osceola County | Seminole County | Overall Region |
|---|---|---|---|---|---|
| Access to transportation | 7.6% | 11.2% | 14.3% | 9.2% | 10.3% |
| Access to primary care | 28.8% | 31.6% | 35.7% | 26.9% | 30.4% |
| Access to specialists | 39.2% | 35.5% | 43.7% | 35.4% | 37.2% |
| Access to affordable health care | 42.1% | 46.5% | 51.6% | 45.0% | 45.7% |

Source: Central Florida Community Collaborative Community Survey, Strategy Solutions, Inc.

Figure 68: Barriers to Care for Children (0-17 years), Community Survey 2019

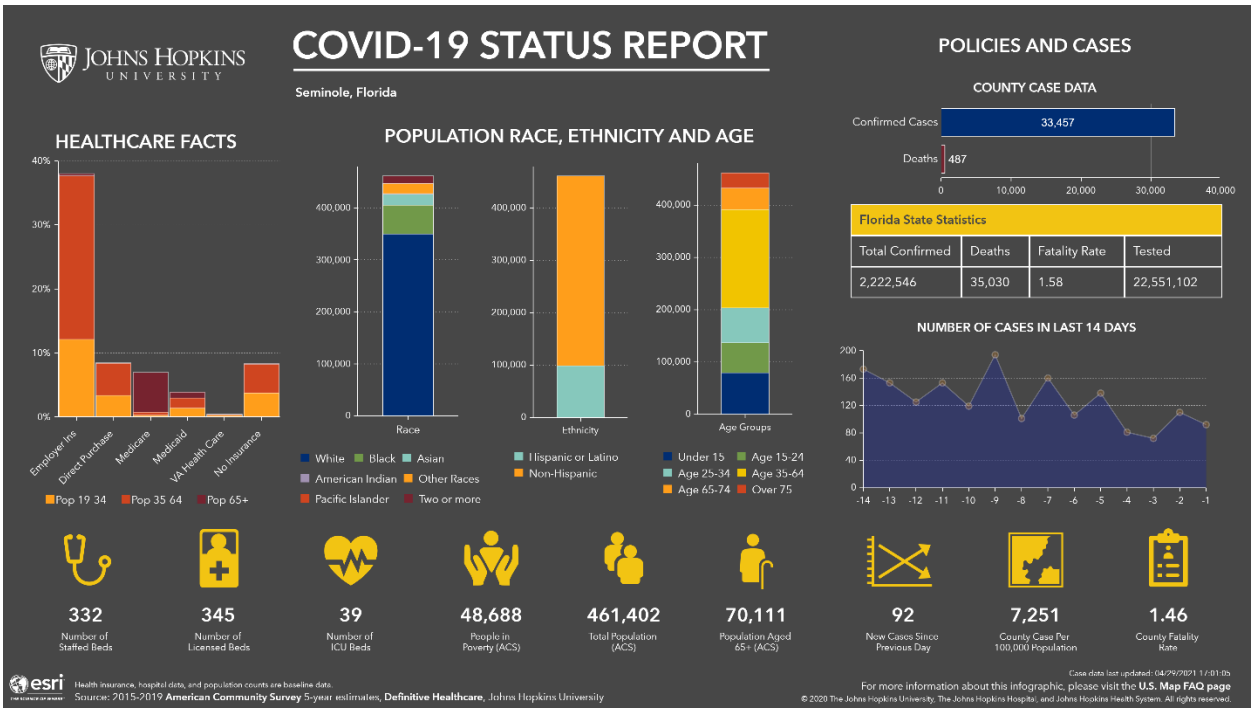



| | Orange County | Osceola County | Seminole County |
|---|---|---|---|
| Child is uninsured | 7.0% | 5.2% | 17.5% |
| Child has been without insurance at some point | 11.0% | 14.5% | 9.5% |
| Difficulty finding a physician for child in past year | 15.4% | 15.6% | 12.9% |
| Difficulty getting appointment for child in past year | 13.7% | 21.4% | 23.9% |

Source: 2019 PRC Child & Adolescent Health Needs Assessment

## Guidelines During COVID-19

As experts in global public health, infectious diseases and emergency preparedness, Johns Hopkins have been at the forefront of the international response to COVID-19. Their website (Home - Johns Hopkins Coronavirus Resource Center (jhu.edu)) is a resource to help advance the understanding of the virus, inform the public, and brief policymakers to guide a response, improve care, and save lives. The below diagram is a summary of COVID-!9 data for Seminole County for the past 14 days (as of 4/30/2021).




To fully understand how Covid-19 impacted and continues to effect communities across the county will require rigorous data analysis over time. Preliminary data indicates that low-income and minorities communities suffered at higher rates when compared to the general population. Early implications of the virus' inequity and impact have been revealed. Continuously monitoring reliable sources for new data, revised guidelines, and treatment options will go far to mitigate disparity among vulnerable populations. According to John Hopkins:

> *Black Americans are more likely to get COVID-19 than other races and are dying at nearly twice the rate of White Americans. They are also less likely to participate in COVID-19 vaccine clinical trials and are less willing to get the vaccine. Many parallels exist between HIV and COVID-19: Black Americans are also more likely to get HIV, less likely to participate in HIV clinical research and less likely to benefit from HIV prevention medications than other communities. While other communities mounted a response to the COVID-19 pandemic, many Black Americans navigated intersectional COVID-19, HIV, racial discrimination, and poverty. What have we learned from both cases?*
>
> ***Words, images, and perceptions matter.*** *We are inundated daily with headlines about COVID-19 vaccine 'distrust' or 'hesitancy' among Black Americans. But what is the difference, and does it matter? In short, yes.*

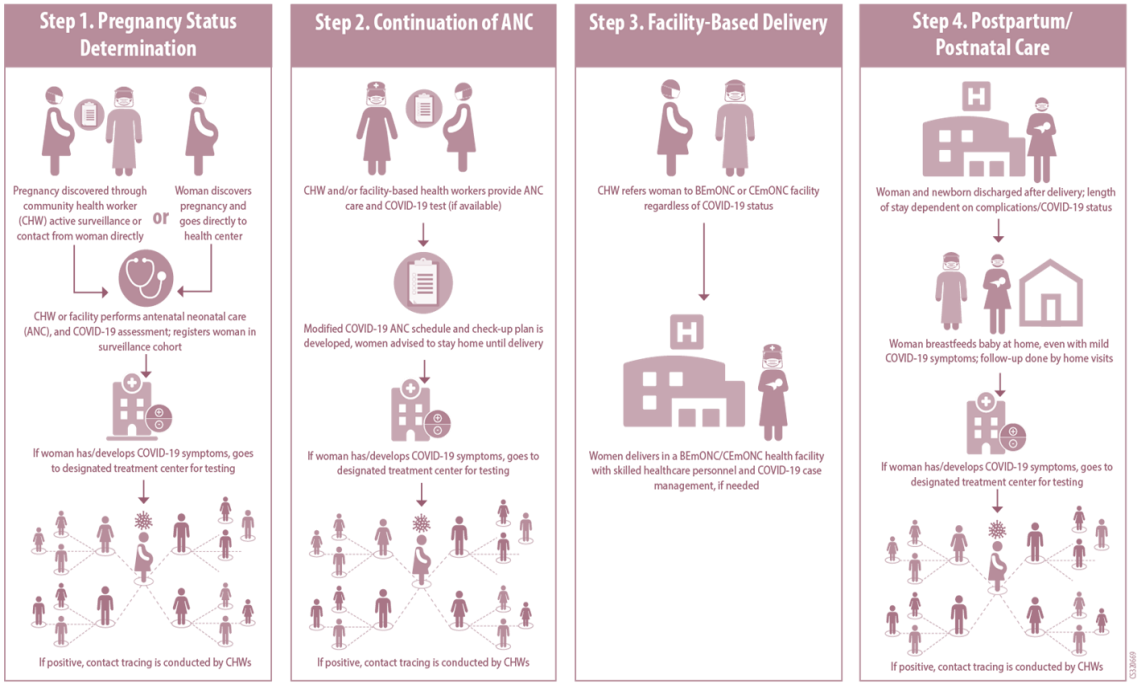
*Vaccine hesitancy is broadly defined as a continuum from vaccine refusal to acceptance. The headlines using this phrase imply personal preferences and views. However, there is plenty of literature that shows our individual decision-making to get vaccinated may be reduced because of seeing these very images telling us that Black Americans are not getting vaccinated. Very few of these headlines identify trustworthy sources for Black Americans to go for information about the vaccines. Even fewer headlines discuss the role of clinicians and researchers in working to overcome distrust and negative perceptions of the vaccine and in encouraging trust in vaccinations.*

***Trust is central to uptake.*** *Whether we portray it as hesitancy, mistrust, distrust or any other term, all Black Americans need access to information about the vaccine and side effects. They need to know why some groups are eligible to be vaccinated before other groups and why high rates of vaccination are needed for everyone to be protected (community, or herd, immunity). Black Americans are rightly distrustful of the short timeline to COVID-19 vaccine approval and production. There is not a single community in which we, the authors, have worked, whether on COVID-19 or HIV, where the legacy of ethical violations such as the Tuskegee study or Henrietta Lacks is not mentioned. If public health practitioners are not appropriately equipped to help Black Americans overcome these valid concerns, how can trust be built and vaccine acceptance be promoted successfully? Acknowledging these very real concerns, as the U.S. Surgeon General did, is a start in trust building, but we must continue to provide education about the process through which the vaccine was tested and produced.*

***Address the issue of access.*** *Across the media, we see portrayals of vaccine hesitancy in Black American communities, often with little to no effort to balance reporting on vaccine scarcity due to lack of access. Stories abound of Black American communities where low vaccine stock is to blame for low rates of vaccination, not hesitancy. Additionally, structural racism has guaranteed Black Americans a poorer quality of care than others, even when they are willing to seek care. Even before vaccine availability, there were disparities in access to COVID-19 testing.*

*Public health practitioners must take cues from people already leading these efforts so as not to dilute or duplicate; many of these leaders have worked in HIV prevention and know the pitfalls of repeating the errors of the past. Media outlets should also ensure accurate and balanced reporting that frames the whole community, not just one narrative of hesitancy. Partnering with Black churches and having Black researchers and clinicians in leadership roles in entities like the COVID-19 Prevention Network, the National COVID-19 Resiliency Network and the Black Coalition Against COVID can prioritize engagement in Black American communities and go a long way toward building on assets and promoting vaccinations. Source: [The Full Picture: Accurately Framing COVID-19 Vaccine 'Hesitancy' among Black Americans - Johns Hopkins Coronavirus Resource Center (jhu.edu)]*

Below are the recommendations from the CDC to assist women of childbearing age as they navigate the health system for their maternal and child health care needs during a global pandemic.




## Step 1. Determine Pregnancy Status

The first step in providing maternal and newborn services during the COVID-19 pandemic is to determine pregnancy status. Once a woman discovers she is pregnant, she will either contact a Community Health Worker (CHW) to provide an antenatal care (ANC) assessment or visit a health center facility directly to confirm her pregnancy and receive ANC. Alternatively, pregnancies in the community may be discovered through routine pregnancy surveillance. In this instance, facilities will provide pregnancy and COVID-19 assessments using the surveillance process and tools described in Slide 2. Note that both the woman and CHW should be wearing face masks when in the same room. In the health facility, the waiting area should be a well-ventilated room (or an outside space) in which other outpatients/families are socially distancing and wearing masks.

At the first point of contact between a pregnant woman and a CHW/healthcare provider, the woman will be enrolled in the pregnancy register cohort and local area monitoring system which helps CHWs follow the woman throughout her pregnancy and determine her estimated delivery date. During pregnancy assessment, women should be evaluated for potential SARS-CoV-2 infection, the virus that causes COVID-19, by considering the presence of suggestive symptoms, contact with family members or other persons with diagnosed or presumed COVID-19, and the extent of COVID-19 spread within the community. CHWs should be aware that pregnant women with COVID-19 may have mild symptoms (such as fatigue and headache). Additionally, other serious health conditions (e.g., malaria, dengue, preeclampsia, gestational diabetes) have similar

symptoms to COVID-19, and thus CHWs must be vigilant in assessing these possibilities. If a CHW suspects a pregnant woman has COVID-19 either due to symptoms of COVID-19, potential recent contact with family members or other persons with diagnosed or presumed COVID-19, or both, the pregnant woman should be referred for testing.

Points of contact between women and health providers at which COVID-19 may be detected and steps for referral include:

Women without COVID-19 symptoms**:**

- If a woman does not have symptoms of COVID-19, then she should be referred to a health facility for a routine ANC visit.

Women with COVID-19 symptoms:

- If a CHW discovers during *initial assessment* that a woman has symptoms suggestive of COVID-19 or recent close contact with someone with COVID-19, the CHW should refer the woman to a COVID-19 testing and treatment center immediately. Women should receive information on home isolation while waiting for the test results, and if test is positive, she should follow the United Nations Population Fund (UNFPA). Women who test positive for COVID-19 should have contact tracing follow-up in the community.
- If a woman exhibits symptoms of COVID-19 during a *health facility assessment*, she should be referred to a treatment center for a COVID-19 test as promptly as possible, after conducting assessments for other conditions which can present with similar symptoms.
- If at any point during the initial ANC or pregnancy status assessment a woman exhibits severe symptoms consistent with COVID-19 (specifically, trouble breathing; persistent pain or pressure in the chest; new confusion; inability to wake or stay awake; bluish lips or face; fever > 38.6 °C; or severe cough, nausea, vomiting, or diarrhea), she should immediately be referred to the COVID-19 treatment center for treatment.

## Step 2. Continue Antenatal Care (ANC) Visits

The second step in providing maternal and newborn services during the COVID-19 pandemic is to encourage the pregnant woman to continue ANC visits. After a woman receives pregnancy confirmation from a CHW or facility (Step 1), she should receive an initial ANC visit from a CHW or visit to facility. Health providers in facility should provide testing for HIV, tetanus toxoid (TT) immunization, syphilis and Hepatitis B infection testing, blood pressure measurement, urine checks for protein, and assess for other chronic conditions or diseases that can impact pregnancy as appropriate. During this first ANC visit, a CHW or health provider should work with the woman to develop an ANC schedule and check-up plan. Monthly ANC visits are recommended, but the schedule may be adapted depending on context and changed programming/conditions during the COVID-19 pandemic. CHWs and health facilities should educate all women on COVID-19 symptoms, importance of home care, maintaining social distancing, wearing a facemask when meeting with visitors, and maintaining good hygiene at home until delivery unless they experience pregnancy-related complications (including abdominal pain, dizziness, vaginal spotting, or bleeding) and/or severe symptoms consistent with COVID-19.

Women with COVID-19 symptoms:

If these symptoms occur during any ANC visit, CHWs or healthcare workers should refer women to COVID-designated treatment centers for testing and treatment, with contact tracing follow-up as needed. CHWs should also be vigilant to assess for other serious conditions that may cause similar symptoms.

Note: As COVID-19 testing becomes more available, all women should be prioritized to receive a COVID-19 test during routine ANC visits in health facilities.

**Step 3. Facility-based Delivery**

The third step in providing maternal and newborn services during the COVID-19 pandemic is facility-based delivery. CHWs should refer **all** women to a Basic Emergency Obstetric and Newborn Care (BEmONC) or Comprehensive Emergency Obstetric and Newborn Care (CEmONC) facility, as appropriate, for delivery with a skilled healthcare worker, regardless of COVID-19 status. Appropriate handover should be ensured so that the receiving facility understands if the woman has had a confirmed case of COVID-19 diagnosed within the previous 14 days. Facilities should follow the standard operating procedure (UNFPA) for delivery during COVID-19, including appropriate infection prevention and control (IPC) practices. CHWs should identify and record women who deliver at home during their visits to the women's homes.

Women with COVID-19 symptoms:

Women who test positive for COVID-19 or with symptoms consistent with COVID-19 infection should remain in facility after delivery until COVID-19 symptoms clear. Facilities should consult current UNFPA guidelines for discharge recommendations.

In the event of a COVID-19 outbreak or exposure in the facility, the length of stay in the health facility (e.g., 24 hours) may be shortened to reduce potential COVID-19 exposure of the mother and baby. If maternal or neonatal complications are identified, they should be attended to or referred, as is appropriate.

**Step 4. Postpartum/postnatal Follow-up Care**

The fourth step in providing maternal and newborn services during the COVID-19 pandemic is postpartum/postnatal follow-up care. After an uncomplicated delivery, **women who have tested negative** for COVID-19 should be discharged home.

Patients with symptoms consistent with COVID-19 should come back to the facility only after fever has resolved for 3 or more days without the use of any medications and 7 days have passed since the onset of symptoms, unless there are any medical emergencies, in which case she should come back immediately. If a woman is experiencing COVID-19 symptoms and pregnancy or postpartum complications, she must be seen in an isolated room with no other patients.

Pregnancy and neonatal outcomes should be tracked during postpartum follow-up visits using a postnatal care (PNC) checklist at home within one week of delivery (postpartum surveillance). Breastfeeding should be continued, with assistance from the family to pump breastmilk as needed, regardless of mild COVID-19 symptoms. Women should wear a face mask while breastfeeding or expressing breast milk and wash their hands for at least 20 seconds with soap and water before breastfeeding and after expressing breast milk.

If women return as outpatients to a facility for postnatal care, the waiting area should be a well-ventilated room (or even an outside space) in which other outpatients/families are socially distancing and wearing masks. If severe COVID-19 develops during the postpartum period, women should be referred to designated COVID-19 treatment centers.

Note: Training on infection control and prevention (IPC) measures must be provided to each CHW and all facility-based health workers before beginning service activities. Community-based contact tracing should occur for all women who test positive for COVID-19.

# COMMUNITY NEEDS ASSESSMENT SUMMARY

A Community Health Needs Assessment is a systematic process used to identify gaps between the current health outcomes and those that are needed to improve overall community health. Differences between the perceived needs of the community and the documented epidemiological needs must be considered. A needs assessment also serves as the foundation for developing the planning processes to improve population health through collaboration among community organizations. By identifying community strengths and weaknesses, resources can be directed toward developing and implementing effective solutions to improve health outcomes. A data-driven needs assessment leads to the prioritization of needs and determines the most effective and efficient interventions for achieving the desired results.

Health needs assessments consist of several components to accurately analyze the current population health status, identify barriers encountered by the target population, and develop a timely implementation plan that will lead to improved health outcomes. Data are gathered from primary and secondary sources to identify community needs and assets. In developing and executing this service-delivery plan, primary research is continuously collected in the form of client and provider surveys. Secondary data for health indicators was gathered from the following sources: The Florida Department of Health FLHealthCHARTS, County Health Rankings, U.S. Census Bureau, 2019 Community Health Needs Assessment, 2019 PRC Child & Adolescent Community Health Needs Assessment, Florida Department of Children and Families, Florida Department of Education (FLDOE), Enhanced HIV/AIDS Reporting System (eHARS), and FIMA data (obtained when available).

In addition to the above referenced data sources, the assessment will include an Investigation of Fetal Deaths. Using fetal death certificates (only certificates for birth weight of 500 grams or more or 20 weeks' gestation or more):

- Deaths due to maternal factors – lupus, age, diabetes, obesity, and hypertension
- Deaths due to placental failures/disease
- Fetal abnormalities

General: Fetal death certificates are required in Florida when the fetus weighs 500 grams or more or is 20 weeks' gestation or more. If the fetal death certificate is fully completed, there is significant data present that can indicate possible etiology. Data from the 2014 National Vital Statistics Report on Cause of Fetal Death indicated an average stillbirth rate of 611.7 per 100,000 live births in the U.S. Causes are usually grouped by Maternal, Fetal, or Placental type.

Risk factors for fetal death include:

- Race
- Advanced maternal age
- History of prior fetal demise
- Maternal infertility
- Obesity
- Paternal age

Although every attempt was made to gather and analyze the most current data, there are certain

limitations that should be noted.

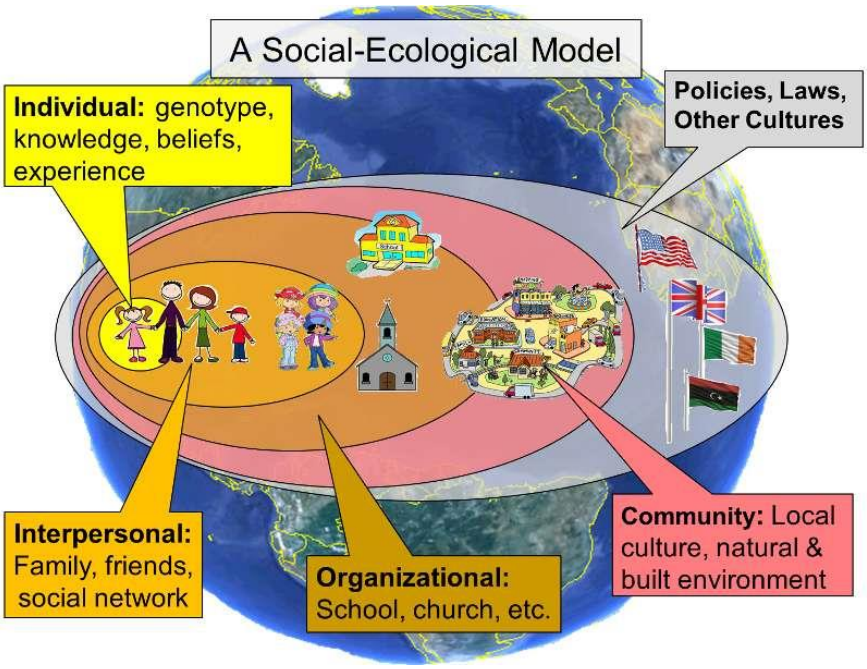
- Seminole County's population is predominantly white. For this reason, some data indicators are not available for black or other races. Additionally, there is limited data available for the Hispanic population.

- The sample size used for the 2019 PRC Child and Adolescent Community Health Needs Assessment produced statistically significant data at the county level. Limited data is available through crosstab queries for specific age ranges, gender, race, ethnicity, and ZIP Code.

Participation in the development and execution of a community-driven process has the potential to enhance program effectiveness, leverage limited financial resources, and strengthen the public health system. Collaboration among community partners can lead to improved health for all residents.

Serving all pregnant women and infants is the mission for the Healthy Start Coalition. However, our county is unique in its demographics and socioeconomic standing, so we must recognize and focus on the areas that reflect disparity and need. Data from targeted geographic areas enabled the identification of specific barriers that affect vulnerable populations in our community. Information gleaned from community surveys and focus groups provided detailed data regarding barriers experienced by Seminole County residents. A comprehensive data analysis facilitated the prioritization of needs to be addressed during the next five years.

Social-ecological models were developed to help people understand the interrelationships among various personal and environmental factors that exist in communities. The Social-Ecological Model of Health (SEM) is a public health framework used to holistically describe four levels of influence that explain the complex interrelationships between individuals and the social context within which they live, learn, work and play. The next figure outlines the Socio – Ecological Model of Health.




Source: Boston University School of Public Health

The SEM provides a framework to help understand the various factors and behaviors that affect health and wellness. With this model, the Collaborative can closely look at the social determinants that influence choices and outcomes. Several agencies and community members were involved with further identifying the specific barriers addressed by the assessment and analysis. Surveys and focus groups in these areas also contributed to the assessment of barriers. The Coalition was able to extract areas of importance or greatest need was by information received.

Seminole County is one of the state's 67 counties and covers 309.22 square miles. The total population is slightly over 472,775 residents with approximately 1,529 persons per square mile. The county consists of the following 7 cities: Altamonte Springs, Casselberry, Longwood, Lake Mary, Oviedo, Winter Springs, and Sanford. Each community in Seminole County is unique and the data gathered from each area reflects those distinctive differences.

As part of our ongoing effort to focus on vulnerable communities, socioeconomic indicators at the Census Tract (CT) level were analyzed to identify specific factors that may contribute to poor health outcomes. The CT's were chosen based on their high poverty rates and low educational attainment.

- Total population for each of identified census tract
- Percent of population living below 185% of the Federal Poverty Level (FPL)
- Percent of the population by race and ethnicity
- Percent with households without an available vehicle
- Percent of adults over 25 years of age who had not earned a high school diploma

The City of Sanford is located at the extreme northern end of Seminole County. Sanford is one of Central Florida's oldest communities, and the largest city in the county. Seven vulnerable CT's were identified.

**Census Tract (CT) 205** - is bordered by Highway 46 and Lake Monroe. It reports a population of 2,661 residents. Racially, 49.8 percent of the population is Black African American; 24.5 percent White, and 17.5 percent Hispanic. The percentage of the population living below 185% of poverty is the highest in Sanford at 71.7 percent. More than a quarter (25 percent) of the residents do not own a vehicle. Those over the age of 25 years without a high school diploma accounted for 17.0 percent of the population.

**Census Tract 201.01 -** is adjacent to census tract 205 and is bordered by Highway 46 and Lake Monroe. The total population of 1,221 residents are predominantly white (73.7%). Black residents accounted for 19.7 percent of the population while Hispanics represented 17.3 percent of the population. Poverty for those below 185% of the FPL accounted for 36.5 percent of residents. Just over fifteen percent of people living in this CT did not own a vehicle. Additionally, 9.4 percent of persons over 25 years old did not have a high school diploma.

**Census Tract 201.02** - is bordered by Highway 46 and CT 201.01. The total population of 1,255 is predominantly White at 66.8 percent, while Blacks represent 29.6 percent of residents. The Hispanic population is relatively small representing 5.2 percent of all residents. Poverty for those living below 185% of the FPL was 21.4 percent. Sixteen percent of households did not have an available vehicle. The percent of persons over 25 years of age without a high school diploma at 9.0 percent was lower when compared to other vulnerable CT's in Sanford.

**Census Tract 202.01** - is bordered by CR 415, SR 46 and Lake Monroe. The population of 2,204 residents is almost evenly split racially with 50.3 percent reporting as White and 45.7 percent reporting as Black. Ethnically, 15.0 percent of the population was Hispanic. Half of the population (49.7 percent) were living below 185% of the FPL. Just over eight percent of households were without an available vehicle. Nearly one quarter of the population (24.5 percent) over 25 years of age did not have a high school diploma.

**Census Tract 209.01** - is bordered by SR 417, SR 46, and Highway 17/92. The population of 4,814 residents are predominantly White (49.5 percent) with the Black population accounting for 33.6 percent of residents. Hispanics represented 39.9 percent of the population. More than fifty percent of the population lived below 185% of the FPL and 15'6 percent of households did not have an available vehicle. The percent of adults over 25 years old without a high school diploma was 9.2 percent during 2015-2019.

**Census Tract 209.03** - is bordered by SR 417, Highway 17/92, and Airport Blvd. The population of 10,102 is predominantly White at 64.8 percent. Black residents account for 19.5 percent of the population while Hispanics represented 35.3 percent of residents. Those living below 185% of the FPL accounted for 42.8 of all households. Just over seven percent of households did not have a vehicle. Adults, ages 25 and older who did not have a high school diploma accounted for 11.1 percent of that population group.

**Census Tract 211** - is commonly known as the community of Midway which is bordered by Highway 415 and Highway 46 and covers 1.4 square miles. Before it became the home of the Orlando-Sanford International Airport, this area was known for its numerous orange groves and agricultural produce. The population of 3,404 is predominantly Black (52.4 percent) with White residents representing 35.7 percent of the population. Hispanics accounted for 19.6 percent of residents in this CT. Just over thirty percent of households were living below 185% of the FPL and 4.3 percent of households did not have an available vehicle. Of those over 25 years of age, 14.7 percent had not earned a high school diploma.

Figure 69: Socioeconomic Indicators for Selected Census Tracts in Sanford, Florida

**Sanford, Florida (2015-2019)**

| | ZIP Code 32771 | | | | | ZIP Codes 32771 & 32773 | |
|---|---|---|---|---|---|---|---|
| **Census Tracts** | **205** | **201.01** | **201.02** | **202.01** | **211** | **209.01** | **209.03** |
| | | | | | | | |
| Total Population | 2,661 | 1,221 | 1,255 | 2,204 | 3,404 | 4,814 | 10,102 |
| People under 185% of poverty (%) | 71.7 | 36.5 | 21.4 | 49.7 | 31.8 | 50.5 | 42.8 |
| Dominate Race | Black | White | White | White | Black | White | White |
| Black or African American (%) | 49.8 | 19.7 | 29.6 | 45.7 | 52.4 | 33.6 | 19.5 |
| White (%) | 24.5 | 73.7 | 66.8 | 50.3 | 35.7 | 49.5 | 64.8 |
| Hispanic or Latino, of any race (%) | 17.5 | 17.3 | 5.2 | 15.0 | 19.6 | 39.9 | 35.3 |
| Percent of households with no vehicles available (%) | 27.6 | 15.3 | 16.1 | 8.3 | 4.3 | 15.6 | 7.5 |
| Percent of population over 25 years of age without a high school diploma (%) | 17.0 | 9.4 | 9.0 | 24.5 | 14.7 | 9.2 | 11.1 |

Source: U.S. Census Bureau

Oviedo, Florida is located about 20 minutes Northeast from downtown Orlando. It is part of the Orlando-Kissimmee-Sanford Metropolitan Statistical Area. It is about 15.4 square miles.

**Census Tract 213.12** - is within the Oviedo ZIP Code of 32765 which had a population of 5,503 residents of which 81.4 percent were White and 6.4 percent were Black. Hispanics accounted for twenty percent of the population. The percentage of households living below 185% of the FPL was 21.1 percent with 4.0 percent of households without an available

vehicle. Four percent of the adult population 25 years and older were without a high school diploma,

**Census Tract 213.16** - within the Oviedo ZIP code of 32765 which had a population of 4,519 residents of which 74.3 percent were White and 9.1 percent were Black. The Hispanic population represented 16.2 percent of all residents. The percentage of households living below 185% of the FPL was 18.7 percent. The percentage of those over the age of 25 years without a high school diploma was low at 1.3 percent. This and the fact that no households were without a vehicle may be explained by its close location to the University of Central Florida (UCF) which is in Orange County. The UCF student population, ages 18-22 years, fluctuates throughout the year. Women in this age range are subject to unintended pregnancies. Further review of related data points for this populations are needed. An opportunity to collaborate with the Healthy Start Coalition in Orange County may be appropriate since the student live within the borders of Orange and Seminole counties.

Figure 70: Socioeconomic Indicators for Selected Census Tracts in Oviedo, Florida

**Oviedo, Florida (2015-2019)**

| | ZIP Code 32765 | |
|---|---|---|
| **Census Tracts** | **213.12** | **213.16** |
| | | |
| Total Population | 5,503 | 4,519 |
| People under 185% of poverty (%) | 21.1 | 18.7 |
| Dominate Race | White | White |
| Black or African American (%) | 6.4 | 9.1 |
| White (%) | 81.4 | 74.3 |
| Hispanic or Latino, of any race (%) | 20.0 | 16.2 |
| Percent of households with no vehicles available (%) | 4.0 | 0.0 |
| Percent of population over 25 years of age without a high school diploma (%) | 4.0 | 1.3 |

Source: U.S. Census Bureau

Altamonte Springs is a suburban city located north of the City of Orlando. It is approximately 9.5 square miles.

**Census Tract 217.05** – is considered Forest City within ZIP Code 32714. The population of 5,285 residents was 74.1 percent White, 12.4 percent Black and 40.0 percent Hispanic. Over thirty percent of residents were living below 185% of the FPL. Nine percent of the adult population (25 years and older) had not earned a high school diploma. Eight percent of the population was without an available vehicle.

Figure 71: Socioeconomic Indicators for Selected Census Tract in Altamonte Springs, Florida

**Altamonte Springs, Florida (2015-2019)**

| | ZIP Code 32714 |
|---|---|
| **Census Tracts** | **217.05** |
| | |
| Total Population | 5,285 |
| People under 185% of poverty (%) | 31.5 |
| Dominate Race | White |
| Black or African American (%) | 12.4 |
| White (%) | 74.1 |
| Hispanic or Latino, of any race (%) | 40.0 |
| Percent of households with no vehicles available (%) | 8.0 |
| Percent of population over 25 years of age without a high school diploma (%) | 9.0 |

Source: U.S. Census Bureau

According to the Attainable Housing Strategic Plan for Seminole County (November 2020) Affordable housing is defined as the occupant(s) is/are paying no more than 30% of his/her income for gross housing costs, including utilities (Source: 2018 Regional Affordable Housing Initiative). Households spending more than that are considered “cost burdened”. The Regional Initiative found that 26.7 percent (44,750) of Seminole County’s 167,549 households were cost burdened.

**High Number of Cost Burden Households:**

- 89% of households with income under $20,000
- 73% of households with income $20,000-$34,999
- 57% of households with income $35,000-$49,999

**Housing Stock/Inventory**

- Currently there are 5,421 units in Seminole County that are required to maintain affordability through the Low-income Tax Credit (LIHTC) Program.
- From 1997 through 2012 a total of 2,225 units were released from the affordability requirement and converted to market rate rents.
- Approximately 1,500 units are at risk of conversion to market rent rates over the next five (5) years due to the 15 year “opt out” provision.

**Funding Limitations**

- The funding programs currently available to the County (Federal, State) are limited to households with incomes 30% to 120% of Area Median Income (AMI)
- Instability of the State Housing Initiatives Partnership Program (SHIP Funds); and
- There is no current Federal funding assistance for households at 140% of AMI. SHIP has been used in some jurisdictions, but these funds are subject to set-aside requirements.

**Impacts from a Lack of Affordable Housing**

Housing instability leads to:

- Frequent moves, negative educational outcomes, and physical/behavioral health problems in adults and children.
- Reduced ability for individuals and families to afford critical necessities such as healthcare, education, and food.
- Low-income wage earners are at a higher risk for homelessness when paying more than 30.0 percent of monthly income on rent/mortgage.

Health Insurance coverage in 2015-2019, at 89.2 percent for those 19-64 years of age, increased from 84.9 percent in 2011-2015. The overall county rate indicated that 90.5 percent of the population had health insurance. Slightly less than thirty percent of residents were covered by public insurance. Rates of insurance were higher among those who were employed when compared to unemployed residents.

Uninsured inpatient hospital visit data was gleaned from the hot spot analysis for AdventHealth Altamonte Springs. The analysis includes all uninsured inpatient visits (Figure 51) and focuses on those visits within the hot spot for fiscal years 2016 through 2018. The top five census tracts in the hot spot included the cities of Altamonte Springs, Casselberry, and Longwood. The unemployment rate averaged about five percent; approximately 15 percent of the population was living below the federal poverty level. The average annual median household income was $42,936. The 458 uninsured inpatient visits from within the hot spot cost the hospital more than $18.9 million and accounted for 18.2 percent of all uninsured inpatient visits between 2016 and 2018. More than half (64.7 percent) of uninsured inpatient visits were made by White patients. Additionally, patients aged 40-49 accounted for 26.9 percent of uninsured inpatient visits. Sepsis, unspecified organism, was the most frequent primary diagnosis code and had the highest total cost from uninsured inpatient visits within this hot spot at 5.2 percent and with a total cost of more than $1.7 million. Essential (primary) hypertension was the most frequent secondary diagnosis from uninsured inpatient visits within this hot spot at 5.2 percent and with a total cost of more than $700,000 for the same time-period.

Figure 72: AdventHealth Altamonte Springs Uninsured Inpatient Visit Comparison (2016-2018)

| Criteria* | Data Snapshot |
|---|---|
| Total uninsured inpatient visits | 2,510 |
| Total uninsured inpatient cost | $103,736,366 |
| | |
| Total uninsured inpatient visits in hot spots | 458 |
| Total uninsured inpatient cost in hot spots | $18,922,818 |
| Percent of uninsured inpatient visits in hot spots | 18.2% |
| | |
| Total homeless uninsured inpatient visits | 192 |
| Total cost for homeless uninsured inpatient visits | $7,036,282 |
| Percent of homeless uninsured inpatient visits | 7.6% |

Public transportation in Seminole County includes SunRail railway system and the Lynx bus service. There are four SunRail stations in Seminole County with connections to bus services. The frequency of bus services range between 30 minutes during peak times and 60 minutes off peak. This can create challenges for pregnant mothers, with or without small children, who rely on public transportation for any type of appointment. Many families that may have an automobile are unable to afford the associated costs with traveling to/from appointments. Other transportation possibilities include Uber and Lift ride sharing services. Coupons for these services are becoming more readily available and likely to increase in the future. Although more transportation options are slowly being offered in the county, the associated cost and travel time continue to be barriers.

The 2019 PRC Child & Adolescent Needs Assessment revealed that 28.1% of Seminole County live births did not receive prenatal care in the first trimester of pregnancy. The percentage of births

to teens, ages 15-19 years, at 3.3 percent was the lowest among the three-county area which included Orange and Osceola counties. Birth trends for teens has continually decreased over the past ten years.

According to Healthy People 2030, women's health before, during, and after pregnancy can have a major impact on infants' health and well-being. Women who get recommended health care services before they get pregnant are more likely to be healthy during pregnancy and to have healthy babies.

AdventHealth and OrlandoHealth's Community Health Needs Assessment also highlighted an increased in infant mortality, births to mothers who were obese, preterm births and low birthweight births. According to the survey respondents, health insurance coverage increased among some of the more vulnerable populations such as those with less than a high school diploma and those with low income yet a substantial percentage of the population experiences challenges accessing health care. The survey cited barriers that included transportation, culture/language, awareness, health literacy, affordability lack of access to specialty services, and difficulty getting appointments.

Payment for healthcare services and/or the benefit of third-party coverage is a reoccurring barrier. In March 2021, a plan was introduced to the Tallahassee legislature to extend the amount of time new mothers could be eligible for Medicaid from 60 days to one year. This would cost the state $93 million and taxpayers about $240 million to cover about 98,000 mothers in Florida. This extension, passed in June 2021, will ensure better care and services for both mothers and babies. During 2019-2020, 64.0 percent of all women who received a Healthy Start service were enrolled in Medicaid. This was lower when compared to the state at 76.6 percent. Navigating Managed Care Organizations and the Affordable Care Act online application process add additional challenges when seeking to obtain healthcare insurance. Community members surveyed expressed the inability to locate providers that accepted Medicaid for the services desired by the mother. Births to uninsured mothers decreased from 4.2 percent in 2004 to 3.6 percent in 2017.

Childcare assistance was an issue of concern that was conveyed by individuals surveyed in the community. The Early Learning Coalition is one of the community partners involved with the coalition to further research and define the precise issues that contribute to the perceived issue. Focus groups and additional data will be utilized throughout the process.

The Public Health Services Act, section 2719 requires health plans and insures to make certain accommodations for the provision of the summary of benefits (SOB) and the unform glossary in a culturally and linguistically appropriate manner. The threshold for this accommodation is set at 10.0 percent or more of the population who are literate in the same non-English language. Seminole was not listed as one of the identified areas.

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) aim is to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities. The Principal Standard:

> *Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy and other communication needs.*

The Florida Department of Health in Seminole County completed an assessment of services provided to the public to ensure that they met CLAS standards. Other community partners have completed their specific reviews of CLAS standards as well. Some families operate from a cultural standpoint that may not adhere to the medical recommendations set forth for healthy pregnancies. Families follow traditional cultural or parenting patterns to differing degrees, depending on a wide range of factors, including the primary language the family speaks at home and in the community, the family's level of education, the family's religious affiliation, the family's country of origin, the length of time the family has lived in the United States, the family's degree of acculturation, and where the family currently lives.

Although providers and staff have worked hard to provide a culturally competent environment for all patients, the need to accommodate all ethnicities and languages is a constant challenge. This can prevent obstacles when seeking health care. Many factors must be considered to address cultural differences not only across all cultures but within each culture as well. Additionally, income may be a stronger predictor of family preferences and expectations than some aspects of culture, thus leading us back to the understanding that no barrier is an isolated occurrence.

Pregnant women with behavioral health issues face additional problems as they are less likely to seek prenatal care especially if noncompliant with medication and/or counseling. There is often denial of the existence of the pregnancy and the first care she receives is in the emergency room. The focus of this care is to avoid negative birth outcomes and may not address the mental health status of the mom. Providers treating women with impaired psychological function must provide the patients with information about where to find help if pregnancy occurs. Keeping mental health facilities informed on what programs are available is a priority. Since the advent of Managed Care, Medicaid clients are referred to their HMO for mental health services. The Healthy Start program utilizes Aspire Health Partners and Melting Walls Family Consultants for mental health providers.

In Seminole County, the illegal or alien status client is provided immediate assistance through the local health department. There is a very small number of families that present at the Florida Department of Health in Sanford requiring maternal and child services. Every member of the family is provided immediate Medicaid for 9 months. In the few instances where additional maternal services are needed, the mother is provided one-on-one assistance the same day in applying for WIC and/or the Healthy Start Program. This is a convenient "real time" service as both programs are collocated in the same building. In many cases, clients may present from our neighboring Orange County. These families are assisted as well. Community Health Centers, Inc., which has several sites, provides healthcare to the uninsured immigrants.

Many of our underserved patients feel the physician is not interested in the patient. A plan to survey local physician groups with the goal of improving the perceptions of the physician and patient would be beneficial on many levels. The goal is to reduce barriers that prevent access to care.

Inadequate system capacity is driven by cost (set fees within Medicaid), utilization of the needed services, and quantity of physicians to provide the services. Although many of the obstetricians and gynecologists in Seminole County accept pregnancy Medicaid, there is a lack of providers to serve those at high-risk. For this reason, there are a significant number of mothers referred to services in Orange County where there are more specialty providers.

Other factors that affect the capacity building, especially for neonatal intensive services are associated with the underlying physician or population preferences regarding specific treatment

practices rather than the supply of the services. Expanding capacity in maternal child health produces better health outcomes.

Over the past five years (2015-2019), the rate of OB/GYN providers per 100,000 population has decreased from a high of 10.1 in 2016-2017, to 9.0 per 100,000 population in 2019-2020.The actual number of OB/GYN also decreased from 46 in 2016-2017 to 43 in 2019-2020. As of 2014, Seminole County has 20 OB/GYN provider offices: 17 private practices, 2 Correctional Facilities, 3 midwifery services providers (1 with a birthing center) and 3 hospitals. Most of the providers accept Pregnancy Medicaid as well as various private medical insurances. The county recently added 10 NICU II beds in AdventHealth in Altamonte Springs. This may affect the number of women delivering in Seminole County who were historically referred to Winnie Palmer Hospital in Orange County for specialty care services. Around 25%-30% of the pregnant women who reside in Seminole County receive services in the neighboring counties (Orange and Volusia) by personal choice.

# FISHBONE DIAGRAM ANALYSIS

A fishbone diagram visually categorizes the potential causes of a specific problem with the main purpose of finding a root cause or causes. A thorough review of the data identified three overarching issues that are directly related to infant mortality: low birth weight, pre-conception & Inter-conceptional care, and prenatal screening. Despite various efforts, the question remains "Why do our babies continue to die?" This was viewed as the main issue in Seminole County and became our unanimously agreed upon problem statement.

The fishbone diagraming process was used to structure our brainstorming sessions around probable causes. The input gathered was sorted into useful categories that included: Access to care issues, poverty; health of mother before pregnancy, low birth weight; medical insurance problems, lack of social support, lack of community services, domestic violence, and transportation issues.

What follows is an overall view of our efforts to construct a fishbone diagram that indicates all the relevant causes affecting the problems and placing them in a specific category (see above list). For each cause, the question "Why does this happen?" was asked and the responses were recorded into the diagram.

**Poverty**

Local social service providers have observed the gradual increase of families living below poverty level who rely on their services. Due to a lack of finances, there appears to be a shift in the make-up of families with various cultural backgrounds and beliefs merging into one household. Multi-generational households increase the potential for elder family members who may have had a different level of education, sway their influence on the young prenatal mothers of today. Many elders did not receive the same level of prenatal care available today and are uninformed about the need and benefits of care provided during pregnancy. Regrettably, these are not rare situations as there appears to be an increase in this type of household structure. Within the target areas in Seminole County, the poverty rate increase correlated with an increase in the percentage of residents who lacked high school diplomas. Research showed that the educational level of the mother had a negative impact on the birth outcome. Those with less education are bound to experience limitations to reading and comprehension which then hinders employment opportunities. Adolescent women are at a higher risk for unplanned pregnancies that lack prenatal care and education further increasing the likelihood of health complications for the mom and her baby. When parents do not embrace the importance of healthcare for themselves, they do not see the benefits of continued preventive healthcare for their children.

**Health of Mother Before Pregnancy**

Preparing the body for pregnancy through good nutrition and exercise can mitigate the stress and anxiety associated with being pregnant. A pregnancy that occurs too early, before all the changes of maturity have occurred, can result in poor birth outcomes as often the case among young teen mothers. Very young adolescent women have little knowledge of what occurs to the body during

pregnancy. There is usually little to no planning for their conception or the routine medical care that can detect many genetic and/or chromosomal abnormalities early in pregnancy.

Diet is critical in pregnancy to assure enough calcium, protein, and folic acid are taken prior to conception to lessen birth defects such as neural defects (spina bifida, encephalopathy, and others). Marital status, denial of pregnancy, and social stigma are additional factors that prevent the best possible birth outcome.

Domestic violence causes injuries to the mother that affect the health of the fetus. Individual behaviors such as smoking, alcohol consumption and drug use are extremely dangerous to the developing baby. Good mental health during pregnancy has the potential to reduce the possibility of endangering situations such as postpartum depression.

**Lack of Community Services**

The lack of community services and social support are interconnected issues contributing to infant mortality in Seminole County. Eliminating barriers toward achieving desired maternal-child-disease prevention outcomes should include access to comprehensive perinatal services, including preconception/inter-conception care and social services. This requires an integrated to identify the medical and psychosocial risks that begin at preconception and extend throughout the pregnancy and postpartum periods. Family-centered care, including a review of the parents' attitudes toward the pregnancy, family life, childcare practices, environmental stressors, support systems, and interest in childbirth education classes should be included in the care model. All women are entitled to a caring environment during pregnancy.

**Lack of Social Support**

Infant mortality is a major public health problem in under-resourced communities and represents significant costs for families, communities, and health systems. Provision of social support to pregnant women has been proposed as an intervention to reduce the incidence of infant mortality. Social support is broadly defined to include advice and counseling (on health-related behaviors such as nutrition, rest, stress management, and substance use), paternal involvement, provision of transportation for clinical appointments, household help, guidance on weight gain, and cultural beliefs and practices. The theory is that social support has a mediating effect on the relationship between life stress from a range of causes and poor pregnancy outcomes such as infant mortality.

Media engagement was determined to be a tool to address the legislative needs for local and state advocacy as it supports maternal and child health. The forefront of initiatives must be clearly articulated with the assistance of lobbyists. This ensures that the specific issues for the county are known and addressed to lead to better outcomes for families. The media can be used as a method for transferring knowledge to the community that supports all aspects related to maternal and child health.

Low income coupled with complicated social issues limit access to needed resources and the transportation required to attain them. Yet, when intervention services are provided in a home, Seminole County is currently at a disadvantage with the limited number of home-based programs that could identify and support specific maternal needs of the family.

### Domestic Violence

The term intimate partner violence is also known as domestic violence, spouse abuse, or woman abuse. We utilize the definition of “intimate partner” as a current or former partner, including a spouse, boyfriend, or girlfriend. Almost seventy-five percent of acts of violence against women, over the age of 18 years, are perpetrated by a current or former husband, cohabitating partner, or date. In other cases, the perpetrator is another family member, such as a parent or guardian, or a more casual acquaintance. Violence during pregnancy may be a more common problem than conditions for which pregnant women are routinely screened. The Division of Reproductive Health of the National Center for Chronic Disease Prevention and Health Promotion studies have found possible associations between intimate partner violence and unintended pregnancy, delayed prenatal care, and behavioral risk factors such as smoking and alcohol and drug abuse.

### Low Birth Weight Babies

Twins or multiple conceptions increase the risk for a low birthweight baby. Babies weighing less than 2,500 grams are often immature with stunted growth and delayed development.

If early prenatal care is obtained, many low birth weights can be prevented with diet and avoidance of risky behaviors such as smoking and drug use. Even second-hand tobacco smoke is thought to be a risk for the developing fetus. The underlying health problems of the mother, including diabetes, hypertension, genetic factors, anorexia, or previous low weight births can be controlled with appropriately timed care to increase the chances that the baby will be born at a healthy weight. Limiting factors have been the lack of specialty high-risk providers and transportation to appointments and follow-up exams.

### Access to Care

Without access to care, small problems become critical health issues resulting in poor birth outcomes. Underlying disease may not be detected (diabetes, hypertension), preeclampsia, other complications are a danger to the mother and baby. There may be lack of access to medical care early on because of insurance problems, especially if Medicaid enrollment is needed. High-risk providers may be unavailable due to a lack of transportation or location. Late entry into insurance programs can cause delays in receiving health and dental care. In some foreign-born or ethnic groups, customs of delivery and care prolong access, especially if there is a language barrier. Births with no prenatal care are a high risk for complications.

### Medical Insurance Barriers

As evidenced in the growing body of literature, medical insurance is an important construct to clinical medicine, public health, and public affairs alike. Medical insurance is correlated with increased access to medical services, increased help seeking behaviors, and a reduction in the financial burden of medical care. In Seminole County Florida, 10.1 percent of employed adults, 19-64 years, were without health insurance during 2015-2019. This was lower when compared to the state at 16.9 percent.

Public health insurance plans (i.e., Medicaid) do not guarantee the same access to care that private insurance plans offer. While insurance coverage can empower women to seek care, socioeconomic barriers often prevent mothers from successfully navigating the system to attain ongoing care. In some ethnic groups and among foreign-born citizens, customs of delivery and care can further prolong entry into prenatal care, especially if there is a language barrier.

## Transportation

Early and adequate prenatal care ensures healthy pregnancies through screening, management of risk factors, monitoring of health conditions, education, and counseling on healthy behaviors during and after pregnancy. Common barriers to accessing prenatal care as early as required (or at all) can include transportation issues. A review of Seminole County census tracts in the areas of highest need revealed that homes reporting no vehicle available were as high as 26.7 percent.

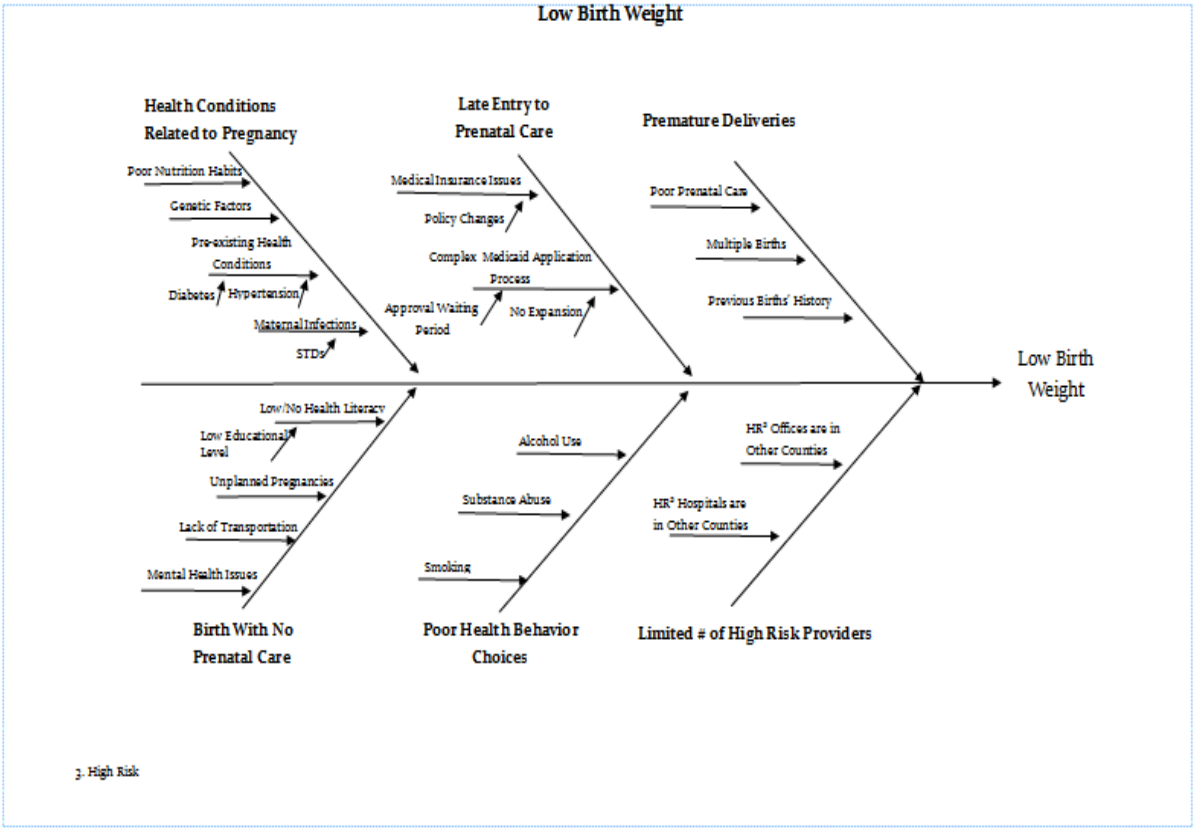
The primary option outside of private transportation is public transportation. Seminole County is serviced by the Central Florida Regional Transportation Authority (CFRTA), also known locally as Lynx. They provide 77 daily bus routes in the tree-county area. FASTLINK is a weekday morning and afternoon services designed to provider quicker services by reducing stops along certain corridors. The SunRail commuter line launched in 2014 connects twelve stations through the area with four locations in Seminole County (Sanford, Lake Mary, Altamonte Springs, and Longwood). There remain four cities where SunRail is still not available. The system operates over 49 miles with 16 stations through Volusia, Seminole, Orange and Osceola counties. The county has for-profit private taxicab services that provide transportation to community members at a cost. Survey data collected over the past 2 years from Seminole County community members continues to list the lack of adequate access to transportation as a barrier to care.

The top socioeconomic disparities in Seminole County include limited access to public or private transportation, lack of high-risk providers and obstetric providers who accept Medicaid, lack of dental health services, limited affordable childcare, low health literacy and lack of unawareness of resources for women and families living below the federal poverty level. This combination of barriers can become critical and result in poor birth outcomes such as premature births, stillbirths, and other complications. A lack of early and coordinated care often means that underlying diseases may not be detected (e.g., diabetes, hypertension, preeclampsia) further impacting birth outcomes.

The fishbone diagram and its subsets will serve as a roadmap for the coalition as we continue to develop our service delivery plan for our maternal and childcare healthcare system. Continuing to collect community input regarding the needs and barriers to services will enable the development and implementation of interventions to improve population health.

Many data points were considered to identify the specific issues affecting our community. This effort emphasized the importance developing a diverse and inclusive delivery plan. The Data Committee focused on 3 main factors to address: Low birth weight, preconception and inter-conception care, and prenatal screening rate. It is understood that as work continues in the neighborhoods and the coalition, the three main factors could change.

## FIRST BONE: Low Birth Weight




**PROBLEM IDENTIFIED**: Premature Deliveries

In addition to maternal health during the current pregnancy, a history of prior preterm is an important factor. In 2019, 8.9 percent of births were <37 weeks gestation. Not all of these were to first time moms. The rate of stillbirths increased to 8.3/1,000 deliveries from 7.6/1,000 deliveries in 2015. Multiple births usually result in lower birth weight babies and often prematurity. The existence of multiple births in the family should be reported as well. If there is a history of multiple births and/or prematurity, the mom may be sent to a high-risk obstetrician for specialty care.

### How this Impacts MCH/Birth Outcomes:

In Seminole County (2017-2019), preterm births among White woman, at 8.4 percent, were lower when compared to the state (9.3 percent) and preterm births among Black & Other at 11.8 percent. Reaching 37 weeks of gestational age is a measure of success in achieving a full-term pregnancy. Births that occur before 37 weeks gestation (preterm births) have lower chances of survival and higher chances of short and long-term health problems when compared to term births. Studies show that premature infants have a significantly increased risk of developing neurological impairments as they grow older. Infants born prematurely are also at a greater risk for mortality and other health and developmental issues. The care for premature infants is more costly. Reducing the rate of premature births will require more engagement from healthcare

providers, renewed focus on education and increased social services support. These overlapping factors are leading contributors to poor birth outcomes among racial and ethnic groups who are socioeconomically disadvantaged.

**How the Healthy Start Coalition Can Improve it:**

The coalition can create a network of partnerships across community providers to improve education the importance of preconception and inter-conception care. A strong focus should be placed on receiving care early in the pregnancy. The coalition can work to establish a multidisciplinary team to assess the community factors that can best addressed to increase education and awareness throughout the county.

**PROBLEM IDENTIFIED:** Health Conditions Related to Pregnancy

Since maternal and child health reflects the overall health of a community, it is important to look at addressing several health status indicators as an opportunity to improve birth outcomes. The percentage of White women who were obese when pregnancy occurred (24.0 percent) was only slightly lower when compared to Black & Other women at 27.7 percent. Among Hispanic women, 26.7 percent were obese when they conceived. Rates for overweight status was similar across racial and ethnic groups, ranging from 26.4 percent among Black women to 29.2 percent among Hispanic women. Although our statistics do not break out the incidence of pre-pregnancy or gestational diabetes or births to women with pre-existing hypertension. These health issues have been identified as having potential negative impacts on birth outcomes and will be added as a question to future surveys.

**How this Impacts MCH/Birth Outcomes:**

Women who are overweight or obese while pregnant are more likely to have premature births, babies with birth defects like neural tube defects, or babies who are large for gestational age. These women are more likely to have complications during labor and birth, and their babies are at a higher risk of developing heart disease, diabetes, and obesity later in life. Despite the current obesity epidemic, maternal underweight remains a common occurrence with potential adverse perinatal outcomes. Singletons born to underweight women have higher risks of preterm birth and low birth weight. Other pre-existing conditions or genetic factors not identified and controlled in the first trimester can cause serious complications for the mother and baby.

**How the Healthy Start Coalition Can Improve it:**

The coalition will work on improving surveys/questionnaires in the community to identify low birth weight “red flags”. A partnership with obstetricians and general practitioners to distribute educational media on the importance of maintaining a healthy weight through diet and exercise.

**PROBLEM IDENTIFIED:** Prenatal Care by Trimester of Pregnancy

**How this Impacts MCH/Birth Outcomes:**

Prenatal care (PNC) visits provide benefits to both the mother and baby and are used to monitor the progress of a pregnancy. To achieve the greatest benefit for both the mother and baby, it is

recommended that women begin PNC visits in the first trimester of pregnancy or as soon as pregnancy is suspected or confirmed. Early PNC allows health care providers to identify potential problems as early as possible so they can be prevented or treated before they become serious. Ensuring that all women receive early and adequate PNC is a top maternal and child health priority. Public health programs emphasize access to early PNC services for teens, women with less than a high school education, and Black and Hispanic women.

Seminole County worked hard to reduce the percentage of births with no prenatal care. In 2019, 1.6 percent of births in the county did not have any prenatal care. This was lower when compared to the state rate at 2.4 percent. Births with second trimester care was higher at 14.8 percent but still lower than the state at 16.7 percent. Rates for births with care staring in the third trimester were 3.6 percent for the county and 5.1 percent for the state.

**How the Healthy Start Coalition Can Improve it:** Problem does not warrant action at this time.

**PROBLEM IDENTIFIED:** Poor Health Behavior Choices

**How this Impacts MCH/Birth Outcomes:**

Smoking during pregnancy is associated with increased risk of low birth weight and Sudden Infant Death Syndrome (SIDS). Eliminating smoking before pregnancy is one of the most effective ways to reduce the risk of low birth weight, SIDS, and other infant health problems.

In Seminole County (2017-2019), 2.6 percent of live births were to mothers who smoked during pregnancy. Among women in Florida, the rate was 4.4 percent. White women were more likely to smoke (2.9 percent) when compared to Black women at 1.7 percent. Smoking while pregnant was lowest among Hispanic women at 1.4 percent.

In Seminole County (2016), almost twenty percent of women engaged in heavy or binge drinking. This was higher when compared to women in the state at 13.7 percent. This is the highest percentage of binge drinking among Seminole County women since reporting began in 2002. This is a critical issue to preconception and inter-conception care when it is estimated that 50.0 percent of women did not intend to become pregnant at the time of conception.

Local data on substance abuse during pregnancy are difficult to obtain. The State of Florida has taken an active interest in reducing substance use, specifically prescription drug use in pregnant women. Although substance abuse in women tends to decline with age, up to 21% of pregnant teens aged 15-17 report some form of illicit drug abuse. Women who are addicted to illicit substances during pregnancy often pass this addiction through the placenta to baby. The exposure to illicit substances in-utero often causes many complications including, but not limited to, Neonatal Abstinence Syndrome (NAS), in which the baby experiences withdrawal symptoms (sometimes so severe that baby requires morphine or even methadone treatment); low birth weight and very low birth weight; SIDS; and other serious birth defects. While the Healthy Start Coalition is limited in its potential to help mothers address substance abuse issues that are often socioeconomic in nature, health education is a priority of the coalition. The coalition will continue to support efforts to help mothers receive the type of support necessary to reduce or end illicit substance dependence.

**How the Healthy Start Coalition Can Improve it:**

Meeting women wherever they are on the health spectrum is extremely important to the Healthy Start Coalition of Seminole County and present an opportunity to improve health outcomes.

**PROBLEM IDENTIFIED:** Limited Number of High-risk Providers

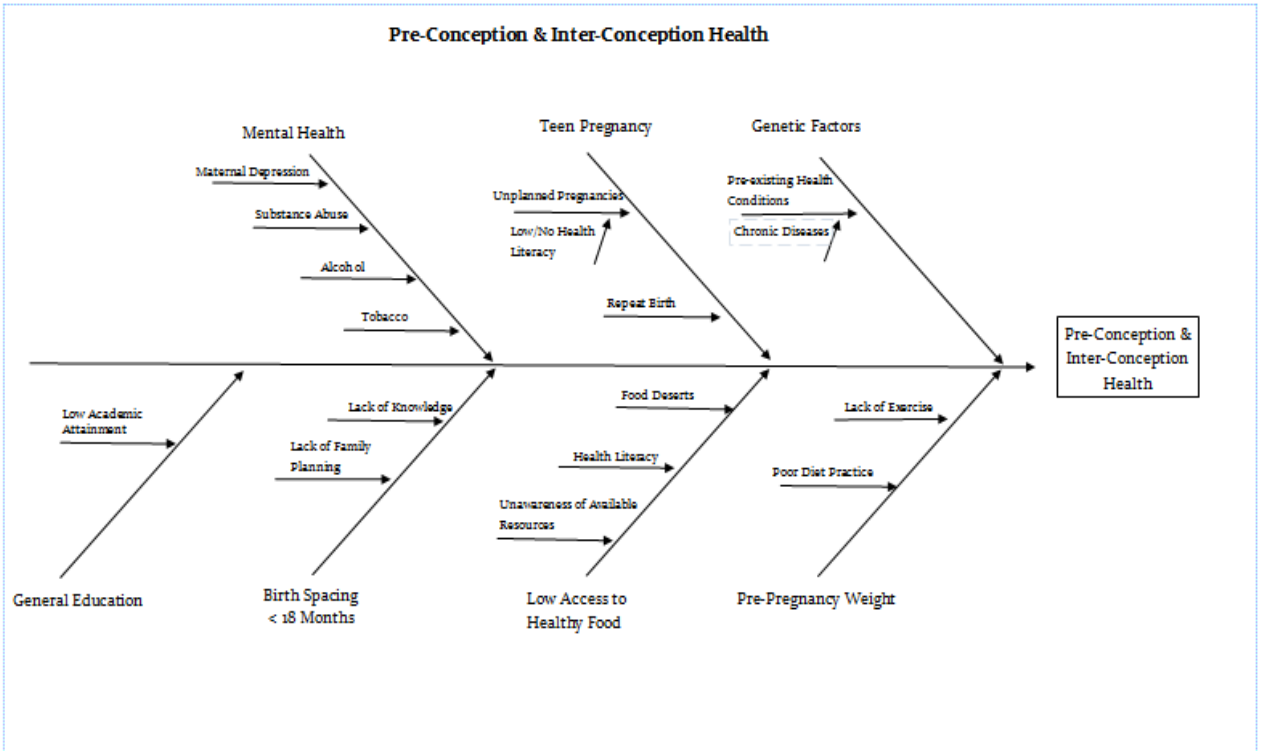
**How this Impacts MCH/Birth Outcomes:**

Data reflects that 65.2 percent of Seminole County's infant screens were completed by an Orange County provider. Winnie Palmer Hospital is the closest high-risk hospital for Seminole County residents, as well as it being the Regional Perinatal Intensive Care Hospital for the State of Florida. Over 42 percent of Seminole County's prenatal screenings are tagged to Orange County, where Winnie Palmer is located.

**How the Healthy Start Coalition Can Improve it:**

The coalition will collaborate with Orange and Osceola counties in a tri-county effort to work with obstetricians and the only high-risk hospital in area. The goal is to provide a continuum of care that provides access for the women in the targeted ZIP Codes and census tracts that have the greatest need. The coalition will also work with the Medical Society, as well as other partners, to encourage a satellite office in the county for easier access for high-risk mothers.

# SECOND BONE: Preconception & Inter-Conceptual Health




**PROBLEM IDENTIFIED:** Genetic Factors

### How this Impacts MCH/Birth Outcomes:

Early prenatal care that captures patient history is the first step in screening for potential genetic predisposition. In the case of Tay-Sachs disease or cystic fibrosis, testing can be expensive and not readily available. For other genetic conditions, as in Down syndrome, there is routine testing for women older than 35 years as chromosomal abnormalities are much more common population. During 2010-2014, there were 22 babies born with Down syndrome.

### How the Healthy Start Coalition Can Improve it:

The coalition will work with doctors, community partners, and the Medical Society to make additional educational resources available to all providers throughout the county on the importance of genetic counseling, within our preconception and inter-conception care program. The coalition will work toward ensuring that all women have access genetic counseling and will work with Medicaid providers to find additional methods of funding to obtain genetic testing, if desired.

**PROBLEM IDENTIFIED:** Pre-pregnancy BMI Too High

**How this Impacts MCH/Birth Outcomes:**

Women who are overweight or obese while pregnant are more likely to have premature births, babies with birth defects like neural tube defects, or babies who are large for gestational age. These women are more likely to have complications during labor and birth, and their babies are at a higher risk of developing heart disease, diabetes, and obesity later in life. Complications associated with being overweight and obesity include gestational diabetes mellitus, hypertension, preeclampsia, cesarean delivery, and postpartum weight retention. Similarly, fetuses of pregnant women who are overweight or obese are at increased risk of prematurity, stillbirth, congenital anomalies, and childhood obesity. Obese women are also less likely to initiate and sustain breastfeeding. The percentages of women with obese weight status at the time pregnancy occurred have increased among all races and ethnicities with the highest rates among Black Non-Hispanic women. This places an additional burden on communities where Blacks are the dominant race.

**How the Healthy Start Coalition Can Improve it:**

The coalition supports offering inter-conception education counseling, which includes the provision of specific information concerning the maternal and fetal risks of obesity in pregnancy, nutrition consultation, and encouragement to adopt exercise programs to all overweight or obese women. Nutrition and exercise counseling should be continued postpartum and before attempting another pregnancy.

**PROBLEM IDENTIFIED:** Low Access to Healthy Food

**How this Impacts MCH/Birth Outcomes:**

Studies show that inadequate consumption of folic acid and inadequate nutrition prior to pregnancy care, can result in poor birth outcomes. According to the USDA, Economic Research Service, Food Environment Atlas, Access, and Proximity to Grocery Store (2015), Seminole County's population with low access to a store is 27.8% (116,001) and those who are low income/low access to a grocery store account for 7.16% of this population. The Florida Environmental Public Health Tracking System (2015) identified 2 of our targeted areas (ZIP code 32773, census tract 209.03 and ZIP code 32765, census tract 213.12) where only 23.4% and 31.0% of the population live within a ½ mile distance of a healthy food source, respectively.

In 2019, the Black population in Seminole County accounted for 12.0 percent of the total population. This was much lower when compared to the state at 16.1 percent. Analysis of the targeted census tracks revealed that predominately Black communities has higher rates of poverty when compared to overall county rate. For the time-period spanning 2017-2019, the Seminole County poverty rate of 11.3 percent lower than the state rate at 14.7 percent. By race and ethnicity, the White population has lower rates of poverty (9.6 percent) when compared to the Black and Hispanic populations at 16.9 and 16.0 percent, respectively.

**How the Healthy Start Coalition Can Improve it:**

The coalition will continue to support WIC efforts and initiate partnering with a local nutritionist group. This new plan would involve a mobile food bus with the ability to bring fresh fruits and vegetables and provide nutrition education directly into communities of highest need. Support will involve securing funding resources to facilitate service of the mobile food bus into Seminole County residents in targeted ZIP Codes and census tracts.

**PROBLEM IDENTIFIED:** Pregnancy Interval Less Than 18 Months

**How this Impacts MCH/Birth Outcomes:**

A short pregnancy interval (less than 18 months) is a risk factor for preterm birth. According to the literature, maternal serum and erythrocyte concentrations of folate decrease from the fifth month of pregnancy onwards and remain low for a long time after delivery. Women who become pregnant before folate restoration is complete have a raised risk of folate insufficiency at the time of contraception and during pregnancy. Therefore, their offspring have higher risk of neural tube defects, intrauterine growth retardation, and preterm birth.

In Seminole County (2015-2019), the counts of births with less than 18 months are greatest in the ZIP Codes of 32771 at 691 births, 32773 at 415 births, and 32765 at 459 births. These are our targeted ZIP codes, all of which experience greater health disparities, and all are home to several black communities.

**How the Healthy Start Coalition Can Improve it:**

The coalition supports inter-conception education and is looking at ways to improve engagement of women of childbearing age in the targeted ZIP codes and census tracts regarding best practices for healthy pregnancy outcomes.

**PROBLEM IDENTIFIED:** Teen Pregnancy

**How this Impacts MCH/Birth Outcomes:**

Data reflects that the frequency of births increases as the age of the mother increases during their teen years. The rate of teen births to women 15-19 years of age in Seminole County at 10.4/1,000 population is lower when compared to the state at 16.2/1,000 population. Among races, the rate for White teens births, at 8.8/1,000 population was lower when compared to Black teen moms at 15.4/1,000 population.

**How the Healthy Start Coalition Can Improve it:**

The coalition can engage with adolescents/teenagers through parent-youth relationship programs. Culturally tailored programs with other community partners can increase psychosocial skill building as well as behavioral skills in the targeted ZIP Codes (32771, 32773, 32714 and 32707) with the highest rate of teen births.

The coalition could also adopt the Centers for Disease Control and Prevention's Community Wide Initiative by utilizing the program's goals and 5 key components. The key components are:

- Community Mobilization and Sustainability
- Evidence-Based Programming
- Increased Youth Access to Contraceptive/Reproductive Health Care Services
- Stakeholder Education
- Working with Diverse Communities.

These core components could lead to definitive performance measures to address teen pregnancy in Seminole County.

**PROBLEM IDENTIFIED:** General Education

**How this Impacts MCH/Birth Outcomes**:

Research shows that mothers with a less than a high school education are at higher risk of poor pregnancy management and adverse birth outcomes. Poor health before pregnancy contributes to preterm births, low birth weight babies, major birth defects, pregnancy complications, and even maternal and infant deaths. In Seminole County, the percentages of those over the age of 25 years without a high school diploma was greatest among the Black population at 10.1 percent when compared to the White population at 4.6 percent. Among Hispanics, 9.8 percent did not have a high school diploma.

**How the Healthy Start Coalition Can Improve it:**

The coalition can work with the Seminole County Schools system to implement culturally appropriate programs to increase knowledge on the importance of graduating high school in the most vulnerable Zip Codes. This would increase the percentage of graduates while decreasing the number of teen births and possibly more appropriate baby spacing.

**PROBLEM IDENTIFIED:** Mental Health

**How this Impacts MCH/Birth Outcomes:**

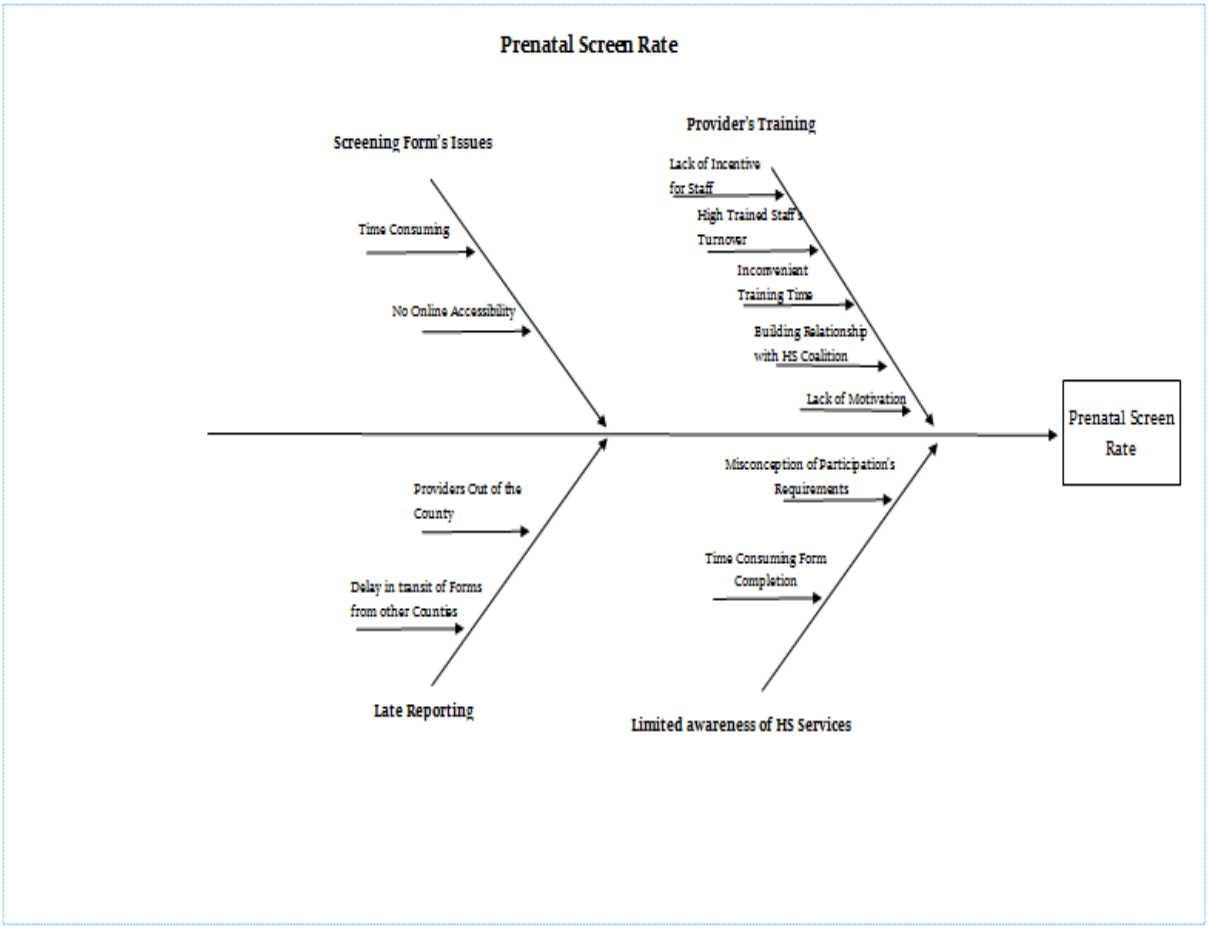
Most women experience depression at some point throughout their lives, but directly before, during, and after pregnancy, when mood disorders have a greater potential to negatively impact the well-being and survival of baby It is important to note that good mental health is an important health factor for the mother and baby in the presence of substance use. In Seminole County, the ZIP codes that experience the highest rates of prenatal depression include Altamonte Springs (32714), Casselberry (32707), Oviedo (32765), and Sanford (32771 & 32773).

Although a maternal infant healthcare system exists in Seminole County, varying levels of provider collaboration can create gaps in accessing affordable comprehensive, community-based, and culturally competent healthcare. The Affordable Care Act and other health insurance plans may offer limited in-network providers and availability of specialists for referrals.

**How the Healthy Start Coalition Can Improve it:**

The coalition can continue to work with women in the inter-conception period to connect them to mental health services and develop a maternal infant care resource inventory as a first step in addressing preconception, prenatal, and infant healthcare gaps.

## THIRD BONE: Prenatal Screen Rates




**PROBLEM IDENTIFIED:** Provider Unawareness of Services / Screening Forms

**How this Impacts MCH/Birth Outcomes:**

Over the past year, a survey designed to gauge providers' knowledge and attitudes about the Healthy Start Program was developed and disseminated to area OB/GYNs. A total of 17 surveys were completed. Over forty percent of those surveyed reported that there was a lack of staff knowledge about the Connect program. More than seventy-five percent of providers did not know that they could be part of the Healthy Start Coalition by joining the FIRM team, becoming a general member or by volunteering with various program components.

Most providers did not provide insight on the top three complaints or concern of their patients or the top three healthy disparities. The information collected should be interpreted with caution and may not reflect the actual prenatal environment.

Top 3 Complaints/Concerns:

- Transportation
- Cost
- Child Care

Top 3 Health Disparities:

- Lack of knowledge, information
- Finances
- Importance of prenatal care

**How the Healthy Start Coalition Can Improve it:**

The coalition will bring information to the local Medical Society for dissemination throughout the professional medical community. A collaboration of partners is needed to work with our hospitals and clinics to provide educational classes on the need and benefit of completing accurate screenings for the health benefit to mother and child. The coalition would also work to secure funding to continue with the Community Liaison position that facilitates the relationships and education for providers in the community.

**PROBLEM IDENTIFIED:** Increase the Prenatal Screen Rate

**How this Impacts MCH/Birth Outcomes:**

Prenatal screening is intended to be available to all pregnant women and babies through their healthcare provider. This was developed to assist providers and Healthy Start staff in determining the mother's eligibility and need for Healthy Start services. The tool helps to identify any relevant risk factors or existing needs related to the health of a woman's pregnancy. This pre-screening for Healthy Start services has been identified as an area of opportunity for improvement in Seminole County.

According to the Healthy Start Report, the prenatal screening consenting rate (how many women say "yes" to the screen) has continually decreased from 88.3 percent in 2017-2018 to 83.7 percent in 2019-2020. Of the total forms processed, 83.8 percent consented to screening with 67.8 percent consenting to participate. The Healthy Start Coalition will continue to provide a consistent screening message to providers and appropriate training to make it easy for them to understand the benefits of offering and completing the Healthy Start screening to all pregnant women.

The average rate of Positive Screens (HS screening consent was "Yes" and computed score was 6 or more) by the priority ZIP codes identified a higher concentration of pregnant women who scored a positive screen in Sanford for the fiscal years 2019-2020 (62.8 percent). The most affected ZIP codes were in Sanford 32771 with 34.6 percent, and 32773 with 28.2 percent. Altamonte Springs accounted for 57.2 percent, and the most affected ZIP code areas were 32714 with 25.5 percent and 32701 with 31.7 percent. Casselberry (32707) was also impacted, with a 20.6 percent positive screens.

Other factors such as the lack of incentives for providers and their staff, turnover of trained staff, and a high volume of clientele contributed to the lack of motivation for providers to participate in trainings, educational activities, and referral of program participants. According to the 2019-2020 Healthy Start ADHOC Report, 42.6 percent of the prenatal screenings reported came from Orange County and 55.1 percent were completed in Seminole County. Because the prenatal screening is not available electronically, it is dependent on postal service delivery to the proper counties. This has a negative impact on the timeliness of receipt and subsequent action.

**How the Healthy Start Coalition Can Improve it:**

- Targeted and enhanced in-service training, outreach, education, and marketing need to be conducted with prenatal care providers and birth facilities in targeted ZIP Code areas to better identify risk and support provider linkage to home visiting program through Connect.
- Increase the general community's awareness of the Connect Program, its availability, and benefits through outreach and marketing activities.
- Closer review of the ZIP Code areas with the most critical risk factors and health disparities that the Connect Program can positively impact.
- Identify and support training opportunities to providers regarding mental health and other issues and the resources available in the community.
- Work closely with other Healthy Start Coalitions in the region to minimize the negative impact of the low percentage of referrals from their providers to the Connect program.
- Increase OB/GYN participation within the Healthy Start Coalition.

**PROBLEM IDENTIFIED:** Increased Infant Screen Rate

**How this Impacts MCH/Birth Outcomes:**

Florida's Healthy Start Infant Risk Screening Instrument is a brief questionnaire that helps the birthing facility identify infants who are at increased risk for post-neonatal or infant mortality during the first year of life, or at risk for adverse health and developmental outcomes. Infants with a score of 4 or more are approximately 6 times more likely to die within the first year after birth. Therefore, early intervention is the key for a positive outcome.

Completion of the State's Healthy Start Infant Screen provides entry into this voluntary program. According to the Healthy Start Executive Summary Report, 4,680 Seminole County babies were born during fiscal years 2019-2020 and 97.3 percent of all babies received the screening. Screening rates have remained stable over the last 3 years. The infant screening rates in Seminole County have consistently been slightly higher when compared to state rates. This indicates more infants, and their families have access to Healthy Start services which could be a result of the electronic screening and a continuous improvement directly related to the infant screening. Sanford's ZIP codes 32771 and 32773 accounted for the highest percentage of babies born during 2015-2019, at 15.3 percent and 9.3 percent, respectively. Altamonte Springs accounted for 18.2 percent of births in ZIP Codes 32707 (8.7 percent) and 32714 (9.4 percent).

Oviedo accounted for 11.6 percent of all births. The average county percentage for infants screened was 97.3 percent in 2019-2020. In Sanford, only 38.5 percent of infants has a positive score.

Babies who are born at-risk are eligible to receive case management and related support services for their families through the Healthy Start program, which focuses on risk reduction, support, and linking families with needed healthcare and related services. “High risk” means there are environmental or medical risk factors, including physical, social, or economic factors, in the baby’s life that increase the risk of death in the first year or contribute to poor health and development. According to the Healthy Start 2019 ADHOC Report, of the infants who received screening 12.7% had scores that made them eligible for Healthy Start program services.

Risk factors for infants include maternal age less than 18; maternal age over 18 but education is less than 12th grade; mother’s race is other than white, unknown, or multiple races; mother is not married; the number of prenatal visits is zero, one, or unknown; infant weighs less than 2000 grams; mother used tobacco or alcohol during pregnancy; or the infant has an abnormal condition or congenital anomaly. The accurate completion of the Infant Screening and the prompt referral to services are two important factors that contribute to a successful outcome. Seminole County residents’ birth locations reported during fiscal years 2017-2019 were as follows:

- Born in a Seminole County hospital or birthing facility – 32.4%
- Born in a hospital or birthing facility in Orange County – 64.5%
- Born in Volusia County – 0.31%
- Born in in Osceola County – 0.55%
- Born in other county hospitals or birthing facilities – 0.9%

The above percentages ultimately have a direct link to the prompt referral of high-risk infants.

**How the Healthy Start Coalition Can Improve it:**

- Work with hospitals to improve infant screening rates to better identify infants at risk and improve linkages.
- Coordinate with all birth centers in the service area to ensure rates are reviewed, significance is understood, and strategies for improvement are developed in partnership.
- Implement provider and consumer incentive programs to increase screening rates.
- Perform a closer review of the ZIP Code areas with the most critical risk factors and health disparities that the Connect Program can impact positively.
- Work closely with other Healthy Start Coalitions in the region to minimize the negative impact of the low percentage of referrals from their providers to the Connect program.
- Provide technical support to providers to help them improve infants consenting participation rates.
- Educate women about Healthy Start Prenatal and Postnatal screenings and home visiting programs.
- Promote and support community partnerships to increase public awareness about infant health issues.
- Offer educational materials to providers.

- Identify resources and, if possible, provide training to providers about smoking cessation, substance misuse, obesity, dental care, and other factors that impact birth outcomes.
- Provide educational tools to clients and the community about maternal infections that can impact pregnancy outcome.

# OUTCOME OBJECTIVES STRATEGIES AND ACTION STEPS

The coalition developed a draft Outcome Objectives Strategies and Action Steps plan to continue the process of specifically addressing the needs that were identified in Seminole County, as outlined in the previously submitted Fishbone Analysis. Data supported the need to address certain issues on a grassroots level. The coalition was able to identify and list partnership efforts that currently exist with the program that should be continued and capitalized on. There is also a great opportunity for the coalition to build additional collaborations in the community to address new concerns.

The Data Committee examined information on maternal and child health statuses and available social services information. Key areas with gaps in services were identified and needed strategies to address are indicated with some still under development. This will continue to be a fluid process as the landscape of maternal and child health in Florida and our local community continues to evolve.

| Selected Indicator | Current Status | | Service Area 5-Year Goals 2021-2026 |
|---|---|---|---|
| | Seminole | State | |
| Black Infant Mortality Rate per 1,000 live births | 12.2 | 10.0 | 11.5 |
| Infant Low Birth Weight<br>• Black Infant LBW<br>• Hispanic Infant LBW | <br>10.8<br>6.2 | <br>12.7<br>7.5 | <br>10.0<br>6.0 |
| Preconception and Inter-conception care<br>• Repeat Births Teens, Ages 15-19 years<br>• Births with inter-pregnancy interval <18 months | <br>9.0<br>32.9 | <br>14.1<br>34.9 | <br>8.5<br>32.6 |
| Prenatal and Postnatal Screen Rate<br>• Women's screen rate<br>• Women's consent rate<br>• Infant consenting participation rate | <br>55.1<br>83.7<br>91.3 | <br>66.9<br>90.7<br>88.4 | <br>66.9<br>90.0<br>93.0 |

Source: FLHealthCHARTS (2019); FLPublicHealth (2019-2020) Prenatal and Infant Screening Reports

| Indicators/5-Year Goals | Proposed Action Steps |
|---|---|
| Black Infant Mortality Rate<br>(Reduce to 11.5%) | • Establish and implement FIMR project to determine the causes of infant deaths.<br>• Increase public awareness and education about black infant mortality in targeted ZIP codes.<br>• Increase awareness and education about black infant mortality among prenatal and infant care providers in Seminole County. |
| Infants' Low Birth Weight<br>• Black - Reduce to 10.0% or less<br>• Hispanic - Reduce to 6.0% or less | • Increase public awareness and education about black and Hispanic infant's low birth weights in targeted ZIP codes.<br>• Integrate cultural competency training for home visitation and enhanced services.<br>• Increase awareness and education about black and Hispanic infant's low birth weights among prenatal and infant care providers in Seminole County. |
| Preconception and Inter-conception Care<br>• Repeat Birth Teen Ages 15-19 (Less than or equal to 18.0%)<br>• Birth with Interpregnancy Interval < 18 months (Less than or equal to 34.3%) | • Increase public awareness and educate teens about preconception, inter-conception, and birth, with interpregnancy intervals < 18 months for targeted ZIP codes.<br>• Collaborate with schools that have a program for pregnant teens to assist them with accessing available services such as early prenatal care, breastfeeding education, WIC, etc.<br>• Provide parenting and childbirth education in the targeted ZIP codes with the highest percentages of interpregnancy intervals < 18 months. |
| Prenatal and Postnatal Screening Rates<br>**a.** Increase women screened rate to 66.9%<br>**b.** Increase women consent rate to 90.0%<br>**c.** Increase Infant Screening Rate (Consenting Participation) to 93.0% | • Community Liaison will continue working with prenatal health providers, hospitals, birthing centers, and home-birth providers on screening education and implementation.<br>• Develop/implement a public education and awareness campaign to promote Healthy Start Prenatal and Postnatal screening.<br>• Identify and implement provider and consumer programs such as a newsletter, download the screening report to the coalition's website, etc., as a motivational tool to increase screening rates.<br>• Continue to advocate for the electronic prenatal screen and seek funding for the awareness campaign. |

# CATEGORY A ACTIVITY

## QUALITY ASSURANCE AND QUALITY IMPROVEMENT PLAN

The coalition will implement a Quality Assurance and Quality Improvement (QA/QI) plan that will examine the processes of service provision, address customer satisfaction, be data driven, monitor achievement of performance measures and desired outcomes, and focus on continuous improvement. The Coordinated Intake and Referral Program utilizes the Well Family System (WFS) and the Health Management Information System (HMIS) to assist administration and direct service supervisory staff in monitoring outcomes and identifying areas for further evaluation. The Centralized Intake and Referral (Connect Program) staff and Healthy Start Program providers are trained in the use of WFS, and quality controls have been integrated into the policies and procedures related to our Quality Management Plan.

The plan will ensure that Healthy Start and Connect Program services are delivered in a manner complying with the must current Healthy Start Standards and Guidelines (State of Florida, Department of Health) and according to contract provisions. Procedures and protocols will be reviewed to ensure compliance with the contract, including adequate staffing, reporting, coding, quality improvement activities, and data entry.

An important part of the external QA/QI process is the periodic auditing of our direct care service provider during the fiscal year. In Seminole County the Coalition has the Centralized Intake and Referral (Connect Program) that refers participants to the home visiting program of their choice available in the community for services. Participants that want to receive care coordination with Healthy Start Program, are referred to an Independent Provider contracted by the Coalition. Both, the Centralized Intake and Referral (Connect Program) workers and the HS Independent Contractors receive any technical assistance and trainings needed from the Coalition staff, or from the most appropriate source to access for such assistance.

Quarterly and yearly reviews will be conducted with data from both HMS and WFS to ensure goals are being met. The coalition will utilize these reviews with the program to continuously improve to meet and exceed our deliverables obligation. Forms that have been preapproved will be utilized for these tasks. (See Appendices C and D.)

Internally, the coalition has operational and programmatic guidelines that are utilized and reported to the board monthly and quarterly to the general body of the coalition. The monthly internal reports provide updates and progress made by the program and coalition on achieving its performance measures and any corrective action strategies that need to be identified and implemented. The coalition also utilizes a self-assessment tool containing questions related to all aspects of daily and overall operations of the organization. The board is currently provided monthly reports for review on the coalition's administrative and operational duties. Upon execution of the full contract, these reports will also include the program's service delivery. The board considers training of its members very important. As such, training resources utilized at board and/or general coalition meetings include TRAIN Florida Learning system, Seminole County Government, and local content experts on governing boards' roles, responsibilities, and strategic planning.

The Coalition created a QA/QI committee and will update as needed in coordination with current Service Delivery Plan Committee/Data Committee to further assist with continuous development, oversight, and improvement to the specified goals of the service delivery plan and purpose of this coalition. These committees will develop a calendar of viable meetings to ensure that we are able to have participation from all partners and a consistent standard schedule of monthly or bimonthly.

Both the internal and external QA/QI plans will allow the coalition to clearly determine when problems with service delivery develop, when providers need technical assistance, and when its overall funding strategy requires reallocation. The coalition will utilize file reviews, shadowing workers, satisfaction surveys, and self-assessments to formulate any continued strategies for improvement. Finally, the coalition's overall intent is to continuously monitor internal and external activities that identify areas that may need attention. Feedback and evaluation are essential in ensuring that we meet the requirements of our Service Delivery Plan. The overall intent of the Quality Assurance process is to ensure that at minimum, the Healthy Start Standards and Guidelines are met or exceeded.

## ALLOCATION METHODOLOGY

This year an allocation plan for Healthy Start funds was developed by reviewing the recent budgetary history and priorities established by the existing program, as well as the intention of the current Services Delivery Plan being developed. Priorities that are being established, as well as strategies that are being outlined in the action plan, were also taken into consideration. The entire system of care will require continuous evaluation to ensure the current providers are sufficient and provide insight where additional/other services can be implemented. The coalition staff developed a proposed allocation plan based upon the information received and the parameters established by the current availability of resources. Monthly review of expenditures, as well as the monthly invoices provided by the Department of Health – Seminole will provide an additional level of monitoring to ensure we are appropriately expending funds in the best manner. The Healthy Start Coalition Board approved the allocation plan for the initial year, with the ability to review on an ongoing basis and modify if necessary, to maximize the effectiveness with which resources are available to ensure services are provided to the community and resources are maximized to achieve established goals.

The Healthy Start Coalition has contracted with five independent contractors for the provision of Direct Services. Coordinated Intake Referral (CIR) is managed by 4.5 FTE housed within the Coalition. The FY 20/21 allocation methodology plan includes service dollars from the Base and Network funding in the amount of $867,332.00. This includes $281,470 for subcontracted services, $70,111.80 for coordinated services, and $134, 041.50 for the coalition. The coalition is continuously working with the program to ensure these current listed resources are the most beneficial to our families. The community resource directory has provided additional options in several categories that may prove to be more appropriate in certain geographic areas of the county. This is an ongoing annual evaluation process to ensure we are optimizing our levels of care and resources to the community.

The budget for Administrative Planning is $53,958.20. The coalition will continue to utilize the following considerations in determining the allocation of Healthy Start dollars:

1. Community need.

2. Agency performance (service delivery and cost-effectiveness) as reflected in its most recent annual QA/QI report.
3. Accessibility to target populations, including identifying and engaging at-risk pregnant women and families.
4. Other county- or population-specific factors identified by the coalition.

# CATEGORY B ACTIVITY
## ACTION PLAN

***Black Infant Mortality Rate: Increase public awareness and education in targeted ZIP codes.***

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?**

According to Seminole County's Needs Assessment, the 2019 black infant mortality rate in Seminole County is higher than the state rate. The current black infant mortality rate is 2.5 times the white infant mortality rate and almost two times the Hispanic infant mortality rate. In 2019, the white infant mortality rate was 4.8/1,000 live births and the death rate among Hispanic infants was 6.8/1,000 live births. The black infant mortality rate was 12.2/1,000 live births. There are ZIP Code areas in Seminole County where Non-Hispanic Black and, to a lesser degree, Hispanic women have consistently accounted for higher infant mortality rates than non-Hispanic white women. Further research is needed to understand and address these factors.

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

Black Infant Mortality Rate

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

1) Healthy Start Needs Assessment 2019
2) FLHealthCHARTS 2015-2019 by race, ethnicity, and ZIP Codes

**2. PLANNING PHASE QUESTIONS**

**a. What strategy has been selected to address this?**

1) Increase public awareness and education about Black infant mortality in targeted ZIP Codes.
2) Implement FIMR project to determine the causes of infant deaths.
3) Increase awareness and education about Black infant mortality among prenatal and infant care providers in Seminole County.

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

1) Data analysis of Vital Statistics files
2) Maternal Child Health Indicators and Surveillance Data
3) Documentation of educational material distributed among prenatal and infant care providers.

**c. Where/how will you get the information?**

HSCSC staff will obtain data from the Department of Health, Vital Statistics, Data Committee Team, and community partners in the targeted ZIP code areas and will collaborate regarding the educational material distribution with Healthy Start Providers, Connect Program staff, and other sources as needed and identified.

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

There will be more information and available research to understand and interpret the factors that contribute to the higher infant mortality rate among non-Hispanic Black women in Seminole County. The community and consumers from the targeted ZIP Code areas will be more knowledgeable about the factors that negatively impact the pregnancy outcome, leading them to avoid or minimize those factors. Ultimately, Black infant mortality will decrease.

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

Black infant mortality cases receiving a data review, Black infant mortality rate, and community partners' feedback.

**f. Where/how will you get the information?**

Data will come from Florida Vital Statistics data and any HSCSC Data Committee documents and reports.

## ACTION STEPS – BLACK INFANT MORTALITY RATE: Public Awareness and Education

| Action Steps | Person Responsible | Start Date* | End Date* |
|---|---|---|---|
| 1. Collaborate with DOH for Child abuse death reviews. | Executive Director<br>HSCSC Data Committee<br>Community Liaison | July 1st 2021 | June 30th 2026 |
| 2. Analyze and review data from the Florida DOH to identify underlying causes of black infant mortality and develop recommendations for reducing the rate in Seminole County. | Executive Director<br>Data Committee | July 1st 2021 | June 30th 2026 |
| 3. Establish linkages and relationships with hospitals and other organizations that might provide insight and expertise about infant mortality to the coalition. | Executive Director<br>Community Liaison<br>HSCSC | July 1st 2021 | June 30th 2026 |
| 4. Participate in community events to promote awareness of black infant health disparities among potential customers of the home visiting programs. | Executive Director<br>Community Liaison<br>HSCSC | July 1st 2021 | June 30th 2026 |
| 5. Develop and analyze annually statistical reports regarding county's rates and plans to address disparities identified. | Executive Director<br>Data Committee<br>Community Liaison | July 1st 2021 | June 30th 2026 |
| 6. Share findings of data analysis with provider network, Healthy Start providers, and other stakeholders by distributing the report on a quarterly basis. | Executive Director | July 1st 2021 | June 30th 2026 |
| 7. Develop and implement a training plan for Healthy Start providers and Connect Program workers who are culturally competent and support reducing health disparities among African American women and babies. | Executive Director<br>Community Liaison<br>HSCSC | July 1st 2021 | June 30th 2026 |
| 8. Develop annual outreach activities in targeted ZIP Codes to engage into service those women who have multiple risk factors but may fear the system. | Executive Director<br>HSCSC<br>HS and Connect Program | July 1st 2021 | June 30th 2026 |
| 9. Distribute quarterly, culturally sensitive educational materials regarding healthy pregnancies and healthy babies to providers and birthing facilities to reduce health disparities. | Executive Director<br>Community Liaison | July 1st 2021 | June 30th 2026 |

*Action Steps are reviewed and updated annually.

## ACTION PLAN

***Infant's Low Birth Weight: Increase public awareness and education.***

*A) Black Infants' Low Birth Weight  B) Hispanic Infants' Low Birth Weight*

### 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?**

According to the Seminole County Needs Assessment low birth weight among Black infants, at 10.8 percent, was lower when compared to the state rate at 12.7 percent. The current Black infant low birth weight rate (2019) is more than twice the white infant low birth weight rate (5.1 percent) and almost two times the Hispanic infant's low birth weight rate (6.2 percent). There are ZIP Code areas in Seminole County where Black and Hispanic women have consistently accounted for higher infant low birth weight rates than non-Hispanic white women. Further research is needed to understand and address these factors.

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

Black and Hispanic Infants' 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)?**

1) Healthy Start Needs Assessment 2019
2) FLHealthCHARTS, 2015 - 2019 by race/ethnicity and ZIP Codes
3) Postnatal Infant Screening

### 2. PLANNING PHASE QUESTIONS

**a. What strategy has been selected to address this?**

1) Increase public awareness and education about Black and Hispanic infants' low birth weight in targeted ZIP Codes.
2) Integrate cultural competency training for home visiting and enhanced services.
3) Increase awareness and education about Black and Hispanic infants' low birth weight among prenatal and infant care providers in Seminole County.

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

1) Healthy Start Data and performance report.
2) Documentation of educational culturally sensitive material distributed in collaboration with the community partners about infants' low birth weight.
3) Number of program workers that completed a Cultural Competence Training with satisfactory post test results.
4) Consumers' surveys.

**c. Where/how will you get the information?**

Data will be obtained from FLHealthCHARTS reports, HSCSC reports, prenatal/infant healthcare providers reports, logs of educational material distributed in the targeted ZIP Code areas, Healthy Start providers and Connect Program workers, Health Start Learning Management System training database, available data systems, and other sources as needed and identified.

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

There will be more information available to understand and interpret the factors that contribute to LBW among Black and Hispanic infants. The community and consumers from the targeted ZIP Code areas will be more knowledgeable about the risk factors associated with infants' low birth weight. Black and Hispanic women of childbearing age will learn how to identify and, where possible, avoid or minimize the direct and/or indirect factors that can impact pregnancy outcomes and infants' birth weight. Ultimately, Black, and Hispanic infants' low birth weight rates will decrease.

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

Rate and percentage of Black and Hispanic infants' low birth weight reports, FLHealthCHARTS reports regarding the LBW rates in the targeted ZIP Code areas, and consumers' and community partners' feedback.

**f. Where/how will you get the information?**

Information will be gathered from FLHealthCHARTS reports, Healthy Start ADHOC reports, consumer surveys, marketing materials, Postnatal Infant Screening, and any HSCSC Data Committee documents and reports.

## ACTION STEPS – BLACK AND HISPANIC INFANTS' LOW BIRTH WEIGHT:

**Increase public awareness and education.**

| Action Steps | Person Responsible | Start Date* | End Date* |
|---|---|---|---|
| 1. Develop and analyze statistical reports annually regarding county's rates and plan to address disparities identified. | Executive Director<br>HSCSC Data Committee<br>Community Liaison | July 1st 2021 | June 30th 2026 |
| 2. Identify and discuss possible causes of Black and Hispanic infants' low birth weight and develop a plan to address the specific needs in both communities. | Executive Director<br>HSCSC Data Committee<br>Community Liaison | July 1st 2021 | June 30th 2026 |
| 3. Monitor screening data quarterly to track participation of Black and Hispanic women from the targeted ZIP code areas in the home visiting program. | Executive Director<br>HSCSC Data Committee<br>Community Liaison | July 1st 2021 | June 30th 2026 |
| 4. Distribute, on a quarterly basis, culturally sensitive educational materials regarding infant's low birth weight to the prenatal care providers, hospital, and birthing facilities. | Executive Director<br>Community Liaison | July 1st 2021 | June 30th 2026 |
| 5. Participate in a variety of health fairs and community events in the targeted ZIP Code areas bi-annually, to promote awareness and prevention of Black and Hispanic infants' low birth weight to potential home visiting program customers and to the community in general. | Executive Director<br>Community Liaison<br>HSCSC<br>HS and Connect Program | July 1st 2021 | June 30th 2026 |
| 6. Identify resources in the community that can offer culturally sensitive education and how the life course theory and social determinants of health affects Black and Hispanic pregnant women, regarding direct/indirect factors that can impact | Executive Director<br>Community Liaison<br>HSCSC | July 1st 2021 | June 30th 2026 |

| | | | |
|---|---|---|---|
| infants' birth weight and to establish inter-agencies collaboration for referrals. | | | |
| 7. Continue promoting tobacco cessation to pregnant women and families in the targeted ZIP codes. | HSCSC<br>HS and Connect Program | July 1st 2021 | June 30th 2026 |
| 8. Continue promoting SUID education to pregnant women and families of Seminole County. | Executive Director<br>HSCSC<br>HS and Connect Program | July 1st 2021 | June 30th 2026 |
| 9. Identify cultural barriers in parenting and provide sensitivity trainings and education to Healthy Start Program providers annually. | Executive Director<br>HSCSC | July 1st 2021 | June 30th 2026 |
| 10. Integrate annual cultural competency training for home visiting and enhanced services. | Executive Director<br>HS Program Providers | July 1st 2021 | June 30th 2026 |
| 11. Evaluate Black and Hispanic infant's low birth weight rate annually to determine effectiveness of strategies. | Executive Director<br>Data Committee | July 1st 2021 | June 30th 2026 |

*Action Steps are reviewed and updated annually.

## ACTION PLAN

***Preconception and Inter-conception Care: Increase public awareness and educate teens for targeted ZIP codes.***

*A) Repeat Births Teen Ages 15-19* *B) Birth with Interpregnancy Interval < 18 Months*

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 number of reported repeat births to Seminole County teens aged 15 -19 years of age (9.0 percent) has decreased over the past five years. Slightly higher rates are among those who are 18 -19 years of age at 10.0 percent. It is known that women with a pregnancy interval less than 18 months are at greater risk of delivering a LBW infant compared to women with pregnancy intervals of 24-36 months. The health of the mother is one of the most important predictors for a positive birth outcome. In this age group, inter-conception care and the importance of delaying another pregnancy until other achievements (optimal health, education completion, and economic self-sufficiency) have been accomplished, is encouraged.

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

      Repeat births to teen's ages 15-19 years and births with interpregnancy interval <18 months.

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

      Data from FLHealthCHARTS, HSCSC Needs Assessment, Prenatal Screening data and report, Healthy Start ADHOC report were utilized.

2. PLANNING PHASE QUESTIONS

   a. **What strategy has been selected to address this?**

      1) Increase public awareness and educate teens about issues with preconception, inter-conception, and births with interpregnancy interval < 18 months for targeted ZIP codes.

2) Collaborate with schools that have a program for pregnant teens to assist with accessing and linking to available services, such as early prenatal care, breastfeeding education, WIC, etc.
3) Provide parenting and childbirth education in the targeted ZIP codes with the highest percentages of interpregnancy interval < 18 months.

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

Data from Healthy Start ADHOC Report, counts of parenting educational sessions given to Healthy Start and Connect Program participants, and a count of educational sessions given to the teens in the targeted ZIP Codes.

**c. Where/how will you get the information?**

We will compile all resources currently available in Seminole County to include a variety of appropriate parenting and health-related classes by utilizing our partners and their knowledge of the community. We will reach out to the appropriate organizations operating in Seminole County with an offer to collaborate on behalf of our community residents and establish partnerships designed to support the learning initiatives we intend to implement. HSCSC staff will also get related information from FLHealthCHARTS data by ZIP Codes, Healthy Start and Connect Program reports, Maternal and Child Health Reports, Prenatal Screening Report, and other sources as identified and needed.

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

We expect a reduction in the percentage of repeat births to teens ages 15 -19 years. We also expect to see a decrease in the percentage of births with interpregnancy interval <18 months. We intend to target the age groups experiencing the highest rates of repeat teen births.

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

Data will be compiled from FLHealthCHARTS, Vital Statistics, Healthy Start and Connect Program, Maternal and Child Health Summary Reports, and HSCSC reports indicating the types of education provided, attendees, and any additional pre-/post-test results.

**f. Where/how will you get the information?**

From sources listed directly above and partners conducting education sessions.

### ACTION STEPS – PRECONCEPTIONANDINTERCONCEPTION CARE:

**Increase public awareness and educate teens about pre- and inter-conception issues for targeted areas.**

| Action Steps | Person Responsible | Start Date* | End Date* |
|---|---|---|---|
| 1. Analyze and review all related and available data from the Florida DOH and HSCSC quarterly. | HSCSC Data Committee<br>Community Liaison<br>Executive Director | July 1st 2021 | June 30th 2026 |
| 2. Identify and meet with prospective community organizations to explore collaboration opportunities. | Community Liaison<br>Executive Director | July 1st 2021 | June 30th 2026 |
| 3. Establish referral and linkages with schools, community-based organizations, and other organizations that might provide needed services, such as but not limited to family planning and education to pregnant or parenting teens. | Community Liaison<br>Executive Director | July 1st 2021 | June 30th 2026 |
| 4. Identify possible causes of repeat teen pregnancy among 15-19-year-olds and plan for reducing the rate in Seminole County on an annual basis. | HSCSC Data Committee<br>Community Liaison<br>Executive Director | July 1st 2021 | June 30th 2026 |
| 5. Identify and discuss causes of pregnancy intervals less than 18 months and develop proposed recommendations for reducing the rate in Seminole County on an annual basis. | HSCSC Data Committee<br>Community Liaison<br>Executive Director | July 1st 2021 | June 30th 2026 |
| 6. Communicate results of data analysis to the community annually. | Executive Director | July 1st 2021 | June 30th 2026 |
| 7. Provide parenting education, inter-conception care education, and assistance with accessing available services to pregnant and parenting teens such as early prenatal care access. | Community Liaison<br>Healthy Start and Connect Program<br>HSCSC | July 1st 2021 | June 30th 2026 |
| 8. Work with prenatal care providers to provide preconception and inter-conception education to women of childbearing age, with technical assistance and/or educational sessions. | Community Liaison<br>Executive Director | July 1st 2021 | June 30th 2026 |

| | | | |
|---|---|---|---|
| 9. Review annually repeat teen pregnancy rates among 15-19-year-olds and baby spacing to determine if strategies/actions were effective. | HSCSC Data Committee<br>Community Liaison<br>Executive Director | July 1st 2021 | June 30th 2026 |
| 10. Work to incorporate the use of social media to educate teens and young adults on pre- and inter-conceptual care issues. | Community Liaison<br>Health Start Providers | | |

*Action Steps are reviewed and updated annually.

## ACTION PLAN

***Prenatal and Postnatal (Infant) Screening Rate: Increase Rates in Seminole County***

*A) Women Screened Rate* *B) Women Consent Rate* *C) Infant Consenting Participation Rate*

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 Healthy Start prenatal screening instrument is used to guide pregnant women most likely to be at risk into the system of care needed to optimize their birth outcomes. As soon as at-risk women enter the system of care, their chances of having good birth outcomes increase. Therefore, there is a need for continuous improvement in screening and consenting to participate rates in Healthy Start.

   The Healthy Start postnatal (infant) screening instrument provides entry of newborns at-risk into the Healthy Start system of care. Improving the consenting to participate rate will increase the opportunity for babies to receive the services needed.

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

   Healthy Start Prenatal and Postnatal (Infant) Screening rates.

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

   1) Healthy Start Prenatal Executive Summary Report
   2) Healthy Start Postnatal (Infant) Executive Summary Report
   3) Healthy Start ADHOC Report
   4) Healthy Start Screening Reports

2. PLANNING PHASE QUESTIONS

   **a. What strategy has been selected to address this?**

   1) Community Liaison to continue working with prenatal care providers, hospitals, birthing centers, and home-birth providers on screening education and implementation.
   2) Develop/implement a public education and awareness campaign to promote Healthy Start Prenatal and Postnatal screening.
   3) Implement provider and consumer iincentives to increase the screening rate.

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

1) Number of in-service trainings to medical providers.
2) Healthy Start Screening reports by individual providers.
3) Prenatal offer rate, screening rate, and consenting to participate rate reports.
4) Postnatal offer rate and consenting to participate in HS program rate reports.
5) Amount and type of educational materials distributed among providers, hospitals, and birthing centers.
6) Amount of Connect Program services information directed to consumers were distributed at the prenatal care providers, hospitals, and birthing centers.

**c. Where/how will you get the information?**

1) Logs and documentation of in-service and outreach methods.
2) Executive Summary Prenatal and Postnatal Reports.
3) Individual prenatal care provider and birthing facilities offering and screening rates.
4) Amount and type of the literature distributed among providers, hospitals, and birthing centers.

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

There will be an increase in the offer rates, screening rates, and consenting to participate in Healthy Start Prenatal and Postnatal screening rates. This will facilitate the identification of the most at-risk pregnant women and newborns in the targeted areas in the county. Also, the providers, participants, and the community will become more knowledgeable about the screening tool and the services available to them.

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

1) Executive Summary Reports.
2) Healthy Start Prenatal and Infant ADHOC Reports.
3) Individual prenatal care provider and birthing facilities offering and screening rates.
4) WFS reports.

**f. Where/how will you get the information?**

FLHealthCHARTS, State of Florida screening reports via the Healthy Start reports website, Healthy Start Screening Reports, individual provider performance information from the Well Family System, and the locally developed HSCSC summary of activities.

**ACTION STEPS – PRENATAL & POSTNATAL SCREENING RATE:**

**Develop/implement a public education and awareness campaign to promote Healthy Start screening**

| Action Steps | Person Responsible | Start Date | End Date |
|---|---|---|---|
| 1. Monitor and review on a quarterly basis the prenatal and postnatal screening rates trends. | Executive Director<br>Community Liaison | July 1st 2021 | June 30th 2026 |
| 2. Identify and discuss on a quarterly basis the accuracy and timeliness of the prenatal and postnatal screens that are completed and submitted to the Florida DOH in Orange County. Identify trends and issues with the completion of the forms and provide technical assistance as needed. | Executive Director<br>Community Liaison | July 1st 2021 | June 30th 2026 |
| 3. Develop and analyze monthly statistical reports regarding the county's rates and plan to address disparities identified. | HSCSC Data Committee<br>Community Liaison<br>Executive Director | July 1st 2021 | June 30th 2026 |
| 4. Review the current schedule of outreach efforts by Healthy Start contracted providers and HSCSC staff annually. | Executive Director | July 1st 2021 | June 30th 2026 |
| 5. Conduct in-service training and outreach to prenatal care providers and birthing facilities that have low screening rates on an ongoing basis. | Community Liaison | July 1st 2021 | June 30th 2026 |
| 6. Monitor screening data to track progress monthly. Analyze Healthy Start Executive Summary Report to evaluate the following outcomes related to Healthy Start screening:<br>• Percentage of potential participants offered screens (compared to estimated number of pregnant women/number of births for same time-period).<br>• Percentage of potential participants consenting to and receiving screens; total | Community Liaison<br>HSCSC Data Committee | July 1st 2021 | June 30th 2026 |

| | | | |
|---|---|---|---|
| percentage of positive screens and screens referred for other factors.<br>• Percentage of potential participants (or their families) consenting to participate. | | | |
| 7. Review screening data quarterly and coordinate with hospitals and birthing centers staff to conduct accurately, and consistently Healthy Start screenings by providing technical assistance as needed. | Community Liaison | July 1st 2021 | June 30th 2026 |
| 8. Distribute, on a biannual basis, educational material regarding healthy pregnancy and healthy babies to the prenatal care providers and birthing facilities as part of the providers' and consumers' program. | Community Liaison | July 1st 2021 | June 30th 2026 |
| 9. Develop a newsletter as a marketing and educational tool to increase the screening rate and distribute it to the prenatal care providers and birthing facilities staff on a biannual basis. | Community Liaison | July 1st 2021 | June 30th 2026 |
| 10. Review screening data monthly and distribute a report to the prenatal care providers and birthing center staff to inform them about their performance regarding the screening rates. | Community Liaison<br>HSCSC Data Committee | July 1st 2021 | June 30th 2026 |
| 11. Participate in community events to promote awareness of home visiting programs available in the community among potential customers, with the purpose of increasing participation quarterly. | Community Liaison<br>HSCSC Staff | July 1st 2021 | June 30th 2026 |
| 12. Conduct in-service training and outreach to birthing facilities that have low screening rates on an ongoing basis.<br><br>Coordinate with all birth centers in Seminole County to ensure rates are reviewed and strategies for improvement are developed in partnership. | Community Liaison | July 1st 2021 | June 30th 2026 |
| 13. Evaluate prenatal and postnatal rates annually to determine effectiveness of strategies. | Executive Director<br>Data Committee<br>Community Liaison | July 1st 2021 | June 30th 2026 |

*Action Steps are reviewed and updated annually.

# CATEGORY C ACTIVITY

***Assisting Chemically Dependent Pregnant Women and Substance-exposed newborns***

## 1. PLANNING PHASE QUESTIONS:

**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 Coalition will work with other community agencies to identify and refer mothers who present with a substance use problem and/or have a substance-exposed newborn to the appropriate service providers within the county. We will complete an assessment and submit to the Seminole County Sheriff's Office within 72 hours.

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

Timely identification of the mothers and infants in need of assistance will be provided access to the wrap-around support required to address the issues that contribute, cause, and determine their outcomes.

**c. What information will you gather to demonstrate that you have implemented this strategy? As intended? What will you do?**

1) Healthy Start Data and performance report.
2) Documentation of referrals received from community partners and the Sheriff's Department.
3) Number of providers that completed a cultural competence training with satisfactory post test results.
4) Consumer surveys.

**d. What do you expect to be the immediate EFFECT of this strategy on the population who receives the intervention/exposed to the strategy?**

By assessment through pre- and post-testing, we expect the mother to gain knowledge on the immediate effects of avoiding substances for her own health and the improved health/outcome of her child.

**e. What information will you gather to demonstrate that you effected a change in knowledge, attitude, and behaviors?**

Executive Summary Reports, Healthy Start Prenatal and Infant ADHOC Reports, individual surveys on knowledge gained and behavior change, as well as WFS Healthy Start screening data that will reflect the decrease in number of cases.

### ACTION STEPS – Assisting Chemically Dependent Pregnant Women and Substance-Exposed Newborns

| Action Steps | Person Responsible | Start Date* | End Date* |
|---|---|---|---|
| 1. Conduct educational training for Healthy Start Program providers and Connect Program workers on the resources that are currently available within the area to refer presenting mothers. | Executive Director Community Liaison | July 1st 2021 | June 30th 2026 |
| 2. Work with prenatal providers on education mothers on available resources within the community. | Executive Director Community Liaison | July 1st 2021 | June 30th 2026 |
| 3. Educate and refer mothers to providers that offer services for substance use/exposure. | Executive Director Community Liaison HSCSC | July 1st 2021 | June 30th 2026 |
| 4. Review annually the data on identified mothers and babies to determine effectiveness of strategies. | Executive Director Community Liaison HSCSC Data Committee | July 1st 2021 | June 30th 2026 |
| 5. Developed a partnership with the Seminole County Sheriff Department to create a Safe Care Of Plan. | Executive Director Community Liaison | July 1st 2021 | June 30th 2026 |
| 6. Attend community agency meetings that address substance use and other related services. | Community Liaison HSCSC Data Committee | July 1st 2021 | June 30th 2026 |

*Action Steps are reviewed and updated annually.

The Healthy Start Coalition of Seminole County, Inc. and partners will continue to analyze the most current data as received, so that the strategies and action plans will be developed to achieve the desired outcomes. It will not be a single intervention, but a series of community partnerships that will assist in addressing the identified issues in Seminole County. The coalition will continue to build the relationship with the Seminole County Sheriff's Office. There has been a memorandum of understanding between the two entities in the past. The coalition has participated in meetings to reinstitute that relationship. Four components will exist in our continued planning:

1) Early and continued risk assessment
2) Health promotion and counseling
3) Medical and/or psychosocial intervention
4) Substance-abusing mothers and substance-exposed newborns

The desire of the coalition is to address the family by utilizing the life course theory model. The desire is to educate the community that change, and improvement can be achieved by working

with the whole family, one generation to the next. A healthy mother starts with her grandmother and mother. The cultural practices that may have a significant bearing on our health disparities are generational. As we change the thought process and address the behaviors, we improve the outcomes. It does not stop at the birth of the first child but must be continued to introduce the benefits of baby spacing and continued healthy family dynamics. These ideas will be a part of the overall process to continuously identify risks: medical, environmental, psychosocial, and others. The Healthy Start Coalition of Seminole County, Inc., is dedicated to improving the outcomes for the mothers and babies of our community.

# CONCLUSION

The Healthy Start Coalition of Seminole County has developed this Service Delivery Plan with the support and consensus of key leaders throughout our community and county. Our 4 main priority focus areas are consistent with our adopted purpose:

> *To establish and maintain a community-based inter-conception prenatal, postpartum, and infant care coalition, comprised of persons representing the public, private sector, state and local government, providers, community alliances, and maternal and child health organizations, who will identify the needs of Seminole County, devise and implement a service plan to meet the identified needs pursuant to Florida Statutes on a continuing basis, and allocate and leverage funds to support action planning.*

It is with the dedication and commitment that our coalition anticipates the successful implementation of this Service Delivery Plan and the accomplishments of our stated goals for 2021-2025.

# QUALITY ASSURANCE AND QUALITY IMPROVEMENT PLAN

The Healthy Start Initiative was implemented on April 1, 1992 in the state of Florida to reduce infant mortality, reduce the number of low birth weight (LBW) babies and improve health and developmental outcomes. Healthy Start offers universal prenatal and infant screening to identify pregnant women and infants at risk for adverse birth, health, and developmental outcomes. Pregnant women and infants who are screened into the Connect Program Healthy Start or are self-referred are offered care coordination and wraparound services that support families in reducing risk factors.

Improving the quality of the programs funded by the Healthy Start Coalition requires a coordinated effort by the organization. It is the Coalition's responsibility to guarantee that all pregnant women and children birth to age three who are determined to be eligible continue to receive quality services. The Coalition will implement a Quality Assurance and Quality Improvement (QA/QI) plan that will examine the processes of service provision, address customer satisfaction, be data driven, monitor achievement of performance measures and desired outcomes, and focus on continuous improvement. Healthy Start utilizes the Well Family System (WFS to assist administration and direct service supervisory staff in monitoring outcomes and identifying areas for further evaluation. Healthy Start providers and Connect Program workers are trained in use of WFS and quality controls have been integrated into the policies and procedures related to our Quality Management Plan

The plan will ensure that Healthy Start and Connect Program services are delivered in a manner complying with the must current *Healthy Start Standards and Guidelines* (State of Florida, Department of Health) and according to contract provisions. Procedures and protocols will be reviewed to ensure compliance with the contract, including adequate staffing, reporting, coding, quality improvement activities and data entry.

The QA/QI plan will allow the Coalition to clearly determine when problems with service delivery develop, when providers need technical assistance, and when its overall funding strategy requires reallocation. Finally, the Coalition's compliance activities outlined in this document should identify areas needing attention.

## I. Healthy Start Coalition Board of Directors and Committees

### A. Board of Directors.

**a.** The Board of Directors is responsible for approving all contracts.
**b.** The Board of Directors makes the final decision on all contracts and allocated funding.
**c.** Issues of contract compliance, amendments or termination shall be referred to the Board of Directors.
**d.** The Board of Directors has the responsibility to evaluate, hire or fire and determine the salary of the Executive Director.
**e.** The Board of Directors will assure the Bylaws and Policies and Procedures are up to date and followed.
**f.** Board Members will be chosen based on areas of expertise and representation of appropriate/relevant organizations and community members.
**g.** New Board Members will go through an orientation soon after their election.

**h.** Minutes will be taken at all Board Meetings.
**i.** The Executive Director staffs the Board of Directors.

### B. Executive Committee

**a.** Reviews Healthy Start issues and other community Maternal and Child Health (MCH) concerns in determining agenda items for meetings of the Board of Directors.
**b.** Provides recommendations to the Board of Directors regarding actions the Coalition should take based on regular reports received from the Executive Director regarding the MCH system of care.
**c.** The Executive Director staffs this committee.

### C. Quality Assurance and Quality Improvement (QA/QI) Committee

**a.** Reviews providers' performance, timeliness of reporting, staffing turnovers and other issues that may affect the providers' ability to provide quality services, and make recommendations on improvement.
**b.** Recommends initiation, continuation and/or discontinuation of funding with contracted providers to the Board.
**c.** The Coalition will recruit members of community organizations who have expertise in quality improvement and have in place a quality improvement plan. A minimum of four (4) people will be invited to participate.
**d.** Reviews the Coalition's quality improvement processes and provides recommendations.
**e.** Attends committee meetings on quality improvement efforts when scheduled.
**f.** Reviews quarterly reports submitted by the providers and provides feedback/questions to the Executive Director or designee regarding those reports. The providers will have the opportunity to respond to the feedback/questions.
**g.** Recommends the appropriate committee to conduct annual program audits and/or administrative audits of all contracted providers. The QA/QI Committee Chair and the Executive Director or designee will structure the audits.
**h.** Provide annual reports to the Executive Committee regarding the status of all contracts and regarding any recommendations for modifications or enhancements of the improvement plan.
**i.** Provide recommendations to the Executive Committee and the Board of Directors regarding continued funding of the contracts.
**j.** The Executive Director or designee will staff this committee.

### D. Data Analysis/Evaluation Committee

**a.** Collects and evaluates data as appropriate, including performance and outcome objectives for Healthy Start and Connect Program core services, to be disseminated to the appropriate committee working on related issues.

### E. Finance Committee

**a.** The Coalition's Contract Manager will conduct annual finance audit of all contracted providers. The Finance Committee Chair and the Executive Director will structure the audits.
**b.** Provides recommendations to the QA/QI Committee regarding continued funding of the contracts.

### F. Other Committees

**a.** Other committees will be formed according to the focus areas chosen in our SDP.

## II. Reporting Requirements

Reports to the Healthy Start Coalition are critical to the QA/QI process to monitor progress and overall program success, as well as to identify best practices.

### A. Quarterly Reports

**a.** All contracted providers will be required to submit quarterly reports to the Coalition. These reports shall be data driven which indicate whether services are delivered at an appropriate level of intensity and duration. The Executive Committee and Coalition staff will determine data elements that shall be included in those reports.
**b.** Coalition Staff will be responsible for generating the quarterly report and presenting it to the QA/QI Committee for review.
**c.** The QA/QI Committee will review quarterly reports and present the information to the Board.

### B. Monthly Review Reports

**a.** The Healthy Start program manager or designated representative of the contracted provider responsible for administration of the program will conduct internal monthly record reviews using the forms included in the contract. Records reviews will be performed in accordance with the must current *Healthy Start Standards and Guidelines* (State of Florida, Department of Health). A complete summary of the records reviewed and a written status on each outcome and performance measures will be included in the quarterly reports submitted to the Coalition.

### C. Financial Reports

**a.** The Coalition's Contract Manager and the Coalition's Accountant will monitor financial information and information will be shared with the Coalition's Treasurer or Finance Committee Chair.

## III. Program Audit

**a.** The Healthy Start Coalition will perform one annual audit of the Healthy Start contracted providers. This audit may include, but is not limited to, case records

review, class observations, home visits, personnel file audits, financial audits, and staff meetings.

**b.** The Healthy Start Coalition will assess performance using administrative records, self-reported data from the service providers, and client satisfaction surveys.

**c.** The annual audit will consist of three parts:

1) Entrance interview with the provider responsible for managing Healthy Start services
2) Record review of randomly selected prenatal and postnatal records,
3) Exit interview with the program manager and other contracted provider to discuss the strengths, concerns, and strategies for improvement.

**d.** The Healthy Start provider found to be non-compliant with the contract will be required to formulate a corrective action plan which must be furnished to the Healthy Start Coalition no later than 10 days upon receipt of the audit report. The QA/QI Committee will review the corrective action plan and approves, as necessary.

**e.** Subject to the availability of funds, The Healthy Start Coalition will contract with independent entity(ies) to conduct evaluations of the Healthy Start program components in Seminole County.

## IV. Contracts

**a.** To promote fairness, objectivity, and impartiality for selection and funding of contract service providers, the Coalition will review various options in selecting Healthy Start service providers. Those options will be presented to the Executive Committee for recommendation to the Board of Directors to include maintaining the status quo; developing a Request for Proposal, Invitation to Negotiate, or Invitation to Bid process in the second year of the service delivery plan; or other methodology recommended by the board. The Coalition will incorporate performance standards as an integral part of the contracting process. As part of the funding decision, the Coalition proposed targets and goals for each performance measure would be specified in each Healthy Start provider contract. The Board of Directors will make the final decision on all the contracts.

## V. Other QA/QI Strategies and Controls

**a.** All Healthy Start staff will be familiar with the must current *Healthy Start Standards and Guidelines* and other areas, as necessary.
**b.** The Executive Director or designee will work with the Florida Department of Health in Seminole to assure a standard pre-service and in-service training plan/curriculum for continuous training to employees.
**c.** It is the responsibility of the Healthy Start provider to train new staff as needed.
**d.** The provider will maintain record of completed trainings for each Healthy Start staff.

**e.** All QA/QI Internal Controls will comply with the Healthy Start Coalition of Seminole County Operational Policies and Procedures and the Healthy Start Coalition of Seminole County Financial Policies and Procedures Handbook.

## VI. Quality Management of Coalition Operation

**a.** The Executive Director, the Board of Directors and Coalition staff will develop action items for the Agency work plan and set dates for completion. Work plan will be reviewed every quarter to update staff on Coalition activities as well as monitoring completion of action items as targeted. Goal: to have 85% of the work plan completed during the fiscal year.

**b.** The QA/QI Committee will develop an Annual Community Survey, an Annual Healthy Start Participants Satisfaction Survey, and an Annual Providers Satisfaction Survey to measure the general qualities and internal standards related to professionalism, working environment, knowledge base and accuracy of communication, and timeliness in responding to the community and providers.

**c.** The Annual Community Survey will be disseminated to community agencies in which the Coalition has interagency agreements, service involvement or community partnership. Questions will address staff responsiveness to requests as well as service delivery activities in the county. The QA/QI Committee will compile and report the results to the Coalition staff. Areas identified for improvement will be targeted by Coalition staff in the Agency work plan.

**d.** The Annual Healthy Start Participants Satisfaction Survey will be distributed by the contract provider to all Healthy Start participants. The QA/QI and the Data Committees will collect and evaluate the data to establish opportunities for improvement and to assess the quality improvement program. Based on the results, the Coalition may set priorities for quality improvement activities related to maternal and child health indicators that may be integrated into the service delivery plan and added to provider contract(s).

**e.** The Annual Providers Satisfaction Survey will be disseminated to all contract providers to elicit feedback on the Coalition's efficiency and effectiveness in helping providers maintain and improve services to Healthy Start participants. The QA/QI Committee will compile and report the results to Coalition staff and the areas identified for improvement will be targeted by in the Agency work plan and communicated to providers in the annual Provider Meeting.

**f.** An annual evaluation will be completed by the QA/QI Committee utilizing an employee self-assessment checklist and responses from community, program participants and providers surveys when available. Coalition staff will complete a self-assessment checklist to assess ongoing compliance with state statues and contract compliance.

**g.** The QA/QI Committee will review the assessment and improvement plan annually with the Executive Director for needed revisions, modifications or

enhancements and the final update to the plan will be discuss in the annual QA/QI Committee meeting.

**h.** The Coalition will complete an annual self-assessment to ensure provider response satisfaction as well as monitoring of internal functions that are sufficient and meet the local, state, and federal requirements of operation. (see attached Self-Assessment Checklist below).

## Healthy Start Coalition Self-Assessment Checklist

| Standard | Yes | No | Comments |
|---|---|---|---|
| **Organizational Structure** | | | |
| By-laws are available | X | | |
| The Coalition has a mission statement and statement of philosophy or values | x | | |
| There is a current organizational chart | X | | |
| Job descriptions for each staff are in their personnel files | X | | |
| The personnel policies and procedures are reviewed annually | x | | |
| There is a grievance policy and procedure for personnel | X | | |
| There are Coalition publications available for review | X | | |
| There are historical records and news articles for review | X | | |
| There is a current voting membership list | X | | |
| **Governance** | | | |
| Decisions are made in accordance with the by-laws | X | | |
| By-laws are reviewed by the Coalition annually | x | | Will be reviewed at Annual Meeting |
| The Board of Directors meet on a regular basis | X | | |
| Board files with agendas, meeting minutes, and material disseminated are up to date | X | | |
| The Executive Director's performance is evaluated by the Coalition annually | X | | |
| **Fiscal Management** | | | |
| The fiscal policies and procedures are reviewed annually | X | | |
| There is documentation of not-for-profit status | X | | |
| There is current proof of liability insurance | X | | |
| There is a budget for the current fiscal year | X | | |
| Prior written approval is obtained when using direct service dollars for administration. | X | | |
| Use of direct service dollars for administration is in compliance with DOH policy. | X | | |
| The allocation of available HS funds to local providers is determined annually at a minimum and updated as required. | X | | |
| Required match is in compliance with contract and statute | X | | |

| | | | |
|---|---|---|---|
| Coalition members get regular feedback on Coalition expenditures and revenues | X | | |
| **Standard** | **Yes** | **No** | **Comments** |
| **Membership** | | | |
| There is an established, organized method of member recruitment | X | | |
| There is an established, organized method of member enrollment | X | | |
| There are strategies for recruiting consumer members | X | | |
| Members are assessed for:<br>Areas of expertise<br>Potential contributions<br>Preferences for committee work | X | | |
| New members are oriented in a timely manner | | | In Progress |
| Orientation includes:<br>Coalition mission<br>Coalition goals and objectives<br>Coalition structure<br>Healthy Start Overview<br>History of Coalition<br>Coalition's achievements<br>Coalition's challenges<br>Status of projects<br>Calendar of Coalition activities<br>Expectations of members<br>Privileges of membership<br>Budget and financial status<br>Sunshine Law | X | | |
| Orientation is expanded for board and executive committee members | X | | |
| Members are given opportunities to participate in the work of the Coalition through committees and workgroups | X | | |
| Nominations for voting seats, board, executive committee, and offices are made in accordance with the by-laws | X | | |
| Members are provided educational opportunities related to their Coalition responsibilities | | | In Progress |
| Coalition members receive regular updates on progress toward goals and objectives | X | | |
| **Committees** | | | |
| Committee and work assignments are made in accordance with the by-laws | X | | |
| **Standard** | **Yes** | **No** | **Comments** |
| Committees are given clear expectations with timelines | X | | |
| Committees are provided, to the extent resources permit, support and technical assistance needed | X | | |
| Committees submit written progress reports for review by the general coalition membership | X | | |
| Committee files with agendas, meeting minutes, and material disseminated are up to date | X | | |

| Meetings | | | |
|---|---|---|---|
| Coalition meetings are accessible | X | | |
| Meeting times are convenient to most of its members | X | | |
| There are strategies for making meetings accessible to consumers | X | | |
| Notices of meetings are disseminated to members in accordance with Florida's Sunshine Law | X | | |
| Members have an opportunity to give advance input to meeting agendas | X | | |
| Agendas and supporting documents are disseminated in advance of the meeting | X | | |
| All items on the agenda are discussed | X | | |
| Meetings begin and end on time | X | | |
| Minutes reflect meeting proceedings accurately | X | | |
| Minutes are disseminated in a timely manner | X | | |
| **Networking/Development** | | | |
| Coalition members receive regular updates on progress towards goals and objectives | X | | |
| There is an organized approach to acknowledging contributions of members and others | X | | |
| There is an organized, ongoing process of obtaining feedback from varied audiences on the Coalitions' functioning. | X | | |
| The Coalition is in regular contact with the local legislative delegation | X | | |
| The community at large is aware of the Coalition and its mission | X | | |
| The Coalition works independently of the County Public Health Unit(s) | X | | |
| **Standard** | **Yes** | **No** | **Comments** |
| The Coalition works cooperatively with the County Public Health Unit(s) | X | | |
| The Coalition conducts community development activities to educate the public about HS and to gain community input and support. | X | | |
| **Contract Reporting Requirements** | | | |
| The Service Delivery Plan is updated every three years and submitted by the due date. | | | |
| The action plan of the Service Delivery Plan is updated annually and submitted by the due date. | | | In progress |
| Quarterly progress reports on implementation of the Action Plan are submitted to the State by the due date | | | |
| The Legislative Report for the fourth quarter is submitted by the due date. | | | |
| **Contract and Service Delivery Requirements** | | | |

| | | | |
|---|---|---|---|
| There is a written internal QA/QI plan for Coalition operations. | X | | |
| There is a written plan for monitoring HS providers. | | | |
| There is corrective action for providers not meetings standards. | | | |
| There is a system in place to assure providers receive HSSG training. | | | Currently under HSP |
| Strategies to increase screening rates are implemented. | X | | Within Plan |
| There is a process for measuring and enhancing the progress towards reaching outcome and performance measures | X | | |
| All contracted providers have an internal QA/QI system in place. | | | |
| Providers submit summary QI record review forms | | | |
| HS eligible women and children 0-3 receive:<br>An initial contact by contracted provider according to the RAC model<br>Assigned a level of service by the provider<br>Funneled into care coordination and wraparound services as needed<br>An individualized plan of care by the contracted provider is in the chart review | | | |
| There is a plan and process for ensuring providers of clinical prenatal and delivery services are offered screening training. | | | |
| There is a process for ensuring that the HS risk screen is offered to pregnant women and newborns. | | | |
| Provider's service tasks are in accordance with HSSG | X | | Currently through HSP |
| **Standard** | **Yes** | **No** | **Comments** |
| Contracts are in accordance with the Coalition's SDP and needs assessment | | | In Progress in the year of Administrative Building of Coalition |
| Contracts and subcontracts contain the following:<br>Scope of service description<br>Reimbursement description<br>Participant eligibility description<br>Provision of general information to participants<br>QA/QI description<br>Grievance process available to participants<br>Mechanism for ensuring compliance with the HSSG | | | |
| Outreach activities to eligible women and children 0-3 are implemented in accordance with HSSG | | | |
| There is a process for assuring that all contracted providers code accurately. | | | |

## Internal: Coalition

| OBJECTIVE 1 | COALITION AND BOARD MEETINGS WILL BE HELD TO CONDUCT THE BUSINESS OF THE COALITION ON A QUARTERLY BASIS |
|---|---|
| Activity 1.1 | Ensure dates/times of meetings are established and made public |
| Timeline/ Frequency | Quarterly, as needed |
| Person Responsible, Title | Board, Thelisha Thomas - Executive Director |
| Performance Measure | 100 % compliance (i.e., 4 minimum) |
| Indicator | Review of minutes/activities of meetings |
| Activity 1.2 | Ensure dates/times of Coalition and Committees are determined and made public |
| Timeline/ Frequency | Biannually |
| Person Responsible, Title | Thelisha Thomas, Executive Director |
| Performance Measure | 100 % of meetings are held |
| Indicator | Review of Notice and/or meeting |
| Activity 1.3 | Review characteristics of good governance |
| Timeline/ Frequency | Yearly |
| Person Responsible, Title | Board members, Executive Director |
| Performance Measure | The Board will identify 4 characteristics, review 1 for updated improvement/implementation at local level |
| Indicator | Review of minutes, policy update and other materials |

| OBJECTIVE 2 | CONTRACT DELIVERABLES WILL BE SUBMITTED |
|---|---|
| Activity 2.1 | Compile data/documents needed for monthly /quarterly reports |
| Timeline/ Frequency | Monthly/ Quarterly |
| Person Responsible, Title | Thelisha Thomas, ED<br>Carmen Guzman, PM |
| Performance Measure | 100 % of reports are submitted timely |
| Indicator | Review of deliverables and other reports on regular basis |
| Activity 2.2 | Prepare and approve monthly expenditure reports |
| Timeline/ Frequency | Monthly |
| Person Responsible, Title | Thelisha Thomas, Executive Director |
| Performance Measure | 100 % of reports completed |

| | |
|---|---|
| Indicator | Review and submission of Financial reports/ documents |
| Activity 2.3 | |
| Timeline/ Frequency | |
| Person Responsible, Title | |
| Performance Measure | |
| Indicator | |

## External: Subcontracted Providers

| OBJECTIVE 1 | CONTRACT AND SERVICE DELIVERY REQUIREMENTS |
|---|---|
| Activity 1.1 | Service Performance will be measured for reaching quality outcomes and compliance measures |
| Timeline/ Frequency | Monthly |
| Person Responsible, Title | Carmen Guzman, PM |
| Performance Measure | 90 % compliance for expected outcomes and measures |
| Indicator | Monthly reports will be generated from available data systems (i.e. WFS, FL Charts, other) |
| Activity 1.2 | Subcontractors will be monitored with record reviews |
| Timeline/ Frequency | Quarterly |
| Person Responsible, Title | Carmen Guzman, Program Manager |
| Performance Measure | 10% of cases or minimum of 10 records will be selected from each subcontractor to monitor progress with the Care Coordination Review Form with 90% compliance |
| Indicator | Care Coordination Review Form |
| Activity 1.3 | CIR will be monitored for system of care compliance |
| Timeline/ Frequency | Quarterly |
| Person Responsible, Title | Carmen Guzman, Program Manager<br>Carolina M Fernandez, Staff |
| Performance Measure | 10% of cases or minimum of 10 records will be selected from each advisor to monitor progress with the Record Review Form with 90% compliance |
| Indicator | Review Form and WFS Reports |

| OBJECTIVE 2 | TRAINING |
|---|---|
| Activity 2.1 | Subcontractors will receive HSSG training in accordance with statue |
| Timeline/ Frequency | Quarterly, within 90 days of hire; completion by 12 months |
| Person Responsible, Title | Thelisha Thomas, ED<br>Carmen Guzman, PM |
| Performance Measure | 100% of subcontractors will be registered for training; 90% will have completed within 12 months of hire |
| Indicator | Evidenced by review of subcontractor file/record |
| Activity 2.2 | Coalition staff will receive necessary training to fulfill requirements of position |
| Timeline/ Frequency | Quarterly, within 90 days of hire; completion by 12 months |
| Person Responsible, Title | Thelisha Thomas, ED<br>Carmen Guzman, PM<br>Carolina M Fernandez, Staff |
| Performance Measure | 100% of staff will be registered for training; 90% will have completed within 12 months of hire |
| Indicator | Evidenced by review of personnel file |
| Activity 2.3 | |
| Timeline/ Frequency | |
| Person Responsible, Title | |
| Performance Measure | |
| Indicator | |

# RESOURCE INVENTORY

The Seminole County resource inventory describes current prenatal and infant services in our service area, displaying a comprehensive picture of the continuum of care to include the organizations and individuals providing needed services. Updates to the resource directory are incorporated on an ongoing basis as new providers enter, expand/reduce, or leave our service area. Information is regularly solicited from coalition partners and community members, verified, and entered to the resource inventory. This information is shared with partners and community members via emails, website postings, and during meetings. The link to the directory is provided below.

The Resource Directory (seminolepreventioncoalition.org)

A complete comprehensive update will be conducted during each service delivery planning cycle. Information will be gathered in a variety of ways to include but not be limited to medical provider surveys, coordinated reporting of service changes by Healthy Start direct service providers, coalition staff, and the coalition's general membership. In the future we hope to build upon the resource inventory by providing additional information (where available and not limited to) about the availability and accessibility of services for our participants.

Another important resource is Central Florida's Heart of United Way 2-1-1 system, a free, 24-hour information and referral helpline that links people in need with assistance from more than 2,000 local health and human service programs. Staffed 24 hours per day by highly trained and multilingual operators, 2-1-1 is available to assist participants in our service area.