Healthy Start
Coalition of Orange County

Every baby deserves a healthy start

Service Delivery Plan

2021 - 2026

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Healthy Start Coalition of Orange County, Inc.

SERVICE DELIVERY PLAN
2021 - 2026

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A. Introduction

History of the Healthy Start Coalition of Orange County

Celebrating 30 years of service!

Under the leadership of the late Governor Lawton Chiles, the Healthy Start initiative was passed by the Florida Legislature in 1991 to ensure that all babies born in the state of Florida are given the opportunity to have a healthy start in life. The stimulus for this legislation was Florida's poor standing on key maternal and infant health indicators of infant mortality, low birth weight, teen pregnancy, and access to prenatal care. Healthy Start's key components are: universal screening of pregnant women and newborns to identify those at risk for poor birth, health and development outcomes; care coordination health education and referral services for those identified at risk; and expansion of Medicaid eligibility for pregnant women and payment to providers. One final key component of the Healthy Start initiative was establishment of community-based prenatal and infant health care coalitions with a mandate to assess the maternal-child health needs of the community and ensure a system of care for mothers and babies is available. The Healthy Start Coalition of Orange County, Inc. (formerly the Orange County Healthy Start Coalition) was incorporated in 1992 in response to this legislation and has been working ever since to improve birth outcomes for women and infants in Orange County. Our mission statement identifies the scope of our work: ***"to improve maternal and child health in Orange County through community partnerships"***. By participating in community initiatives and strongly advocating that preconception and pregnancy are the beginning of a healthy childhood, the work of the HSCOC embodies our belief that "every baby deserves a healthy start".

Coalition staff members participate in multiple community initiatives, task forces, and committees in order to advocate for the health and needs of mothers and babies in our county. Our Coalition membership consists of approximately 200 people representing community-based agencies, health care providers, program participants, business representatives, policy makers, government representatives, community leaders, and physicians as well as other concerned residents interested in improving maternal-child health outcomes. Our Board of Directors (Appendix I) draws from this group and each member brings to the coalition special skills, decision-making power, knowledge and resources, as well as sensitivity to the needs of families in our county. Together, we seek to integrate data and research findings with community expertise in order to plan, implement and evaluate our county's maternal-child health system of care. This 2021-2025 Needs Assessment (and Service Delivery Plan) reflect this process while also building on initiatives outlined in the previous plan.

The Coalition has contracted with the Department of Health in Orange County (DOH-O) as its provider of Healthy Start services since the program began. Over the years a valuable and

trusting partnership developed and flourished. Our program at DOH-O met the challenge of providing more intensive services to our clients when the Medicaid Waiver was passed in 2001, including implementing the MomCare program and again when MomCare transitioned into the Coordinating Intake and Referral process (CIR), also known as Connect. In addition, our program staff successfully transitioned to Healthy Start's new Well Family data system, despite the many challenges that such a huge conversion entailed. Finally, because of the quality of the nurses in our program at DOH-O, the Coalition opted to place both our Nurse-Family Partnership program at DOH-O when funding was received for this implementation as well as our Child Abuse Prevention and Treatment (CAPTA) initiative for drug-affected women and infants.

The Coalition contracts with Aspire Health Partners for mental health services for our clients through a home visit model. We also manage a small contract for courier services (for pick-up/delivery of screening forms). At the start of fiscal year 2020-21 we chose to end our contract with a small nonprofit farmworker organization for one position that provided initial contact services to pregnant clients at a community health center due to budget concerns; however, this organization will be able to continue half-time funding for this position for two more years.

Major Accomplishments in Last Five Years

Since submitting our last Service Delivery Plan (SDP), covering the period of 2010-2015, the Healthy Start Coalition of Orange County can proudly highlight numerous major accomplishments as described below.

Core Outcome and Performance Measures

HSCOC has continued to successfully meet or exceed its core outcome and performance measures as established by contract with the Florida Department of Health. Despite challenges in meeting time frames required in measures negotiated with the Agency for Health Care Administration as a result of changes related to our state's move to Medicaid managed care and the split of Healthy Start funding, processes put in place to improve performance have been successful.

Nurse-Family Partnership (NFP)

After our original 3-year grant from Heart of Florida United Way for a local NFP project ended in 2017, HSCOC has continued to maintain funding for this high-quality nurse-home visiting program. This support has come from our state legislature, the West Orange Healthcare District, Orange County Government and our Coalition's own unrestricted reserves. Our project has always maintained fidelity to the NFP model at a rate at or above the national goal as well as at or above the average fidelity rate of other NFP projects in Florida.

Affordable Care Act

Until August of 2015, HSCOC had successfully served as the coordinating entity for our local Florida KidCare Partnership activities. Changes in grant requirements and in our internal staffing led to the decision to withdraw our Coalition from this role. However, we later assumed the role of fiscal agent for our county's management of funding for the Affordable Care Act's (ACA)

outreach services; 5 navigators provide health insurance access services through this partnership. It is our intent to continue as fiscal agent pending future developments with ACA.

Healthy Start Program Partnerships

With the guidance and leadership of our Healthy Start program director at DOH-O, we can site several memoranda of agreement that have been forged with community agencies to allow our services to better meet the needs of pregnant women and infants. Although established a number of years ago, they are still current and include the following:

1. *Orange County Female Detention Center* – Within our own Healthy Start program, we have successfully maintained this partnership to provide care coordination services to the pregnant inmates and to support their transition plan when released.

2. *Prosperitas Leadership Academy* – We have also continued our partnership at this alternative high school for at-risk teens. Pregnant and interconception teens (who have experienced a pregnancy/infant loss) receive education, referrals and support from a care coordinator at the school.

3. *Aspire Health Partners* – Our Healthy Start nurse is able to visit her clients who are in this behavioral healthcare agency's substance abuse residential treatment center. She is able to provide care coordination and health education to pregnant/parenting clients there and to assist in their transition back into the community once treatment is concluded.

4. *Covenant House* – Our agreement allows us to provide services to their resident teen clients who are pregnant or parenting.

Coalition Community Partnerships

As a key stakeholder in maternal-child health issues in our community, HSCOC has worked with community leaders and other related agencies to improve our system of care. Just as the expression "it takes a village to raise a child" conveys the sense of working together, HSCOC believes it is important to understand the issues impacting the well-being of our community and to align with those groups and initiatives that are working to improve our system of care for mothers and babies. Because there is a vast array of these partnerships and initiatives in which we have participated during past years, not all can be listed. Therefore, we have summarized those that have had the most impact.

1. *Primary Care Access Network (PCAN)* - Since its formation in 2000, PCAN has been working to address the needs of the uninsured/underinsured in Orange County. PCAN is an award-winning integrated health network that includes Orange County Government, primary health care centers, community agencies, hospitals, volunteer health providers and other social services, and operates a full range of primary and secondary care services for over 150,000 uninsured residents of Orange County. Funded by sliding scale fees, as well as federal, state, county and community partner dollars, it has been recognized as a state and national model. PCAN is credited with a 26% reduction in the number of visits to emergency rooms in our area by offering a medical home to the uninsured; the number of PCAN sites consists of 17 clinics.

Despite our presence on the PCAN committee, prenatal care continues to be viewed as "specialty" care and is not included in the primary care services provided to the uninsured.

2. *Children's Cabinet* – The HSCOC's executive director is a charter member of our county's Children's Cabinet. Meeting monthly, this group of approximately 50 agencies works to create positive outcomes for all children in our county by educating its members on relevant issues, collaborating to promote each other's programs and initiatives and informing the community of challenges to the well-being of our children. The Children's Cabinet is very involved in the ACEs movement and sponsors movies and town hall meetings to enourage the advancement of this research and the effects on children and families.

3. *Early Learning Coalition* – HSCOC's executive director also continues as a member of the Board of Directors for the Early Learning Coalition (ELC) which has led to various activities, including annual donations from the ELC of hundreds of books for our families each year to encourage early literacy and/or child development materials like ASQ kits for all Healthy Start home visitors. In addition, our executive director has been able to educate local leaders about the connections between preconception/prenatal health, birth outcomes, school readiness and the role Healthy Start plays in all these critical areas. We have also joined a recently-formed tri-county "K-Ready" task force that will address birth-5 issues such as home-visiting programs and area resources that impact kindergarten readiness; currently only 45% of children are testing ready to enter kindergarten.

4. *Early Head Start* - Two Early Head Start (EHS) programs have existed in our area for a number of years: one is home-based through our Children's Home Society and the other is center-based through our local child care coordinating agency. EHS's creation on the federal level in 1994 to address the comprehensive needs of low-income children birth-3 and pregnant women closely coincided with the creation of Florida's statewide HS program. This common feature of our programs has been a source of challenge in our current CI&R project (see below) but one which has been successfully addressed.

5. *Community Health Centers, Inc. (CHC)* - The success of the "Strong Start" project that was piloted with a few years ago with HS coalitions in the Tampa area led us to work with our local federally-qualified health center, the Community Health Centers, Inc. (CHC), to place a care coordinator in one of their prenatal clinics. While it is not a high-risk clinic in the same way as the Strong Start pilot, this clinic serves an area of Orange County with many Hispanic farmworkers and low socioeconomic African-American families; the farmworkers are primarily Mexican and their birth outcomes tend to be good but for many of the African-Americans, birth outcomes are poor. Our Healthy Start care coordinator is able to more readily engage the woman as they meet first at the clinic to review her risk factors; initial intakes are more successfully completed and services can begin more quickly. The CHC benefits as their clients' many needs can be addressed and their care complemented with the education, support and reinforcement that Healthy Start can provide. This collaborative model is also found at two local health department clinic sites, and most recently, at another FQHC, True Health. Healthy Start staff at these locations have ensured accurate screening, initial intakes and care coordination services for these vulnerable populations.

6. *Other Partnerships* – Because the social determinants of health are so critical to preventing infant mortality, our Coalition has joined in a local health and hunger task force led by our local food bank in an effort to meet nutritional needs of families. We continue to advocate for the needs of pregnant women and to promote breastfeeding practices.
Because Winnie Palmer Hospital (part of Orlando Health) is the largest birthing facility in the southeast US (delivering more than 14,000 babies each year or about 40 infants each day), we focused on placing three Healthy Start care coordinators at this hospital who could contact families of infants who scored at risk before their discharge and then more effectively explain our program, engage them in services or provide contact information and resources for future need. This collaboration with the birth registry staff has proven to be very successful. A similar arrangement was approved at our other large hospital system, Advent Health (formerly Florida Hospital) but resignation of our staff person and changes in this hospital's vendor approval policies have delayed a replacement. We placed a Healthy Start nurse half-time in Winnie Palmer's NICU to serve families there; however, because this HS-NICU position proved very difficult to recruit and hire, we decided to split an existing NFP nurse who had worked in this NICU before.

In an attempt to help coordinate our community's need for bereavement services, a HSCOC staff member joined a newly-formed bereavement committee at Advent Health Orlando three years ago. The purpose was to ensure all families suffering a fetal or infant loss could access information about support groups, counseling and other related services to help them cope with their loss. Two difficulties emerged: as with many volunteer groups, maintaining momentum has been slow as participants have other job responsibilities to prioritize over this initiative; and ensuring time is available when meetings are held to explain all the existing services that are available, how to access them, who is the targeted client/individual, etc. HSCOC developed a brochure of programs and services we know of to share with any of our clients when it becomes necessary and the bereavement committee developed a website of resources (www.pilrn.org).

A HSCOC staff member served as secretary of the Florida Breastfeeding Coalition (FCB) two years ago. It was our intent that by becoming involved, we would benefit in two ways: we would more readily have access to the latest research, educational materials and ways to promote breastfeeding; and two, we could ensure that other members knew about services provided through Healthy Start. Just as with the bereavement committee, a challenge of the FBC was having board members who are volunteers with full-time jobs, and to further extend the challenge experienced with the committee, the FBC members are spread throughout the state.

Begun in 2008, we have continued to supply our Healthy Start "Mall" though donations received and funds raised. Clients exchange points earned through positive health behaviors for items needed/wanted for their babies or for themselves. (In 2019-20, 420 clients redeemed items from our Mall.) This initiative has proven to be very successful, and while it is an attempt to reward clients for their successes, we find that many women rely on their points for needed diapers due to their economic situations.

Improvement in Health Indicators

Although data trends in maternal-child health indicators are discussed elsewhere, there are several major accomplishments, or improvements, that we highlight here. They are the following:

- Infant mortality decreased 16%
- Neonatal mortality rate decreased 12%

- Post-neonatal mortality rate decreased 12%
- Black post-neonatal rate decreased 28%
- Breastfeeding initiation increased 3%
- Death from SIDS (Sudden Infant Death Syndrome) decreased 60%
- Death from SUIDS (Sudden Unexpected Infant Deaths) decreased 42%
- Percent of 2-Year Old Children Immunized increased 17%
- Teen Births decreased 38%

Healthy Start Marketing and Resource Development

Striving to keep abreast of and share maternal-child health issues and noteworthy trends, the Coalition has identified areas by which it can technologically advance to better engage the community while remaining conscious of the bottom line. This includes sharing educational information on social media platforms, i.e. Facebook and Twitter, online engagement through e-newsletters and through mass communication like AM radio and webcasts. These efforts help to ensure that the community has readily available information to help address maternal and child health, that our target audience, Orange County residents understand how to access our services. Additionally, securing revenue apart from state and federal funding reserved for direct program services is needed to address our families' many needs and to offer additional supportive programs. This is another important focus of our work and includes revenue from grant funds, donations and revenue obtained through various fund-raising activities. Together, these activities aid us in reaching our goal of improved birth outcomes.

1. *Program Marketing* – The Coalition established a Marketing and Resource Development Committee to assist in in this work, that is to oversee general marketing standards and policies for our programs to follow and when developing and launching marketing initiatives. This work includes:
   - ensuring proper use of Healthy Start branding content, including logos, symbols and quotations, for program marketing initiatives
   - determining best practices for HS Ad/PR initiatives
   - approving the development of general marketing materials for the Coalition (i.e. HS flyers, brochures, platforms, radio segments, etc.)

2. *Community Events* – In the development of and participation in community-based events, the HSCOC believes it is important to understand the purpose of the event and its relevance to our overall efforts at promoting Healthy Start, including both social service and corporate donor-based events. One of our major community events is the "Celebration of Motherhood", a fundraising breakfast held near Mother's Day each year. This event has raised up to $25,000 in support of our local initiatives while engaging community sponsors and prestigious guests regarding important maternal-child health issues. Over the years, the breakfast has welcomed well-known medical professionals and maternal-child health advocates to speak to an important faction of our community donor population reigniting attendees' passion for collective impact. Through sponsorships, corporate support and mutually beneficial purpose, the HSCOC will continue through its marketing committee to participate in and host annual community events with mission-based directives and community donor appeal.

B. Community Needs Assessment

Plan Development Process

After almost 30 years of engagement with our community, the Healthy Start Coalition of Orange County continues to use a multi-faceted assessment process to determine what specific factors are affecting our system of care for mothers and babies and/or are negatively impacting birth outcomes. This process is dynamic in nature, recognizing the changing and growing environment of Central Florida, a highly transient, tourist-oriented community. Through ongoing review of MCH data, our collaboration with the many partners described above, our participation in community initiatives, and with input from our board, coalition members, our subcontracted providers and our clients, the HSCOC has continued to identify and address the needs that have arisen which impact the well-being of women, children and our perinatal health care delivery system. The model that describes this work of the HSCOC is MAPP, or *Mobilizing for Action through Planning and Partnerships*, a community-driven strategic planning process for improving community health. Essentially, application of the MAPP components for us can be described in the following manner:

Phase 1 – Organizing for Success & Partnership Development: We determined the overall time-frame, people needed and tasks to accomplish. Our core team was the Coalition staff and HS program manager and the MAPP committee was comprised of our Infant Mortality Task Force.

Phase 2 – Visioning: We shared the required elements that comprise our service delivery plan and the process involved with our board of directors and MAPP committee.

Phase 3 – Assessments: This phase occurred over several months and consisted of collecting and analyzing our indicator data, and community and consumer input. To assess current social/economic/political issues impacting our community maternal-child health, three questions were continually asked among gatherings of board members, staff, subcontracted providers, and other community stakeholders in various venues throughout the year:

1. What issues are negatively impacting our system of care, i.e., access to prenatal care and/or Healthy Start services?
2. What trends/situations are occurring in our community that are contributing to poor outcomes?
3. What strategies can improve the situation?

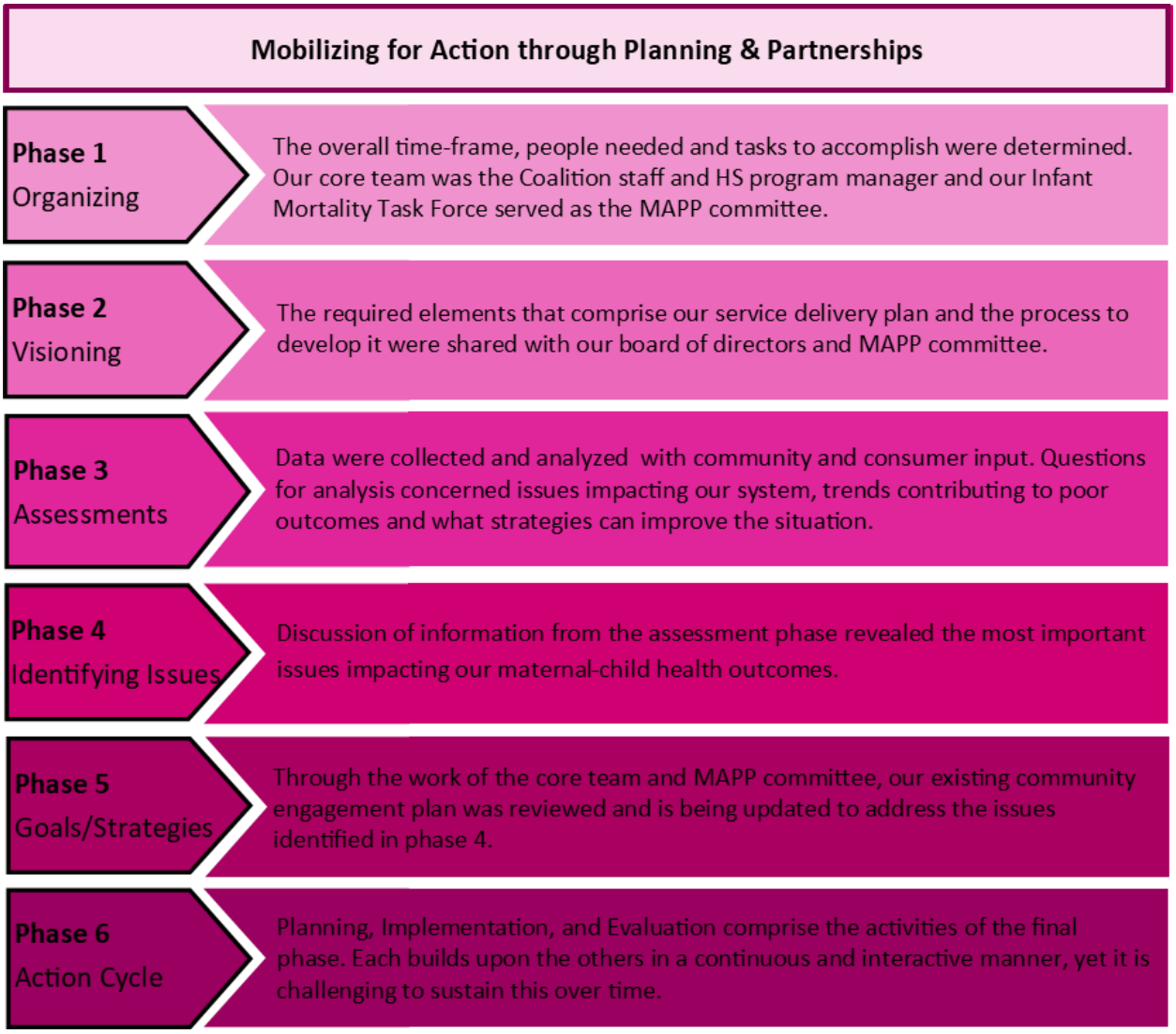
(These assessment activities and information collected are described below.)

Phase 4 – Identifying Strategic Issues: Targeted areas emerged through discussion of the information gathered during the assessment phase and were recognized as important issues impacting our maternal-child health outcomes. These issues will be updated and incorporated into our existing Community Engagement Plan.

Phase 5 – Formulate Goals/Strategies: Through the work of the core team and MAPP committee, our existing community engagement plan was reviewed and is being updated to address the issues identified in phase 4.

Phase 6 – Action Cycle: Planning, Implementation, and Evaluation comprise the activities of the final phase, yet they are not the end of the process. Each of these activities builds upon the others in a continuous and interactive manner. During this phase, the efforts of the previous phases begin to produce results, as we develop and implement our plan for addressing our targeted goals from phase 5. This is also one of the most challenging phases, as it may be difficult to sustain the process and continue implementation over time.

Using this model as we revise, update and build on our existing community engagement plan, we assessed our community and reviewed data, prioritized issues, identified our engagement strategies, and will soon begin the evaluation process of these efforts as we continue to promote the health of mothers and babies in Orange County. This MAPP can be summarized with the following graphic.



Health Changes and Trends

Perhaps the biggest change to our community, indeed to the state of Florida and our country, has been the pandemic wrought by COVID-19. Its impact on our mothers and babies has been enormous as the lives of many of our families have been upended: jobs have been lost, basic needs have intensified, health risks have increased. Our home visiting services were transitioned to telehealth and all in-person gatherings stopped. This inability to meet personally in groups impacted how we provided health education and awareness about Healthy Start, how we collected community input and how we met to identify and resolve issues.

Despite the switch to telehealth, we surprisingly experienced an initial increase in successful contacts with potential and established clients, likely due to mandated home confinement and only a gradual reopening of the economy. Whether this trend remains is unclear for two reasons: many of our Healthy Start and CIR staff were reassigned by the Dept. of Health-Orange to our county's need for COVID testing and contact tracing. Although all who had been reassigned were returned after four months into the pandemic, it is unknown whether the health department will reassign them again should the county's need require their services. The second reason is the unknown date of a return to in-person home visits when the safety of both the client and the worker can be assured.

Although it has been 3 years (Sept. 2017) since Hurricane Maria hit Puerto Rico and Florida, its effects linger. Thousands of residents from that island came to Florida seeking refuge and recovery and Central Florida was one of the main areas of resettlement. However, the infrastructure in Orange County was not designed for such an influx and many found themselves without shelter. HSCOC immediately began work with local Hispanic organizations to ensure families with pregnant women and/or infants had access to our services and resources. (See below.)

Community Input

HSCOC's ongoing involvement with multiple community agencies contributes to this MAPP process by facilitating our awareness of and participation in developments in our county concerning maternal-child health. This involvement provides us with input which helps to guide our work and can be summarized with the follow major initiatives over the recent past:

Florida Healthy Babies Initiative (HBI) - Now into its fifth year of DOH sponsorship, this initiative continues in our county with support of the Healthy Start's Infant Mortality Taskforce. This collaboration is part of a statewide initiative to positively influence social determinants of health and reduce racial disparity in infant mortality.

Findings: In Orange County, based on the data compiled, we've chosen to focus on infant safe sleep environment messaging by engaging and educating businesses associated with cribs and associated furnishing. Our outreach strategy includes the FHB representative who is establishing relationships with local baby stores and educates them about infant safe sleep practices. The education provided includes presentations to retail staff on the importance of safe sleep environments for infants, a packet of information about safe sleep information and (where

permitted) signage depicting the ABCs for sleeping infants – **A**lone, on their **B**acks, and in a **C**rib free of bumpers, blankets, pillows and toys.

Coordinated Intake and Referral (CI&R) Process currently known as "Connect" – This initiative started with federal funding granted to the Florida Association of Healthy Start Coalitions through their MIECHV initiative and was aimed at improving effective partnerships among programs servicing families with children ages 0-5. The ultimate goal is to have a system that would ensure families receive the services most appropriate to their needs and preferences. We chose to develop our system in conjunction with Osceola and Seminole County Healthy Start Coalitions making it a tri-county process. The reason for this was because other MCH programs tend to be based in Orange County but include client eligibility and services in the other two counties as well; in addition, many women from Osceola and Seminole choose to deliver their babies at Winnie Palmer Hospital in Orange County. (This hospital is the largest birthing hospital in the southeast US and their Neonatal Intensive Care Unit is the fourth largest in the United States.) A clear example of this overlap is Healthy Families: Winnie Palmer Hospital employs staff to conduct HF in both Orange and Osceola counties; Children's Home Society is based in Orange Co. but provides HF services in Seminole County. Therefore, trying to secure agreements and processes in Orange County alone would be difficult at best and would confuse both programs' staff and families in what and who worked where. Our three HS Coalitions and all home visitation program in the tri-county region formed the *Home Visiting Advisory Committee***.** This group meets once a quarter throughout the year to review numbers of clients referred to each home visitation program in addition to reviewing how efficient and successful is the referral process, the data reporting system and any barriers that need to be identified and addressed.

Findings: A few challenges related to this process still remain: 1) our local system of infant home visitation services is not as seamless, coordinated and clearly defined as we desire causing confusion among clients regarding each program's goals and scope of services, eligibility requirements, referral process, etc.; 2) our home visiting programs are all based at separate agencies with no commonly-funded intake unit and perhaps more importantly, 3) state and federal-level program requirements, as well as different funding stream requirements, seem to be impacting the level of collaboration between all programs as system changes are limited based on these requirements. However, the HSCOC remains committed to ensuring our CI&R/Connect process operates at the best level possible.

Infant Mortality Task Force - Throughout each year, members of this task force review and discuss a variety of maternal-child health indicators that include but are not limited to infant mortality, LBW, prematurity, births to teens, late entry or no entry into prenatal care and SUID/SID. They continue to acknowledge the unrelenting impact of *social determinants of health* on women of childbearing age and continue to focus on ways to disseminate education about the important of *preconception health* to ameliorate the problem. Adding to this is the unforeseen impact of COVID-19 on our community. Identifying the ways our community members prefer to communicate and receive health messages is an ongoing process. We continue to implement our ongoing strategy to utilize social media as a vehicle for health awareness. In acknowledgement of the social media habits of women currently in their childbearing years, we continue to post health messages on our Twitter and Facebook accounts in addition to our newly added Pinterest and Instagram accounts; included in these messages is our request to all our

followers that they forward to their network of followers these same messages. In addition, we periodically engage in "boosting" of key health messages as needed for greater reach. While the health messages are focused on interconception, prenatal, postnatal and infant care, we've also added COVID-19 health information.

Findings: During the monthly meetings of this group, there were also discussions of general findings of the County's Child Death Review (see below). Safe sleep environments still proved to be an ongoing factor in these death reviews and our local DCF office has joined us to develop strategies to address this issue. An additional consideration each fall is the March of Dimes release of their birth outcomes' report card; Florida consistently ranks low and in 2019 earned ranking of "C- ".

Child Death Review Committee – Our executive director, as well as a Healthy Start nurse supervisor, attend the monthly meetings of our area's child death review committee in which deaths of children birth-5 with any former findings of abuse/neglect are examined.

Findings: Most of the infant deaths are due to unsafe sleep practices, including co-sleeping, placing an infant on their tummy to sleep, using a pillow or blanket, and/or placing an infant on a sofa or chair to sleep. Unsafe sleep deaths are even found in homes with cribs. It appears from our review that hospitals provide the information before an infant is discharged; pediatric offices and home visitation programs also provide the information as part of their protocols, but we often hear that the grandparents will influence the new parents by saying "the baby will sleep better" and "I did it with you and you are fine" or out of fear of the baby choking. We also hear other reasons for co-sleeping including making breastfeeding more convenient, the parents feeling the baby is safer with them, the parent not hearing if the baby is not beside them, lack of space for a crib and fear of stray bullets in a dangerous neighborhood. There are also those who advocate for the "family bed" for better bonding. These beliefs are difficult to change despite evidence the rate of SIDS has declined more than 45% since the inception of the Back to Sleep Campaign which includes safe sleep practices. Our Coalition supports the American Academy of Pediatrics policy against co-sleeping even if the mother is breastfeeding and we provide education both to our clients and in the community on safe sleep practices. In addition, it was determined that there were no deaths in which Orange County Healthy Start had been involved, or in other words, all infant deaths showed evidence that either the mother had refused HS, the mother could not be found or was lost to contact, or the case was closed due to mother's choice to not continue in services. An example of a response to the concern of safe sleep was to secure, modify and distribute the Ounce of Prevention's Safe Sleep educational wall, ceiling and floor clings to Community Health Centers, local hospitals, health departments and private pediatric offices throughout the County.

In addition to these descriptions above, other community input and data were collected and studied through our participation in different groups' efforts to find solutions to local maternal-child health problems. These groups included the following:

Our Healthy Start Care Coordination and CI&R provider - the Florida Department of Health in Orange County (DOH-O) – Regularly held meetings with our HS service provider supplied ongoing and up-to-date information about issues such as needs of our families, trends the staff were seeing in the communities they served, ideas for improving how services were provided, etc. As topics are reviewed, discussions occur regarding potential strategies to

implement that would address these topics where possible; many, unfortunately, are linked to social determinants of health (SDH) in which we have very little influence, such as our county's critical lack of affordable housing and subsidized quality childcare. The COVID pandemic intensified the impact of these SDHs on the lives of our families. However, through ongoing updates (that is, staff inservices) on available community services, our HS staff are able to provide their clients with referrals and help in accessing these vital resources. Their knowledge of resources made available from the federal and state funding support due to the pandemic has been especially valuable to our families in need.

Local Federally-qualified Health Centers (FQHCs) – Our partnership with one FQHC, the Community Health Center, continued with the ongoing placement of Healthy Start workers at both clinics that offer prenatal care. The second local FQHC, True Health, agreed to placement of a care coordinator just as the pandemic began but this person was able to begin services there on July 1, 2020. Having CIR and HS services directly available to clients who present at clinic appointments increases the chances of engagement and recruitment into our programs. Both FQHC companies serve large African-American, Hispanic and Haitian populations.

Health and Hunger Task Force – The Health and Hunger Task Force was created by our local Second Harvest Food Bank to gather together agencies that work with children and families in Orange County and which see hunger as an issue that effects health. With increased requests to our local food bank and the large number of children on free/reduced lunch in the schools, hunger emerged as a widespread community problem. While there are numerous food drives and generous donations of food, a forgotten element in the hunger issue are the people with medical conditions whose health is impacted by their diet, such as those with diabetes. High-risk pregnant women are also part of this subgroup of people in need of particular foods, not just whatever is available at a food pantry. This Task Force has been working to ensure that: a health clinic that serves diabetic patients has healthy options; medical providers issue prescriptions for the foods appropriate to the patient's diagnosis; hospitals include food bank/pantry locations in their discharge planning for patients in need as well as for their employees in need; and that information is available to agencies on which food pantries can meet needs of pregnant and breastfeeding women. The task force is also working to ensure fresh fruits and vegetables are available at the food pantries. The Coalition executive director has served on this task force since its inception.

Consumer/Family Input

Also contributing to our MAPP process are four primary sources of consumer/family input that are summarized below.

Client satisfaction surveys – These surveys have consistently shown that our clients are very satisfied with our Healthy Start services as well as our provider, the FL Department of Health in Orange County. In our most recent annual review (2019-20), 313 returned surveys, 92.97% indicated an overall satisfaction rating indicated an overall satisfaction rating of "agree" or "strongly agree". This rating includes our childbirth education classes, safe sleep education classes, and Daddy Boot Camp classes taught by our program staff. Also, 93.92% of survey

participants felt their Healthy Start worker was well informed, helpful and able to answer all of their questions. When asked if the Healthy Start services they received were beneficial, 91.69% indicated a rating of "agree" or "strongly agree". In regards to survey measures that rate the friendliness and politeness of the Healthy Start worker, all survey participants indicated a rating of "agree" or "strongly agree". Additional feedback shared by participants as to the program and services included common words such as "informative", "helpful", and "friendly".

HS Staff Input - Challenges facing Healthy Start families are many and varied. Common barriers Healthy Start clients experience which may prevent desired pregnancy and infant health outcomes are related to income, healthcare, housing, daycare, resources, prenatal care and transportation. Many clients have low-wage jobs or even work two part-time jobs (employers thus avoid paying benefits) to try to keep up with the cost of living. This spirals into many unfortunate effects, including not qualifying to receive needed public assistance and clients obtaining no healthcare insurance coverage. Having no insurance, being an undocumented worker and closed clinic sites are main reasons for women seeking no or late prenatal care. Cost of living is high in this area and affordable housing is extremely limited, so clients are living in unsuitable housing, even motels, and in unsafe communities. Cost of daycare is also high, especially for infants, and subsidized childcare is not available through our childcare coordinating agency due to extensively long wait lists. Some clients lack the ability to obtain car seats, cribs or pack-n-plays and often are in environments with insufficient storage space for these items even if they had them. While Healthy Start provides bus passes to help with transportation issues, public bus routes have an inadequate number of stops and multiple transfers causing extended trips and other challenges to overcome for our families.

To determine the impact of the pandemic on our families, we conducted a COVID assessment of Healthy Start clients during August and September 2020. The goal was to identify areas of need and connect families with the appropriate resources such as rent/utilities assistance, food and mental health counseling, especially as some clients mentioned feeling depressed and alone during this time. In an effort to provide direct assistance, clients were asked what size diapers they needed to determine if HSCOC could assist to help offset that expense for another dire need such as rent or utilities. After conducting this assessment on 192 Healthy Start clients during COVID-19, most indicated occupational shifts and the adoption of more health precautions (see Appendix II). When asked if access to care for the mother or baby was problematic due to the pandemic, most reported no issues. Clients that did experience issues with access to care cited insurance, transportation, and safety concerns due to COVID-19 as the primary causes of the service barrier. Of the 10 percent of assessment participants mentioning they or an immediate family member being sick due to COVID-19, only 25 percent said they were personally ill. Healthy Start continues to monitor these COVID-affected families, providing community referrals, baby items and personal protective equipment (masks) to clients in-need, and encouraging social distancing through telephonic/video conference visits.

The Orange County Sherriff's Office Outreach Program conducted a door-to-door survey of residents' needs in several high-risk areas of our county. These surveys were conducted a few months before the pandemic and then were suspended until late fall 2020. The survey included questions pertaining to pregnancy and infancy so we offered to help summarize these surveys in order to glean information that would contribute to our Healthy Start goals. Unfortunately, after

several attempts to collaborate, to date we are still waiting for response. We anticipate successful partnership as the pandemic begins to resolve.

Information acquired through our CI&R (Coordinated Intake and Referral) unit called CONNECT is a continuous source of consumer input. An important part of this process includes inquiring why families refused services and if there were any services they needed they could not get. The following reasons were given for refusing/declining home visiting services:

- Families are scared and don't want anyone visiting them due to COVID-19 fears. Some say they're not accepting services until COVID-19 ends.
- Some are focused on searching for jobs and have no time for programs.
- Parents are trying to meet their basic needs, they are worried about eviction and deportations, and all are not privy to the various technology or software being used to virtually connect with HV partners.
- Additional reasons for declining services also included: "didn't have time", "didn't know work schedule" and "already a parent", moms already have support at home, working part-time or not working at all and have more availability to be home.

We also know that many women have expressed fear of immigration concern and the "public charge" threat that existed over the past number of months.

These responses make it evident that social determinants of health coupled with COVID-19 continue to play a major role in creating challenges and barriers for families to overcome and many are ones that our programs are not fully equipped to address. In addition, Healthy Start and other home visiting programs could benefit from research-based methods and best practices to engage families in accepting services.

Summary of Data Source

Florida Vital Statistics and Florida CHARTS – The health indicator data were obtained from these two databases as well as our pre- and postnatal screening data. The screening data provide us with as assessment of how well pregnant women and infants are entering our system of care.

Well Family System – This data system has served to monitor how well are Healthy Start services are being delivered to our families. It also provides us with the mechanism to monitor billing for our Medicaid clients in order to track our funding levels.

Healthy People 2020 and 2030 – This information allowed us to measure ourselves against target goals set by the United States Department of Health and Human Services for health standards for our nation by the year 2020 and in preparation for 2030. *Healthy People* emphasizes health-promotion and disease-prevention in a wide array of health indicators, including those for maternal-child health.

Zip Code Data - This information is compiled and shared by our Orange County Dept. of Health partner and is updated each year as data become available. The data are analyzed and used to

determine the scope of our special initiatives and outreach efforts. The information is useful as we analyze issues occurring in our community and examine where needs are developing. Finally, these data are also shared with community partners who frequently request targeted MCH zip code data for their own grant writing purposes. (To date, Covid reassignments by DOH-Orange has prevented time for staff to update and complete this chart with current data.)

Community Health Needs Assessments – A Community Health Assessment (CHA) is a comprehensive review and analysis of public health, socioeconomic and other demographic data. In addition to not-for-profit hospitals, county health departments in Florida are also required to conduct a CHA to determine public health priorities. Due to the overlap in requirements for not-for-profit hospitals and the Departments of Health, in 2012 the Central Florida Community Collaborative (the Collaborative) was created and included community partners, of which we were one. In Orange County, for the 2019 CHA, the Collaborative expanded to include four local Federally Qualified Health Centers (FQHC). Staff from the Coalition participated in groups looking at data and determining areas of focus for their joint plans. These assessments supported our Coalition's own data reviews and since Maternal Child Health was determined by the hospitals to be an area for improvement, we have continued to be involved in their ongoing planning. In addition, the Department of Health in Orange has pulled from the participants listed above and convened a group to develop their Community Health Improvement Plan (CHIP). One of their goals pertains to reducing the Black Infant Mortality Rate in Orange County and a HSCOC staff person is co-lead along with their Health Equity Coordinator. Community partner meetings to develop strategies and outcome measures are slated to begin in January 2021.

The following sites were used to complete our county demographic assessment:

- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health
- Florida Legislature Office of Economic and Demographic Research
- U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates
- QuickFacts.
- 2020 ALICE (Asset Limited, Income Constrained, Employed) Report, Heart of Florida United Way

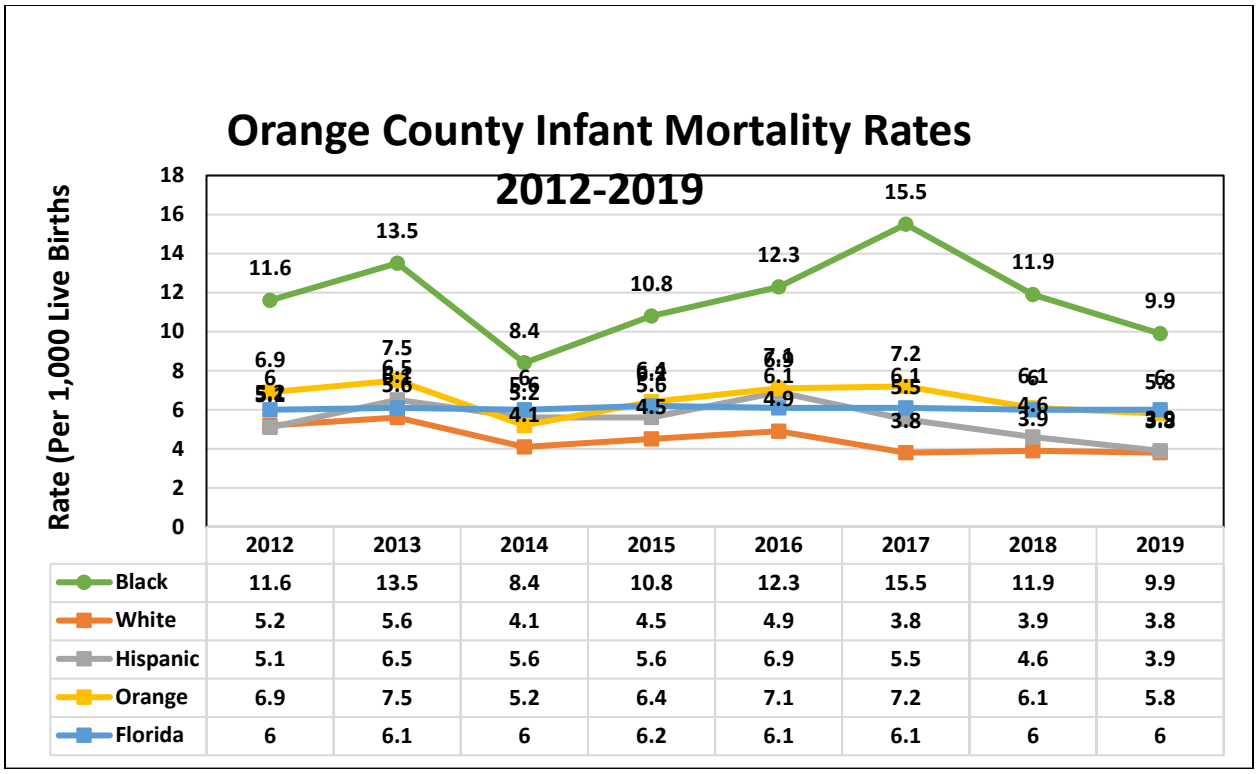
C. Needs Assessment Findings

Overview of Data

Infant Mortality

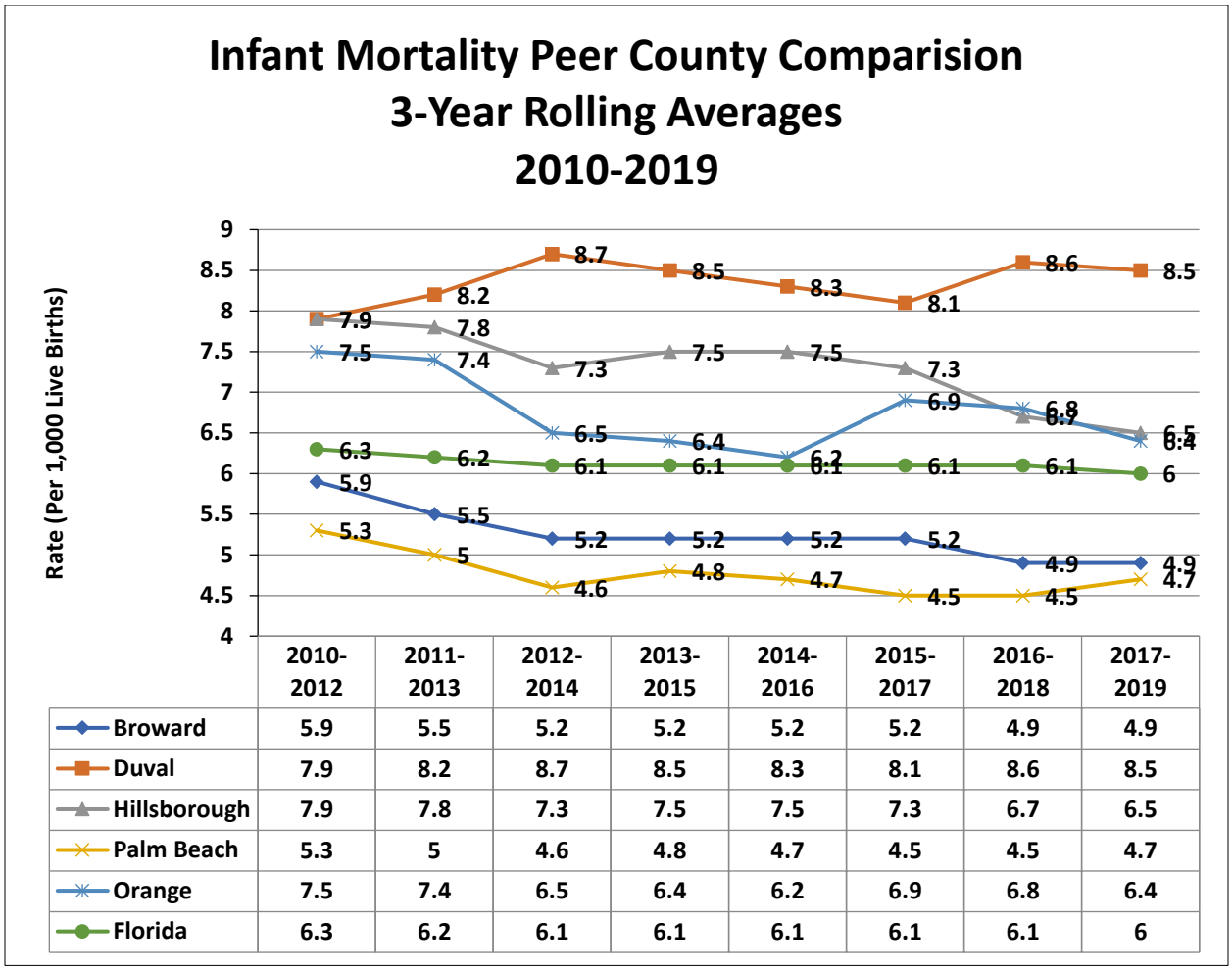
Infant mortality is expressed as infant (birth to 364 days) deaths per 1000 live births, i.e., the number of infants who have died before their first birthday. While many infant deaths are due to conditions incompatible with life, many more deaths are preventable. These rates allow for Healthy Start to determine the well-being of infants and women of reproductive age within its

target area and better identify local maternal-child health care needs. Healthy Start strives to prevent deaths through ensuring access to prenatal care and through the provision of needed education and support services.



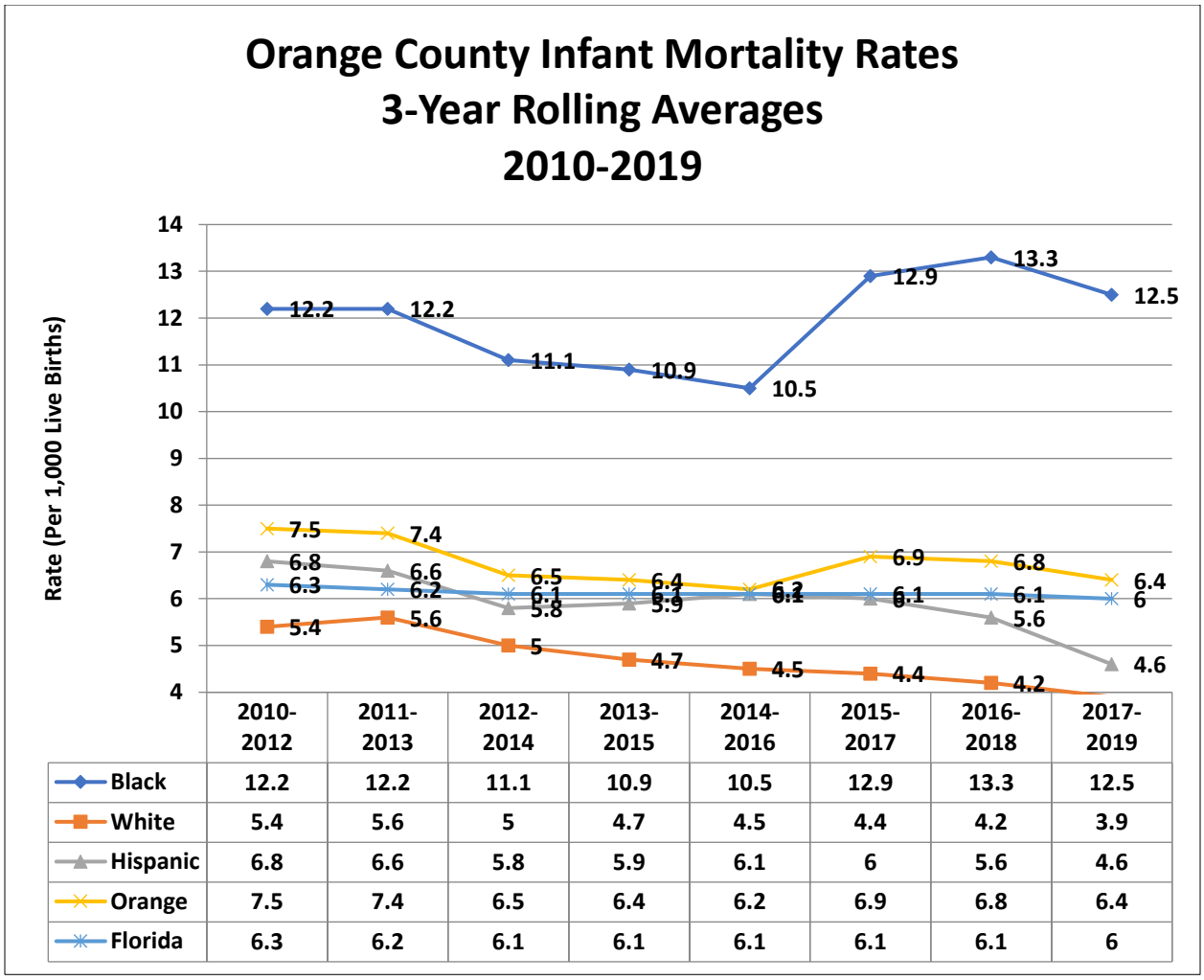
	2012	2013	2014	2015	2016	2017	2018	2019
Black	11.6	13.5	8.4	10.8	12.3	15.5	11.9	9.9
White	5.2	5.6	4.1	4.5	4.9	3.8	3.9	3.8
Hispanic	5.1	6.5	5.6	5.6	6.9	5.5	4.6	3.9
Orange	6.9	7.5	5.2	6.4	7.1	7.2	6.1	5.8
Florida	6	6.1	6	6.2	6.1	6.1	6	6

- Since 2012 our IMR has decreased 16%, from 6.9 to 5.8 overall, with substantial decreases within each racial/ethnic group.
- The Black IMR is now just more than twice the White rate, which illustrates improvement in racial/ethnic health disparities and infant mortality, i.e. the racial gap narrowed from more than four times the difference in 2017.
- Orange County is 0.2 percentage points lower than the state rate after being higher from 2015 to 2018.
- Hispanics overall show a decrease since 2012 rate of 5.1 to 3.9 in 2019 – the lowest recorded Hispanic IMR within Orange County.
- Orange County is below the Healthy People (HP) 2020 goal IMR of 6.0 by .2 percentage points. Therefore Orange County has reached the 2020 HP goal.
- The HP 2030 goal for IMR is 5 percent, with the national baseline rate being 5.8 in 2017. As Orange County did reach the baseline rate in 2019 and has shown IMR decrease since 2012, it is possible to meet the HP 2030 goal with continued education and targeted outreach.



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Broward	5.9	5.5	5.2	5.2	5.2	5.2	4.9	4.9
Duval	7.9	8.2	8.7	8.5	8.3	8.1	8.6	8.5
Hillsborough	7.9	7.8	7.3	7.5	7.5	7.3	6.7	6.5
Palm Beach	5.3	5	4.6	4.8	4.7	4.5	4.5	4.7
Orange	7.5	7.4	6.5	6.4	6.2	6.9	6.8	6.4
Florida	6.3	6.2	6.1	6.1	6.1	6.1	6.1	6

- Orange County's 3-year average rate shows an overall decline of 15% since 2010-12.
- Although currently at only a slightly greater rate than the state average, Orange County's 3-year average rate has decreased while one of its sister counties rates has increased (two counties are higher and two are lower than Orange Co.)

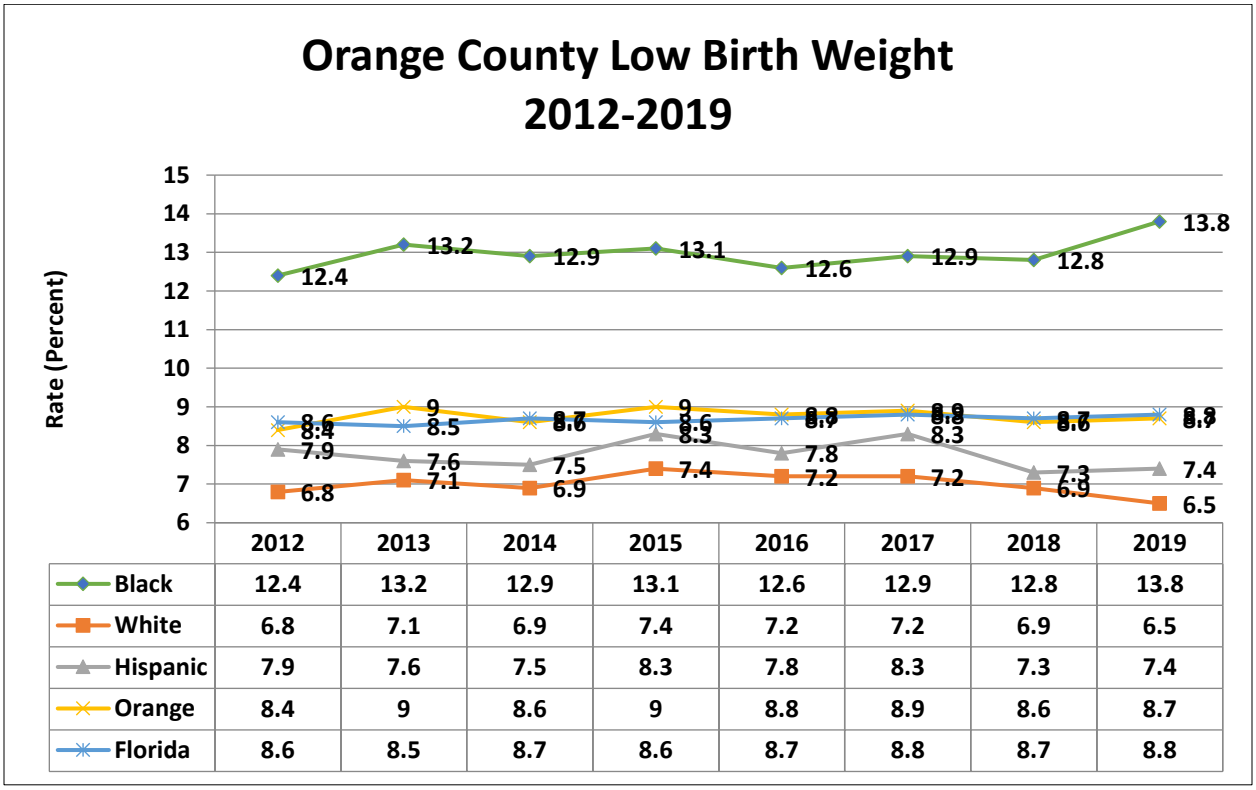


	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Black	12.2	12.2	11.1	10.9	10.5	12.9	13.3	12.5
White	5.4	5.6	5	4.7	4.5	4.4	4.2	3.9
Hispanic	6.8	6.6	5.8	5.9	6.1	6	5.6	4.6
Orange	7.5	7.4	6.5	6.4	6.2	6.9	6.8	6.4
Florida	6.3	6.2	6.1	6.1	6.1	6.1	6.1	6

- 3-year rolling averages by race/ethnic group confirm an increasing trend in Black IMR from 2014-2016, but has since decreased to 12.5. The Black IMR is greater than other area race/ethnic group despite recent decrease.
- The Black 3-year rolling IM rate is more than three times the White rate.

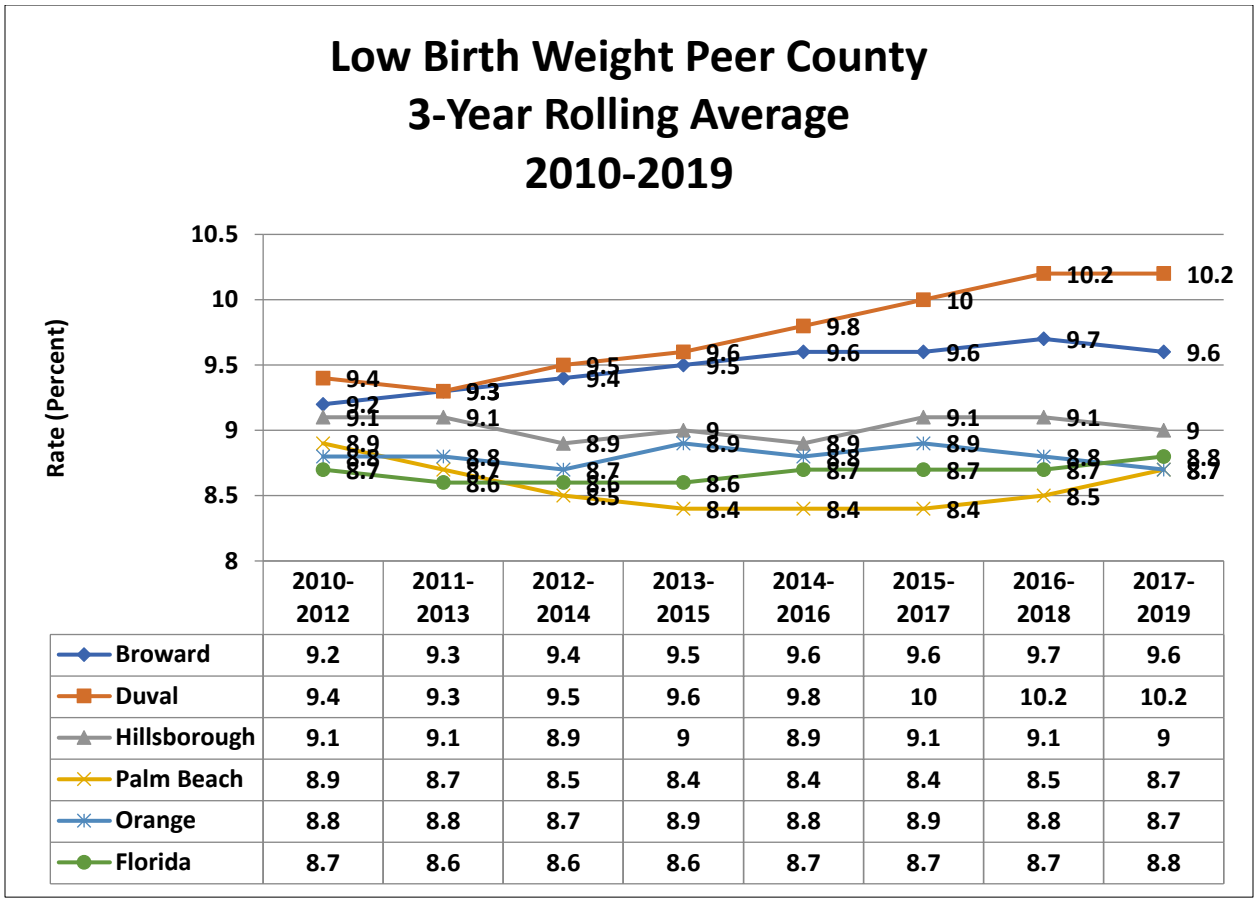
Low Birth Weight

Low birth weight (LBW) infants are those born weighing less than 2500 grams (5 lbs.8 oz.), and very low birth weight infants weigh less than 1500 grams (3lbs.5oz.). Social determinants of health, such as low income/poverty and lack of education, along with chronic health problems of the mother, smoking, alcohol, stress and poor nutrition are associated with an increased risk of having a low birth weight baby. Although advances in medical care have reduced the death rate associated with low birth weight, these infants are more likely to have significant long-term health and developmental problems. In fact, LBW, together with premature birth, is the major factor contributing to infant mortality and thus is one of the strongest predictors of our infants' health and longevity. This data provides Healthy Start with a basis to support local action to combat post-discharge growth restrictions.



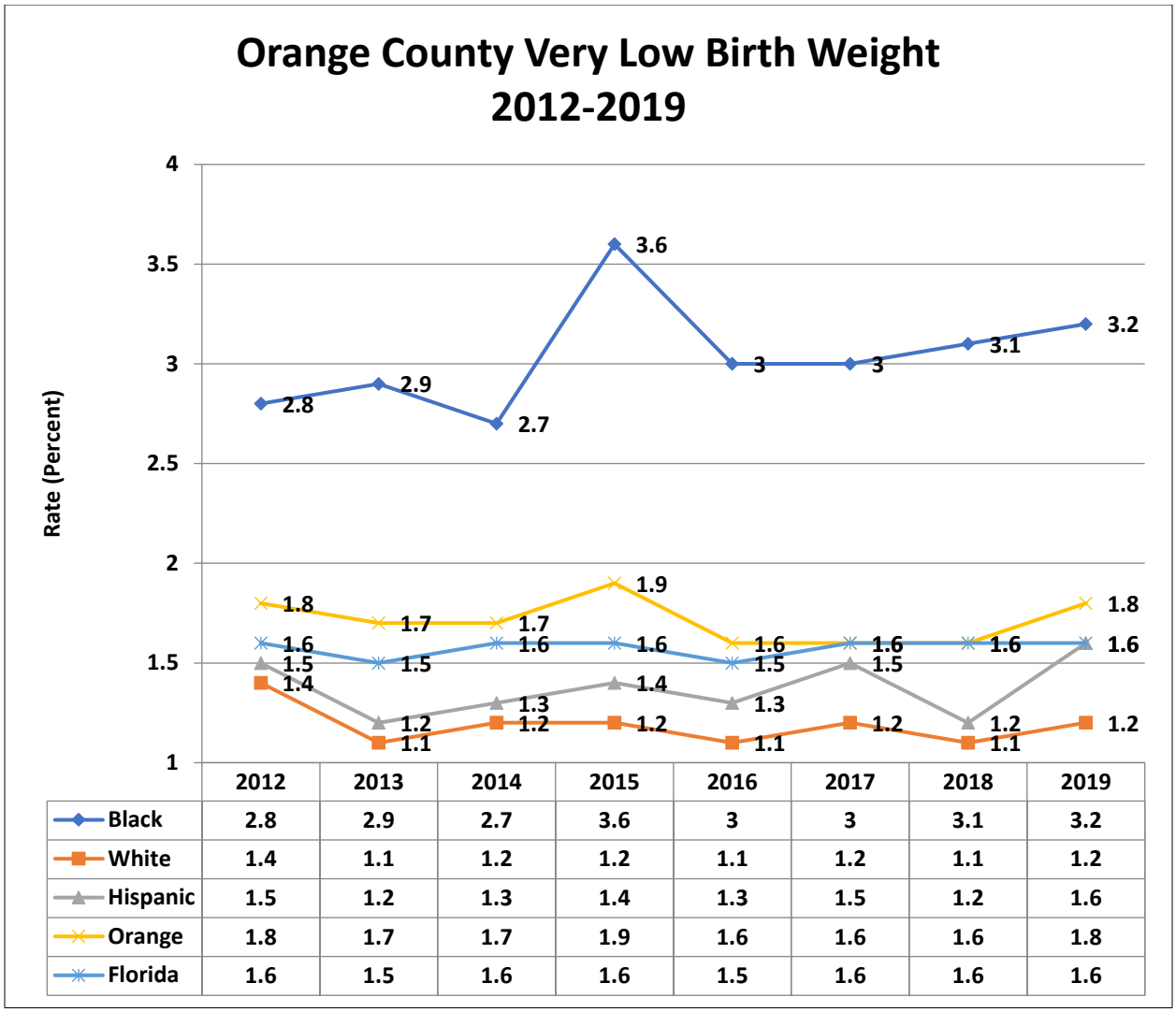
	2012	2013	2014	2015	2016	2017	2018	2019
Black	12.4	13.2	12.9	13.1	12.6	12.9	12.8	13.8
White	6.8	7.1	6.9	7.4	7.2	7.2	6.9	6.5
Hispanic	7.9	7.6	7.5	8.3	7.8	8.3	7.3	7.4
Orange	8.4	9	8.6	9	8.8	8.9	8.6	8.7
Florida	8.6	8.5	8.7	8.6	8.7	8.8	8.7	8.8

- Our overall county LBW rate has slightly increased since 2012 (.3 percentage point increase), but is currently lower than the 2019 state rate of 8.8.
- Orange County Black LBW has increased overall since 2012, as other racial/ethnic groups have shown progress.
- The black yearly rates are consistently approximately two times greater than the white rate.

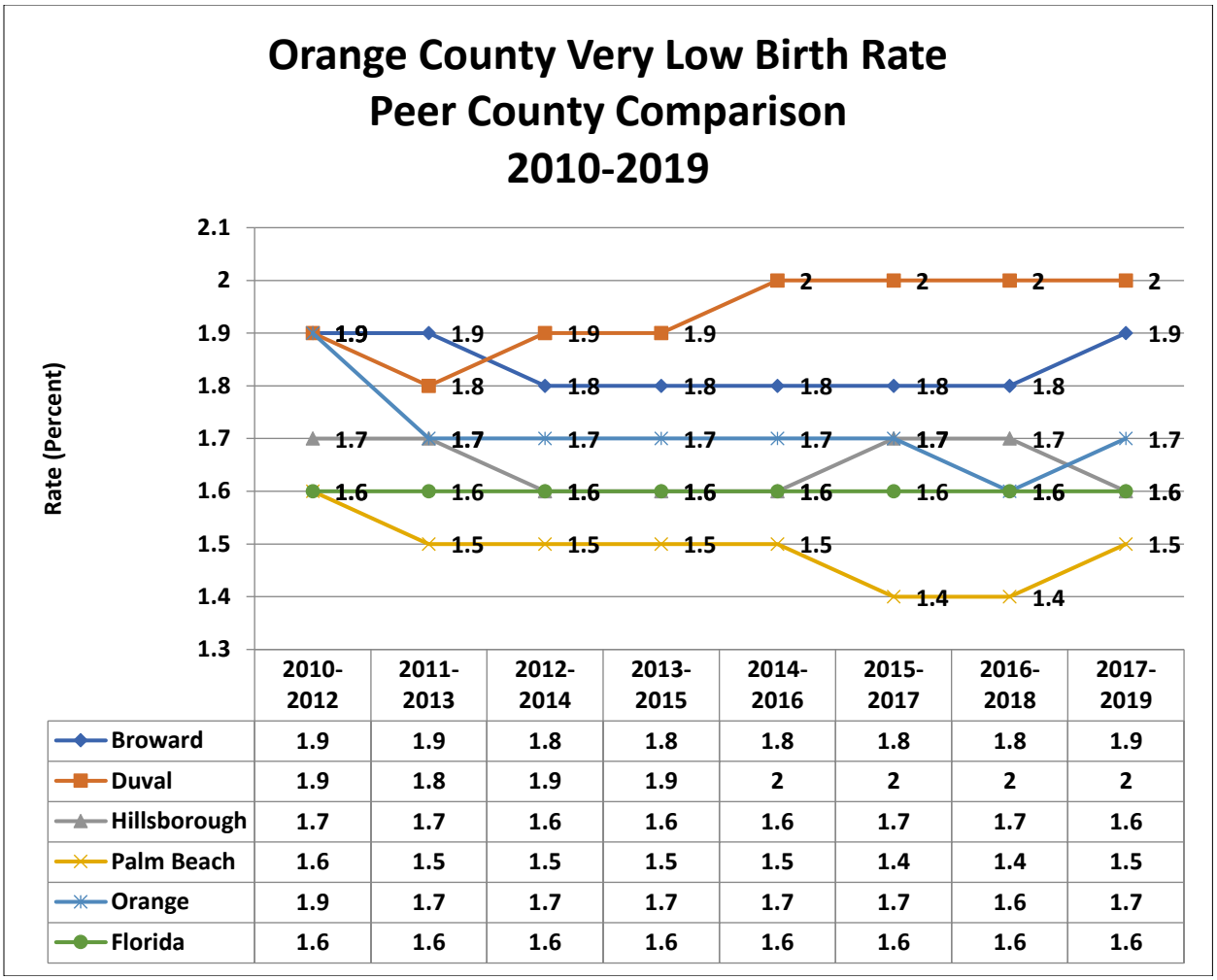


	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Broward	9.2	9.3	9.4	9.5	9.6	9.6	9.7	9.6
Duval	9.4	9.3	9.5	9.6	9.8	10	10.2	10.2
Hillsborough	9.1	9.1	8.9	9	8.9	9.1	9.1	9
Palm Beach	8.9	8.7	8.5	8.4	8.4	8.4	8.5	8.7
Orange	8.8	8.8	8.7	8.9	8.8	8.9	8.8	8.7
Florida	8.7	8.6	8.6	8.6	8.7	8.7	8.7	8.8

- Orange County 3-year rolling rate is lower than Florida's rate and most peer county rates, with the exception of Palm Beach County which is equal to the Orange County rate.
- The Healthy People 2020 goal for LBW is 7.8%. Although Orange County will continue efforts to address LBW continue thorough community-based programming and educational outreach, it is unlikely we will reach the HP 2020 goal based on previous rate averages.

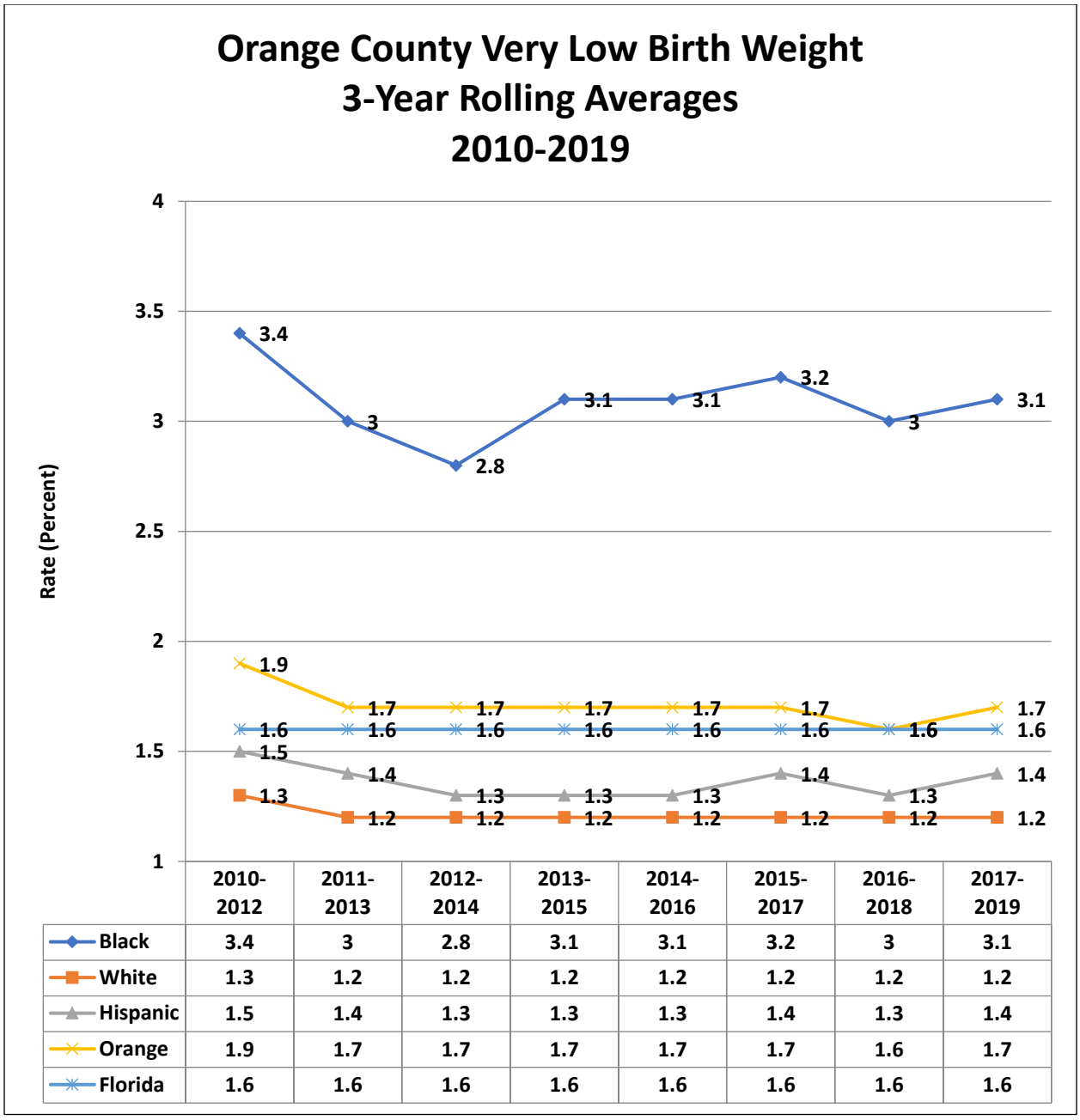


- The Orange County rate virtually parallels Florida's rate, although it is now slightly higher by .2 percentage points.
- Our Black VLBW rate increased 14% since 2012.
- Our Black VLBW rate has stayed higher than the White rate. Black VLBW at 3.2 is now almost three times the White rate of 1.2, but the racial gap has decreased since 2015.
- Our Black VLBW is 2 times greater than our Hispanic rate.
- The Healthy People 2020 goal for VLBW is 1.4%. Although some Orange County racial/ethnic groups show promise in maintaining at or below the national target average, VLBW continues to fluctuate within the county and statewide.



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Broward	1.9	1.9	1.8	1.8	1.8	1.8	1.8	1.9
Duval	1.9	1.8	1.9	1.9	2	2	2	2
Hillsborough	1.7	1.7	1.6	1.6	1.6	1.7	1.7	1.6
Palm Beach	1.6	1.5	1.5	1.5	1.5	1.4	1.4	1.5
Orange	1.9	1.7	1.7	1.7	1.7	1.7	1.6	1.7
Florida	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6

- Orange County's rate of 1.7 percent is currently 0.1 percentage point above the state, remaining relatively the same since 2011-13.
- Orange County is higher than two of its peer counties, Palm Beach and Hillsborough, and lower than two peer counties, Broward and Duval.

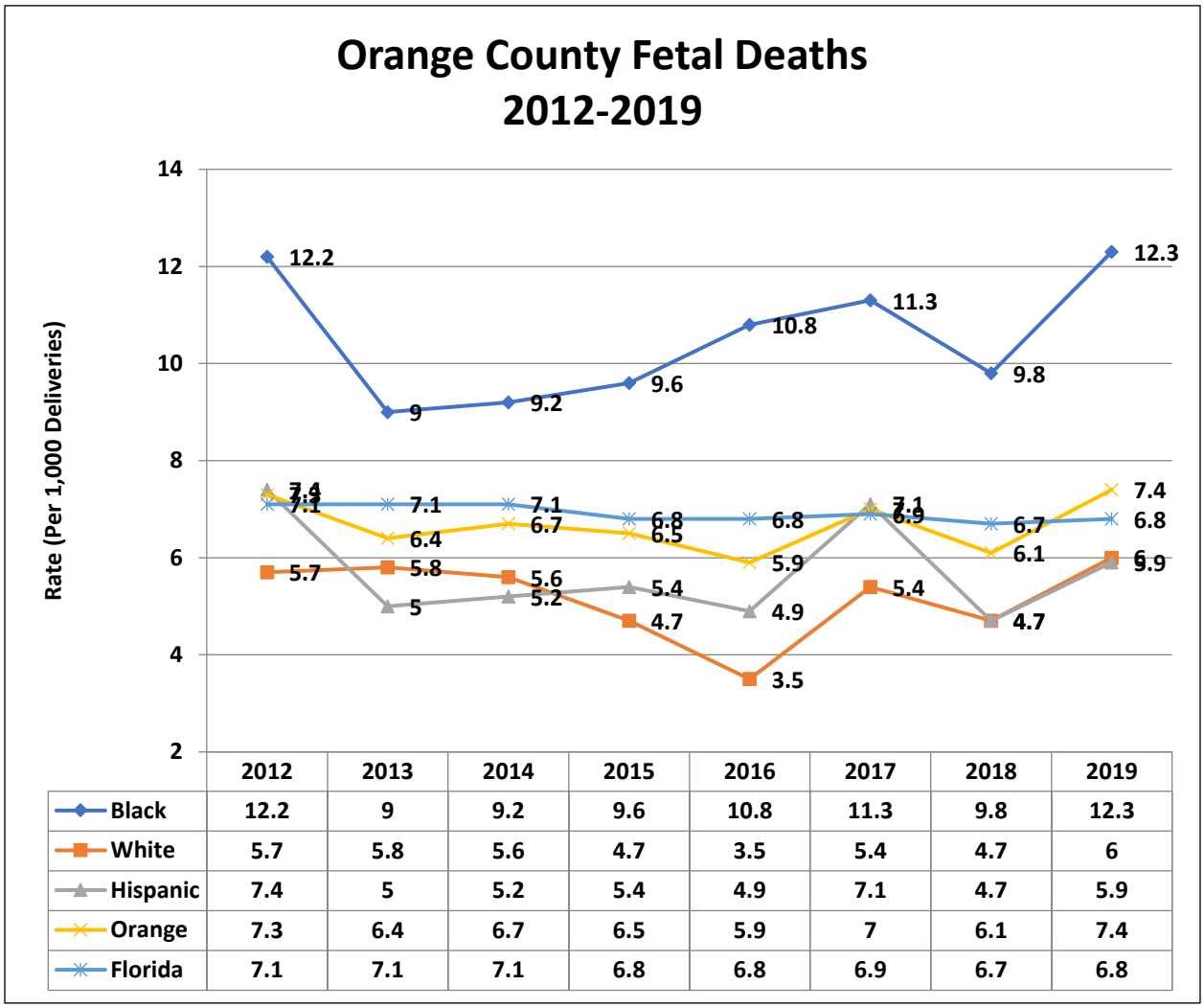


	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Black	3.4	3	2.8	3.1	3.1	3.2	3	3.1
White	1.3	1.2	1.2	1.2	1.2	1.2	1.2	1.2
Hispanic	1.5	1.4	1.3	1.3	1.3	1.4	1.3	1.4
Orange	1.9	1.7	1.7	1.7	1.7	1.7	1.6	1.7
Florida	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6

- The 3-year rolling averages illustrate a small decrease in the Black rate, while Hispanics and Whites stayed essentially the same.
- The Black VLBW has fluctuated over time but remains as the racial/ethnic group with the highest VLBW rate at about double that of Florida's average rate and almost three times that of Orange County's White rate.

Fetal Mortality

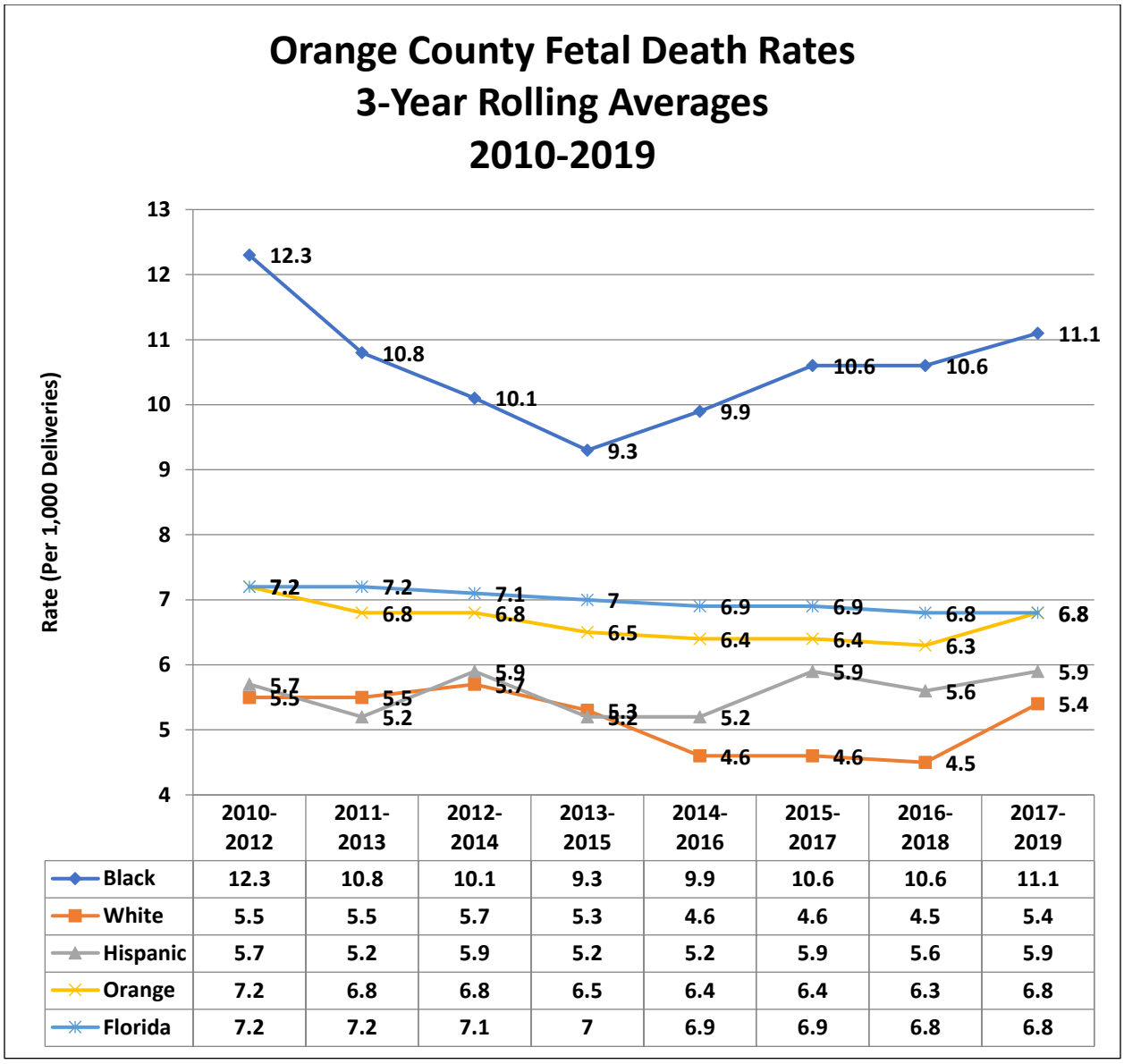
Fetal death rates are defined as the number of fetal deaths, 20 weeks or more gestation, per 1000 live births. A decrease in fetal mortality can be associated with providing for pre/interconception care since many mothers already have chronic health conditions and/or maternal infections by the time they become pregnant which can negatively impact birth outcomes. Although our coalition has not conducted a PPOR (Perinatal Periods of Risk) data review for several years, we know that according to PPOR theory, fetal death rate is a good indicator of the well-being of reproductive age-women and their pregnancies, and helps to identify areas needing increased education or resources.



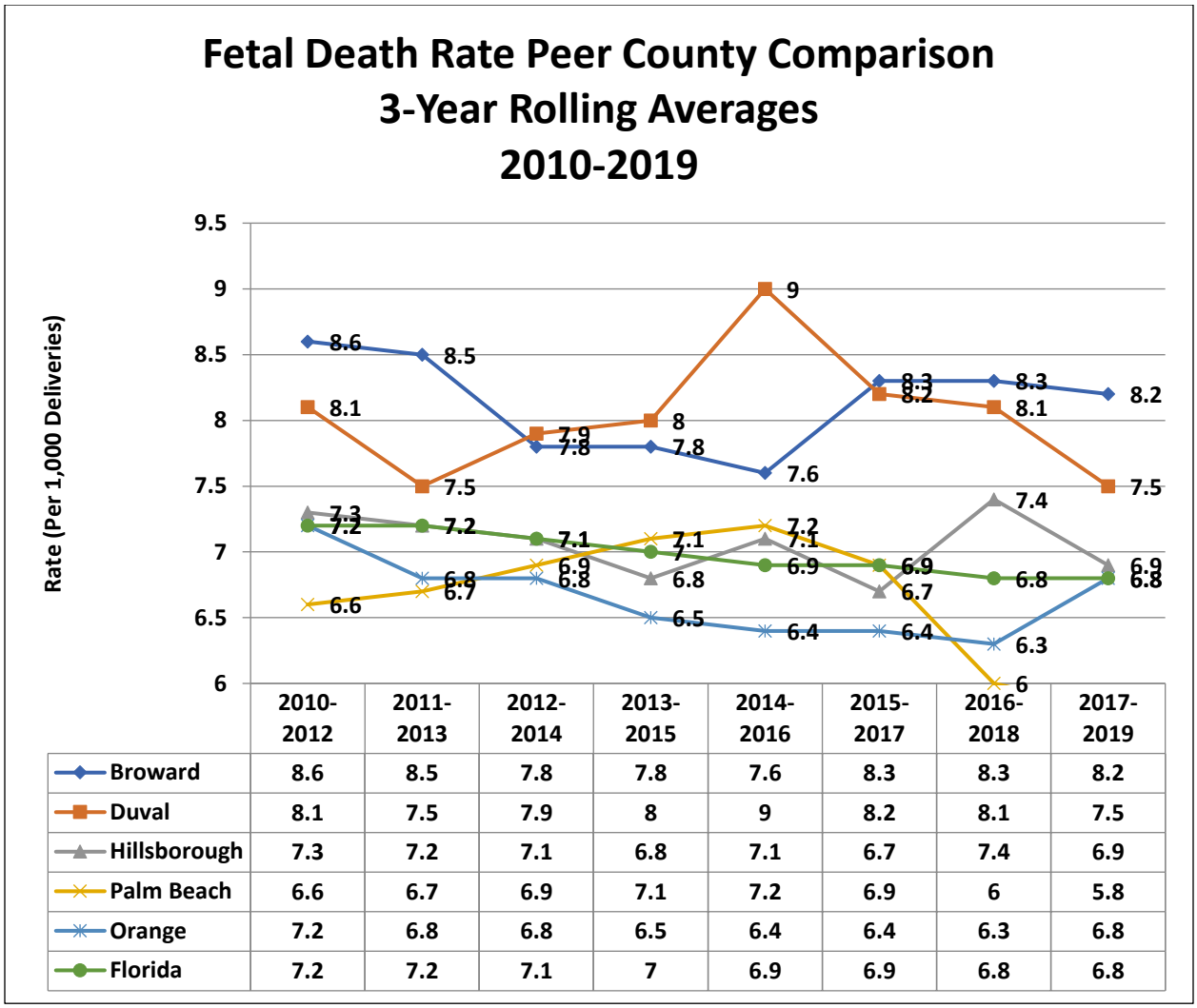
	2012	2013	2014	2015	2016	2017	2018	2019
Black	12.2	9	9.2	9.6	10.8	11.3	9.8	12.3
White	5.7	5.8	5.6	4.7	3.5	5.4	4.7	6
Hispanic	7.4	5	5.2	5.4	4.9	7.1	4.7	5.9
Orange	7.3	6.4	6.7	6.5	5.9	7	6.1	7.4
Florida	7.1	7.1	7.1	6.8	6.8	6.9	6.7	6.8

- Although the County's fetal death rate has fluctuated since 2012, it is essentially the same since then, increasing only from 7.3 in 2012 to 7.4 in 2019. However, it is currently almost 9% greater than the state's rate of 6.8.
- The Black fetal death rate has also fluctuated over time but is essentially the same at 12.3 in 2019 as 12.2 in 2021. This rate is currently more than twice the rate of Whites at 6.

- The Hispanic fetal death rate has decreased since 2012 by 20%, going from 7.4 to 5.9. This rate is lower than our White rate by .1 percentage point.
- The Orange County fetal death rate exceeds the Healthy People baseline rate of 6.2 as well as the 2020 target rate of 5.6. Therefore, we likely will not meet the HP 2020 goal for fetal deaths as our 2019 rate is at 7.4. As the fetal mortality rate reflects 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, we will continue to address the preconception health of mothers within Orange County through interventions and targeted outreach.



- Orange County has stayed the same or lower than the state rate since 2010.
- The Black rate has shown the greatest decrease, going from 12.3 to 11.1 for a 10% decline.

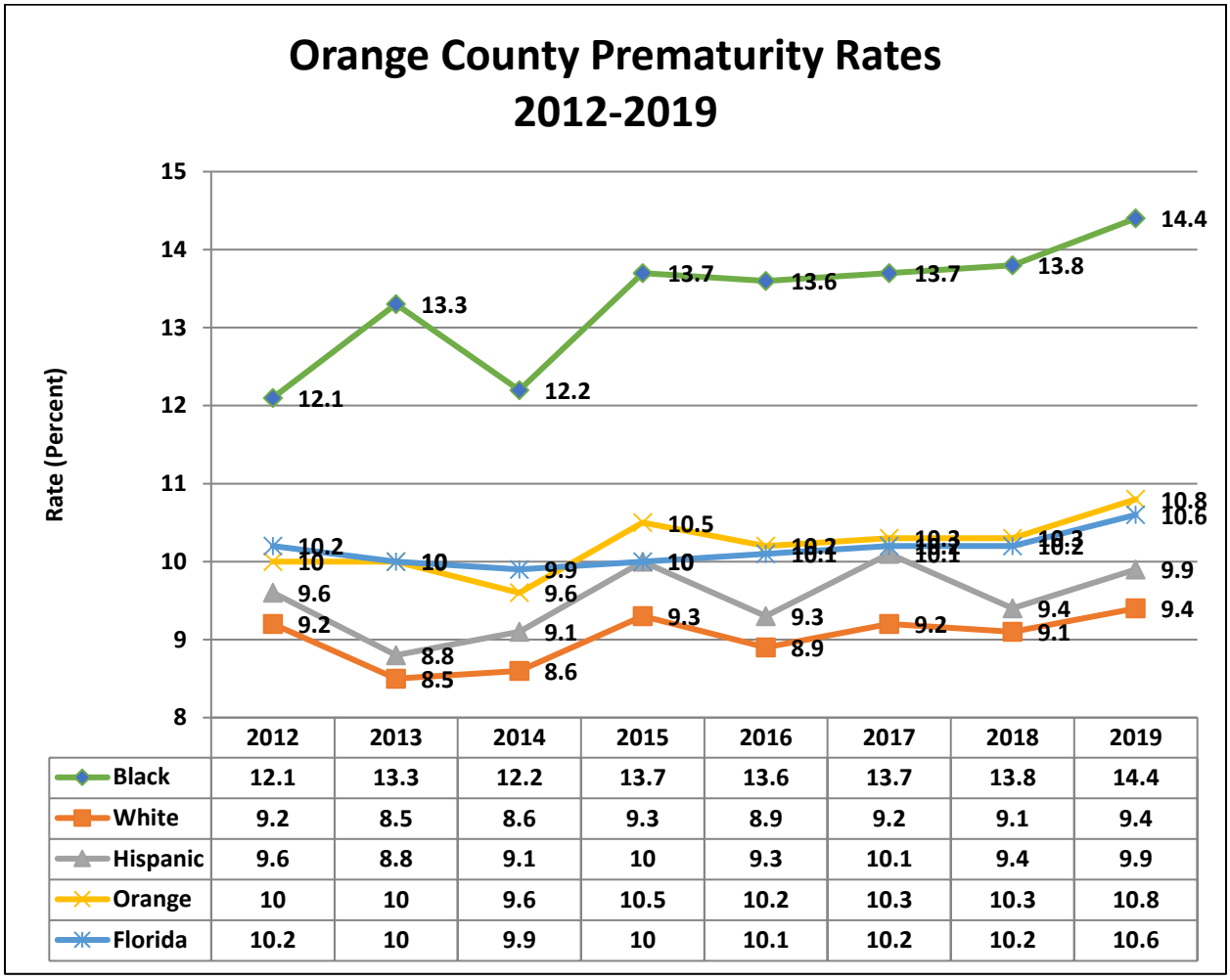


	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Broward	8.6	8.5	7.8	7.8	7.6	8.3	8.3	8.2
Duval	8.1	7.5	7.9	8	9	8.2	8.1	7.5
Hillsborough	7.3	7.2	7.1	6.8	7.1	6.7	7.4	6.9
Palm Beach	6.6	6.7	6.9	7.1	7.2	6.9	6	5.8
Orange	7.2	6.8	6.8	6.5	6.4	6.4	6.3	6.8
Florida	7.2	7.2	7.1	7	6.9	6.9	6.8	6.8

- Orange County's fetal death rate has declined by 6% in 3-year averages and has remained lower or equal to the state rate since 2010.
- Our fetal death rate continues to be one of the lowest among peer counties (Palm Beach County rate is currently a percentage point lower than Orange County at 5.8).

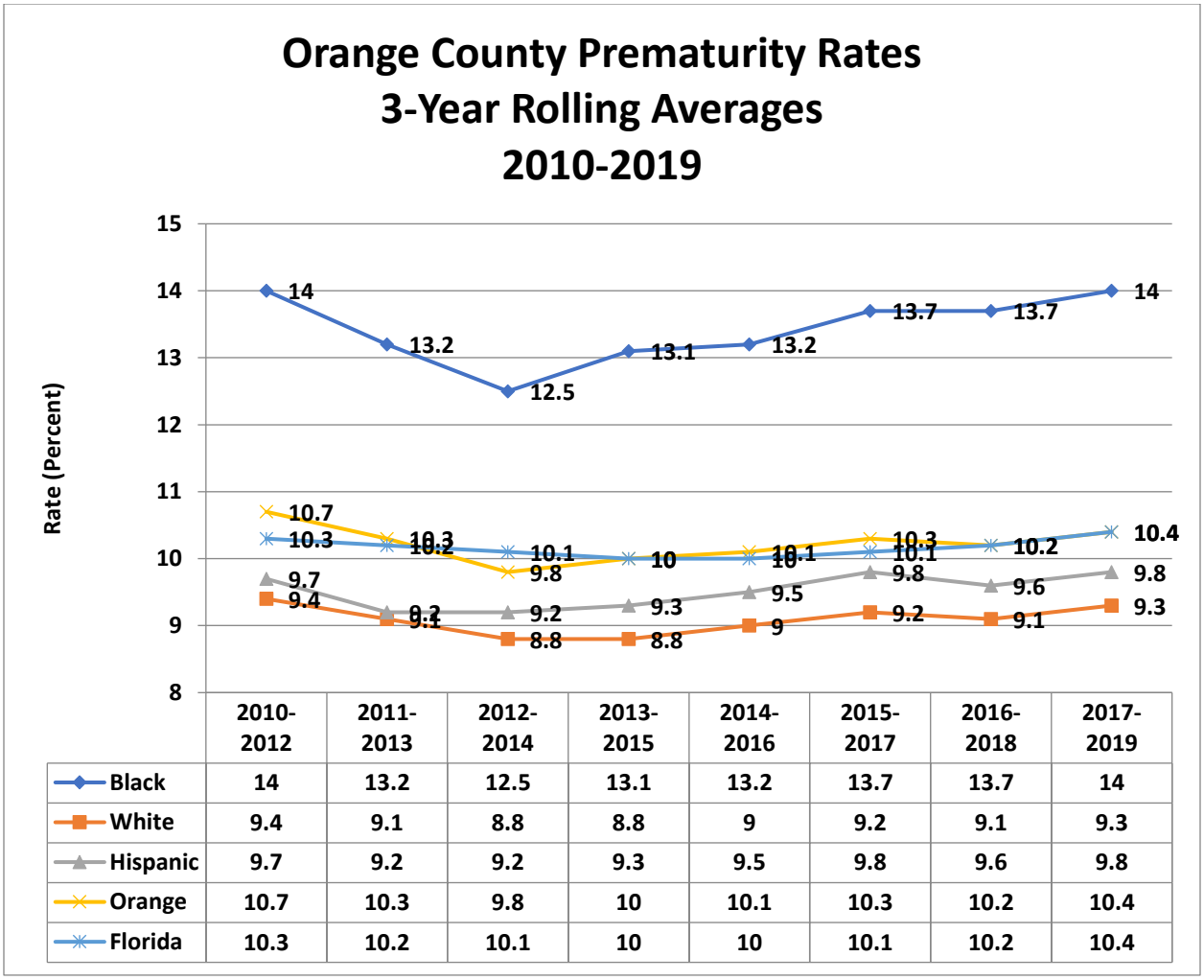
Prematurity

Prematurity, being born too soon, i.e. less than 37 weeks gestation, is a leading cause of infant mortality. As with LBW, babies born too soon are at greater risk of health and developmental problems in comparison to term births.



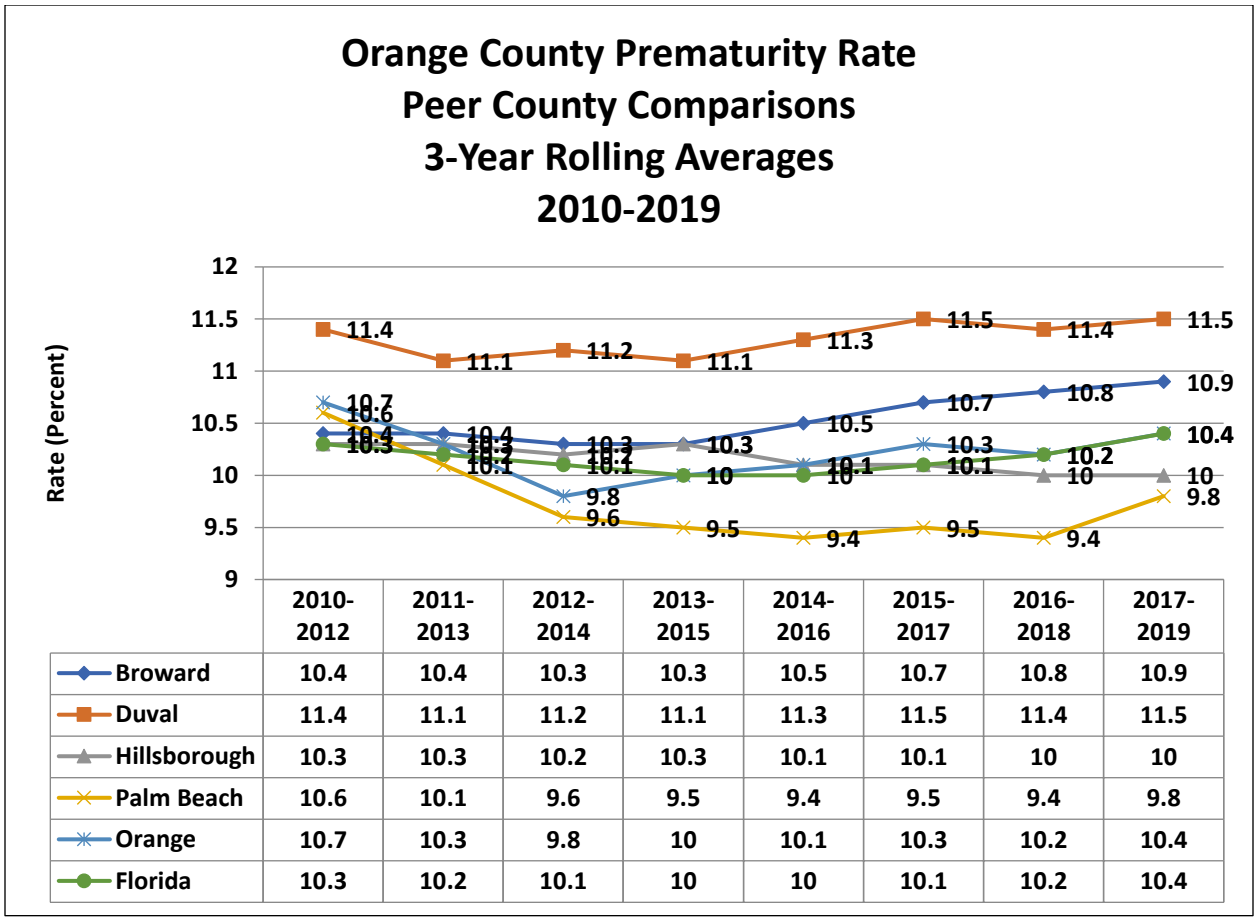
	2012	2013	2014	2015	2016	2017	2018	2019
Black	12.1	13.3	12.2	13.7	13.6	13.7	13.8	14.4
White	9.2	8.5	8.6	9.3	8.9	9.2	9.1	9.4
Hispanic	9.6	8.8	9.1	10	9.3	10.1	9.4	9.9
Orange	10	10	9.6	10.5	10.2	10.3	10.3	10.8
Florida	10.2	10	9.9	10	10.1	10.2	10.2	10.6

- Currently at 10.8 percent, Orange County prematurity rates have increased 8% since 2012, although there has been an increase of less than a percentage point since 2012.
- Orange County prematurity rates for Blacks have increased 19% since 2012 and remain higher than both our White and Hispanic populations.
- The Healthy People 2020 goal for prematurity is 11.4 percent. Currently, Orange County is below this target rate but only by a fraction of a percent.
- The HP 2030 goal for prematurity is 9.4 percent, with the 2018 national baseline of 10 percent. With the HP 2020 goal being met, we will continue to address preterm birth through HS services and communitywide education with the hope of reaching the 2030 national goal.



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Black	14	13.2	12.5	13.1	13.2	13.7	13.7	14
White	9.4	9.1	8.8	8.8	9	9.2	9.1	9.3
Hispanic	9.7	9.2	9.2	9.3	9.5	9.8	9.6	9.8
Orange	10.7	10.3	9.8	10	10.1	10.3	10.2	10.4
Florida	10.3	10.2	10.1	10	10	10.1	10.2	10.4

- Orange County 3-year average decreased 3% from 2010 to 2019 and currently is at the same rate as the state average.

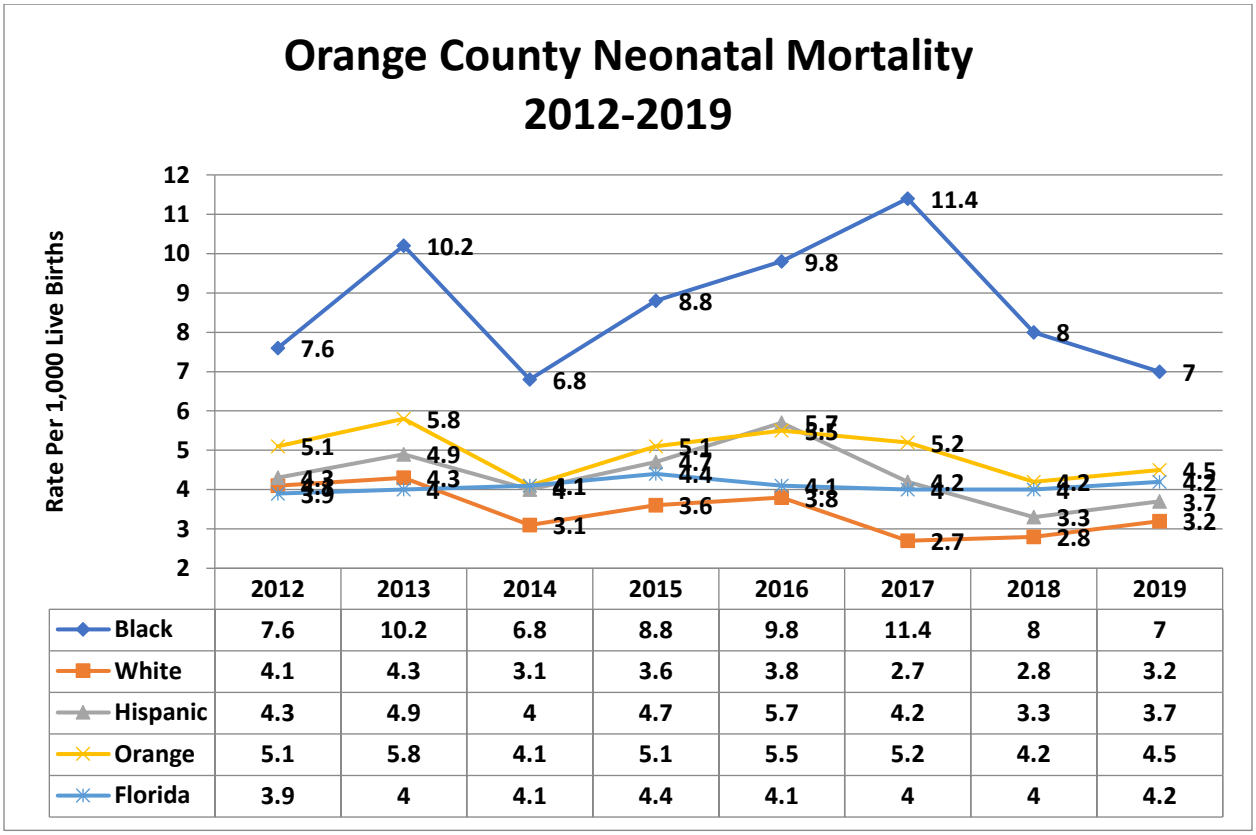


	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Broward	10.4	10.4	10.3	10.3	10.5	10.7	10.8	10.9
Duval	11.4	11.1	11.2	11.1	11.3	11.5	11.4	11.5
Hillsborough	10.3	10.3	10.2	10.3	10.1	10.1	10	10
Palm Beach	10.6	10.1	9.6	9.5	9.4	9.5	9.4	9.8
Orange	10.7	10.3	9.8	10	10.1	10.3	10.2	10.4
Florida	10.3	10.2	10.1	10	10	10.1	10.2	10.4

- Orange County 3-year average equals the state rate but we rank better (i.e. have a lower rate) than our peer counties with the exception of Palm Beach and Hillsborough.

Neonatal Mortality

Neonatal mortality occurs during the first 28 days of life and is strongly correlated with low birth weight, prematurity and other issues related to pregnancy and birth. This indicator, including use and availability of neonatal intensive care, measures the effectiveness of the perinatal high-risk system. The leading causes of death in the neonatal period include congenital anomalies, respiratory distress syndrome, disorders relating to short gestation, and effects of maternal complications.



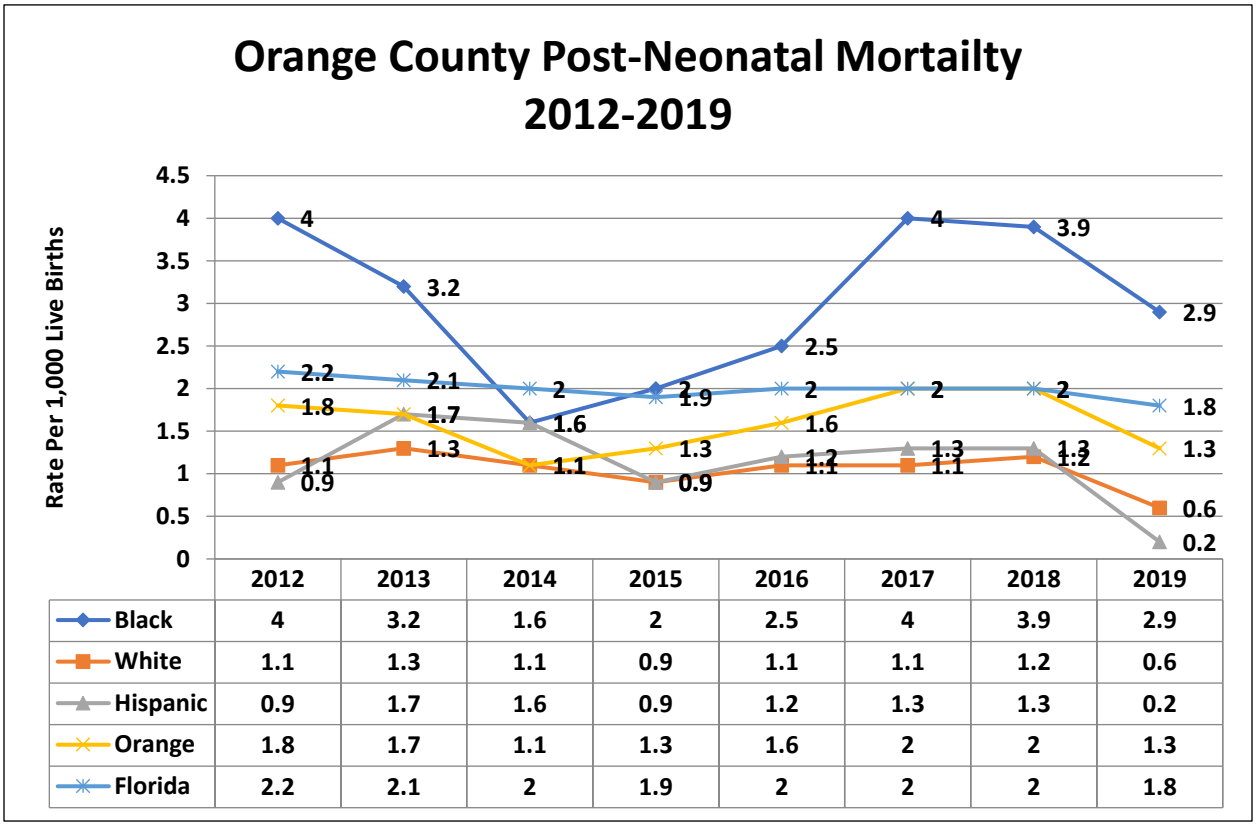
	2012	2013	2014	2015	2016	2017	2018	2019
Black	7.6	10.2	6.8	8.8	9.8	11.4	8	7
White	4.1	4.3	3.1	3.6	3.8	2.7	2.8	3.2
Hispanic	4.3	4.9	4	4.7	5.7	4.2	3.3	3.7
Orange	5.1	5.8	4.1	5.1	5.5	5.2	4.2	4.5
Florida	3.9	4	4.1	4.4	4.1	4	4	4.2

- Orange Co.'s overall rate has decreased slightly since 2012 despite annual fluctuations.
- Our rate has remained higher than the state rate for each year except 2014 when the rates were equal.
- Although Orange County Black neonatal mortality rate remains the highest of all racial/ethnic groups, the Black rate has decreased since 2012 from 7.6 to 7 percent, or an 8% decline.
- Although the Black rate has declined significantly, a disparity gap still exists between it and the White rate, i.e. the Black rate more than two times greater than the White rate. Thus, our effort to focus on improving women's health interconceptionally in order to impact modifiable factors that can contribute to neonatal deaths must continue.

- The Healthy People 2020 target percentage for neonatal mortality is 4.1. Due to rate fluctuation and health disparities among racial/ethnic groups it is uncertain if Orange County or the state will meet the national goal.

Post-neonatal Mortality

Post-neonatal mortality refers to deaths occurring during the period between 28 days and one year of life. These deaths are associated with the lack of effectiveness of the community's child health system of care, as well as socioeconomic factors relating to the child's home environment. The leading causes of death in this period are sudden unexpected infant death (SUID), congenital anomalies, injuries and infection. Area infant services and community outreach are most likely to impact this indicator of infant health. Educational discussion regarding safe sleep and injury prevention will continue to be incorporated within our Healthy Start initiatives to ensure communities' knowledge and understanding on how to avert post-neonatal mortality.

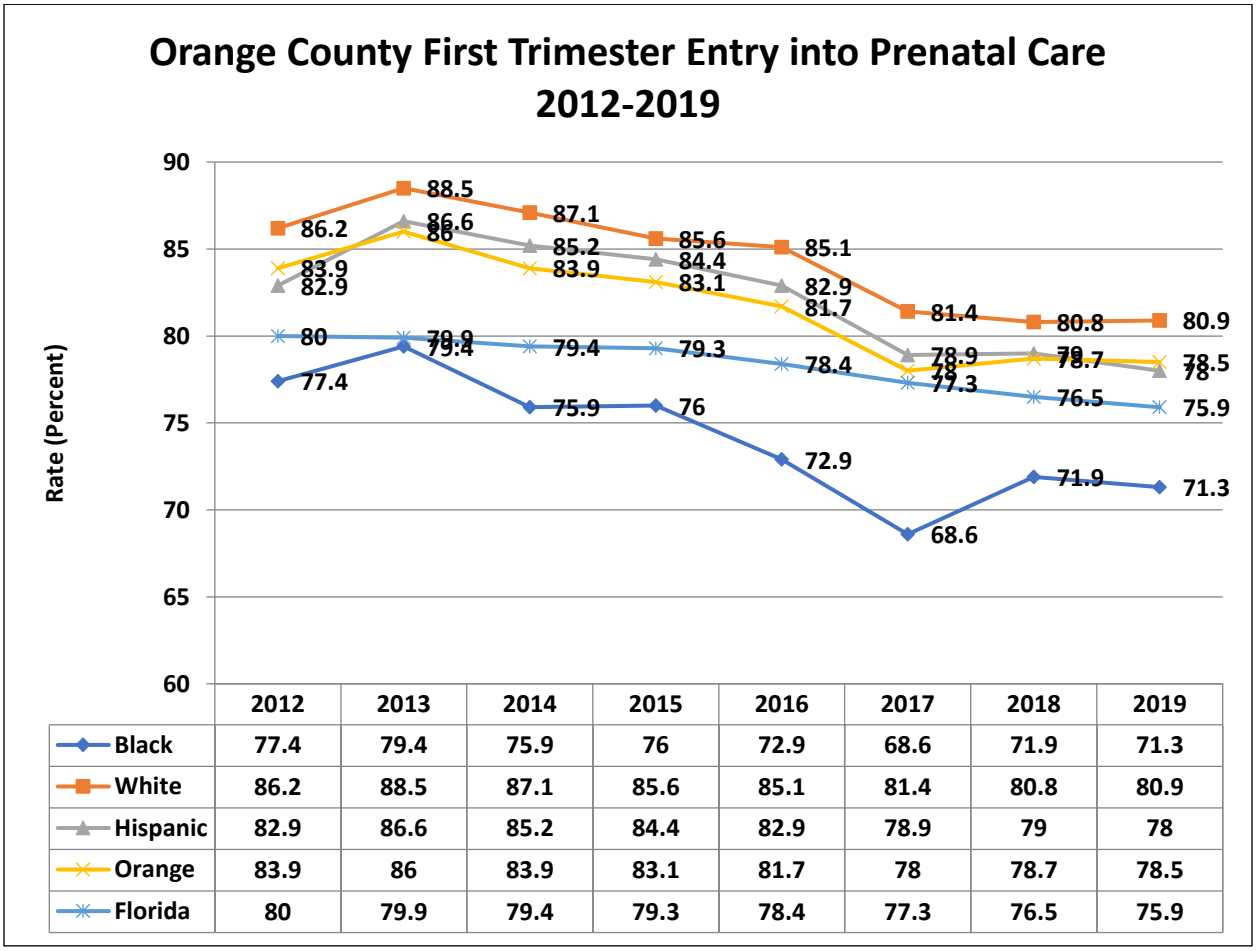


	2012	2013	2014	2015	2016	2017	2018	2019
Black	4	3.2	1.6	2	2.5	4	3.9	2.9
White	1.1	1.3	1.1	0.9	1.1	1.1	1.2	0.6
Hispanic	0.9	1.7	1.6	0.9	1.2	1.3	1.3	0.2
Orange	1.8	1.7	1.1	1.3	1.6	2	2	1.3
Florida	2.2	2.1	2	1.9	2	2	2	1.8

- Orange County's rate has fluctuated since 2012 but has declined 28% and is currently is below the state's rate.
- Our Black rate is almost five times the White and is contributing to the disparity gap in birth outcomes. However, this rate has decreased 28% since 2012.
- The post-neonatal mortality rate for Hispanics is currently 0.2 percent which is the lowest recorded rate for this population in Orange County.
- The Healthy People 2020 target rate for post-neonatal mortality is 2 percent, and at 1.3 currently, Orange County is below the target national rate.
- Our current efforts with community education and services to families with infants must not let up in order to prevent any increase in these rates.

Entry into Prenatal Care

Prenatal care is defined as the medical care of a pregnant woman. First trimester entry to prenatal care is generally believed to be an important factor in promoting positive birth outcomes as a practitioner can monitor the full progress of the pregnancy. The healthcare provider is better able to diagnose and treat medical conditions that threaten the mother and fetus, including conducting a physical and pelvic exam, blood testing, and summarizing the pregnant woman's health history. The provider is also able to provide important health information to the mother during these visits for care. However, early prenatal care does not guarantee a healthy birth, due in part to the variability in the adequacy of prenatal care in terms of continuity and quality. Also, the health of the mother before becoming pregnant is a major determinant of her birth outcome. This particularly is applicable to racial/ethnic populations with health disparities and poor health outcomes due to other social determinants such as a lack of education and toxic stress.

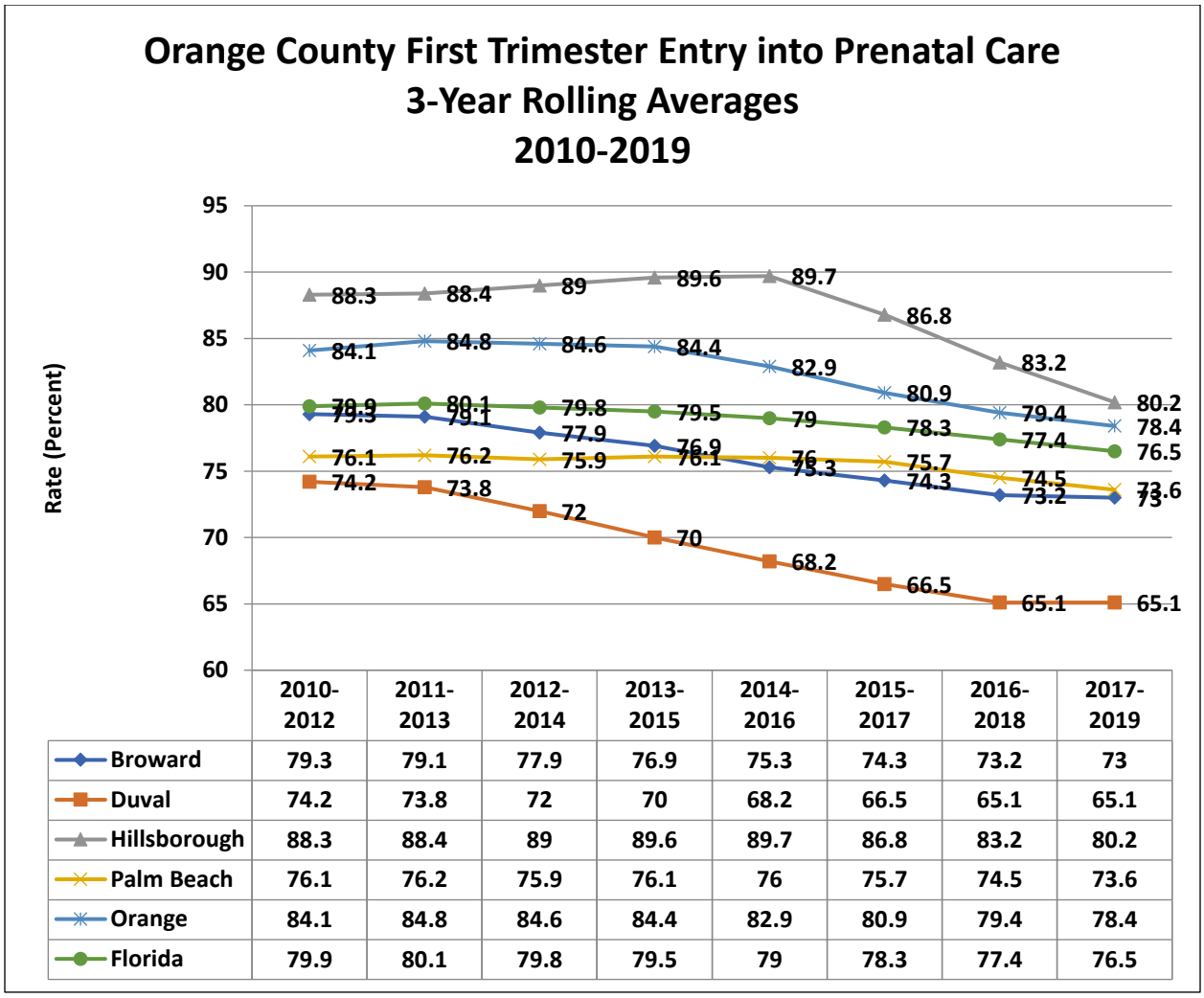


	2012	2013	2014	2015	2016	2017	2018	2019
Black	77.4	79.4	75.9	76	72.9	68.6	71.9	71.3
White	86.2	88.5	87.1	85.6	85.1	81.4	80.8	80.9
Hispanic	82.9	86.6	85.2	84.4	82.9	78.9	79	78
Orange	83.9	86	83.9	83.1	81.7	78	78.7	78.5
Florida	80	79.9	79.4	79.3	78.4	77.3	76.5	75.9

- Our rate for early entry to care was steadily improving until 2013 when it began a decline; this trend is essentially the same across racial groups and for the State.
- More White and Hispanic women continue to enter care in the first trimester as compared to Black women.
- Requirements for Medicaid managed care began in 2014 and uncertainty in where/how to apply, how to choose a plan, what doctors accepted which insurance company,

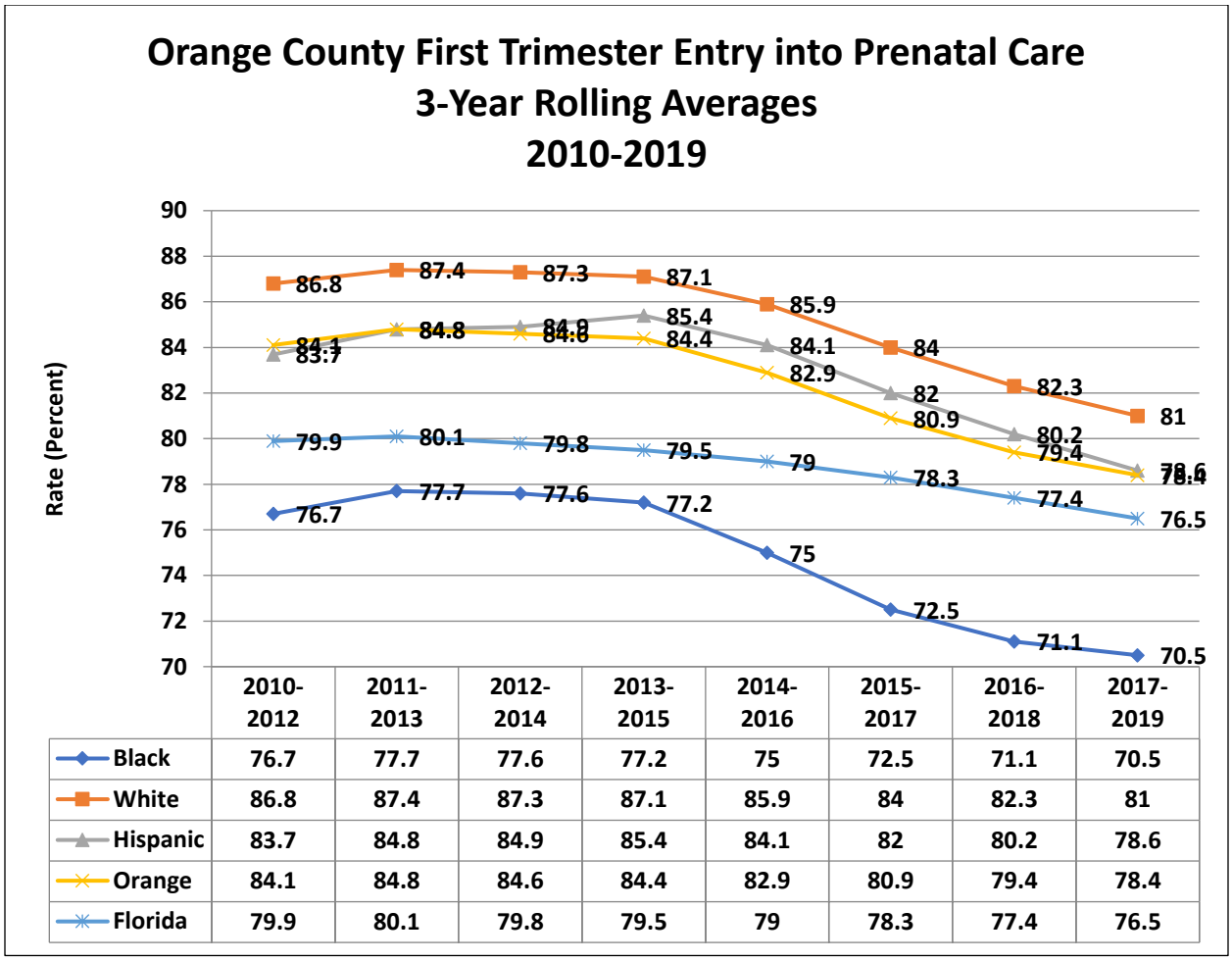
requirements to have primary care referral before beginning prenatal care, etc. were experienced. These challenges, along with being assigned a plan and delays if the client needs/wants to switch, have contributed to the decline in first trimester care.

- The Healthy People 2020 target percentage for first trimester entry into prenatal care is 77.9 percent. Currently, Orange County barely exceeds the national target with 78.5%. While we have surpassed the HP 2020 goal, the rates have decreased over the past 3 years and will likely continue to decrease due to the ongoing difficulties accessing Medicaid.
- The HP 2030 target percentage for first trimester entry into prenatal care is 80.5 percent, with 76.4 percent being the 2018 national baseline. As the county exceeded the 2018 national baseline but overall has experienced a rate decrease, HSCOC must continue to monitor prenatal care access and work towards addressing potential threats (i.e., OB office closures).



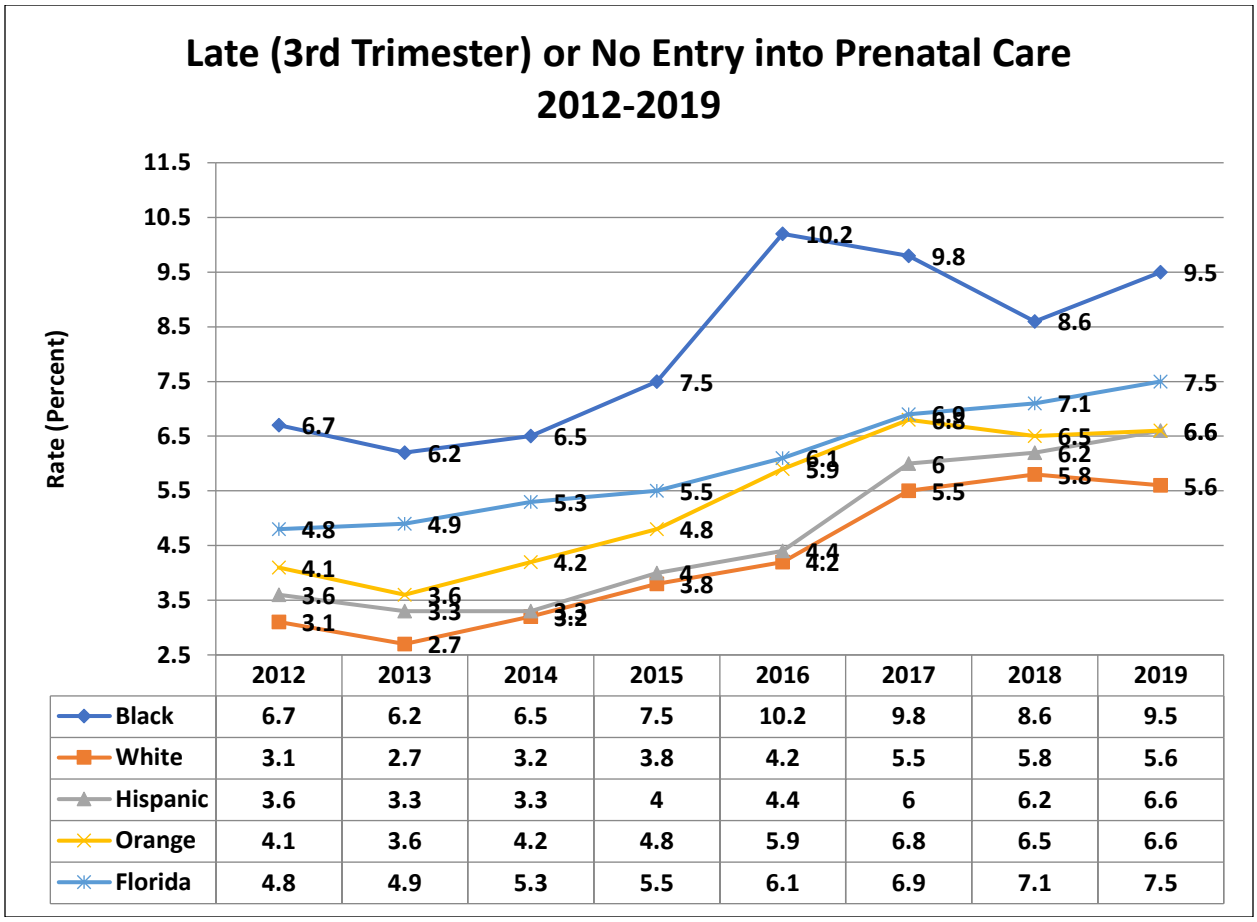
	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Broward	79.3	79.1	77.9	76.9	75.3	74.3	73.2	73
Duval	74.2	73.8	72	70	68.2	66.5	65.1	65.1
Hillsborough	88.3	88.4	89	89.6	89.7	86.8	83.2	80.2
Palm Beach	76.1	76.2	75.9	76.1	76	75.7	74.5	73.6
Orange	84.1	84.8	84.6	84.4	82.9	80.9	79.4	78.4
Florida	79.9	80.1	79.8	79.5	79	78.3	77.4	76.5

- Orange County's average rate of early entry into care has remained higher than the state rate.
- Our average rate is higher than our peer counties with the exception of Hillsborough.
- All peer counties as well as the state average rate has experienced a decline.



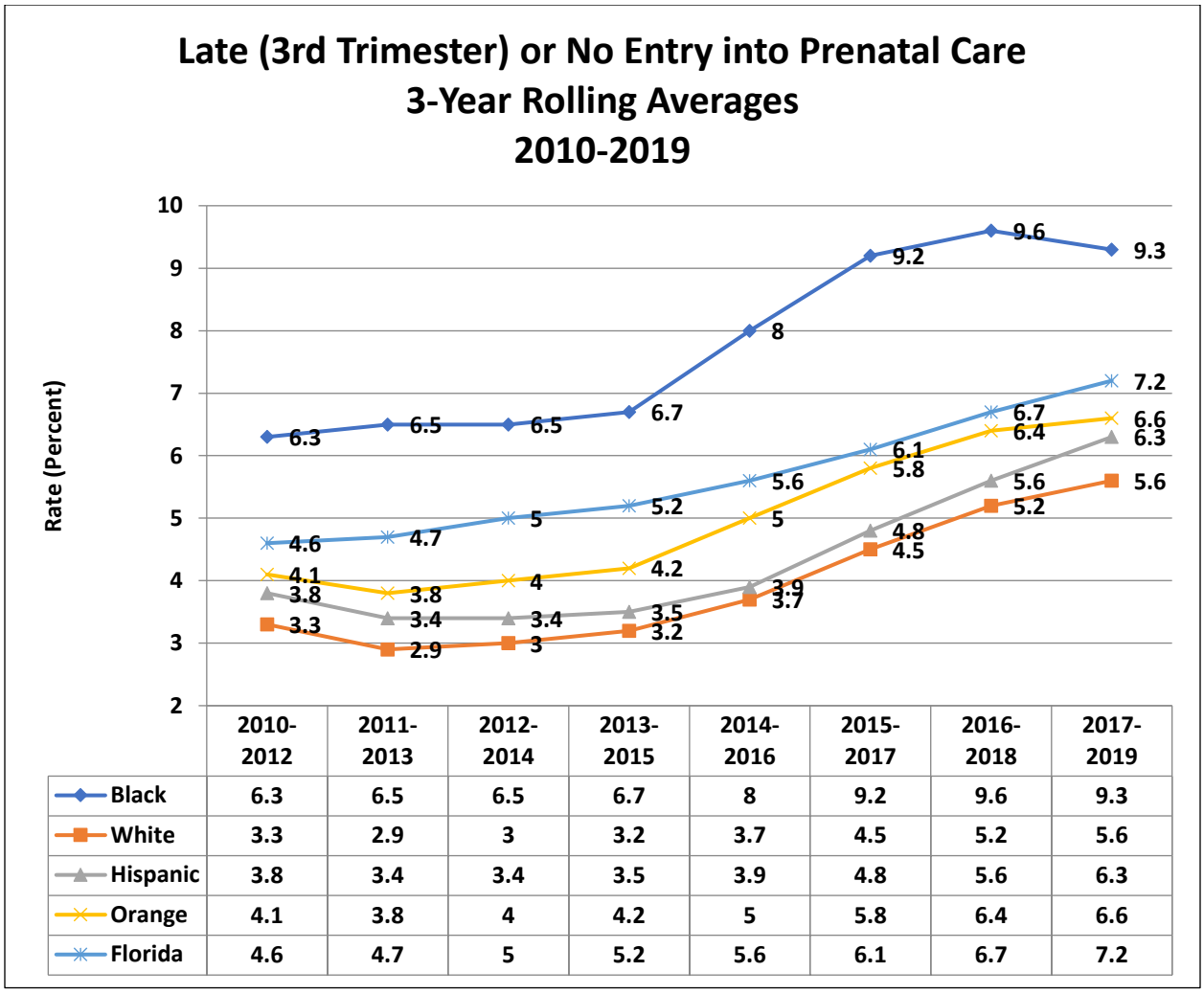
	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Black	76.7	77.7	77.6	77.2	75	72.5	71.1	70.5
White	86.8	87.4	87.3	87.1	85.9	84	82.3	81
Hispanic	83.7	84.8	84.9	85.4	84.1	82	80.2	78.6
Orange	84.1	84.8	84.6	84.4	82.9	80.9	79.4	78.4
Florida	79.9	80.1	79.8	79.5	79	78.3	77.4	76.5

- The 3-year averages confirm the general decrease in early entry to care for the state as well as our county.
- The Black rate is 10.5 percentage points lower than the White rate, indicating fewer Black women are accessing early care.



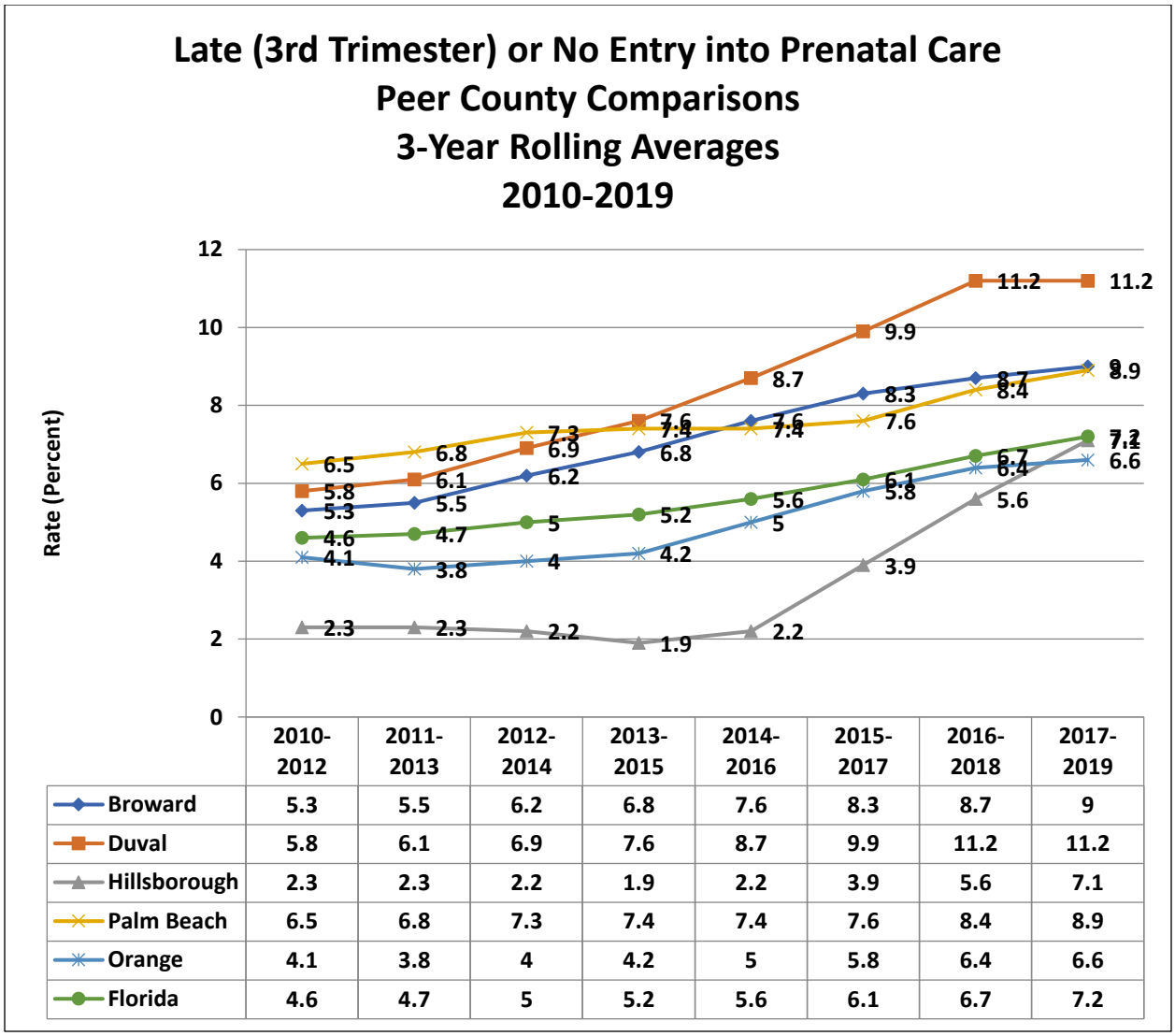
	2012	2013	2014	2015	2016	2017	2018	2019
Black	6.7	6.2	6.5	7.5	10.2	9.8	8.6	9.5
White	3.1	2.7	3.2	3.8	4.2	5.5	5.8	5.6
Hispanic	3.6	3.3	3.3	4	4.4	6	6.2	6.6
Orange	4.1	3.6	4.2	4.8	5.9	6.8	6.5	6.6
Florida	4.8	4.9	5.3	5.5	6.1	6.9	7.1	7.5

- Despite the gradual decrease beginning in 2017, Orange County's rate for late entry to prenatal care has increased 61% since 2012 yet remains below the state rate.
- Late entry has increased for all racial/ethnic groups since 2013.



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Black	6.3	6.5	6.5	6.7	8	9.2	9.6	9.3
White	3.3	2.9	3	3.2	3.7	4.5	5.2	5.6
Hispanic	3.8	3.4	3.4	3.5	3.9	4.8	5.6	6.3
Orange	4.1	3.8	4	4.2	5	5.8	6.4	6.6
Florida	4.6	4.7	5	5.2	5.6	6.1	6.7	7.2

- The 3-year averages confirm the increase in late entry to care across all racial/ethnic groups and for the county as a whole since 2011-2013. The state's rate has also increased.

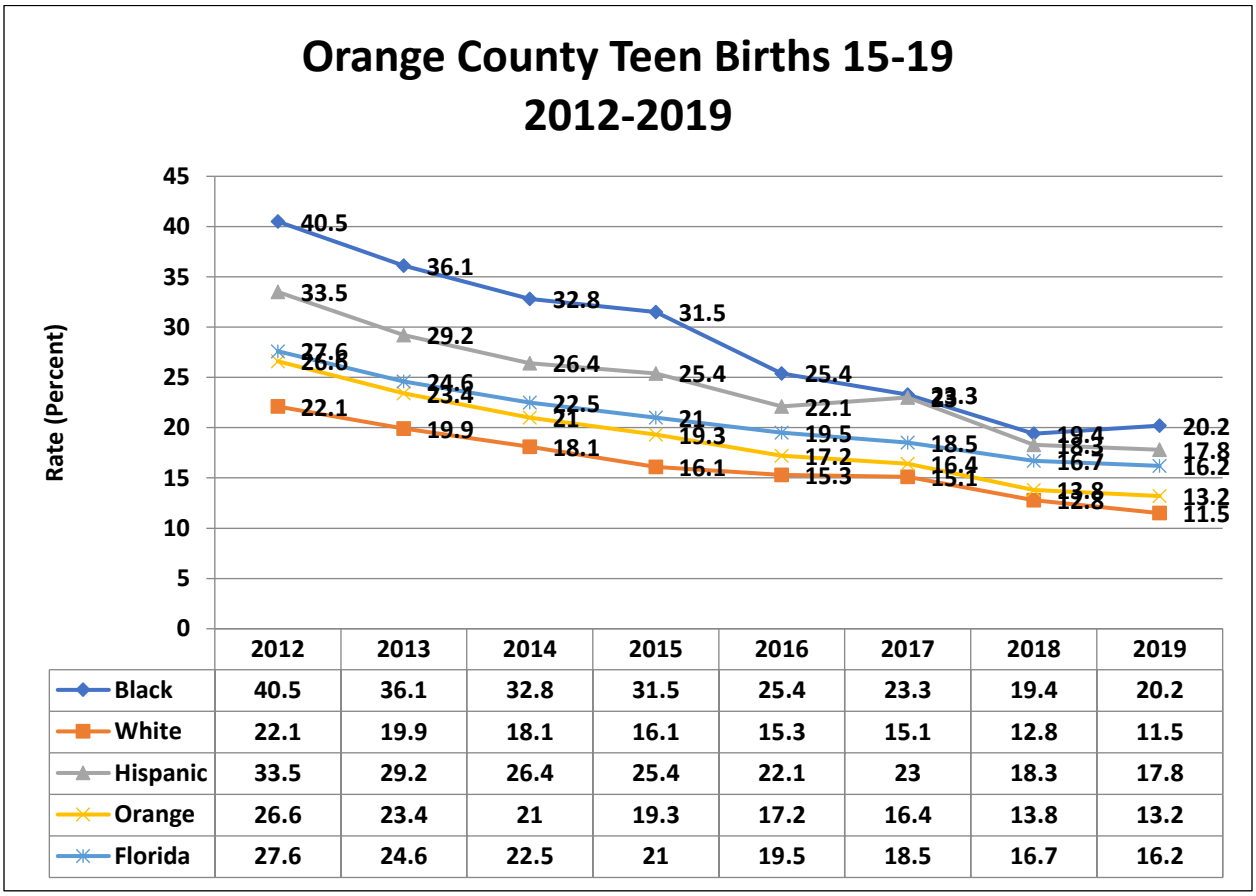


	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Broward	5.3	5.5	6.2	6.8	7.6	8.3	8.7	9
Duval	5.8	6.1	6.9	7.6	8.7	9.9	11.2	11.2
Hillsborough	2.3	2.3	2.2	1.9	2.2	3.9	5.6	7.1
Palm Beach	6.5	6.8	7.3	7.4	7.4	7.6	8.4	8.9
Orange	4.1	3.8	4	4.2	5	5.8	6.4	6.6
Florida	4.6	4.7	5	5.2	5.6	6.1	6.7	7.2

- Orange County peer counties and the state as a whole has experienced an increase in late entry.
- Orange County 3-year late entry to care rates remains lower than our peer counties as well as the State rate.

Teen Births 15-19

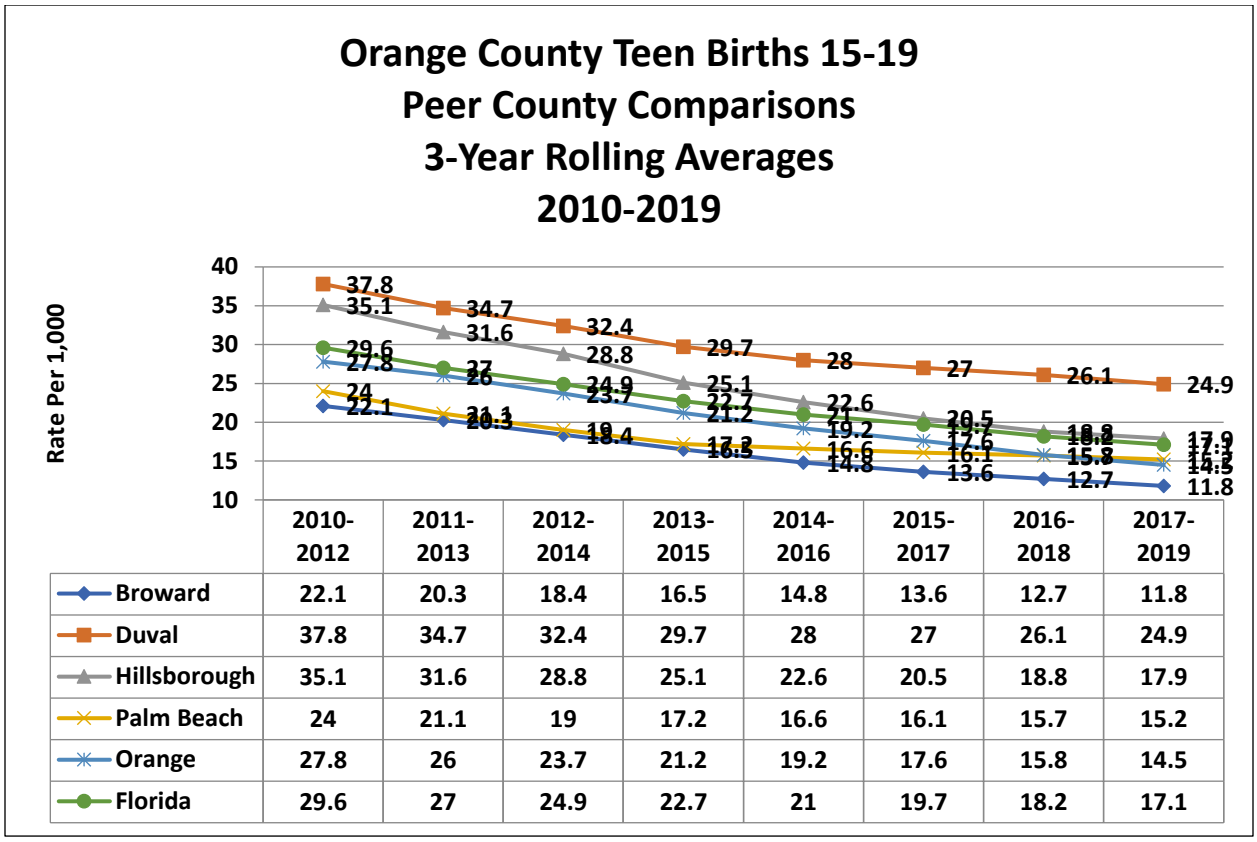
The teen birth rate is the number of births to teens for every 1000 teenage girls 15-19. Since the teenager's body is not fully mature, she is at an increased health risk when pregnant. In addition, her adolescent developmental tasks are interrupted as she takes on the role of mother; frequently she is not able to put her fetus's/infant's needs above her own. Because teens are still in school or have dropped out and are living with their parents or other adults, they are not self-supporting and must rely on family or state assistance to care for themselves and their children. This cycle of children having children is very often repeated from one generation to another. Moreover, due to social stigma surrounding teen pregnancy, adolescents are less likely to determine prenatal needs. Accordingly, this age group ranks high among LBW babies and is susceptible to various issues regarding physical and mental health, neglect, and/or abuse.



	2012	2013	2014	2015	2016	2017	2018	2019
Black	40.5	36.1	32.8	31.5	25.4	23.3	19.4	20.2
White	22.1	19.9	18.1	16.1	15.3	15.1	12.8	11.5
Hispanic	33.5	29.2	26.4	25.4	22.1	23	18.3	17.8
Orange	26.6	23.4	21	19.3	17.2	16.4	13.8	13.2
Florida	27.6	24.6	22.5	21	19.5	18.5	16.7	16.2

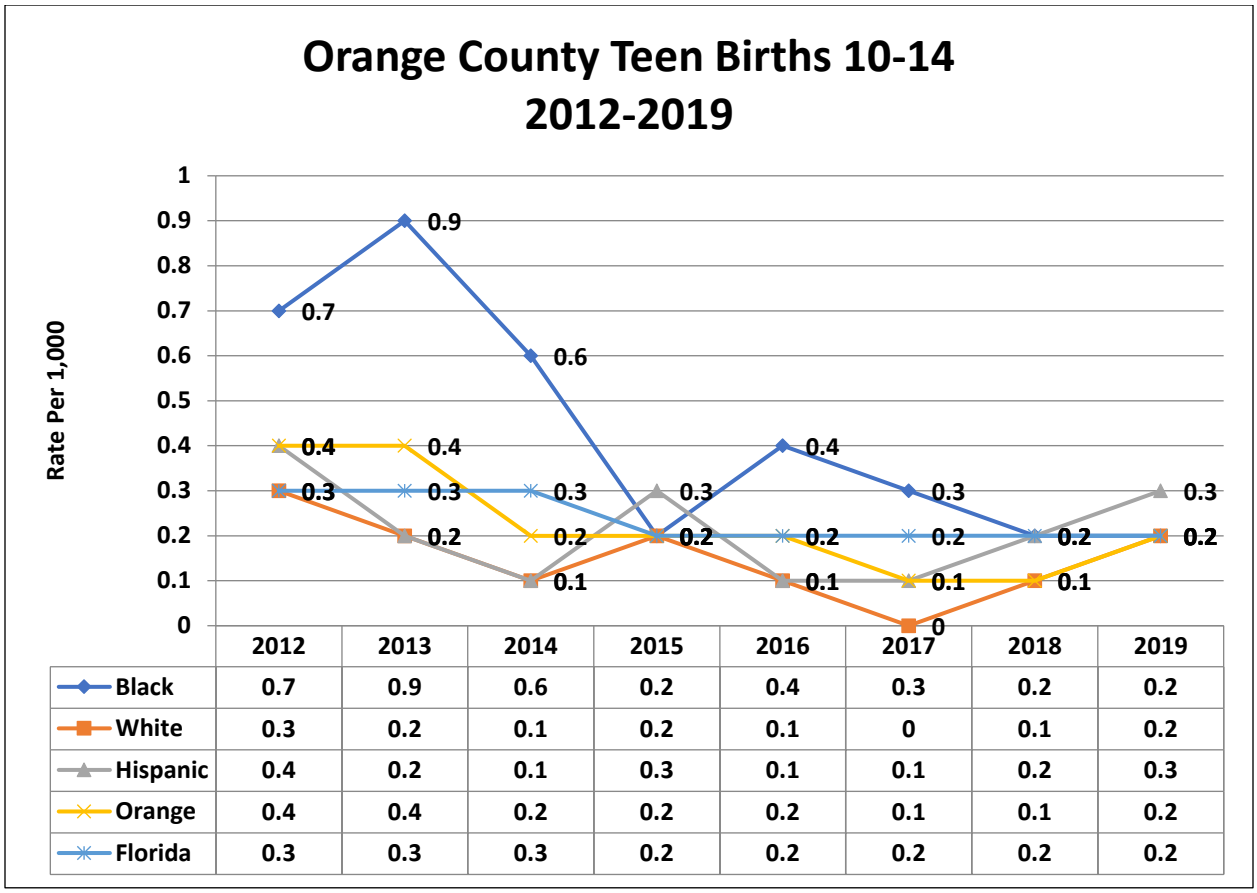
- Since 2012, teen births have declined within Orange County to 13.2 percent and currently rank below the state rate.
- The county 2019 teen pregnancy rate reflects a 50% decrease since 2012. The individual rates include a 50% decrease in the Black rate, a 48% decrease for the White rate, and a 47% decrease for the Hispanic rate.

- Teen pregnancy rates have also declined nationally, due in part to better access to family planning services, comprehensive sex education, social media, and TV reality shows depicting the difficulties in teens raising children.



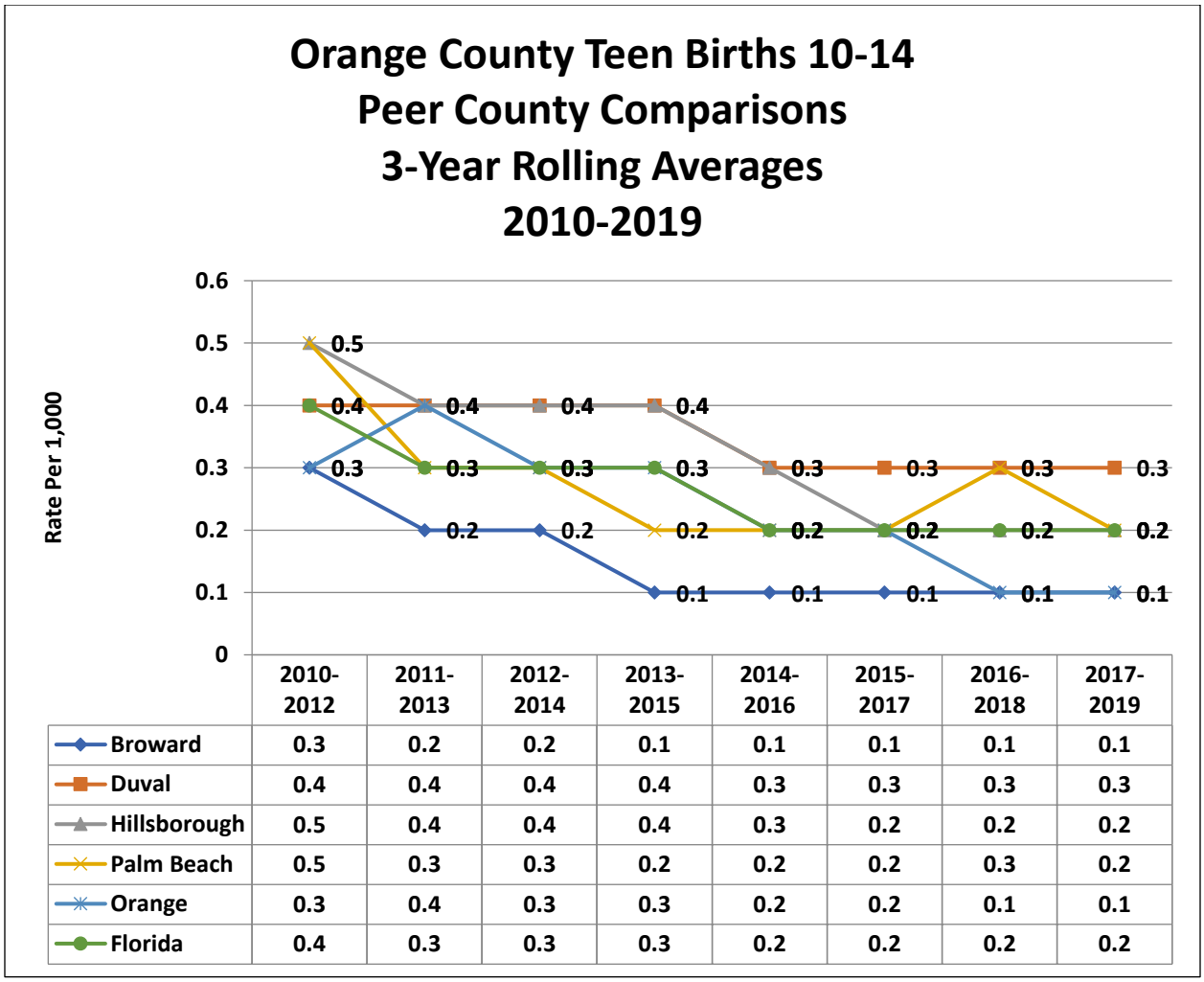
	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Broward	22.1	20.3	18.4	16.5	14.8	13.6	12.7	11.8
Duval	37.8	34.7	32.4	29.7	28	27	26.1	24.9
Hillsborough	35.1	31.6	28.8	25.1	22.6	20.5	18.8	17.9
Palm Beach	24	21.1	19	17.2	16.6	16.1	15.7	15.2
Orange	27.8	26	23.7	21.2	19.2	17.6	15.8	14.5
Florida	29.6	27	24.9	22.7	21	19.7	18.2	17.1

- Rolling averages for Orange County and its peer counties have steady decreased as has the state's rate. Orange County's rate ranks lower when compared to our peer counties and the state rate, with the exception of Broward.



	2012	2013	2014	2015	2016	2017	2018	2019
Black	0.7	0.9	0.6	0.2	0.4	0.3	0.2	0.2
White	0.3	0.2	0.1	0.2	0.1	0	0.1	0.2
Hispanic	0.4	0.2	0.1	0.3	0.1	0.1	0.2	0.3
Orange	0.4	0.4	0.2	0.2	0.2	0.1	0.1	0.2
Florida	0.3	0.3	0.3	0.2	0.2	0.2	0.2	0.2

- A noteworthy achievement is an 71% decline of the Black teen birth rate in Orange County. With this rate decreasing from .7 to .2 percent, the Black and White teen birth rates are now equal to each other as well as to the state rate.
- Despite the fluctuation in teen births within the Hispanic population from 2012 to 2019, the teen birth rate in Orange County decreased 25% overall from 2012 to present.

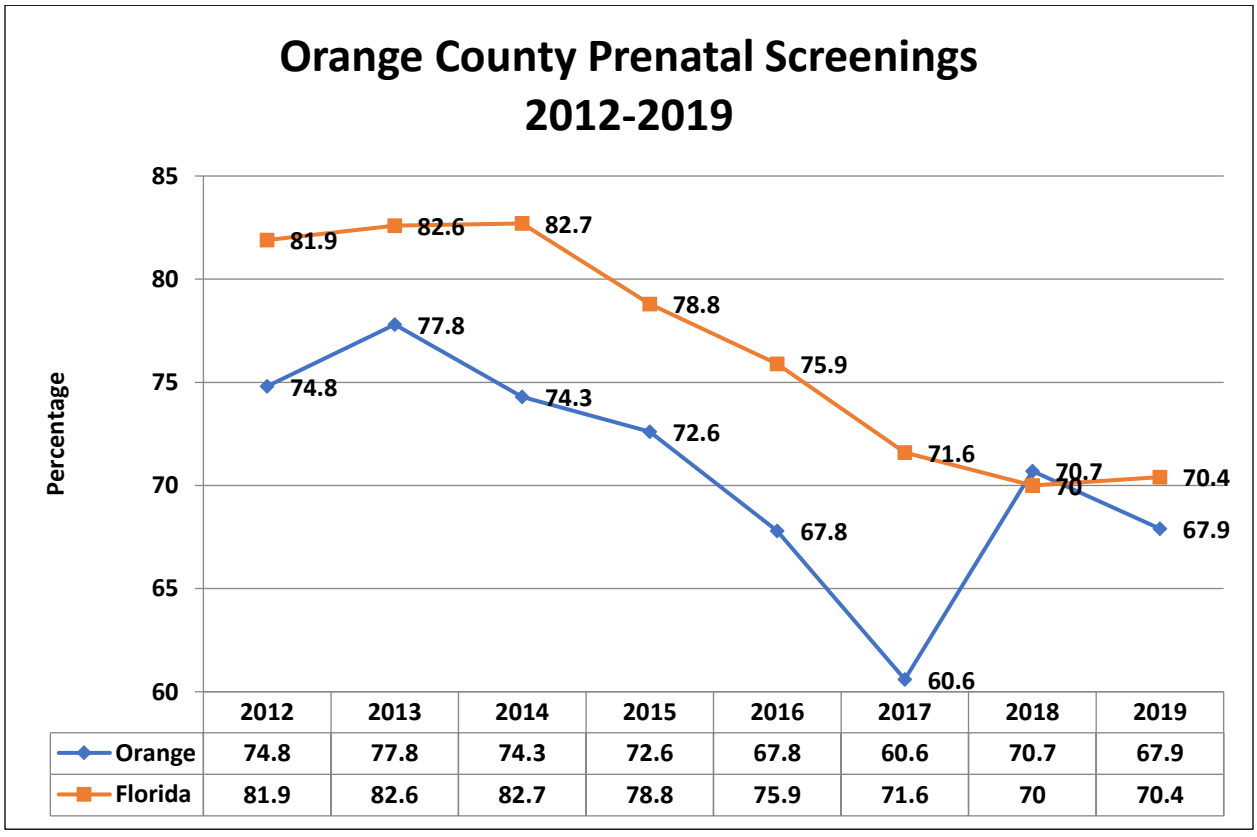


	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Broward	0.3	0.2	0.2	0.1	0.1	0.1	0.1	0.1
Duval	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.3
Hillsborough	0.5	0.4	0.4	0.4	0.3	0.2	0.2	0.2
Palm Beach	0.5	0.3	0.3	0.2	0.2	0.2	0.3	0.2
Orange	0.3	0.4	0.3	0.3	0.2	0.2	0.1	0.1
Florida	0.4	0.3	0.3	0.3	0.2	0.2	0.2	0.2

- The 3-year average for teen births in Orange County has steadily decreased, and is now 50% less than the current state average of .2 percent.
- Rates for all peer counties have consistently decreased when seen in 3-year averages.

Prenatal and Infant Screening Rates

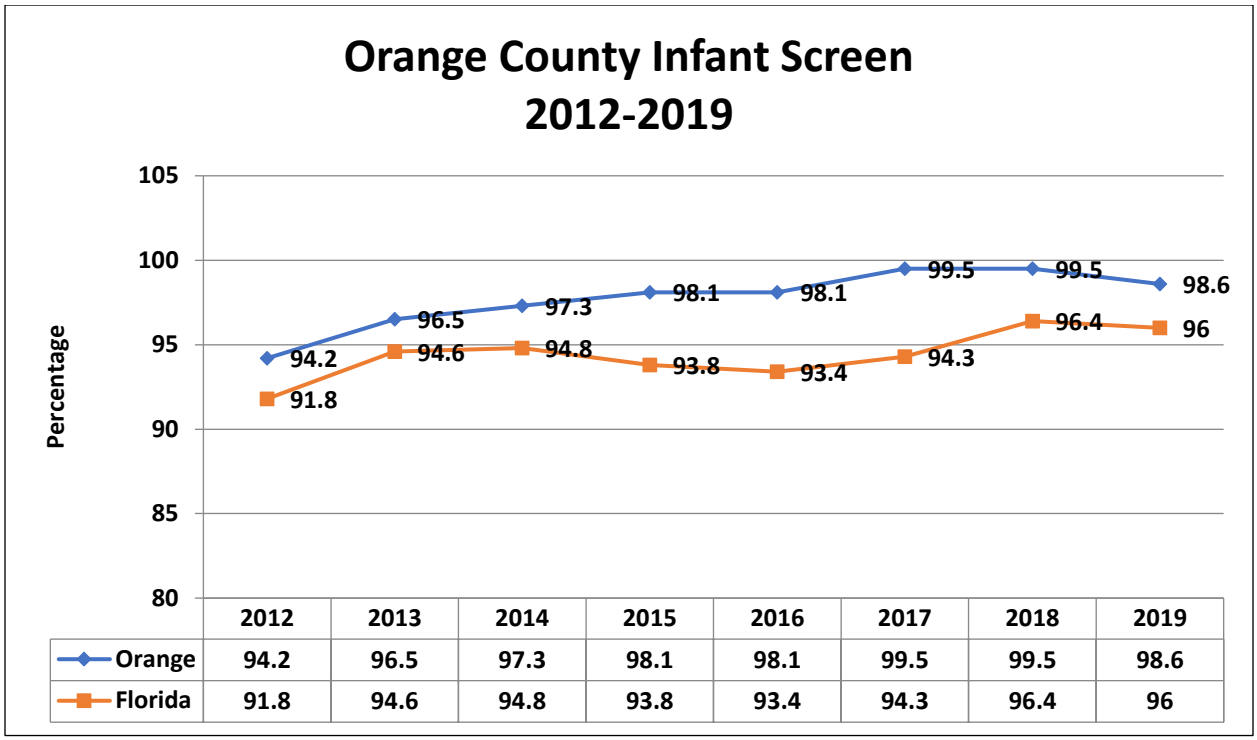
Healthy Start offers two separate screening forms at two distinct points: the prenatal is offered at the woman's first prenatal care appointment and the infant screening is offered at the birthing facility when the baby is born. This latter process is tied electronically to the development of the birth certificate in all Orange County hospitals, birthing centers and midwifery practices (if registered with the state system). However, the challenge to convince OB offices that Healthy Start is not income or insurance-based continues; despite ongoing technical assistance, some prenatal care providers either refuse to screen their clients or "pre-select" those women to whom the screen is offered. In addition, medical records at provider offices are now essentially totally electronic and during this time of Covid-19, some are doing prenatal visits via telehealth; however, our prenatal screen is still paper-based which discourages completion by both the patient and office staff which is difficult to complete via a virtual visit. Also, providers who accept Medicaid sometimes do not complete the prenatal screen because they give priority to other forms that must be completed for the managed care company to ensure payment. Other screening challenges expressed by prenatal providers include the form having confusing consent wording and offices being short staffed. The challenges faced in the hospitals include the timing of patients' discharge, confusion on the different consents required when making a referral and the birth registry process itself.



	2012	2013	2014	2015	2016	2017	2018	2019
Orange	74.8	77.8	74.3	72.6	67.8	60.6	70.7	67.9
Florida	81.9	82.6	82.7	78.8	75.9	71.6	70	70.4

- Although the Orange County screening rate in 2013 reached a high point, both the state and county rates have gradually decreased within the last five years.

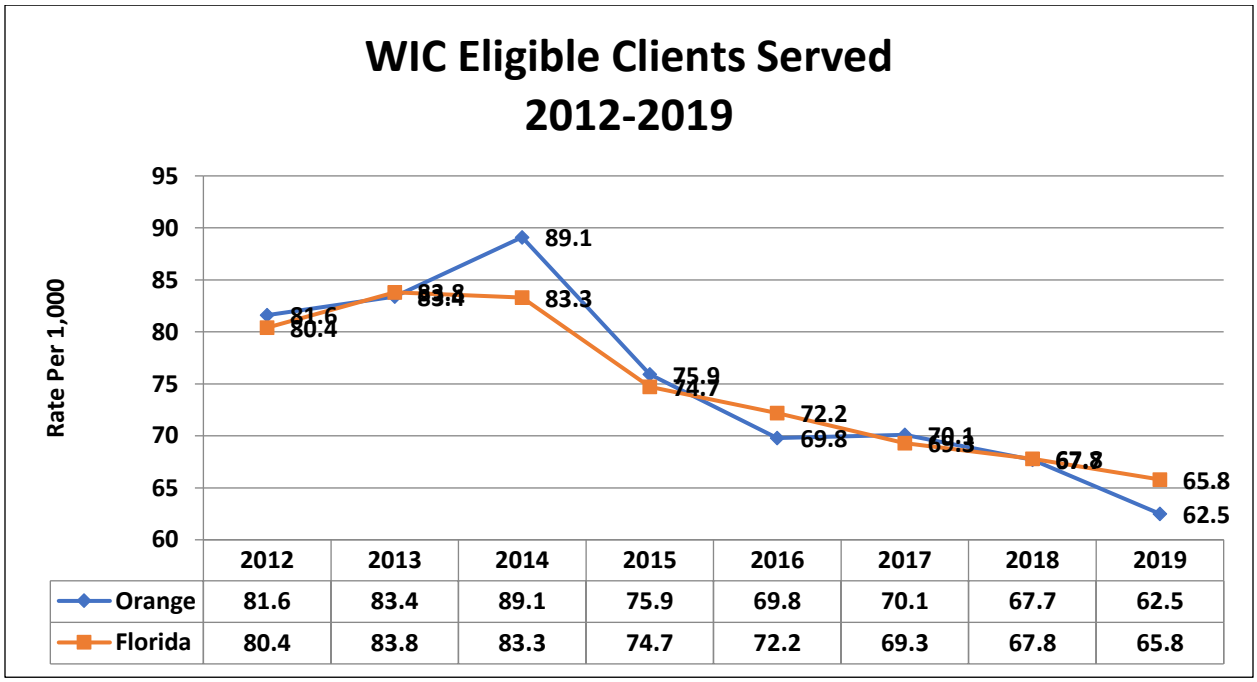
- Despite ongoing technical assistance and support by our Community Liaison, our rates have steadily declined. Unfortunately, we still encounter OB providers who refuse to screen and/or preselect which clients will likely be eligible for HS, as well as the ongoing issue of office staff turnover necessitating frequent (but oftentimes unwanted) training.



- Orange County rate has made a marked increase due in large part to screening policies implemented at Winnie Palmer Hospital and infant screenings being electronically tied to the birth certificate countywide.
- Additional efforts to increase our infant (and prenatal screening) rate have been implemented as of 2018 with the statewide launch of a coordinated screening processes in conjunction with other area infant home visitation programs known as *CONNECT*.

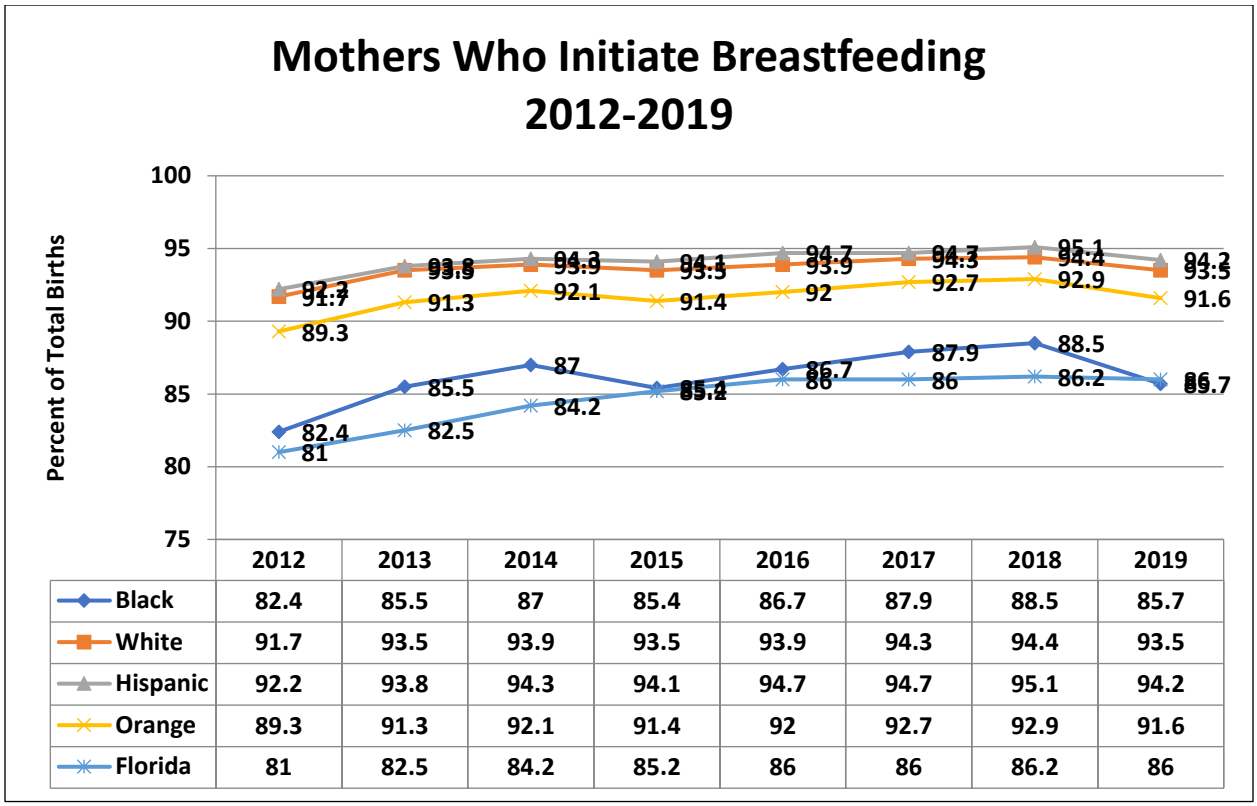
Additional Data

HSCOC chose to examine data related to WIC (Women, Infants and Children Nutrition program), breastfeeding, immunizations and SIDS rates. The first three indicators provide additional insight into the health of our mothers and babies and relate to services provided through or encouraged by Healthy Start care coordinators. SIDS rates relate to overall trends of infant sleep practices by Orange County families and indicate need for or success of community education efforts.



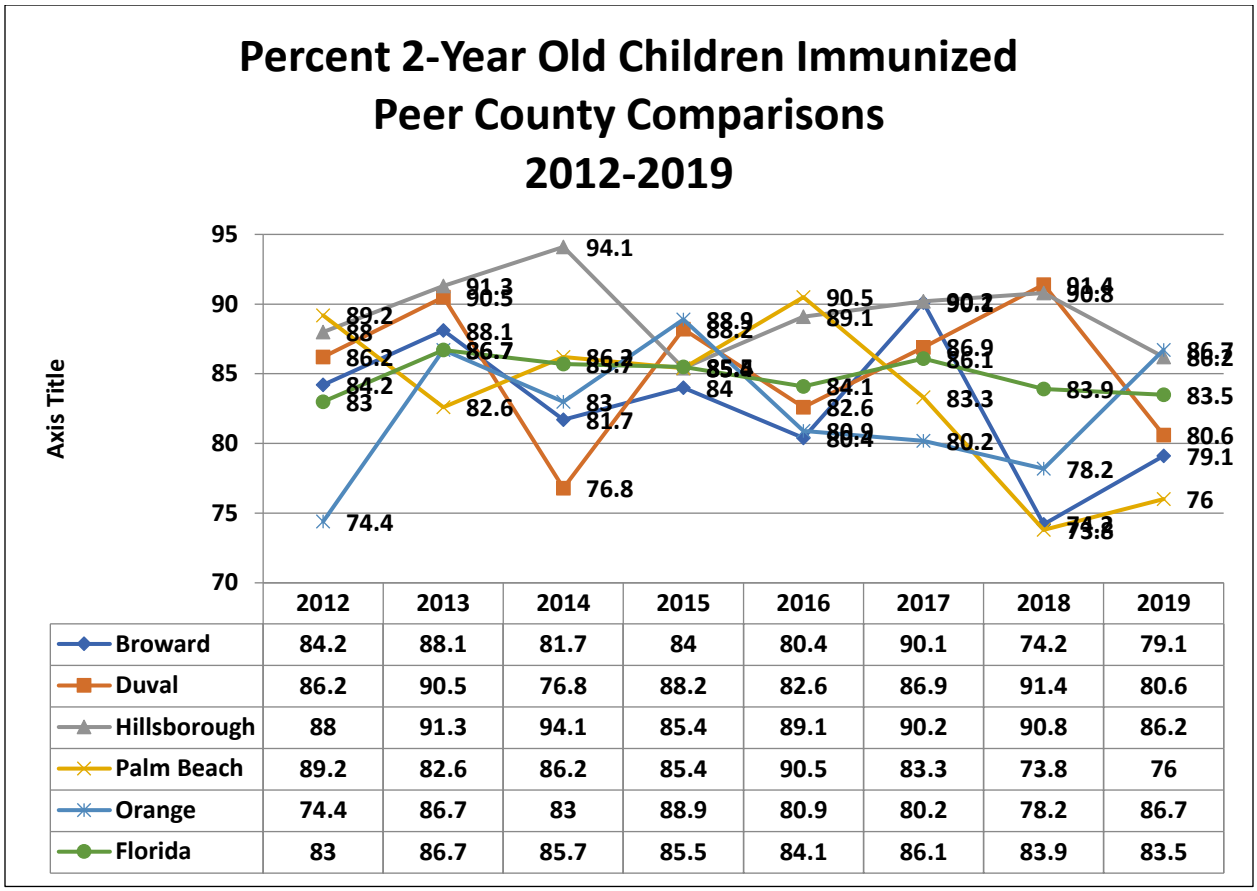
	2012	2013	2014	2015	2016	2017	2018	2019
Orange	81.6	83.4	89.1	75.9	69.8	70.1	67.7	62.5
Florida	80.4	83.8	83.3	74.7	72.2	69.3	67.8	65.8

- Orange County's overall rate of WIC clients served has reached a peak in 2014 at 89%, exceeding the state rate by about 6%.
- Although Orange Co. rate at times was slightly higher than the state's rate, the rate of WIC-eligible clients served statewide has decreased. This could be attributed to fewer individuals qualifying based on income due to improved employment opportunities.



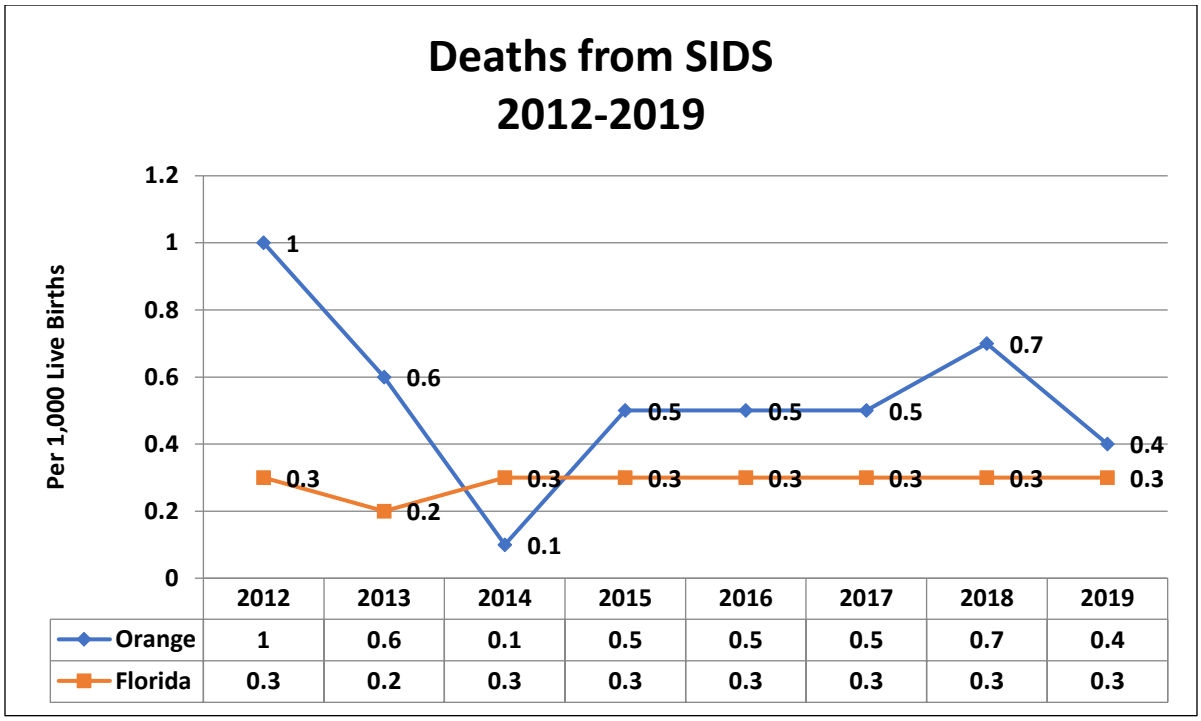
	2012	2013	2014	2015	2016	2017	2018	2019
Black	82.4	85.5	87	85.4	86.7	87.9	88.5	85.7
White	91.7	93.5	93.9	93.5	93.9	94.3	94.4	93.5
Hispanic	92.2	93.8	94.3	94.1	94.7	94.7	95.1	94.2
Orange	89.3	91.3	92.1	91.4	92	92.7	92.9	91.6
Florida	81	82.5	84.2	85.2	86	86	86.2	86

- The Orange County breastfeeding initiation rate has improved by 3% since 2012.
- We have stayed higher than the state rate and share overall growth in women who initiate breastfeeding.
- Healthy People revised their objective from focus on ‘mothers who breastfeed’ to ‘infants who are ever breastfed’; the 2020 goal is 81.9% of infants will who are ‘ever breastfed’. This goal can be reasonably compared to our state data on women who initiate breastfeeding and therefore, our rate surpasses the Healthy People 2020 goal.
- All care coordinators have been trained per HS Standards and Guidelines to provide breastfeeding education; these services are tracked by HS record reviews and through the Well Family data system.

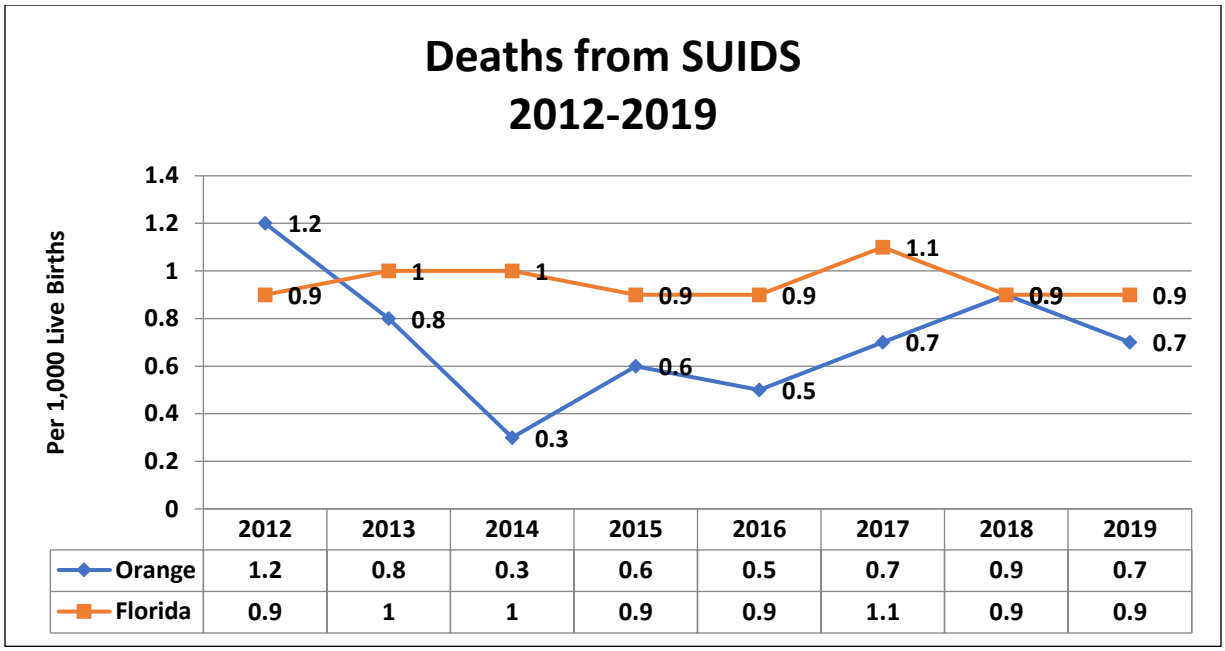


	2012	2013	2014	2015	2016	2017	2018	2019
Broward	84.2	88.1	81.7	84	80.4	90.1	74.2	79.1
Duval	86.2	90.5	76.8	88.2	82.6	86.9	91.4	80.6
Hillsborough	88	91.3	94.1	85.4	89.1	90.2	90.8	86.2
Palm Beach	89.2	82.6	86.2	85.4	90.5	83.3	73.8	76
Orange	74.4	86.7	83	88.9	80.9	80.2	78.2	86.7
Florida	83	86.7	85.7	85.5	84.1	86.1	83.9	83.5

- Since 2012, the Orange County rate has fluctuated but is 16.5% higher in 2019.
- Orange County's rate is now higher than the state average by over 3 percentage points at 86.7 percent.
- Our rate is also higher than of our peer counties.
- HS care coordinators all encourage maintaining immunization schedules with their families; this service is tracked during HS record reviews.



- SIDS is difficult to quantify due to differing opinions. Additional concerns include at least some police officers not recognizing a SIDS diagnosis but rather believing it's really an accident or a homicide without enough evidence. Over the years, we have had a change in medical examiners, and personal beliefs of medical examiners play a role in the diagnosis; there is still no consensus statewide. However, due to our Coalition's work with our Child Review Death committee, we know there has been an increase in deaths due to co-sleeping, even with cribs in the room. These are generally diagnosed as SUIDS. We continue to spread the safe sleep message recommended by the American Academy of Pediatrics and do our best to provide Healthy Start families in need with a pack-and-play with safe-sleep instruction. The biggest help would be for the medical examiners in FL to agree on protocol for diagnosis so counties can compare rates in a more formal way to better understand issues involved.
- As the state overall has remained at the rate of .3 percent in SIDS since 2012, Orange County has experienced a 60 percent decrease in SIDS since 2012.



- Sudden Unexpected Infant Deaths (SUIDS) are defined as deaths to babies less than 1 year of age that occur suddenly and unexpectedly, and whose cause of death are not immediately obvious prior to investigation.

As the state SUIDS rate has stayed within a .2 percentage point margin since 2012, the Orange County rate has fluctuated but did decrease from 1.2 percent in 2012 to .7 percent in 2019 – a 42 percent improvement.

Trend Data Summary

The following summarizes trends of our key indicators described by the data above from the year our last Service Delivery Plan began data, 2012, to the most recent year of available data (at the time of this writing), 2019. As seen in the following chart, we have experienced many positive trends during this time period, and several more than in our previous Plan. In addition, there are a number of indicators in which we exceed Healthy People 2020 target goals and several that exceed rates for the whole State.

From 2012-2019, Healthy Start Coalition of Orange County experienced changes in trends of our maternal-child health indicators

- **Infant Mortality Rate Decreased 16%**
- **Black Infant Mortality Decreased 15%**
- **Neonatal Mortality Rate Decreased 12%**
- **Post-Neonatal Mortality Rate Decreased 12%**
- **Death from SIDS Decreased 60%**
- **Death from SUIDS Decreased 42%**
- **Low Birth Weight Increased 4%**
- **Black Low Birth Weight Increased 11%**
- **Prematurity Rate Increased 8%**
- **Black Prematurity Rate Increased 19%**

Needs Identified from the Assessment Process

The trends that show a number of improvements since our last SDP include declines in our infant mortality rates (IMR), including Black IMR, as well as our SIDS/SUIDS rates. While many factors contribute to improving IMRs, Healthy Start services along with community education and awareness cannot be excluded among them. Therefore, our efforts to ensure quality services and to provide outreach and education will continue and be reflected in priorities of our updated Community Engagement Plan, particularly regarding activities of our Infant Mortality Task Force and other community initiatives such as the health department's Healthy Babies Initiative and health equity committees. We will also continue efforts to overcome challenges in the prenatal screening process with OB providers so that our rates improve and thus more women are provided the opportunity to enroll in HS or other home visiting programs. We anticipate that through these initiatives, momentum will continue in improving our IMRs.

Our SIDS/SUIDS rates also improved, but as with IMR, we must continue our activities aimed at decreasing these rates not only with families of infants but also with new or upcoming women of childbearing age cohorts so that they continue to improve. Emphasis on safe-sleep education through our program staff and collaboration with other agencies to conduct public awareness campaigns will continue.

However, trends did worsen as shown by increases in our low birth weight (LBW) and prematurity rates. Because we know that women's health before pregnancy impacts birth outcomes, we must continue efforts that address this issue. These will include ensuring quality interconception services through HS, ongoing educational messages through our social media reach, collaboration with WIC, pregnancy centers and our mental health provider and our community-based educational events.

Therefore, in summary of the statistical data and community assessment, the primary maternal-child health challenges we face as a community are still factors related to maternal health, infant health, racial disparities, screening and outreach/education. Through further investigation, we know the social determinants of health are external factors but play a huge role in these priorities, so one of our tasks will continue to be how to work with the community to mitigate those societal issues. Priorities addressed in our service delivery plan through strategies and action steps are described later. Community collaboration will continue to play an important role as we work to ensure the best system of care for mothers and babies in Orange County.

D. Description of Additional & Lost Community Resources

New Community Resources

1. Our care coordinator provider, Florida Dept. of Health-Orange, obtained a 5-year renewal for their HRSA grant. Services, however, changed and the centering pregnancy option at one of their clinic sites in a high-risk area was eliminated; case management and mental health

services continued to be offered in this *Bellies, Babies and Beyond* project. The HS screen and CIR process are used to assess client eligibility.

2. A local midwife, known locally and nationally for her client-centered system of care, opened an additional clinic in another area of the county with poor birth outcomes. She has become a true safety-net for women unable to access prenatal care.

3. To better serve pregnant women, we were able to place a care coordinator at two FQHCs in our area: one in a high-risk zip code are of Pine Hills and another in a highly Hispanic area near the airport.

4. The Prenatal-Infant Loss and Resource group formed through efforts of social workers at our two major birthing hospitals. This PILR group works to ensure families learn of and are linked to any of our local bereavement services after suffering a pregnancy or infant loss. Our community liaison participates as a member of this group to provide needed information on Healthy Start to all members.

5. Despite the uncertainty with the Affordable Care Act, our Coalition has continued to serve as fiscal agent through our local PCAN to continue with five health navigators for ACA enrollment in Orange County.

6. Our nationally-affiliated diaper bank began offering our HS program 50 packs of diapers per month for use with our clients as incentives for keeping appointments.

7. A partnership with a major hotel resort chain, the Rosen Hotels & Resorts, has continued to work well; this company provides its employees with medical care through "RosenCare", a patient-centered onsite medical home that provides 24-hour primary care, pharmacy services, case management and office visits, all without worry of loss of job. Prenatal care is provided through a local OB office but their pregnant employees are all referred to CIR for services. HS also participates as a vendor in their annual employee health fair.

7. The ACES movement is very strong in Orange County and is led by the Peace and Justice Institute at Valencia College. Two conferences have been convened to educate the community on ACEs and its long-term effects on the health and well-being of children. The Children's Cabinet also has a tri-county committee to ensure the agencies dealing with children and families are aware of and consider ACEs concepts in their way of life delivering services. Our Children's Advocacy Center shows the movies explaining ACES to any agency or community group interested, totaling about 30 times this year alone. They have also held town hall meetings showing the movies with panel discussions and question-answer sessions following. Another conference is in the planning states for 2021. Our executive director has been on the planning team and participates on the Children's Cabinet ACES tri-county committee.

8. There are a number of initiatives that arose over the last few years that have continued to provide needed services to our county's residents, including a mobile food van to target "food deserts" and our FQHCs expanding to offer behavioral and dental health on site as well as providing primary care services at three local schools.

Lost Resources and Service Gaps

1. With the closure of a DOH-Orange clinic in a high-risk area, prenatal care offered through the evidenced-based centering approach ended. Families were faced with continuing their prenatal care at another DOH clinic site or finding a different provider more conveniently

located. The midwife mentioned above experienced a huge influx of clients needing prenatal care.

2. Childcare subsidies are woefully lacking for families in Central Florida. Our central childcare agency transitioned its computer system so an accurate assessment of the number reported to be on a waiting list for childcare assistance is unavailable at this time; however, lack of subsidized sites continues to be a need overwhelming expressed by our families, and one that has not changed since our last service delivery plan was submitted.

3. Lack of affordable housing continues to be very problematic; service industry wages don't pay enough to cover even small apartments, and subsidies for housing are very limited. This problem was tremendously amplified during the Hurricane Maria crisis with the influx of families from the Caribbean; it has continued to be a huge problem in our area.

4. Public transportation remains difficult with limitations of routes, times and frequency. Local news articles have targeted this lack and described the effects it has on minimum-wage and part-time employees who work at our theme parks but live at great distances from them; the local tax structure and politics impose challenges for these workers who are faced with hours-long bus rides and transfers to reach the parks in time for their shifts.

5. Our number of pregnant women being offered a screen continues to be low. The three major reasons are most likely due to:

- Medicaid no longer reimburses providers for completion of the screening form, rather it is part of the bundled rate from managed care companies
- Medicaid providers complete the required patient forms for reimbursement from the MCOs and don't find our form necessary
- While the infant screening is electronic, the prenatal is paper and the majority of providers have changed to electronic medical records and neglect completing the screen; this became particularly evident during the changes brought by COVID

6. Hurricane Maria created widespread devastation in Puerto Rico in September 2017 and soon after, residents began evacuating. Central FL is second only to New York City in the number of Puerto Ricans residents, and while tens of thousands migrated to the Central Florida area, the Puerto Rican population here has now essentially returned to pre-Hurricane Maria levels (American Community Survey from the US Census Bureau). UCF sociologist Fernando I. Rivera, founder of the Puerto Rico Research Hub, describes this migration as "circular", explaining that economic conditions generate this movement and if one is going to suffer economically here, the preference is to go back and be with family. During the immediate post-hurricane months as families arrived, we worked with local Hispanic organizations to ensure referrals to Healthy Start were made and to also provide car seats and pack-n-plays where needed. We continue to work with these agencies to ensure we are in tune with their needs and we closely monitor their health statistics.

These various service gaps pose difficult challenges for our care coordinators to overcome as they work with their clients to address their risk factors in having a healthy birth. Although there is little we can do to impact the economic crises that many of our families face, we update and develop various objectives and activities in our Coalition's Engagement Plan which represent steps we will take to impact some of these gaps. In addition, our community liaison will continue to address the challenges imposed in the prenatal screening process as she works with our OB provider offices to offer *every* woman a Healthy Start screen.

Resource Directory

Community Resources

Our HS program staff continue to provide clients with information on resources in our community that might be useful or fill an existing need. A resource guide was developed many years ago and continues to be periodically updated so that our staff have up-to-date information to share with their clients regarding these resources. Staff then facilitate access to the resource, whether through a direct contact or written referral.

Provider Resources

A provider directory that was created several years ago continues to be maintained and updated. This directory contains practice name, participating OB/GYN physicians/midwives, contact information to include a Healthy Start contact person and if the practice accepts Medicaid (and which plans) or private insurance only. While maintain updates to the directory is an ongoing effort, it is very useful for provider contacts that take place in the form of Community Liaison provider visits, correspondence via phone and mail to complete query forms as well as mail correspondence to communicate to providers information about the services we're providing to their patients. The directory can also help in connecting clients with a prenatal provider who is close to where they live and accepts their insurance plan. A major obstacle in ensuring all providers participate in the universal prenatal risk screening is that there is no easy method of identifying when a new provider sets up practice; new offices are "discovered" almost exclusively by chance; thus, the provider directory is accurate to the best of our ability. The number of OB/GYNs has been as high as 142 in 2002-03 and as low as 93 in 2007-08. In the last few years, the number of physicians has increased, in part, as we've seen two of the local hospitals, Orlando Health and Advent Health, take over and expand practice locations. A large practice to Central Florida, Women's Care Florida, has also expanded to more locations, not only in our county but others as well. Currently in 2019-20 there are 143 OB/GYNs. A further breakdown shows that these 143 providers comprise 66 separate OB practice sites, 28 of which accept Medicaid; the number of offices accepting Medicaid has decreased dramatically over the last few years. In addition, there are 2 birth center sites and 7 home birth midwives in the Orange County area.

Our county is served by two separate FQHC (federally qualified health center) companies, Community Health Centers, Inc. and True Health, operating 3 different clinic sites; *Connect* staff persons are placed at two of these and we are currently working on trying to place a third. Prior to COVID-19, a *Connect* staff was also at an FDOH-Orange clinic site but this arrangement was ended when they stopped accepting new clients. In addition, 3 *Connect* staff are on-site at Winnie Palmer Hospital, the largest delivering hospital in Orange County, and the process is in place for putting a staff person at Advent Health Orlando as well.

The following chart summarizes the changes over time in our provider network:

	2002-03	**2004-06**	**2006-07**	**2007-08**	**2008-09**	**2017-18**	**2019-20**
OB Providers	142	110	96	93	93	112	143

Total OB Practices						59	66
OB Practices Accepting Private Insurance Only						18	32
OB Practices Accepting Medicaid					49	37	28

Access to prenatal care for our uninsured/underinsured continues to be tenuous as our county health department has decreased prenatal care clinic sites over the last several years and is subject to the state Dept. of Health with its trend to eliminate this care. The FQHCs are the other large provider of Medicaid services and as mentioned above, two FQHC companies provide prenatal care at 3 clinics in the county. Access to prenatal care is limited in our high-risk zip codes, as very few or no OB practices reside in these areas. Apopka, a rural area in the county with a large poor population, has for the longest time had only an FQHC available for pregnant women to receive prenatal care and no OB practices. In 2020, however, an Orlando Health Physician Associates practice has opened in Apopka. Some offices put limitations on the patients they see with Medicaid, requiring them to seek a referral from a primary care physician first while others accept Medicaid but only for their current patients and not new ones. These limitations create further barriers to patients seeking prenatal care. A larger practice with three different office sites in Orange County recently started to accept Medicaid, but soon afterward stopped, stating challenges with Medicaid patients seeking care late into their pregnancy and the difficulty of being reimbursed for services. Although we have 3 delivery hospitals and 2 birthing centers, the vast majority of births occur at Winnie Palmer ("Winnie") Hospital for Women and Babies with more than 14,000/year. Winnie is the largest birthing hospital in both Florida and the Southeast US; it also has the busiest NICU in the US. Since our last SDP, we have been able to engage support of Winnie's birth registry staff to ensure a near 100% postnatal screening rate. In addition, *Connect* staff persons are located at Winnie Palmer Hospital and will soon at Advent Health Hospital, formerly known as Florida Hospital, to ensure screening is completed and all local maternal-child health home-visiting services are offered with the goal of enrolling women in services that best fit their needs and wants for the health of their baby. Currently, there is not a *Connect* staff person at Advent Health Winter Park because this hospital has a history of having the fewest births out of the 3 delivery hospitals as well as the smallest number of infants scoring at-risk, but as we continue our strategies for increasing screening and program referrals, we know it will be worth revisiting the data and consideration for adding a staff person here. The following summarizes the number of prenatal care providers in our county.

Type of Prenatal Provider	**# of Providers**
High Risk Clinics	4
Health Department Clinics	2
FQHC sites	3
Birthing Hospitals	3
Birthing Center	1

Strategies to address screening issues are frequently discussed and then implemented by HSCOC staff. The Community Liaison and Special Projects Coordinator share responsibility for provider visits. The Community Liaison facilitates a bi-monthly meeting with Coalition and Program Office staff to discuss screening challenges and develop strategies for overcoming those challenges with the ultimate goal to improve accurate screening of all pregnant women and infants. This committee is currently exploring the option of merging to focus on screening and CIR issues and strategies together, since they correlate to each other. A Provider Tracking Log has been created to track provider screening rates, screening form errors and the date of last training. The log is used in compiling data for a "provider report card" which we develop for each provider and review with them twice per year; included in this report card is county-specific birth data. The goal is to review this report cards with each provider office's Healthy Start point-of-contact and/or office manager every six months. This strategy is being utilized to strengthen provider relations and to offer an opportunity for education/technical assistance and scheduling trainings to ultimately improve screening rates. We've begun to highlight the patient section of the form, including the consent-to-screen and agreement to have their screening information shared, to also increase screening. This is a strategy we once used thanks to a group of senior volunteers, but when that group disbanded we were no longer able to keep it up. After newly piloting this strategy with a select few low-screening offices, it was found that it helped all of them increase their screening rates, so with the help of staff, board members and volunteers, we've recently been able to expand the use of highlighted screening forms to the majority of providers, especially those with low screening rates.

A *Mental Health Resource Guide* is also updated and used by care coordinators in educating clients on available community counseling resources. We also are connected to the area's pregnancy testing sites (19 current sites), which originally began for the use of our *ABC Fact Sheet* that outlined steps needed for obtaining Medicaid and accessing prenatal care. While getting a proof of pregnancy letter is no longer a requirement for the Medicaid application process, many women still go to the pregnancy centers for testing and help. Working with the pregnancy testing sites allows HS the perfect opportunity for providing not only HS information, but also pre/interconception health information; preconception health has been shown to be a major factor in birth outcomes.

E. Description of Target Population

County Profile

As one of the most visited regions in the United States, Central Florida (Orange, Osceola and Seminole counties) is an ever-growing area driven by its tourism and travel industry. With the largest metropolitan area within the region, Orange County accounts for a substantial amount of the population experiencing poor health and socioeconomic outcomes. We have a population of 1,393,452 as of July 1, 2019, a 21.6% increase over the last ten years (since 2010), with 15.1% of individuals living below the poverty level (U.S. Census Bureau). Remarkably, this statistic of poverty is down from 16.3% over the same time period. However, the area's theme-park attraction for global visitors fosters sales and services careers, a lack of dependable

transportation, low-paying jobs, and access to affordable housing and all remain as critical issues within our community. The struggles low-income families face is reflected in our county schools 69% population (up from 53% reported in our last SDP) needing free-reduced lunch and the reports from schools of the need for food distribution programs during the summers. The following is a detailed profile of Orange County area developed which highlights the breadth and diversity of the county as well as factors which foster difficulty in reaching optimal health, educational, and socioeconomic status for all residents.

Orange County is a budding area in the United States encompassing ethnically diverse populations in all types of developed environments. At 1,393,452 residents, it is one of the most populous counties in the State of Florida. According to the American City Business Journals, Orlando is projected to be the second fastest growing large metropolitan area in the United States moving toward 2030. With an increase in population of over 27,500 on average each year since 2010, and the consistently emerging city of Orlando being the most concentrated urban area within county lines, Orange County has experienced variances in population trends (U.S. Census Bureau, 2010-2019 American Community Survey). Population data from 2010-2019 shows increase in all racial and ethnic groups especially within Black and Hispanic populations, and a sizable increase in the Puerto Rican population with the expectation to trend upward within the coming years. In fact, since 2010 the Black Orange County population has increased almost 23%, and the Hispanic Orange County population increased by about 33% (U.S. Census Bureau).

Fertility is known as a principle determinant of population growth. Along with migration, which is also a familiar concept within Orange County, population change and birth rates are in correlation. Data from 2011 indicates a 16.9 percent increase in Black births, but since this year the birth rate has decreased while the White and Hispanic birth rate has fluctuated between 2 percentage points. Black births decreased from 4,223 in 2012 to 4,159 in 2019, and Hispanic births increased from 4,700 in 2012 to 6,205 in 2019 (Florida CHARTS). White births increased from 9,978 in 2012 to 10,785 in 2019 with the exception of 2016 with 10,507 births.

It is currently projected that the Central Florida area will continue to trend upward in population size. Subsequently, it is expected that Healthy Start's target population – women of childbearing age (11-44) – will also increase. With regards to the last five years, Orange County has experienced over an 8% increase in the number of childbearing-age women. This growth is expected to continue regardless of the current Healthy Start funding capacity which could present challenges in the future in rendering need-based services within our community.

The U.S. Census Bureau indicates the median household income of Orange County from 2012 to 2016 as $49,391, and from 2014 to 2018 as $54,335 – a 10 percent increase. It was not until 2014 that Orange County household income began to trend upward and continues to do so in 2018. The Office of Economic and Demographic Research in Florida indicates Orange County currently averages above the Florida state median household income, and state averages regarding per capital personal income and now within a percentage point of Orange County, and the state median family income surpasses Orange County by just under $1,300. Consequently, the population of the impoverished continues to grow as data indicates the percentage of poor families from 2015 to 2019 increased from 13.6% to 15.6%. However, data indicates for families

with single-parent female homes, as from 2015 to 2018, the percent in poverty decreased from 30 percent to 27 percent (U.S. Census Bureau).

Although a slight improvement from past American Community Survey data, a large segment of Orange County's population is in a constant struggle to maintain a decent living for themselves and their families. Low income families are most impacted by these socioeconomic issues, and this reality is projected to continue as the area's tourism-led economy continues to employ part-time hourly wage workers for minimum pay. A constitutional amendment to increase the minimum wage in Florida to $15 by 2025 was on the ballot during the 2020 general election and was passed by a majority vote of 60.8%. Although economists and small business owners do not all agree, this legislation is a noteworthy achievement in changing the socioeconomic infrastructure of Orange County and understanding that higher-paying, full-time employment with benefits including medical insurance, is the best means of truly supporting families and their needs.

Without such provisions a single-life emergency is sure to devastate an Orange County family and send them spiraling into poverty. The Heart of Florida United Way's *ALICE* report reveals another pandemic, a financial pandemic occurring in our community. The term "ALICE" refers to households that can be classified as the Asset Limited, Income Constrained Employed. They earn more than the Federal Poverty Level, but less than the basic cost of living for the County; they are working families but due to the high cost of living, are living pay check to pay check. In our tourist and service economy, many workers are paid by the hour, a factor associated with low wages. As of 2018, the percent of ALICE Households in Orange County was at 35%, and the state average was at 33%. Based on the response to a 2018 point in time survey, data also revealed that of the 128,670 families with children households, 29 percent are ALICE families and another 20 percent are in poverty.

The ALICE report also lists the 50 townships in Orange County and includes the percentage of residents who are considered both ALICE and in poverty. There are at least six (6) that reported at least 50% and going as high as 81% of their residents in this category; these are predominately minority communities of color and include the townships of Eatonville, Oakridge, Pine Hills, South Apopka, Tangelo Park and Winter Garden/Ocoee.

As the cost of household basics still outpaces wages in Orange County, families continue to struggle with housing, child care, food, transportation, health care, and a basic smartphone plan (ALICE Report, 2020). This is amplified in a time of global pandemic, as COVID-19 has completely shifted household incomes and access to basic needs.

Target Audience for Healthy Start Services

Healthy Start services are available to all women and infants who are eligible by score, by professional judgment or by self-referral. However, with the implementation of the CIR process, CONNECT, women and their families are offered home visiting programs that best meet their needs and preferences. This process has been determined through our local "decision tree", that is, a diagram or algorithm that guides decisions on which home visiting program a family is most

likely suited for (Appendix III). CONNECT workers ensure all participating home visitation programs' eligibility requirements are communicated to women during initial intake so they can make an informed choice. (Note: Our decision tree will be updated in late 2021 post-Covid.)

As found in our prior SDP, the majority of women and their families that Healthy Start continues to serve can best be described as "working poor," with median family household incomes significantly lower than the countywide median income and comparatively low educational attainment. This is confirmed by our HS Medicaid clients who make up about 65-75% of our client total. Many of the women are employed in the tourism and service industries, in hourly-waged jobs that can require them to work weekends, evenings and more than one job to make ends meet. This takes them away from their families for extended periods of time and directly impacts their ability to provide for, nurture, protect, teach and encourage their children. These families often have to move chasing lower rent, do not have employer-offered health insurance, and lack quality, affordable childcare and reliable transportation to get them to and from work and medical appointments. Low-income households typically lack reliable automobiles for commuting, leaving them to rely on public transportation. Although there is a bus system in Orange County, the routes and frequency of buses do not adequately meet the need and the need to change routes at the main hub make using the system very difficult, especially when other children along. With these difficulties in public transportation, we continue to need to purchase bus passes for many of our clients, although many can access bus passes through their Medicaid managed care plan, and to explore rideshare subsidies.

We have continued to target our special project initiatives in high-risk zip codes of our county, and despite occasional improvements in various outcomes, these zip codes have remained essentially the same over time. These areas correspond to "pockets of poverty" within the county that have a high percentage of African-American women of childbearing age and greater than the county-wide average of low and very low birth weight babies, pregnancies to females less than 20 years of age, repeat births to teens, and women with no prenatal care in the first trimester of pregnancy. Our Nurse-Family Partnership project serves several of these areas, as does our CHD's Bellies, Babies and Beyond initiative (federal HS). Outcome data by zip codes (see above) serves as a guide for assessment and planning for special project development.

Finally, the number of substance-exposed newborns (SENs) has steadily decreased over the past five years as Florida and our nation continues to address and educate communities on opioid abuse. The Florida Department of Health Opioid Use Dashboard shown fluctuating but encouraging data regarding infants less than 28 days old that were exposed to opioid prescription or illicit drugs during the mother's pregnancy as a decrease in the rate of Neonatal Abstinence Syndrome Birth Defects has decreased:

Year	Florida Neonatal Abstinence Syndrome Birth Defect Count/Annual Rate Per 10,000 Live Births
2015	1,510 / 67.3%
2016	1,480 / 65.8%
2017	1,503 / 67.2%
2018	1,375 / 62.1%

Since our last SDP, we have kept in relationship with many of local partners addressing this issue including the medical association and the recently re-formed Drug Dependent Newborn Unit in DCF. HSCOC has also participated in area opioid awareness initiatives including Project Opioid – a local consortia that empower community leaders to confront the opioid crisis within the targeted service areas and populations by embracing new strategies and leverage cutting-edge data. We continue to educate intake and service staff on understanding the signs of drug-addicted mothers and how to refer to substance abuse counseling program or appropriate area resources. HSCOC recently received DCF funding through FAHSC (FL Association of Healthy Start Coalitions) to begin providing special services for pregnant women and infants who have exposure to substances. As one of 4 coalitions chosen statewide, we are working closely with our hospitals and the Dept. of Children & Families to engage these clients into our Healthy Start's Safe Futures program and then provide them with an extra 'layer' of services. This layer includes Seeking Safety, an evidence-based counseling model of care designed to help pregnant women and infants attain safety from substance abuse, as well as a Plan of Safe Care to assist mom in setting goals for her and her baby. Our funding supports one registered nurse and is provided through June 2022. In addition, our coalition will begin working with the FL Perinatal Quality Collaborative in 2021 through FAHSC to ensure hospital personnel know about referral processes and resources for pregnant women and infants at risk from substance exposures.

F. Engagement Plan

Engagement Activity Strategic Plan

Objective 1	**Conduct 9 Infant Mortality Task Force (IMTF) meetings focused on addressing racial disparities are held during the FY 19-20.**
Social Determinant of Health Indicator(s)	Education, housing, transportation, employment, poverty, racism, toxic stress
Activity 1.1	**Utilize monthly IMTF meetings to strategize about contributing factors causing infant mortality.**
Timeline/Frequency	July 2021-June 2022
Person Responsible, Title	Elaine Cauthen, Operations & Communication, Dir.
Technique	Consult, Involve, Collaborate and Empower
Performance Measure	Partner organizations will provide updates on their strategies to address SDOH and discuss available MCH data at each meeting.
Indicator	Monthly agenda, sign in sheet, contents of meeting minutes and documentation of actual activity.
Activity 1.2	**Utilize the IMTF to develop opportunities to educate the community on MCH and racial disparities.**

Timeline/Frequency	July 2021-June 2022
Person Responsible, Title	Elaine Cauthen Operations & Communication, Dir.
Technique	Consult, Involve, Collaborate and Empower
Performance Measure	At least two (2) community educational activities will be identified and conducted per year.
Indicator	Monthly agenda, sign in sheet, contents of meeting minutes and documentation of actual activity.
Activity 1.3	HSCOC staff will support the DOH-Orange community health efforts related to MCH by assisting in planning and attending their activities.
Timeline/Frequency	4 activities scheduled from August 2021-June 2022.
Person Responsible, Title	Elaine Cauthen, Operations & Communication, Dir. Executive Director
Technique	Consult, Involve, Collaborate and Empower
Performance Measure	HSCOC's will collaborate and actively participate in at least 90% of planned meetings/activities of the Community Health Program and/or Bellies, Babies & Beyond (BBB) Program
Indicator	Agenda and sign-in sheets.

Objective 2	Maintain or Increase our 73% Prenatal Risk Screening
Social Determinant of Health Indicator(s)	Housing, Education, Employment, Transportation, Poverty, Racism, Toxic Stress,
Activity 2.1	**Conduct provider report card reviews**
Timeline/Frequency	Twice per year
Person Responsible, Title	Kerri Stephen, Community Liaison; Jarred McCovery, Special Projects Coordinator
Technique	Involve
Performance Measure	95% providers agree to schedule Report Card reviews
Indicator	Signed report cards
Activity 2.2	**Target trainings toward providers as needed and requested**
Timeline/Frequency	Ongoing
Person Responsible, Title	Kerri Stephen, Community Liaison
Technique	Consult
Performance Measure	85% of providers with low screening rates and/or high number of query form submissions agree to a training
Indicator	Review meetings scheduled
Activity 2.3	**Foster provider relationships through various communication avenues**
Timeline/Frequency	Quarterly
Person Responsible, Title	Kerri Stephen, Community Liaison; Jarred McCovery, Special Project Coordinator
Technique	Consult
Performance Measure	95% providers will receive communication (in-person visits, mailouts, phone calls, emails, etc.) quarterly from HSC

Indicator	Provider communication log

Objective 3	**Promote Healthy Start Mission by engaging and educating partners monthly on MCH issues**
Social Determinant of Health Indicator(s)	Education, housing, transportation, poverty, racism, stress, employment
Activity 3.1	**Ensure partners are kept abreast of MCH issues**
Timeline/Frequency	July 2021-June 2022
Person Responsible, Title	All staff
Technique	Inform
Performance Measure	Attend at least 2 meetings monthly to update on MCH
Indicator	Agenda and meeting summary
Activity 3.2	**Identify opportunities for new partnerships in county and/or strengthen existing partnerships**
Timeline/Frequency	Quarterly July 2021- June 2022
Person Responsible, Title	All staff
Technique	Collaborate
Performance Measure	2 new contacts established and/or strengthened partnership per quarter
Indicator	Meeting summary and contacts established/strengthened

Objective 4	**Promote awareness of Healthy Start and MCH issues through social media health messaging for each calendar month of FY 21-22.**
Social Determinant of Health Indicator(s)	Education, housing, transportation, poverty, racism, toxic stress
Activity 4.1	**Identify and disseminate a minimum of 2 MCH issues referenced in national health observances for each calendar month**
Timeline/Frequency	July 2021-June 2022 (monthly)
Person Responsible, Title	Jarred McCovery, Special Project Coordinator Elaine Cauthen, Operations & Communication, Dir.
Technique	Inform and Empower
Performance Measure	Number of health message topics posted to social media platforms (Facebook, Twitter, Instagram) each month
Indicator	Monthly analytics from social media postings

G. Allocation Plan for Healthy Start Direct Service Funds

In order to develop an allocation plan, or budget, for our service delivery dollars, HSCOC staff review outcomes of our subcontracted providers as well as their contract amounts with our Board

of Directors. Based on this review and the amount of funding available for the contract year from both DOH and from our Medicaid services through the Healthy Start-MomCare Network, recommendations are made to the Board for either renewing or changing our subcontracted amounts, eliminating the subcontract entirely and/or adding a new subcontractor for some specified amount. After discussion of these issues, the Board of Directors votes on and finalizes the budget at the final board meeting of the fiscal year. The following Allocation Plan will be reviewed and approved by the HSCOC Board of Directors for the 2021-22 contract year. The Allocation Plan will be reviewed and updated annually.

2021-22 ALLOCATION PLAN
HEALTHY START COALITION OF ORANGE COUNTY

Subcontracted Provider Name	*Service*	***Amount***
1. DOH-Orange (Orange Co. Health Dept.)	Care coordination	$2,100,000
2. DOH-Orange – CIR	Coordinated Intake & Referral	600,000
3. Aspire Health Partners	Mental health counseling	51,610
4. Health Education materials	Brochures/materials as needed for client education	10,000
5. Speedy Courier	Pick-up/delivery of prenatal screening forms biweekly	11,024
TOTAL		**$2,772,634**

H. Quality Assurance/Quality Improvement Plan

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 Healthy Start services. The Coalition will implement a Quality Improvement and Quality Assurance (QI/QA) process to monitor the effectiveness of Healthy Start, both internally and externally, in order to:

- ensure that the Healthy Start program and services adhere to the Healthy Start Standards and Guidelines

- ensure that services are provided in a manner that meets the needs of the participants and assures quality care
- ensure that contract performance expectations are met or exceeded and within the allocated contract amount and provide technical assistance as needed
- assist in defining an overall funding strategy

To accomplish these aims, a systematic approach is used by the HSCOC to monitor all aspects of Healthy Start, both internally and externally. The plan will be data driven and focus on continuous improvement.

Internal QA/AQ

1. Structure

Board of Directors:
The Board of Directors is responsible for approving all contracts in conjunction with the funding allocation plan at a minimum of once per year before the start of the new fiscal year. This process is completed after reviews of performance of HSCOC providers are conducted as well as reviews of funding allocations. Any proposed changes to the allocation plan and/or provider contracts needed during the year must be approved by the Board. Members are chosen by an ad hoc Nominating Committee and are based on areas of expertise as well as representation of appropriate/relevant organizations; they are then voted into office at our annual Coalition meeting. New Board members participate in an orientation soon after this election. The Board of Directors ensures the Bylaws and Policies/Procedures are up-to-date and followed. Every two years, the Executive Director and Board Chair conduct a self-assessment with the Board members to ensure they have a good understanding of their responsibilities as Members and of the varied maternal-child health issues they face in their role as Directors of the Coalition.

Executive Committee:
This standing committee is comprised of the HSCOC Chairperson, the Vice-Chair, Treasurer, Secretary, and immediate past Chairperson. This committee reviews and evaluated the work of the Executive Director annually and makes recommendations to the full Board regarding performance and compensation. Other functions are described in the HSCOC by-laws.

Infant Mortality Task Force:
Coordinated by the HSCOC, the IMTF meets monthly with multiple community partners to address the issue of infant mortality, prematurity, low birth weight and racial disparities in birth outcomes. Data is shared and reviewed with agency participants who then develop strategies that will involve the agencies and the community in efforts designed to increase awareness of this issue and to decrease the rates.

Resource Development and Marketing Committee:
This committee creates fund-raising strategies that connect closely to marketing the services of the Healthy Start program and that also promote the benefits to the community for having healthy babies. Appropriate use of social media is also discussed/reviewed with members of this

committee to further promote our HS message as well as current health topics, upcoming events, etc.

Screening Committee:
Held monthly with Coalition and program staff, this committee reviews overall prenatal and postnatal screening and referral rates for Orange County, CIR performance indicators (completed IIs, unable to complete an II, unable to locate, decline services, etc.), and screening and query rates of all providers, including private OB offices, community prenatal clinics and birthing hospitals. The committee allows opportunities to identify problems and generate potential solutions in order to improve our processes and increase successful completion of IIs, referrals and screening rates. Updates are given on strategies that have been implemented, including developing written materials, such as biannual report cards, and motivational activities such as drawings for gift cards after completing the online prenatal provider training.

2. Reporting Requirements

Monthly Reports:
HSCOC is required by contract with both the Department of Health (DOH) and the Healthy Start-MomCare Network (HSMN) to provide monthly reports composed of various items; these include attestations of services provided and funds spent, quantitative outcomes of performance measures, client grievances (if any), and other specific contractual deliverables. Certain financial consequences are imposed based on failures of the Coalition to comply. Payment from DOH to the Coalition is tied to these monthly reports.

Quarterly Reports:
As with the monthly reports, requirements exist for submission of quarterly reports and are subject to financial consequences. The fourth quarter (April-June) report also includes additional items for end-of-the year deliverables.

3. Fiscal Responsibilities

The HSCOC's Executive Director, Assistant Executive Director or Operations and Communications Director must review and approve all monthly administrative and operating expenses; the Assistant Executive Director reviews and approves all invoices submitted monthly by subcontracted providers to ensure accuracy of amounts and completion of monthly deliverables. Once approved, the invoice is paid. The HSCOC part-time financial officer pays bill, prepares all fiscal reports, tracks donations, verifies bank deposits and balances, and assists in preparing the annual budget proposal to the Board. The Executive Director oversees this process.

The HSCOC is required to undergo a professional fiscal audit annually. This audit is presented to the Board and then submitted to appropriate state and federal entities.

4. Monitoring

State-level:

The HSCOC responds to all requirements of DOH and HSMN for annual monitorings, whether conducted onsite or as a desk-audit.

Local level:
A CI&R process was implemented July 2018 and despite some issues, the process continues to evolve. The following QA/QI protocols are in place for internal monitoring.

HSCOC staff will meet weekly/biweekly with the HS Program Manager or her designee to review the progress made in implementing the CI&R system, identifying issues of concern and developing a plan to resolve each issue in a timely manner. As WFS issues arise, they are documented and the appropriate channels for resolution are followed.

Additionally, to ensure no financial consequences are imposed on the Coalition for failure to meet contract deliverables, the HSCOC staff will meet biweekly to review progress on these deliverables pertaining to the Coalition's own responsibilities. These include but are not limited to: submitting completed monthly and quarterly reports: creating/updating a Community Engagement Plan and completing its required activities; continuing provider awareness activities and documenting these; and, participating in meetings and trainings required by our funders. The Coalition's Service Delivery Plan is also updated and progress reports submitted as required.

External QI/QA Plan

In addition to the goals stated above, the Healthy Start Coalition of Orange County will ensure that the HSCOC operates in compliance with both DOH and AHCA contract requirements and with established standards and procedures which outline outcome and performance measures.

To achieve these goals, the staff of HSCOC will: perform the activities described in the Service Delivery Plan and in this QI/QA plan; conduct systematic assessments of services as required; identify strengths and weaknesses; incorporate into our Service Delivery Plan and QI/QA Plan strategies to improve performance and outcomes; and provide systematic follow-up to assure goals are being met. Our QI/QA Plan will be shared with the Board of Directors and incorporated into our subcontracts.

1. Structure

The HSCOC is responsible for monitoring the quality of all Healthy Start Care Coordination and Enhanced Services provided through our subcontracts with local agencies/individuals. In addition, the Coalition monitors the quality of our Coordinated Intake and Referral/Connect process and of any grant-funded local initiatives. Lastly, the Coalition monitors its own operations through coordination with DOH and the Healthy Start-MomCare Network and in collaboration with its professional audit firm (see Internal QA/QI Plan).

Basic outcomes and performance measures required by DOH and/or HSMN contracts are carried into subcontracts with our local providers. Some contract measures with DOH and/or AHCA may change year-to-year but these are typically coordinated through their discussion with the Florida Association of Healthy Start Coalitions (FAHSC) which includes the Healthy Start MomCare Network; as part of this statewide organization, HSCOC participates in the various committees of FAHSC as well as at the quarterly statewide meetings. The Coalition utilizes these guidelines in part in the formation and updating of our Service Delivery Plan and sub-contracts. We will promote our vision for excellent services through negotiations with sub-contractors, and may include additional precise and relevant measures of performance.

2. Assessment of quality

Quality assessments will utilize several methods: record reviews, surveys, data evaluation and periodic focus groups. Qualitative and quantitative data will be extracted from:

1) Well Family System Data Reports
2) Fiscal reports
3) Vital Statistics
4) Staff interviews and observation
5) Community Liaison logs
6) Record reviews
7) HSCC and Enhanced Service Provider Quarterly Assessment Tools (based on subcontracts)
8) Client satisfaction surveys

3. Monitoring

Local level:
HSCOC'S monitoring includes quarterly reviews of contracted performance measures for each of its providers and at minimum, an annual onsite program review as required by its state-level contracts. However, monitoring of the HS service provider, the Dept. of Health-Orange, occurs continually through frequent dialogue/meeting with the HS program director.

Deficiencies in compliance with outcome and performance measures found during the quarterly monitoring require submission by the subcontractor of a Performance Improvement Plan that outlines corrective actions. Status reports must be submitted every three months for long-term situations, and once the deficiencies are corrected. When determining corrective strategies, the following will be considered: impact on participants, support of leadership, system capability, staff training needs, and available funding. HSCOC readily provides technical assistance and support as needed.

The following QA/QI protocols are in place for external monitoring regarding the CI&R process: The Home Visiting Advisory Committee will meet on a quarterly basis to review numbers of referrals and enrollment data. The CI&R reports needed for review at each meeting are dependent on the WFS's ability to generate such reports in a timely manner and making them

available for review and action. If an unexpected issue of concern should arise, an additional meeting(s) may be scheduled to address its resolution as needed.

I. CONCLUSION

The Healthy Start Coalition of Orange County has developed this Service Delivery Plan with the support and consensus from our board and coalition members. Our four priority areas of focus are in alignment with Healthy Start's stated purpose to reduce infant mortality and low birth weight and to improve the health outcomes of babies. With this purpose and our mission in mind, our Coalition anticipates the successful implementation of this Service Delivery Plan and the accomplishments of our stated activities for 2021-2026

Appendix I

Healthy Start Coalition of Orange County
Board of Directors
2020-2021

Executive Committee
Gail Garvin, RN, MPH, Community Member – Chair
Mayra Uribe, Orange County Commissioner—Vice Chair
Nancy Hagan, Community activist- Secretary
Dr. Evers Robinson, Chaplain, Orlando Health – Treasurer
Lauren Josephs, PhD, CEO Visionary Vanguard Group---Immediate Past Chair

Board Members
Jennifer Adams - National Hood-up of Black Women
Heather Collins—FL Hospital Labor and Delivery
Marie Jose Francois –Center for Multicultural Wellness and Prevention
Dr. Cole Greves—Perinatologist, Winnie Palmer Hospital
Mary Jo Hoard, MSW – Therapist, Lutheran Counseling Services
Dr. Candice Jones--Pediatrician
Lynn Nelson – Attorney, ret.
Christina Sparks--Consumer
Jimmy Tercero—CSI special care
Dr. Jane Ierardi—Nemours Children's Hospital
Dr. Dominique DiLorenzo—Advent Health
Katy McGinnis---Attorney
Jessica Galo—Advent Hospital
Lauren Cooper---aide to Representative Anna Eskamani
Valerie Gore—OCPS educator
Diana Larsen—Bridges International
Laurie Stern---Bethany Christian Services
Mexcye Roberts—Attorney
Tabitha Wilson---Consumer

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Appendix II

Healthy Start Care Coordination Pandemic Needs Assessment

1. **How have things changed for you and your pregnancy or delivery during COVID 19?**

2. **Are you able to access health care and services for you and your baby?**
   □ YES
   □ NO, if so, **why not**?
   _____

   _____

3. **Have you, any family member or support person been sick from COVID-19?**
   □ NO
   □ YES, if so, **who**:
   _____
   Relationship: Self Child FOB Parent Other

4. **Have you or anyone in your family had a job loss?**
   □ NO
   □ YES, **who**:
   _____

5. **Are you practicing social distancing?**
   □ YES, if so, **how does it make you feel**?
   □ NO, If not **why not**?

6. **Do you have mask(s) to wear when out in the community?**
   □ YES □ NO

7. **Do you feel lonely or depressed because of COVID-19?**
   □ NO
   □ YES, If so, **what makes you feel this way**?
   Would you like me to refer you to someone who can provide supports? □ YES
   □ NO

8. **Do you have adequate supplies such as food, diapers, and baby wipes?**
   □ YES
   □ NO, If so:
   What size diapers would you need? _____

9. **What can I do to assist you during this challenging time of COVID-19?**

Appendix III