

**HEALTHY START COALITION  
OF  
MIAMI-DADE**

**SERVICE DELIVERY  
PLAN**

**Fiscal Year 2006-2010**

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*Healthy Start Coalition of Miami-Dade*

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### NEEDS ASSESSMENT DATA COMMITTEE:

Judith McCullough, PhD	University of Miami Perinatal Chemical Addiction Research and Education Program
Gerryann Barros, MD	Parkway Regional Hospital
Juanita Colston, MSW	North Dade Health Center
Michelle Del Torral, MSW	Dr. Rafael Peñalver Clinic
Colleen Mauer, MSW	Department of Children and Families
Maria Hernandez, MSW	Children's Home Society/Healthy Families Miami-Dade
Margie Aragon, MPH, CHES	University of Miami Department of Pediatrics/Neonatology
David Brown, MD	University of Miami Department of Family Medicine and Community Health
Beatriz Cruz, MSW	Miami Beach Community Health Center
Lourdes Forster, MD	University of Miami School of Medicine
Raymond Garofalo, MPH, CHES	Borinquen Health Care Center
Rob Harris, MA, MSCIS	Health Council of South Florida
Paul Hunt, PhD	City of Coral Gables
Roslyn Jennings, RN, MHED	Jefferson Reaves Senior Health Center
Pie Kamoso, MD, MPH	Economic Opportunity Family Health Center
Omayra Lamberty, MA	Children's Home Society/Healthy Families Miami-Dade
Elaine Mathews, RN	University of Miami School of Medicine
Vivian Owen, MSW	Avanti Support and Services
Roger Perez, JD	Miami-Dade County Health Department Healthy Start Data Management Office
Lee Sanders, MD	University of Miami
Rodlescia Sneed, MPH	Miami-Dade County Health Department
Ann-Karen Weller, RN, BSN	Miami-Dade County Health Department
Guoyan Zhang, PhD	Miami-Dade County Health Department
Lauren Fordyce, MA	University of Florida
Gladys Rocafort Montes, MEd	United Way/Center of Excellence in Early Education
Jeffrey Brosco, MD, PhD	University of Miami School of Medicine, Department of Pediatrics Mailman Center for Child Development
Guimel Martinez, MPA	Early Childhood Initiative Foundation
Charles Hood	Department of Children and Families
Angela Dunn	University of Miami: SPARK Team

**SERVICE DELIVERY PLAN AD-HOC COMMITTEE:**

Elliot Stern, MA, M.Phil	Williams, Stern and Associates
Graciela Perez , LCSW	Catholic Charities of the Archdiocese of Miami
Diann Gregory, ARNP, CNM, MEd	Miami Dade County Midwifery Program
Gloria Simmons, MSW	Miami-Dade County Public Schools
Jill Little	FSU-CPEIP, 11th Judicial Circuit, Young Parent's Project
Vivian Owen, MSW	Avanti Support and Services
Judith McCullough, PhD	University of Miami Perinatal Chemical Addiction Research and Education Program
Myrna Macatangay, RN	Community Action Agency Head Start/Early Head Start
Gladys Opong-Tetteh, EdS, MEd	Economic Opportunity Family Health Center
Hanna Fink, MSW, MBA	March of Dimes South Florida Division
Omayra Lamberty, MA	Children's Home Society/Healthy Families Miami-Dade
Kathleen Dexter, LCSW	The Children's Trust
Cleide Suguihara, MD	University of Miami Department of Pediatrics, Division of Neonatology
Margie Aragon, MPH, CHES	University of Miami Department of Pediatrics/ Neonatology
Shahnaz Duara, MD	University of Miami School of Medicine, Department of Pediatrics
David Brown, MD	University of Miami Department of Family Medicine and Community Health
Ann-Karen Weller, RN, BSN	Miami-Dade County Health Department
Lilia R. Abril, MD, MA	Community Stakeholder

**TECHNICAL SUPPORT AND ASSISTANCE FLORIDA DEPARTMENT OF HEALTH:**

Daniel Thompson, MPH,	Training and Research Consultant Office of Infant, Maternal and Reproductive Health
Chrissy Gest, MA	Health Services and Facilities Consultant Florida DOH, Office of Planning, Evaluation and Data Analysis
Karen Freeman, MPH, MS	Operations and Management Consultant Manager Florida DOH, Office of Planning, Evaluation and Data Analysis

**HEALTHY START COALITION OF MIAMI-DADE, INC. STAFF CONTRIBUTORS:**

Manuel Fermin, MPA	Executive Director
Diana Sierra, MPH	Research and Planning Manager
Natalia Coletti, LCSW	Education and Training Manager
Trecia K. Matthews, MPH, CHES	Quality Improvement and Assurance Manager
Nadia Huggins-Lauro, MS	Research and Programs Specialist
Lauren M. Fordyce, MA	Doctoral Candidate, University of Florida
Sarah Beth Manuels	Research Coordinator
Doris Nazario	Executive Assistant

**BOARD OF DIRECTORS:**

Sonya R. Albury, MSW  
Judith McCullough, PhD

Lourdes Q. Forster, MD  
Raymond Garofalo, MPH, CHES  
Carmen De Lerma, MD  
Elliot Stern, MA, M.Phil  
Gloria Simmons, MSW  
Kalenthia Nunnally  
Chuck Hood  
Steven Bonwit  
Hanna Fink, MSW, MBA  
Paul Hunt, MSW  
Roger Perez, JD

Grace Laskis

Health Council of South Florida  
University of Miami Perinatal Chemical  
Addiction Research and Education Program  
University of Miami School of Medicine  
Borinquen Health Care Center  
South Miami Hospital Child Development Center  
Williams, Stern and Associates  
Miami-Dade County Public Schools  
Teen Pregnancy Prevention Center  
Department of Children and Families  
Florida Sudden Infant Death Syndrome Alliance  
March of Dimes South Florida Division  
City of Coral Gables  
Miami-Dade County Health Department Healthy  
Start Data Management Office  
Community Action Agency Head Start/Early Head  
Start

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DATA INCLUDED IN 2006-2011 SERVICE DELIVERY PLAN:**

- Agency for Health Care Administration: Medicaid and Cesarean Section data
- Florida Community Health Assessment Resource Tool Set
- Florida Department of Children and Families Child Welfare/Community Based Care Program Office: Domestic Violence and Child Abuse Data
- Florida Department of Children and Families, District 11, Community Services Planning Center, February 2005
- Florida Department of Children and Families: Licensed Day Care Centers
- Florida Department of Health and Vital Statistics - Office of Planning, Evaluation & Data Analysis: Births and Fetal Records linked to Infant Deaths, Healthy Start Prenatal screens and Healthy Start prenatal services with Medicaid, WIC, and Census tract information
- Florida Department of Health, Bureau of HIV/AIDS: HIV/AIDS cases
- Florida Department of Health, Bureau of Immunizations
- Florida Department of Health, Bureau of Medicaid Services
- Florida Department of Health, Division of Disease Control, Bureau of STD: Sexually Transmitted Diseases Data
- Florida Department of Health: Healthy Start Reports
- Florida Department of Law Enforcement: Domestic Violence Arrests
- Florida Legislature's Office of Economic and Demographic Research: Population Estimates
- Florida School Districts: <http://www.firn.edu/doe/eias/flmove/dade.htm>
- Health Council of South Florida Quarterly Hospitalization Surveys: Neonatal Intensive Care Unit Utilization 2003
- Jackson Memorial Hospital/University of Miami WIC Program: Breastfeeding Data
- Miami-Dade County Health Department, HIV/AIDS Surveillance: HIV/AIDS Cases by Race
- Miami-Dade County Health Department, Office of Epidemiology: Asthma Data
- Bureau of Sexually Transmitted Disease Prevention and Control

## TABLE OF CONTENTS

	<u>Page</u>
Acknowledgments	
Executive Summary.....	viii
I. Introduction.....	1
A. Service Delivery Plan Development Process	
II. Summary of Findings from the Updated Needs Assessment.....	2
A. Methodology	
B. Demographics	
1. Population	
2. Geographic Regions	
3. Household Size and Income	
4. Insured/Uninsured Under Age 65	
5. Medicaid Population	
6. Impact on Maternal and Infant Health	
C. Maternal and Child Health Indicators and Trends	
1. Preterm Births	
2. Infant Mortality	
3. Neonatal Mortality	
4. Post Neonatal Mortality	
5. Low Birth Weight Births	
6. Births by Maternal Age	
7. Births to Single Mothers	
D. Overview of Key Findings	
III. Major Health Indicators Selected for The New Planning Cycle.....	22
A. Infant Mortality	
B. Low Birth Weight	
C. Preterm Births	
D. Healthy Start Services	
E. Overall County Priorities	
IV. Target Population and Area of Emphasis.....	32
V. Factors Contributing to the Health Status Indicators.....	36
A. Prenatal Care	
B. Age/Marital Status	
C. Health Problem Analysis	

VI.	Consumer and Provider Input.....	52
	A. Methodology	
	B. Focus Group Planning and Procedures	
	C. Focus Group Demography	
	D. Focus Group Summary	
VII.	Resource Inventory.....	64
VIII.	Healthy Start System.....	65
IX.	Funding Allocation Process.....	70
X.	Category A.....	71
	A. Planning Summary Sheet for the Healthy Start System	
	B. Internal and External Quality Improvement/Quality Assurance Plan	
	1. Healthy Start Coalition Committees	
	2. Reporting Requirements	
	3. Program Audit	
	4. Performance Based Contracts	
	C. Quality Improvement and Quality Assurance Work Plan 2006-11	
X.	Category B.....	81
	Marketing/Community Awareness.....	81
	1. Identified Community-Wide/System Issue	
	2. Planning Phase Questions	
	3. Strategies	
	Community Outreach.....	85
	1. Identified Community-Wide/System Issue	
	2. Planning Phase Questions	
	3. Strategies	
	Healthy Start Provider Development.....	87
	1. Identified Community-Wide/System Issue	
	2. Planning Phase Questions	
	3. Strategies	
	Screening Rate Monitoring and Improvement.....	89
	1. Identified Community-Wide/System Issue	
	2. Planning Phase Questions	
	3. Strategies	

Board and General membership Development.....	92
1. Identified Community-Wide/System Issue	
2. Planning Phase Questions	
3. Strategies	
Infant Mortality.....	95
1. Identified Community-Wide/System Issue	
2. Planning Phase Questions	
3. Strategies	
Fund Allocation.....	98
1. Identified Community-Wide/System Issue	
2. Planning Phase Questions	
3. Strategies	
Quality Improvement and Quality Assurance (QI/QA) .....	100
1. Identified Community-Wide/System Issue	
2. Planning Phase Questions	
3. Strategies	
Teenage Health Education, Parenting and Interconceptional Care.....	103
1. Identified Community-Wide/System Issue	
2. Planning Phase Questions	
3. Strategies	
Attachment A. MomCare Quality Improvement and Quality Assurance Plan.....	105
Attachment B. List of References.....	110

## EXECUTIVE SUMMARY

The Healthy Start Initiative was implemented on April 1, 1992 and has been driven by the mission to reduce infant mortality and morbidity, improve pregnancy outcomes and enhance the health and development of newborns to the age of three. To this end, the Coalition offers universal prenatal and infant risk screening, care coordination, and wraparound services aimed at identifying, preempting and providing the appropriate support to reduce risks to pregnant women and babies. The initiative is funded by state revenue dollars, along with funds from the Maternal and Child Health Block Grant.

The Service Delivery plan is driven by fundamental objectives of the organization, community input and demographic and health data. The report includes initiatives undertaken by the Coalition, funding allocation, data on the population segment targeted to receive benefits, gaps in service provision, and critical feedback from the community. The 2005 Needs Assessment provides a context and foundation for the Service Delivery Plan.

A total of 2.3 million residents occupied Miami-Dade County in 2004; the County had the highest concentration of Hispanics in the State of Florida. Of the 32,551 live births recorded in the previous year, the highest proportion, or 26.5%, occurred among women between the ages of 25-29 years old; while a total of 3,008 were attributed to teens, most of whom were Hispanics between 18-19 years old. Hispanics also accounted for the highest number of repeat births among teen mothers. Slightly more than 10% of all births were found to be preterm. In 2003, Miami-Dade's infant mortality rate of 6.0 in 2003 was lower than state and country rates; however, significant racial and ethnic disparities exist. During pregnancy, 89% of mothers-to-be sought prenatal care in the first trimester in 2003, the majority of which were non-Hispanic Whites.

Community focus groups examined issues related to the availability of services, barriers to access, tendency to utilize services, recommendations and information about individual communities. This input revealed key challenges which will be addressed by the Service Delivery Plan. The framework for Healthy Start service delivery focuses on its 15 Healthy Start Contracted Providers (HSCPs) that are conveniently located within the North, Central and South regions. MomCare, one of the main programs embedded in the Healthy Start Coalition of Miami-Dade, is designed to satisfy many challenges discussed by these focus groups, by targeting at-risk women who are eligible to receive Medicaid benefits.

The 2006-2010 Service Delivery Plan outlines strategies to increase prenatal and postnatal screening in Miami-Dade, collaborate with other organizations on additional initiatives to reduce infant mortality and improve birth outcomes, provide cultural competence training for contracted providers, and undertake other strategies to improve the quality of services offered by the Coalition. In the areas of Risk Screen Monitoring and Improvement, Outreach Initiatives and Teen Health Education, Parenting and Interconceptional Care, strategies to be implemented include street level outreach, conducting focus groups among parenting teens in high-risk neighborhoods, and conducting trainings for prenatal care providers that have low Healthy Start screening rates. In the area of community education, the action plan involves continuing the Coalition's marketing plan, participating in community events, making presentations at health

fairs and public forums to raise awareness about Healthy Start services, and providing trainings for key maternal, infant and child health workers.

The 2006-2010 Service Delivery Plan builds on and expands the initiatives outlined in the 2002-2005 Service Delivery Plan. As a relatively young coalition, incorporated in 2001, the Coalition conducted its first needs assessment in 2001 and used that data to develop the 2002-2005 Service Delivery Plan. A significant portion of that plan focused on the transition of activities from the previous agency to the current Coalition. Prior action plans focused on reducing the infant mortality, low birth weight and preterm birth rates among Non-Hispanic Blacks and Haitians. These goals remain a focus of the most current Service Delivery Plan.

The Healthy Start Quality Improvement and Assurance Plan (QI/QA) maintains the integrity and efficiency of the Coalition. This plan oversees and regulates service delivery and, by extension, Healthy Start Contracted Providers (HSCPs) through security and accountability mechanisms such as audits, site visits, committees, RFPs, contracts and related tools. Various action plans have also been formulated to delineate strategies, procedures and assigned responsibilities aimed at providing services at an optimal level. Strategies of the Healthy Start Board of Directors will include diversifying the composition of the board to expand geographic representation, including leadership from outside of the Coalition, as well as participating in community events. To improve the Fetal Infant Mortality Review program (FIMR), the Coalition will also continue to recruit members of the maternal and infant health community to serve on the Community Action Group (CAG). In addition, it will collaborate with hospitals and organizations such as the Department of Children and Families (DCF), to review the designated 29 fetal and infant death cases each year. In the area of Fiscal Accountability, the Coalition strategies will include conducting an annual internal fiscal audit, verifying that Healthy Start funds are wholly spent on authorized services by contracted providers and determining the total amount of expenditures incurred by each community based provider.

## I. INTRODUCTION

The Healthy Start Coalition of Miami-Dade, under its state charge to reduce infant mortality, lower the number of low birth weight and preterm babies, and improve maternal and child health and development, is committed to providing care coordination and wraparound services to pregnant women and children. The Coalition is in a unique position because it has just begun to re-establish and re-define its role in the community. To this end, it is faced with the challenge of effectively allocating limited service dollars in areas of greater need. In this cycle of the Service Delivery Plan, the Coalition will focus on the following:

- Prioritizing and implementing strategies based on data and best practices to reduce infant mortality rates, the percent of low birth weight births and the percent of preterm births
- Increasing community awareness and involvement regarding the Healthy Start Program as well as the Fetal and Infant Mortality Review (FIMR) Program
- Increasing prenatal screening rates among healthcare providers
- Increasing the number of enhanced services by Healthy Start contracted providers
- Strengthening the Healthy Start Board of Directors and general membership while ensuring fiscal accountability
- Identifying system gaps and developing appropriate responses on an on-going basis as part of a comprehensive Quality Improvement/Quality Assurance Plan

### **Description Of Process Used To Update The Service Delivery Plan**

The Service Delivery Plan is driven by data from the 2005 Needs Assessment. With the help of a contracted programmer and the assistance of community focus groups, Coalition staff have been meeting with the Data Committee and analyzing data since November 2004. The 2005 version examines the most important maternal and infant outcome indicators in Miami-Dade County, as well as Child Health Indicators requested by the Data Committee. The analysis includes a review of each zip code within the county and prioritized geographical areas of most need, based upon seven critical health indicators which include prenatal care, births to teens and unwed mothers, preterm and low-birth weight births, fetal and infant mortality. These findings constitute a significant portion of the 2006-2011 Service Delivery Plan, along with updates of the 2002-2005 version, to reflect current strategies undertaken by the Coalition and its providers.

Upon completion of an initial revision of the strategies in Category B, the Coalition convened the Service Delivery Plan (SDP) 2006 Ad-Hoc Committee to begin review and commentary of these sections. During that time, staff continued to meet weekly to review the remaining sections of the Plan and presented them at each SDP Ad-Hoc Committee meeting. Subsequent revisions, recommendations and edits were then implemented by Coalition staff. The Data Committee and/or SDP Ad-Hoc Committee met sixteen times between November 2004 and March 2006.

## II. SUMMARY OF FINDINGS FROM THE UPDATED NEEDS ASSESSMENT

### A. Methodology

The Healthy Start Needs Assessment 2005 is a surveillance effort spearheaded by the Healthy Start Coalition of Miami-Dade (HSCMD) in collaboration with the Data Committee. *Please see the Acknowledgements for a list of all members.* The Data Committee was first convened in November 2004 to guide Coalition staff in the development of the 2005 Needs Assessment. From November 2004, to February 2006, the Data Committee met 12 times to discuss and review data, content and presentation.

#### Sources of Data

##### *Quantitative*

- Agency for Health Care Administration: Medicaid and Cesarean Section data
- Florida CHARTS
- Florida Department of Children and Families Child Welfare/Community Based Care Program Office: Domestic Violence and Child Abuse Data
- Florida Department of Children and Families, District 11, Community Services Planning Center, February 2005
- Florida Department of Children and Families: Licensed Day Care Centers
- Florida Department of Health and Vital Statistics - Office of Planning, Evaluation & Data Analysis: Births and Fetal Records linked to Infant Deaths, Healthy Start Prenatal screens and Healthy Start prenatal services with Medicaid, WIC, and Census tract information
- Florida Department of Health, Bureau of HIV/AIDS: HIV/AIDS cases
- Florida Department of Health, Bureau of Immunizations
- Florida Department of Health, Bureau of Medicaid Services
- Florida Department of Health, Division of Disease Control, Bureau of STD: Sexually Transmitted Diseases Data
- Florida Department of Health, Healthy Start Reports
- Florida Department of Law Enforcement: Domestic Violence Arrests
- Florida Legislature's Office of Economic and Demographic Research: Population Estimates
- Florida School Districts website, <http://www.firn.edu/doe/eias/flmove/dade.htm>
- Health Council of South Florida, Quarterly Hospitalization Surveys: NICU Utilization 2003
- Healthy Families of Miami-Dade
- JMH/University of Miami WIC Program: Breastfeeding data
- Miami-Dade County Health Department, HIV/AIDS Surveillance: HIV/AIDS cases by race
- Miami-Dade County Health Department, Office of Epidemiology: Asthma Data
- SPARK (Supporting Partnerships to Assure Ready Kids): Project Summary
- The Early Childhood Initiative Foundation: Teach More/Love More
- The Miami-Dade Family Learning Partnership

##### *Qualitative*

- Community focus groups

## B. Demographics

### 1. Population

With more than 2.3 million residents, Miami-Dade County continues to be the most populous county in the State of Florida. Since 1997, the total population increased by more than 12% and, according to the Miami-Dade County Department of Planning and Zoning, is expected to increase to over 2.5 million by 2010. This represents a 6% increase over the population estimates for 2004.

The county is home to the largest concentration of Hispanics in the State of Florida. In 2004, the Hispanic Population, most of whom originated from Latin America and the Caribbean, totaled 1,471,504 and represented 61.6% of the total estimated population. Asians, though smaller in number, accounted for 1.5% of the population in 2004. The number and the percentage of Whites increased slightly during this period, while the percentage of Blacks followed the trend at a significantly lower pace.

**Table 1. Population Demographics of Miami-Dade County, 1997, 2000 and 2004**

POPULATION GROUP		1997	2000	2004
Race: White	Number	1,509,992	1,570,593	1,674,552
	Percent of County	71.9	69.7	70.1
	Percent of State	80.8	78.0	76.5
Race: Black	Number	426,326	457,432	465,817
	Percent of County	20.3	20.3	19.5
	Percent of State	14.8	14.6	15.2
Race: Asian	Number	35,702	31,547	35,832
	Percent of County	1.7	1.4	1.5
	Percent of State	1.7	1.7	2.0
Ethnicity: Hispanic	Number	1,178,172	1,291,176	1,471,504
	Percent of County	56.1	57.3	61.6
	Percent of State	14.6	16.8	19.0
Total Miami-Dade Population	Number	2,100,128	2,253,362	2,388,805
	Percent of County	100	100.0	100.0
	Percent of State	14.4	14.1	13.7
Total Florida Population	Number	14,634,534	15,982,378	17,463,048
	Percent of County	---	---	---
	Percent of State	100.0	100.0	100.0

Source: Office of Economic and Demographic Research; The Florida Legislature.

Approximately 161,838 children under the age of 5 lived in Miami-Dade County during 2004. In the same year, the 65+ population constituted the highest proportion, at 13.4%, which was a consistent trend in the previous years.

**Table 2. Population Estimates by Age, Miami-Dade County, 1997-2004**

AGE GROUPS									
Percent of Total Population									
YEAR	POPULATION	0-4 Years	5-9 Years	10-14 Years	15-17 Years	18-19 Years	20-24 Years	25-29 Years	30-34 Years
1997	2,146,081	6.9%	7.2%	6.9%	4.0%	2.9%	6.5%	7.2%	8.5%
1998	2,172,357	6.7%	7.1%	7.0%	4.0%	2.9%	6.4%	7.2%	8.2%
1999	2,208,140	6.6%	7.1%	7.1%	4.0%	2.9%	6.4%	7.2%	7.9%
2000	2,253,779	6.5%	7.0%	7.1%	4.2%	2.7%	6.4%	7.3%	7.7%
2001	2,285,869	6.6%	6.9%	7.1%	4.3%	2.7%	6.5%	7.1%	7.5%
2002	2,312,478	6.6%	6.7%	7.0%	4.3%	2.7%	6.5%	6.9%	7.3%
2003	2,345,932	6.7%	6.6%	7.1%	4.3%	2.7%	6.8%	6.8%	7.4%
2004	2,379,976	6.8%	6.5%	7.1%	4.4%	2.8%	6.9%	6.7%	7.3%
YEAR	POPULATION	35-39 Years	40-44 Years	45-49 Years	50-54 Years	55-59 Years	60-64 Years	65+ Years	18+ Years
1997	2,146,081	8.4%	7.3%	6.4%	5.6%	4.7%	4.2%	13.4%	75.0%
1998	2,172,357	8.5%	7.4%	6.5%	5.6%	4.8%	4.2%	13.3%	75.1%
1999	2,208,140	8.6%	7.5%	6.6%	5.8%	4.8%	4.3%	13.3%	75.2%
2000	2,253,779	8.5%	7.6%	6.7%	5.9%	4.8%	4.3%	13.3%	76.7%
2001	2,285,869	8.2%	7.7%	6.8%	6.0%	5.0%	4.3%	13.3%	76.2%
2002	2,312,478	8.0%	7.8%	7.0%	6.1%	5.2%	4.4%	13.4%	76.2%
2003	2,345,932	7.8%	7.9%	7.0%	6.0%	5.1%	4.3%	13.4%	76.3%
2004	2,379,976	7.6%	8.0%	7.0%	6.1%	5.2%	4.3%	13.4%	76.3%

Source: Florida Legislature, Office of Economic and Demographic Research. Demographic Conference Database.

Females accounted for nearly 52% of its population in the eight-year period under study. In 2004, 42.4% of women, or 519,554 were of childbearing age between 15-44 years old.

**Table 3. Population Estimates, Females (15-44 yrs), Miami-Dade County, 1997-2004**

Year	Population	Females	Percent of Total Population	15-44 yrs	Percent of Female Population
1997	2,146,081	1,110,381	51.7%	484,519	43.6%
1998	2,172,357	1,123,849	51.7%	488,413	43.5%
1999	2,208,140	1,141,713	51.7%	493,741	43.2%
2000	2,253,779	1,164,680	51.7%	491,792	42.2%
2001	2,285,869	1,180,150	51.6%	503,693	42.7%
2002	2,312,478	1,193,455	51.6%	503,517	42.2%
2003	2,345,932	1,208,959	51.5%	514,564	42.6%
2004	2,379,976	1,225,431	51.5%	519,554	42.4%

Source: Florida Legislature, Office of Economic and Demographic Research. Demographic Conference Database.

## 2. Geographic Regions

The county is divided into the following three planning regions:

### *South Miami-Dade*

South Miami-Dade is located in the southern section of the county. The area's geographic boundaries include Kendall Drive (S.W. 88 Street) to the North, Monroe County line to the South, Biscayne Bay to the East, and the Florida Everglades to the West. This 18 zip code region is a suburban and rural area with an agricultural industry. According to CACI Marketing Systems, the region has an estimated 410,237 residents, representing 18.7% of the total county population.

### Central Miami-Dade

In Central Miami-Dade, the North to South boundaries extend from Okeechobee Road (SR27) to South Dixie Highway and Kendall Drive (S.W. 88 Street) while the East to West boundaries run from the Atlantic Ocean to Krome Avenue (179<sup>th</sup> Avenue). The area encompasses a 32 zip code region which is populated by an estimated 766,320 residents or 34.9% of the county's population, 78.2% of which are of Hispanic origin.

### North Miami-Dade

North Miami-Dade is located in the northern section of the County. The North to South boundaries extend from N.E. 215<sup>th</sup> Street (the Broward County line) to N.W. 20<sup>th</sup> Street, while the East to West boundaries stretch from the Atlantic Ocean to US Highway 27 (Okeechobee Road). The beaches are also considered a part of the North Miami-Dade region. Twenty-nine zip codes comprise the area. North Miami-Dade is populated by an estimated 1,018,222 residents, representing 46.3% of the total county population. There is a high concentration of Blacks (31.6%) compared to 9.8% in the remainder of the county.

### **3. Household Size and Income**

In 2004, there were 821,081 households in Miami-Dade County, with an estimated rise to 822,975 in 2005 and an annual growth rate of 1.5%. The average household size in 2004 was 2.85, which was slightly higher than 2.77 in 2000.

Households with incomes under \$25,000 vary significantly by zip codes. The total number of households with incomes under \$25,000 is 256,998 or 31.1%. The largest number of households with incomes less than \$25,000 is in Hialeah (33012)/North Miami-Dade region with 9,666 low-income households. Zip code 33012 accounts for 39.5% of the total population in that zip code.

### **4. Insured/Uninsured Under Age 65**

Data provided by the Urban Institute and Kaiser Commission indicate that in 2003, 811,637 or 26.7% of the county's population under 65 years of age were uninsured. This estimate is significantly higher than that of the State of Florida average, with a 20.9% uninsured rate, and the United States average, with a 17.7% uninsured rate in 2003.

### **5. Medicaid Population**

The Agency for Health Care Administration reported 941,364 Medicaid recipients in Miami-Dade during April 2005; this figure represents 39% of the total Miami-Dade County population. Of this number, 292,283, or 31%, were females between the ages of 12-55 years old, while 14.6% were 0-5 years old.

### **6. Impact on Maternal and Infant Health**

Infant mortality is a primary indicator of health in a community because of its association with a variety of factors such as maternal health, quality of and access to medical care, socioeconomic conditions, public health practices and the general quality of life experienced by its members. Unique socio-economic factors impact on health in Miami-Dade. In 2003, there were 32,551 live births recorded in Miami-Dade. The 0-4 year old population totaled 2,379,976, or 6.8% and 21.8% of the population were women of childbearing age. Hispanics made up 59.8% of the population, followed by 20% Blacks and 18% Whites in 2004. Slightly more than 31% of the population earned under \$25,000 per year.

## C. Maternal and Child Health Indicators and Trends

### 1. Preterm Births

Preterm births occur when a baby is born prior to 37 completed weeks of gestation. Risk factors for preterm labor include multiple pregnancies (e.g., twins, triplets), past history of preterm delivery, uterine and/or cervical abnormalities, high blood pressure, diabetes, clotting disorders, obesity, infections during pregnancy, cigarette smoking, alcohol use, or illicit drug use during pregnancy.

Between 2000 and 2003, Hispanics naturally accounted for the highest number of preterm live births, since they also accounted for the highest number of overall births in proportion to the number of live births among all ethnic groups studied in Table 1. Non-Hispanic Blacks however, accounted for the highest *proportion* of preterm live births when compared to all other ethnic groups. This was recorded at 14.3% in 2000 but minimally increased to 14.4% in 2003. There was also a decline in the number of non-Hispanic Whites who experienced preterm births; 405 in 2000 and 337 in 2003, while the preterm birth rate for Haitians increased within the same period from 250 in 2000 to 283 in 2003.

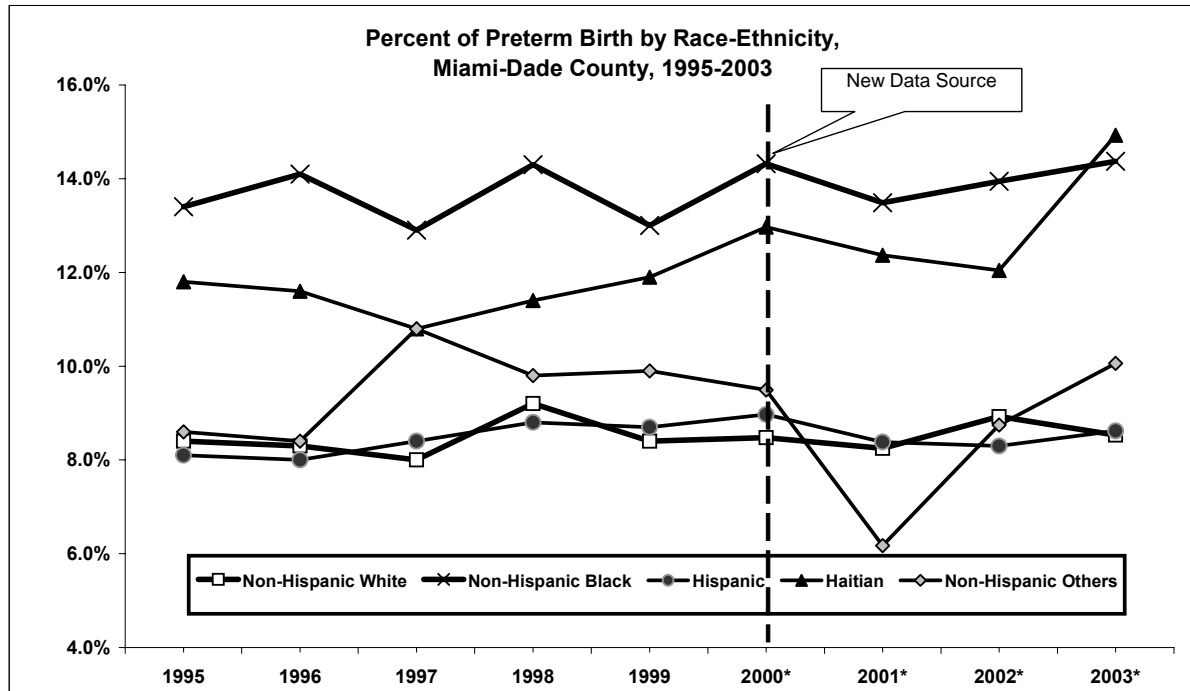
Preterm births among all ethnic groups totaled 3,345 in 2000 and minimally declined to 3,290 in 2003. By 2003, 12.1% of births within the 35+ age group were preterm births while the 35-39 year old subgroup (see Table 2) accounted for the majority among women over the age of thirty-five.

**Table 4. Preterm Live Births by Race-Ethnicity and Maternal Age, Miami-Dade County, 2000-2003**

RACE-ETHNICITY		2000	2001	2002	2003
Non-Hispanic White	Number	405	341	353	337
	Percent	8.5%	8.2%	8.9%	8.5%
Non-Hispanic Black	Number	996	893	880	879
	Percent	14.3%	13.5%	13.9%	14.4%
Hispanic	Number	1,620	1,610	1,621	1,725
	Percent	9.0%	8.4%	8.3%	8.6%
Haitian	Number	250	228	214	283
	Percent	13.0%	12.4%	12.0%	14.9%
Non-Hispanic Others	Number	45	30	42	50
	Percent	9.5%	6.2%	8.8%	10.1%
Unknown	Number	29	19	11	16
	Percent	---	---	---	---
All	Number	3,345	3,121	3,121	3,290
	Percent	10.3%	9.6%	9.7%	10.1%
Age					
10-14	Number	10	10	8	9
	Percent	12.0%	16.4%	12.9%	15.3%
15-17	Number	168	132	120	132
	Percent	12.6%	11.4%	11.2%	12.9%
18-19	Number	275	232	204	210
	Percent	12.6%	10.7%	9.8%	10.9%
20-34	Number	2,285	2,145	2,208	2,263
	Percent	9.7%	9.0%	9.4%	9.5%
35+	Number	601	602	581	676
	Percent	11.7%	11.4%	10.9%	12.1%
Unknown	Number	6	0	0	0
	Percent	---	---	---	---
All	Number	3,345	3,121	3,121	3,290
	Percent	10.3%	9.6%	9.7%	10.1%

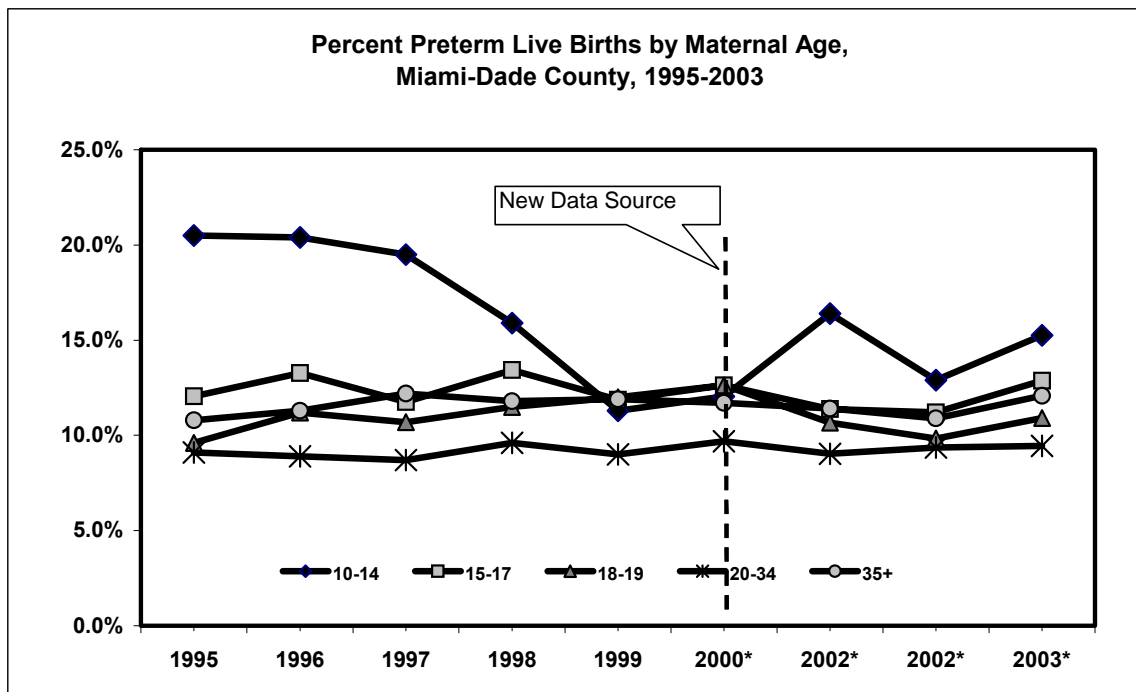
Source: Florida Department of Health, Office of Vital Statistics. This data corresponds to those published in the Florida Vital Statistics Annual Reports for 2000-2003.

**Figure 1. Percent Preterm Births by Race/Ethnicity, Miami-Dade County, 1995-2003**



Source: Miami-Dade County Health Department, Office of Epidemiology, 1999, \*Source: Florida Department of Health, Office of Vital Statistics. This data corresponds to those published in the Florida Vital Statistics Annual Report for 2000-2003.

**Figure 2. Percent Preterm Births by Maternal Age, Miami-Dade County, 1995-2003**



Source: Florida Department of Health, Office of Vital Statistics. This data correspond to those published in the Florida Vital Statistics Annual Report for 2000-2003.

**Table 5. Preterm Live Births by Maternal Age, Miami-Dade County, 2000-2003**

AGE		2000	2001	2002	2003
≤ 14	Number	10	10	8	9
	Percent	0.3%	0.3%	0.3%	0.3%
15-17	Number	168	132	120	132
	Percent	5.0%	4.2%	3.8%	4.0%
18-19	Number	275	232	204	210
	Percent	8.2%	7.4%	6.5%	6.4%
20-24	Number	739	687	640	700
	Percent	22.1%	22.0%	20.5%	21.3%
25-29	Number	795	760	766	786
	Percent	23.8%	24.4%	24.5%	23.9%
30-34	Number	751	698	802	777
	Percent	22.5%	22.4%	25.7%	23.6%
35-39	Number	476	469	468	517
	Percent	14.2%	15.0%	15.0%	15.7%
40-44	Number	115	118	104	141
	Percent	3.4%	3.8%	3.3%	4.3%
45+	Number	10	15	9	18
	Percent	0.3%	0.5%	0.3%	0.5%
Unknown	Number	6	0	0	0
	Percent	0.2%	0.0%	0.0%	0.0%
All	Number	3,345	3,121	3,121	3,290
	Percent	100.0%	100.0%	100.0%	100.0%

Source: Florida Department of Health, Office of Vital Statistics. These data correspond to those published in the Florida Vital Statistics Annual Reports for 2000-2003.

## 2. Infant Mortality

Infant mortality is often considered to be the primary indicator that reflects the health of a nation, due to its association with a variety of factors such as maternal health, quality and access to medical care, socioeconomic conditions and public health practices. In the state, and also in Miami-Dade County, infant mortality rates are currently the lowest in recorded history; however, as conditions continue to improve we must strive to make greater efforts to reduce the number of infant deaths. For example, attempts must be made to achieve the national Healthy People 2010 objective of 4.5 deaths per 1,000 live births.

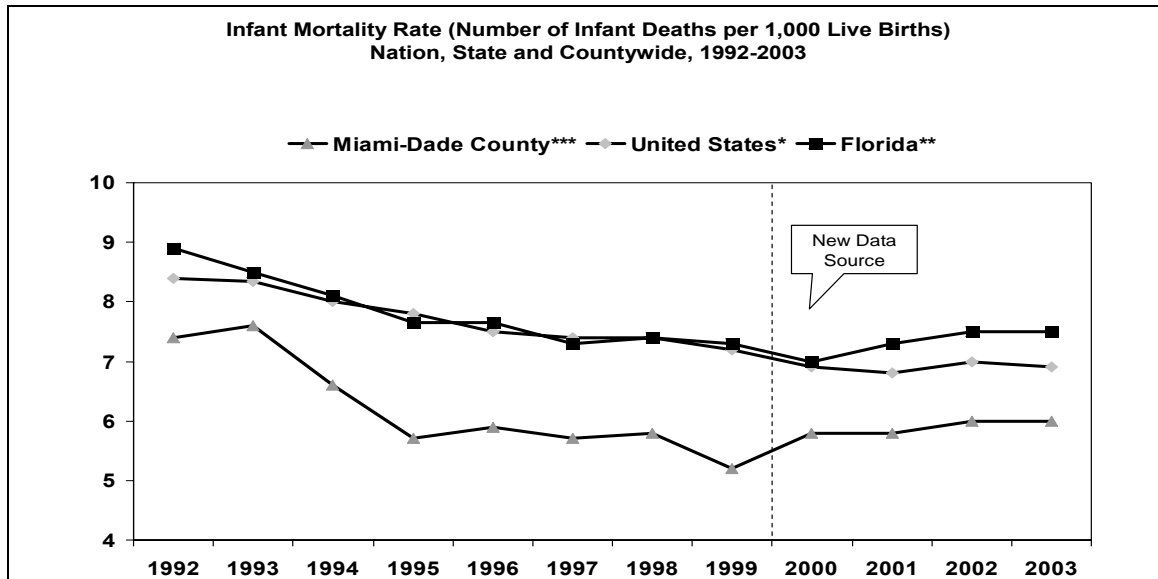
Table 6 shows a lower rate of infant mortality in the county compared to the state and country. Slight changes were made in the rate of infant mortality; in 2000 to 2001, this was recorded at 5.8 and increased to 6.0 in the two years that followed. Rates within the state and country remained fairly consistent with slight increases throughout the period.

**Table 6. Infant Mortality Rate (Number of Infant Deaths per 1,000 Live Births) Nation, State and Countywide, 2000-2003**

		2000	2001	2002	2003
<b>United States</b>	<b>Rate</b>	6.9	6.8	7.0	6.9
<b>Florida</b>	<b>Rate</b>	7.0	7.3	7.5	7.5
<b>Miami-Dade County</b>	<b>Number</b>	186	188	192	194
	<b>Rate</b>	5.8	5.8	6.0	6.0

Source: National Vital Statistics Reports, National Center for Health Statistics, 2004. (State and County data) Florida Department of Health, Office of Vital Statistics, 2004, Source: Florida Department of Health, Office of Vital Statistic, Source: Resident Infant Deaths from the Florida Department of Health, Office of Vital Statistics. These data correspond to those published in the Florida Vital Statistics Annual Report for 2000, 2001, 2002 and 2003.

**Figure 3. Infant Mortality Rate, United States, Florida and Miami-Dade County, 1992-2003**



Sources: 1992-1999: \* Statistical Abstraction of the United States 2000; \*\*Florida Vital Statistics 1993-1999; \*\*\*Miami-Dade County Health Department, Office of Epidemiology, 2000. 2000-2003 data: \* National Vital Statistics Reports, National Center for Health Statistics, 2004. (State and County data) Florida Department of Health, Office of Vital Statistics, 2004. \*\*Florida Department of Health, Office of Vital Statistics; \*\*\*Resident Infant Deaths from the Florida Department of Health, Office of Vital Statistics. These data correspond to those published in the Florida Vital Statistics Annual Report for 2000, 2001, 2002 and 2003.

As shown in Table 7, the infant mortality rate for all races and ethnic groups was 5.2 in 2000 and 6.2 in 2002. In the same period, the rate for Non-Hispanic Whites was 3.6 in 2000 and increased to 5.1 in 2002. The infant mortality rate for Non-Hispanic Blacks was 9.7 in 2000 and increased to 11.1 in 2002; the rate for by Haitians rose from 8.3 in 2000 to 10.1 in 2002. For Hispanics, the infant mortality rate rose from 3.3 in 2000 and 4.6 in 2002. Puerto Ricans had the highest infant mortality rate among the Hispanic population in 2000 while Mexicans/Other Hispanics ranked highest in 2002.

Table 7 also highlights the disparity in the rates of infant mortality between White and non-White races in the same period. A disproportionately higher number of live births were attributed to White women as well as a correspondingly lower rate of infant mortality when compared to non-Whites. Mortality rates also steadily increased among non-Whites reaching 11.4 in 2002 compared to 4.3 among whites in the same year.

**Table 7. Infant Mortality Rates (per 1,000 Live Births) by Maternal Race-Ethnicity and Race, Miami-Dade County, 2000-2002**

MATERNAL RACE-ETHNICITY		2000	2001	2002
Non-Hispanic White	Live Births	4,764	4,113	3,934
	Infant Deaths	17	16	20
	Infant Mortality Rate	3.6	3.9	5.1
Non-Hispanic Black	Live Births	6,933	6,606	6,286
	Infant Deaths	67	73	70
	Infant Mortality Rate	9.7	11.1	11.1
Hispanic	Live Births	18,014	19,192	19,529
	Infant Deaths	59	70	89
	Infant Mortality Rate	3.3	3.6	4.6
Cuban	Live Births	6,850	7,189	7,449
	Infant Deaths	25	15	26
	Infant Mortality Rate	3.6	2.1	3.5
Puerto Rican	Live Births	1,273	1,203	1,222
	Infant Deaths	7	11	7
	Infant Mortality Rate	5.5	9.1	5.7
Central/South American	Live Births	8,650	9,472	9,444
	Infant Deaths	24	41	46
	Infant Mortality Rate	2.8	4.3	4.9
Mexican/Other Hispanic	Live Births	1,295	1,371	1,428
	Infant Deaths	3	3	10
	Infant Mortality Rate	2.3	2.2	7.0
Haitian	Live Births	1,928	1,842	1,775
	Infant Deaths	16	23	18
	Infant Mortality Rate	8.3	12.5	10.1
Non-Hispanic Others	Live Births	473	485	480
	Infant Deaths	4	0	2
	Infant Mortality Rate	8.5	0.0	4.2
Unknown/Missing	Live Births	456	402	348
	Infant Deaths	5	5	2
	Infant Mortality Rate	---	---	---
All	Live Births	32,568	32,640	32,352
	Infant Deaths	168	187	201
	Infant Mortality Rate	5.2	5.7	6.2
<b>MATERNAL RACE</b>				
White	Live Births	21,966	22,480	22,624
	Infant Deaths	75	82	97
	Infant Mortality Rate	3.4	3.6	4.3
Non-White	Live Births	9,407	8,993	8,546
	Infant Deaths	83	100	97
	Infant Mortality Rate	8.8	11.1	11.4
Other	Live Births	1,064	1,081	1,138
	Infant Deaths	5	1	6
	Infant Mortality Rate	4.7	0.9	5.3
Unknown	Live Births	131	86	44
	Infant Deaths	5	4	1
	Infant Mortality Rate	---	---	---

Source: Birth and Fetal Death Records Linked to Infant Deaths, Healthy Start Prenatal and Infant Screens and Healthy Start Prenatal Services with Medicaid, WIC, and Census Tract Information. Prepared by the University of Florida, Perinatal Data Research Center and Florida Department of Health, Office of Planning, Evaluation, and Data Analysis, October, 2003

### **3. Neonatal Mortality**

Neonatal mortality occurs when a baby dies prior to 28 days of life, and is associated with the events surrounding the prenatal period and the delivery. In Miami-Dade County, the neonatal mortality rate increased from 3.8 in 2000 to 4.0 in 2002. Non-Hispanic Black women experienced the highest rates, which decreased from 6.7 in 2001 to 5.7 one year later. Though the actual number of neonatal mortality cases was less among Haitians, rates were highest in 2001 and peaked at 8.1. Neonatal mortality for Non-Hispanic Whites and Hispanics remained relatively consistent, while Puerto Ricans, a subset of the Hispanic group, suffered the highest mortality rate within this group. The non-White races experienced a higher rate of mortality compared to their white counterparts in the period. (See Table 8)

**Table 8. Neonatal Mortality Rates (per 1,000 Live Births) by Maternal Race-Ethnicity and Race, Miami-Dade County, 2000-2002**

Race-Ethnicity		2000	2001	2002
Non-Hispanic White	Live Births	4,764	4,113	3,934
	Neonatal Deaths	12	10	15
	Neonatal Mortality Rate	2.5	2.4	3.8
Non-Hispanic Black	Live Births	6,933	6,606	6,286
	Neonatal Deaths	46	44	36
	Neonatal Mortality Rate	6.6	6.7	5.7
Hispanic	Live Births	18,014	19,192	19,529
	Neonatal Deaths	48	45	64
	Neonatal Mortality Rate	2.7	2.3	3.3
Cuban	Live Births	6,850	7,189	7,447
	Neonatal Deaths	18	10	21
	Neonatal Mortality Rate	2.6	1.4	2.8
Puerto Rican	Live Births	1,273	1,203	1,222
	Neonatal Deaths	7	7	5
	Neonatal Mortality Rate	5.5	5.8	4.1
Central/South American	Live Births	8,650	9,472	9,444
	Neonatal Deaths	21	26	33
	Neonatal Mortality Rate	2.4	2.7	3.5
Mexican/Other Hispanic	Live Births	1,295	1,371	1,428
	Neonatal Deaths	3	2	5
	Neonatal Mortality Rate	2.3	1.5	3.5
Haitian	Live Births	1,928	1,842	1,775
	Neonatal Deaths	11	15	11
	Neonatal Mortality Rate	5.7	8.1	6.2
Non-Hispanic Others	Live Births	473	485	480
	Neonatal Deaths	2	0	1
	Neonatal Mortality Rate	4.2	0.0	2.1
Unknown/Missing	Live Births	456	402	348
	Neonatal Deaths	5	5	2
	Neonatal Mortality Rate	---	---	---
All	Live Births	32,568	32,640	32,352
	Neonatal Deaths	124	119	129
	Neonatal Mortality Rate	3.8	3.6	4.0
<b>MATERNAL RACE</b>				
White	Live Births	21,966	22,480	22,624
	Deaths	59	52	73
	Mortality Rate	2.7	2.3	3.2
Non-White	Live Births	9,407	8,993	8,546
	Deaths	57	62	51
	Mortality Rate	6.1	6.9	6.0
Other	Live Births	1,064	1,081	1,138
	Deaths	3	1	4
	Mortality Rate	---	---	---
Unknown	Live Births	131	86	44
	Deaths	5	4	1
	Mortality Rate	---	---	---

Source: 2000, 2001, 2002, and 2003 Births and Fetal Records Linked to Infant Deaths, Healthy Start Prenatal screens and Healthy Start prenatal services with Medicaid, WIC, and Census tract information. Prepared by the University of Florida, Perinatal Data Research Center and Florida Department of Health, Office of Planning, Evaluation, and Data Analysis.

#### 4. Post Neonatal Mortality

Post neonatal mortality occurs when a baby dies after 28 days old. This is associated with conditions or events that arise after the delivery and is usually indicative of environmental factors impacting the infant. Table 9 shows that the Hispanic population accounted for the lowest mortality rate per 1,000 live births in Miami-Dade between 2000 and 2002. This rate, however, increased from 0.6 in 2000 to 1.3 in 2002. Post neonatal mortality rates among Haitians occurred at a rate of 2.6 in 2000, 4.3 in 2001 and 3.9 in 2002, while in non-Hispanic Blacks the rates were 3.0 in 2000 and 5.4 in 2002.

**Table 9. Post Neonatal Mortality Rates (per 1,000 Live Births) by Race-Ethnicity and Race, Miami-Dade County, 2000-2002**

MATERNAL RACE-ETHNICITY		2000	2001	2002
Non-Hispanic White	Live Births	4,764	4,113	3,934
	Deaths	5	6	5
	Mortality Rate	1.0	1.5	1.3
Non-Hispanic Black	Live Births	6,933	6,606	6,286
	Deaths	21	29	34
	Mortality Rate	3.0	4.4	5.4
Hispanic	Live Births	18,014	19,192	19,529
	Deaths	11	25	25
	Mortality Rate	0.6	1.3	1.3
Cuban	Live Births	6,850	7,189	7,449
	Deaths	8	5	5
	Mortality Rate	1.2	0.7	0.7
Puerto Rican	Live Births	1,273	1,203	1,222
	Deaths	0	4	2
	Mortality Rate	0.0	3.3	1.6
Central/South American	Live Births	8,650	9,472	9,444
	Deaths	3	15	13
	Mortality Rate	0.3	1.6	1.4
Mexican/Other Hispanic	Live Births	1,295	1,371	1,428
	Deaths	0	1	5
	Mortality Rate	0.0	0.7	3.5
Haitian	Live Births	1,928	1,842	1,775
	Deaths	5	8	7
	Mortality Rate	2.6	4.3	3.9
Non-Hispanic Others	Live Births	473	485	480
	Deaths	2	0	1
	Mortality Rate	4.2	0.0	2.1
Unknown/Missing	Live Births	456	402	348
	Deaths	0	0	0
	Mortality Rate	---	---	---
All	Live Births	32,568	32,640	32,352
	Deaths	44	68	72
	Mortality Rate	1.4	2.1	2.2
MATERNAL RACE				
White	Live Births	21,966	22,480	22,624
	Deaths	16	30	24
	Mortality Rate	0.7	1.3	1.1
Non-White	Live Births	9,407	8,993	8,546
	Deaths	26	38	46
	Mortality Rate	2.8	4.2	5.4
Other	Live Births	1,064	1,081	1,138
	Deaths	2	0	2
	Mortality Rate	1.9	0.0	1.8
Unknown	Live Births	131	86	44
	Deaths	0	0	0
	Mortality Rate	---	---	---

Source: Resident Infant Deaths from the Florida Department of Health, Office of Vital Statistics.

## **5. Low Birth Weight Births (<2,500 Grams)**

Low birth weight is of great importance to public health because of the strong relationship between birth weight and infant mortality and morbidity. According to the United States Department of Health and Human Services, low birth weight is the risk factor most closely associated with neonatal deaths. Consequently, improvements in infant birth weight can contribute substantially to a reduction in infant death rates. In terms of morbidity, low birth weight children experience a combination of various neurosensory, developmental, and health problems, which compound clinical and educational developmental problems. For example, the rates of cerebral palsy increase as birth weight decreases.

Although many factors are relevant to the occurrence of low birth weight, short gestational age (preterm birth) is obviously a significant cause. Additionally, it is important to note that prior delivery of a preterm infant is a strong predictor of a low birth weight delivery in subsequent deliveries (Obstetrics and Gynecology 1994; 84: 485-489). Adequate prenatal care with support for good nutrition and other maternal health behaviors and effective patient education as to the signs of preterm labor, has been shown to lessen both the risk of low birth weight and preterm birth.

Low birth weight is further classified into categories: low and very low birth weight. Infants weighing less than 2,500 grams at birth (about 5 pound, 9 ounces) are “low birth weight” (LBW) and those weighing less than 1,500 grams (about 3 pounds, 5 ounces) are categorized as “very low birth weight” (VLBW).

The national Healthy People 2010 Objective aims to achieve a reality in which the percentage of low birth weight babies will be no more than 5%, and the percent of very low birth weight infants will be 0.9%. Table 13 illustrates that throughout the 2000-2003 period, non-Hispanic Blacks accounted for the highest rates of low birth weight births when compared to all other ethnic groups.

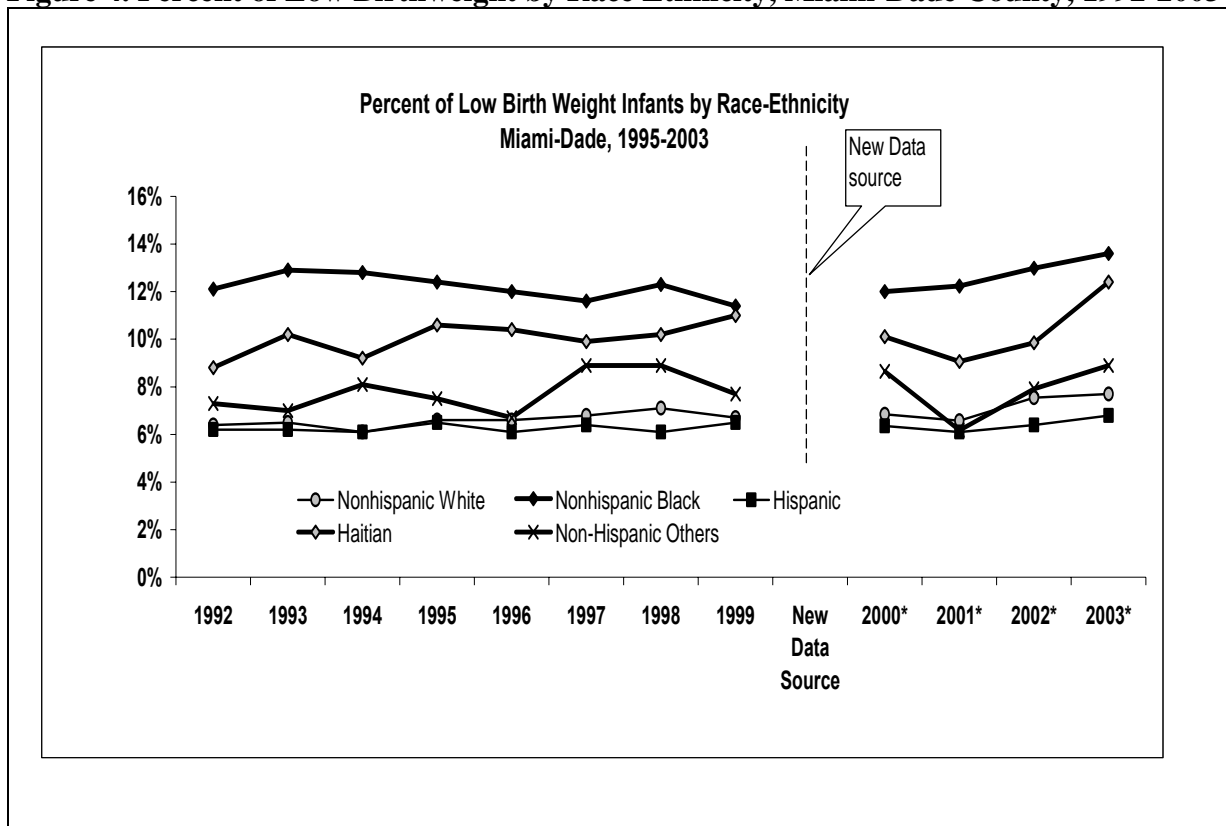
**Table 10. Low Birth Weight Live Births (<2500Grams) by Maternal Race-Ethnicity, 2000-2003**

RACE-ETHNICITY OF MOTHER		2000	2001	2002	2003
Non-Hispanic White	Number	327	272	298	306
	Percent	6.8%	6.6%	7.5%	7.7%
Non-Hispanic Black	Number	833	810	819	833
	Percent	12.0%	12.2%	13.0%	13.6%
Hispanic	Number	1,145	1,172	1,250	1367
	Percent	6.4%	6.1%	6.4%	6.8%
Cuban	Number	424	454	455	506
	Percent	6.2%	6.3%	6.1%	6.6%
Puerto Rican	Number	115	101	112	128
	Percent	9.0%	8.4%	9.1%	9.8%
Central/South American	Number	530	552	596	657
	Percent	6.1%	5.8%	6.3%	6.7%
Mexican/Other Hispanic	Number	81	67	89	76
	Percent	6.3%	4.9%	6.2%	5.9%
Haitian	Number	195	167	175	235
	Percent	10.1%	9.1%	9.8%	12.4%
Non-Hispanic Others	Number	41	30	38	45
	Percent	8.6%	6.2%	7.9%	8.9%
Unknown	Number	22	16	11	11
	Percent	14.2%	12.8%	15.5%	19.0%
All Race-Ethnicity	Number	<b>2,563</b>	<b>2,467</b>	<b>2,591</b>	<b>2,797</b>
	Percent	<b>7.9%</b>	<b>7.6%</b>	<b>8.1%</b>	<b>8.6%</b>

Source: Resident Births from the Florida Department of Health, Office of Vital Statistics.

These data correspond to those published in the Florida Vital Statistics Annual Reports for 2000-2003.

**Figure 4. Percent of Low Birthweight by Race Ethnicity, Miami-Dade County, 1992-2003**



Source: Miami-Dade County Health Department, Office of Epidemiology, 1999; \*Source: Resident Births from the Florida Department of Health, Office of Vital Statistics. These data correspond to those published in the Florida Vital Statistics Annual Reports for 2000-2003.

## 5. Births By Maternal Age

Between 2000 and 2003, the highest percentages of live births occurred among women ages 25-29 years old. Rates were relatively stable with the highest rate within this age group.

An increasing proportion of women ages 35-39 in Miami-Dade gave birth at a rate of 49.1 per 1000 of the population in 2003, an increase from 43.4 in 2000.

Rates of births to teens declined over the past four years in Miami-Dade County and Florida. In Miami-Dade County the birth rate per 1,000 of the population for teenagers less than 15 years, declined from 1.1 in 2000 to 0.8 between 2001 and 2002 then further to 0.7, in 2003. For teens aged 15-17 the rate declined from 28.6 in 2000 to 20.5 in 2003 and among 18-19 year olds, from 73.3 in 2000 to 60.3 in 2003.

When analyzed by age group, 15-19 year olds accounted for 3,508 of total births in 2000. The 10-14 age group accounted for 0.3% in the same year, while live births to 18-19 year olds decreased from 6.7% in 2000 and 2001 to 5.9% of all births to teenagers by 2003. Collectively, these births to teens (10-19 years) represented 3,008 births countywide in 2003, please see the table below.

**Table 11. Resident Live Births, Percent and Rate (per 1,000 women in specified group), by Maternal Age, Miami-Dade County, 2000-2003**

MATERNAL AGE		2000	2001	2002	2003
<= 14	Number	83	61	62	59
	Percent	0.3%	0.2%	0.2%	0.2%
	Rate	1.1	0.8	0.8	0.7
15-17	Number	1,330	1,160	1,071	1,025
	Percent	4.1%	3.6%	3.3%	3.1%
	Rate	28.6	24.3	22.2	20.5
18-19	Number	2,178	2,175	2,074	1,924
	Percent	6.7%	6.7%	6.5%	5.9%
	Rate	73.3	71.6	67.6	60.3
20-24	Number	7,105	7,138	6,855	6,919
	Percent	22.0%	22.0%	21.3%	21.3%
	Rate	97.9	95.9	91.1	87.9
25-29	Number	8,708	8,774	8,646	8,638
	Percent	27.0%	27.1%	26.9%	26.5%
	Rate	106.1	107.9	108.3	107.1
30-34	Number	7,759	7,841	8,084	8,387
	Percent	24.0%	24.2%	25.2%	25.8%
	Rate	89.4	91.4	95.4	96.3
35-39	Number	4,199	4,247	4,339	4,527
	Percent	13.0%	13.1%	13.5%	13.9%
	Rate	43.4	45.0	46.8	49.1
40-44	Number	898	959	927	1,011
	Percent	2.8%	3.0%	2.9%	3.1%
	Rate	10.3	10.7	10.1	10.7
45+	Number	34	68	70	59
	Percent	0.1%	0.2%	0.2%	0.2%
	Rate*	0.17	0.32	0.32	0.27
Unknown	Number	6	2	3	2
	Percent	---	---	---	---
	Rate	---	---	---	---
<b>Total Births</b>	<b>Number</b>	<b>32,300</b>	<b>32,425</b>	<b>32,131</b>	<b>32,551</b>

Source: Florida Department of Health, Office of Vital Statistics. These data correspond to those published in the Florida Vital Statistics Annual Report for 2003.

Source: Florida Department of Health, Office of Vital Statistics. These data correspond to those published in the Florida Vital Statistics Annual Report for 2003. \* Denominator consists of women aged 45-59 years.

The adverse health and socioeconomic consequences of pregnancy and childbearing among teenagers are well recognized. Teenage mothers are more likely than older women to receive inadequate prenatal care and to experience inadequate weight gain during pregnancy, maternal anemia, and pregnancy associated hypertension. Labor and delivery complications such as fetal distress are also reported frequently among teenage mothers. Moreover, babies born to young mothers are at an increased risk of giving birth to babies of low birth weight, preterm birth, newborn anemia, respiratory distress syndrome, meconium aspiration, and assisted ventilation.

### **E. Births to Single Mothers**

In 1999, single mothers, who accounted for 41% of all women who gave birth, delivered a total of 12,900 babies. 13,741 infants were born to single mothers in 2003. The highest geographic concentrations of single mothers were found in Homestead/Leisure City (33030), West Homestead (33034) and Goulds-West (33170) in South Miami-Dade; Central's Downtown (33128, 33130 and 33132), and Overtown community (33136), have the highest rates; and Opa-Locka (33054), Carol City (33056), Little Haiti/Wynwood/Miami (33127),

Allapattah/Brownsville/Melrose/Liberty City (33142), Liberty City (33147), Miami Shores/El Portal (33150) and Westview/Lakeview/North Miami/Pinewood (33167) in North Miami-Dade are the highest ranking areas with rates ranging from 56.8% or higher for all births.

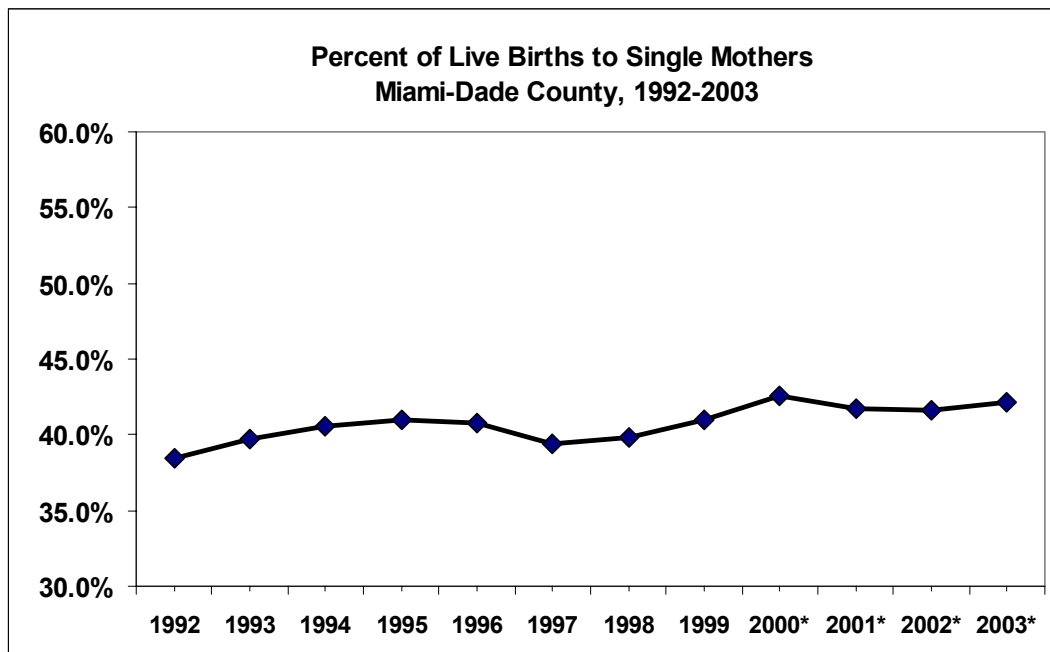
**Table 12. Percent of Live Births by Marital Status Miami-Dade County, 1992-2003**

MARITAL STATUS		1997	1998	1999	2000*	2001*	2002*	2003*
Unmarried	Number	12,344	12,580	12,900	13,742	13,522	13,362	13,741
	Percent	39.4%	39.8%	41.0%	42.5%	41.7%	41.6%	42.2%
Married	Number	18,956	19,048	18,586	18,548	18,893	18,769	18,809
	Percent	60.5%	60.2%	59.0%	57.4%	58.3%	58.4%	57.8%
Not Classified	Number	7	4	1	10	10	---	1
	Percent	---	---	---	---	---	---	---

Source: Miami-Dade County Health Department, Office of Epidemiology, 1999

\*Source: Resident Births from the Florida Department of Health, Office of Vital Statistics. These data correspond to those published in the Florida Vital Statistics Annual Reports for 2000-2003.

**Figure 5. Percent of Live Births to Single Mothers Miami-Dade County, 1992-2003**



Source: Miami-Dade County Health Department, Office of Epidemiology, 1999.

\*Source: Resident Births from the Florida Department of Health, Office of Vital Statistics. These data correspond to those published in the Florida Vital Statistics Annual Report for 2000-2003.

## **D. Overview of Key Findings**

In conclusion, a review of the data from the 2005 Needs Assessment reveals the following challenges:

- A highly diverse population will require increasingly culturally competent services.
- The proportion of uninsured individuals in Miami-Dade is higher than state and national averages; lack of insurance can be a significant barrier to accessing health care services.
- A significant proportion of families (31%) have annual incomes of \$25,000 or less, suggesting that socioeconomic status and related poor health outcomes are a significant issue for the Coalition's service population.
- Non-Hispanic Black and Haitian women experience higher rates of infant mortality, preterm birth and low birth weight than women of other ethnicities.
- An increasing number of births are occurring in women over the age of 35, who are at increased risk for complications of pregnancy.
- The teen birth rate is declining, but is still significantly higher than Healthy People 2010 objectives. Pockets of increased teen pregnancy rates are found in targeted zip codes across Miami-Dade.

These challenges are virtually identical to those found in the 2001 Needs Assessment, and reflect demographic and health status trends that will continue to drive the development and delivery of maternal, infant and child services in Miami-Dade County.

### III. MAJOR HEALTH INDICATORS SELECTED FOR THE NEW PLANNING CYCLE

Health indicators are standard measures that allow us to cross-reference and compare various populations, such as infant mortality or life expectancy.

The data reported in this section were obtained from various sources, each one noted at the bottom of each data table as well as acknowledged in the Acknowledgements section of this document. Please note that numbers may differ slightly from those reported in the Florida Department of Health Annual Reports, due to methodological differences in “cleaning” the data. Slight variations, which are not statistically significant, may also be evident due to the use of either the Official Single Year Birth or Death files, versus the Official Linked Birth and Death Files.

Indicator data for 2003 were ranked by zip code from the poorest to best health outcome for those areas in which 200 or more births occurred. The Data Committee designated seven health indicators to be reviewed: late/no prenatal care, birth to teens, births to unwed mothers, preterm births, low birth weight births, fetal mortality, and infant mortality. The Committee determined that these seven indicators would capture the greatest number of contributing factors, and mothers and babies at risk

**Table 13. Seven (7) Critical Health Indicators, Miami-Dade County, 2003**

Health Indicators	Number	Percent/Rate
Late/No Prenatal Care	511	1.6%
Births to Teens (10-19)	2,985	9.2%
Births to Unwed Mothers	10,733	33.3 %
Preterm Births	3,248	10.1 %
Low Birth Weight Births	2,766	8.6 %
Fetal Mortality	278	8.6*
Infant Mortality	193	6.0*

\* Fetal Mortality Rate and Infant Mortality Rate per 1,000 live births  
 Source: Florida Department of Health - Office of Planning, Evaluation & Data Analysis

Out of the seven critical health indicators identified by the Data Committee, three were selected for the action planning process: infant mortality, low birth weight and preterm delivery. The data Committee selected these indicators based on findings from the 2005 Needs Assessment, the mission of the Coalition, and input from the community. Additionally, there are associations among these three birth outcomes; therefore, efforts designed to reduce rates of one may have an ancillary impact on others, particularly since the other indicators (i.e. late/no prenatal care) can affect all three outcomes. Targeting these three indicators enables the Coalition to use resources efficiently to address major health issues. The prevalence of the risk factors associated with infant mortality, low birth weight and pre-term delivery will be presented in this document. In addition to the three birth outcome health indicators, the Coalition also decided to focus on indicators of performance for the Coalition, including screening rates. The major health indicators selected for this SDP are virtually identical to those in the previous SDP, as these major health issues remain a serious concern for the Miami-Dade community.

## **A. Infant Mortality (Neonatal and Postnatal)**

### **1. Data, Trends and Risk Factors**

Infant mortality is often considered the primary indicator of the health of a nation because of its association with a variety of factors such as maternal health, quality and access to medical care, socioeconomic conditions and public health practices. In the State and also Miami-Dade County infant mortality rates are the lowest in recorded history, but as conditions continue to improve, we must strive to make greater efforts to reduce the number of infant deaths.

#### Trends and Statistics: Nationally

Throughout the twentieth century, infant mortality has been decreasing but in 2002, the rate increased from 6.8 (per 1,000) to 7.0 (per 1,000) making it the first increase in infant mortality within the United States in over forty years. Using the linked infant mortality and live birth files, researchers argue that this increase is primarily concentrated within the neonatal period (Kochanex et al 2004; MacDorman et al 2005; Matthews et al 2004). With the exception of American Indian mothers, infant mortality increased for all races/ethnicities in 2002 (MacDorman et al 2005).

Research using the linked files demonstrated that infant mortality significantly increased among two of the leading causes of death: 1) disorders related to short gestation and low birthweight; and 2) newborns affected by maternal complications of pregnancy. Nearly all of the infant deaths from these two causes during 2002 occurred among very low birthweight infants (98% and 95% respectively) and together with the evidence of the majority of deaths occurring during the early neonatal period, researchers have concluded that birth weight may be the most important variable in the increase in infant mortality from 2001 to 2002 (MacDorman et al 2005).

#### Trends and Statistics: Miami-Dade County

Infant mortality rates in Miami-Dade County also reflect this increase. Rates reached a historical low of 5.1 per 1,000 in 1999, yet steadily increased to 5.8 per 1,000 in 2000 and 2001 and 5.9 per 1,000 in 2002. Deaths among neonates accounted for 67.9% of infant deaths in Miami-Dade County for 2002 while rates remained highest among Non-Hispanic Blacks in Miami-Dade. (Maternal and Infant Health Indicators: Highlights in Miami-Dade County, 2002).

Geographic areas with high rates of infant mortality include (33032) Homestead/Redland/Princeton, (33034) Homestead/Florida City, (33170) Goulds/Quail Heights in South Miami-Dade; (33128) Downtown, (33131) Downtown/Bayfront, (33136) Overtown, (33143) Coral Gables/South Miami in Central Miami-Dade; and (33054 and 33056) Opa Locka, (33137) Morningside/Wynwood/Little Haiti, (33047) Liberty City, (33167) Miami Shores and North Miami and (33169) North Miami Beach in North Miami-Dade all with rates of 8.4 or higher.

### **2. Gaps and Needs**

- Lack of family planning and interconceptional education, particularly focusing on women's health between and before pregnancies
- Insufficient knowledge regarding the benefits of folic acid consumption during pregnancy leading to insufficient folic acid consumption
- Lack of or inadequate prenatal care

- Lack of knowledge regarding adequate and recommended infant sleeping position
- Smoking and second hand smoke exposure during pregnancy and in home in which children reside
- Lack of adequate documentation regarding the circumstances surrounding sudden infant death syndrome (SIDS) death
- Education regarding the prevention of both unintentional injury and intentional injury, including but not limited to motor vehicle accidents and household safety
- Lack of provider and parental training and education regarding Shaken Baby Syndrome
- Cultural barriers affecting access to appropriate care during pregnancy
- Lack of adequate identification of postpartum depression and post-partum follow-up.

## **B. Low Birth Weight**

### **1. Data, Trends and Risk Factors**

An infant's weight at birth is considered one of the most important predictors of its survival chances. Infants born less than 2,500 grams (5 lbs, 8 oz) are considered low birth weight (LBW) and in turn, those born weighing less than 1,500 grams (3 lbs, 4 oz) are considered very low birth weight (VLBW). LBW infants are either preterm (less than 37 weeks gestation) or small for gestational age (SGA), which is weighing in the smallest 10<sup>th</sup> percentile for gestational age. In the 1970's researchers began to focus on the small for gestational age (SGA) infants by designating them as the result of intrauterine growth retardation (IUGR), therefore recognizing that these infants are not LBW because they were born preterm, but instead are considered smaller than fetuses of the same gestational age (Wilcox, 2002).

Low birth weight is one of the greatest contributors to infant mortality and morbidity in the United States. Neonatal death is 40 times more likely among LBW infants and 200 times more likely among VLBW infants, as well as being at increased risk for neurological problems such as cerebral palsy, mental retardation, and lower respiratory tract conditions (Kiely et al 1994:185). Low birth weight has also been found to be associated with increased risk for childhood cancers (Daling et al 1984; Okcu et al 2002).

#### Trends and Statistics: Nationally

The number of infants born low birthweight declined in the United States from 1970 to 1980, but has been increasing slowly for the past 25 years (MacDorman et al 2005; Martin et al 2002). During 1980 and 2000, the percentage of LBW infants increased 11.8% and the number of VLBW infants increased 24.3% (MMWR 2002:589). Most recent estimates designate 1.5% of all births as VLBW and 7.8% as LBW during 2002 in the United States (MacDorman et al., 2005:15; NVSR 2003:89).

#### Trends and Statistics: Miami-Dade County

Similar to LBW rates in the nation, rates of infants born at low birth weights are on the rise in Miami-Dade County. The percent of LBW infants increased to 8.1% in 2002 from 7.9% in 1999 and up from 7.8% in 1991. Miami-Dade County continues to be higher than the national average—the rate of LBW nation wide was 7.6% in 1999 and 7.1% in 1999. Comparable to the increasing rates nationwide, when broken down by maternal race/ethnicity, most groups experienced a slight increase in low birth weight (non-Hispanic White; non-Hispanic Black). In Miami-Dade County, the percentage of infants born of low birth weight remained highest among

non-Hispanic Blacks, at 13% in 2002. In contrast, rates among Hispanic mothers remained relatively stable while they decreased among Haitian mothers; from 11% in 1999 to 9.8% in 2002 (Florida Department of Health 2002).

## **2. Gaps and Needs**

- Tobacco Use/Smoking education regarding use and exposure during and after pregnancy
- Lack of adequate treatment for drugs and alcohol abuse during pregnancy
- Poor maternal weight: pre-pregnancy and prenatal underweight and obesity
- Inadequate utilization of prenatal care
- Lack of education to pregnant women about the effects of tobacco/smoking
- Lack of education to pregnant women about the effects of drugs and alcohol
- Lack of screening by the prenatal care providers
- Lack of knowledge regarding adequate nutrition during pregnancy
- Lack of adequate referrals during pregnancy for obese pregnant women
- Undocumented women having little or no access to prenatal care
- Lack of transportation to obtain essential services, including prenatal care and other psycho-social services
- Vaginal, urinary tract infections and sexually transmitted diseases, coupled with lack of screening, identification and treatment of infections
- Inadequate baby-spacing and lack of adequate family planning services and interconceptional care education

## **C. Preterm Births**

### **1. Data, Trends and Risk Factors**

Most pregnancies last around 40 weeks. Babies born between 37 and 42 weeks of pregnancy are called full term. Babies born before 37 completed weeks of pregnancy are called premature or preterm. About 12 percent of babies in the United States are born preterm. Of those, the majority (84 percent) are born between 32 and 36 weeks of gestation. About 10 percent are born between 28 and 31 weeks of gestation, and about 6 percent are born at less than 28 weeks of gestation (March of Dimes, accessed on March 1, 2006 at [http://www.marchofdimes.com/prematurity/5196\\_5799.asp](http://www.marchofdimes.com/prematurity/5196_5799.asp)).

It is important to recognize the difference between preterm and birthweight, which led the National Council for Health Statistics to refine the World Health Organization's definition: "Infants who are premature because of curtailed gestation (gestational age < 37 completed weeks) are designated 'preterm'... Infants who are premature by virtue of birthweight (2500 grams or less at birth) are designated 'low birth weight infants'" (Blackmore and Rowley 1994: 179). Preterm delivery is considered one of the predominant proximate causes of low birth weight, and together with LBW, is one of the leading causes of infant mortality.

The three causes of preterm delivery are thought to be: (1) preterm spontaneous labor, (2) premature rupture of membranes (PROM), and (3) medically indicated preterm birth due to maternal or fetal indication (Moutquin, 2003; Mattison et al., 2001). Spontaneous preterm labor accounts for the majority of preterm births, with some researchers estimating close to 50% of preterm births are spontaneous. PROM and medically indicated preterm birth account for 25% of preterm births each (Moutquin, 2003).

Infants born preterm currently have an increased chance of survival than in the past, largely due to significant technological advances in neonatal intensive care units (NICUs). Some of the most important advances include the increased usage of assisted ventilation in the delivery room and surfactant therapy (Petrou, 2003). Most preterm infants born at < 32 weeks gestation will remain in the NICU until close to term in order to allow their organs to mature so that infants can survive independently of intensive care. Due to the immaturity of organ systems in preterm births, infants face increased risk of complications (Ward and Beachy, 2003). Yet while technological advances in NICU have decreased the overall cases of mortality, some researchers argue that these advances also increase long-term disability through sustaining infants whose chances of survival were negligible before the development of the NICU (Doyle et al., 1989; Lorenz et al., 1998).

Moreover, although medical technology has improved the chance of survival of preterm babies, they are still more likely to suffer from a series of serious complications including but not limited to (as listed by the March of Dimes):

- **Respiratory distress syndrome (RDS).** About 24,000 babies a year - most of who were born before the 34th week of pregnancy - suffer from this breathing problem. Babies with RDS lack a protein called surfactant that keeps small air sacs in the lungs from collapsing.
- **Apnea.** Premature babies sometimes stop breathing for 20 seconds or more. This interruption in breathing is called apnea, and it may be accompanied by a slow heart rate. Premature babies are constantly monitored for apnea. If the baby stops breathing, a nurse will stimulate the baby to start breathing by patting him or touching the soles of his feet.
- **Intraventricular hemorrhage (IVH).** Bleeding in the brain occurs in some very low birthweight babies, with the most premature babies at highest risk. The bleeds usually occur in the first three days of life and generally are diagnosed with an ultrasound examination.
- **Patent ductus arteriosus (PDA).** PDA is a heart problem that is commonly seen in premature babies. Before birth, a large artery called the ductus arteriosus lets the blood bypass the lungs because the fetus gets its oxygen through the placenta.
- **Necrotizing enterocolitis (NEC).** Some premature babies develop this potentially dangerous intestinal problem (usually 2 to 3 weeks after birth), which leads to feeding difficulties, abdominal swelling and other complications.
- **Retinopathy of prematurity (ROP).** ROP, an abnormal growth of blood vessels in the eye, occurs mainly in babies born before 32 weeks of pregnancy. It can lead to bleeding and formation of scars that can damage the retina of the eye, sometimes resulting in vision loss and blindness.
- **Jaundice.** Premature babies are more likely than full-term babies to develop jaundice because their livers are too immature to remove a waste product called bilirubin from the blood. In addition, premature infants may be more sensitive to the ill effects of excess bilirubin.
- **Anemia.** Premature infants often are anemic, which means they do not have enough red blood cells.
- **Chronic lung disease (also called bronchopulmonary dysplasia).** Chronic lung disease most commonly affects premature infants who require ongoing treatment with supplemental oxygen at 36 weeks postmenstrual age (after conception).

- **Infections.** Premature babies have immature immune systems that are inefficient at fighting off bacteria, viruses and other organisms that can cause infection. Serious infections that are commonly seen in premature babies include pneumonia (lung infection), sepsis (blood infection), and meningitis (infection of the membranes surrounding the brain and spinal cord).

#### Trends and Statistics: Nationally

The percentage of preterm births rose from 12.1% to 12.3% during 2002 to 2003. This increase follows the trend that has been occurring for the past 13 years, up 16% since 1990. Although many researchers are speculating that this increase is likely the result of the growth in multiple births which are more likely to be delivered preterm (Hamilton et al 2004), there are a myriad of other reasons that are yet unknown. Importantly, it should be noted that since, 1981 when the trend switched from an overall decline in premature births, there has been a 33% increase in the rate of prematurity. Furthermore, by 2003, almost half a million babies in the US were born prematurely

#### Trends and Statistics: Miami-Dade County

The rates of preterm births in Miami-Dade have fluctuated over eight years. From 1992 to 1997, there was a decline in preterm births from 10.6% to 9.5%. The preterm birth rates increased in 1998 to 10.3%, but declined in 1999 to 9.8%. Seven zip code areas in North Miami-Dade, two in Central Miami-Dade, and three in South Miami-Dade had high rates of preterm births.

In Miami-Dade, nearly 10% of all mothers who gave birth in 1999 experienced a preterm birth. From 2000-2003, this rate remained somewhat constant and experienced a negligible increase to 10.1% in 2003. In 1999, the percentage rate for non-Hispanic Whites was 8.4%; non-Hispanic Blacks, 13.0%; Hispanics at 8.7% and Haitians at 11.9%. By 2003, these rates increased to 8.5%, for non-Hispanic whites, 14.4% non-Hispanic blacks and 14.9% for Haitians while the rate among Hispanics declined to 8.6%. By age group, the rates of preterm births hovered between a low of 9.5% among 20-34 year olds and a high of 15.3% among 10-14 year olds of all known racial/ethnic groups.

The 45+ age group experienced the highest percentages of preterm live births between 2000 and 2003, however these numbers must be interpreted with caution since the number of live births among this group is not very large in comparison to other age groups. This rate fluctuated throughout the period but reached its lowest at, 12.9 in 2002 and its highest at 30.5% in 2003. The 40-44 year old group also experienced its highest percentage at 13.9% in 2003 and its lowest, 11.2% in 2002. The lowest recorded rate of all age groups was 8.7% which occurred among the 25-29 year old group in 2001. In fact, this group accounted for the lowest rates of all age groups in the period.

In 2003 the highest rates of preterm births were in Homestead/Naranja (33033), Perrine (33187) and Cutler Bay (33189) in South Miami-Dade; Overtown (33136) and Downtown (33130) in Central; and Opa Locka/Carol City (33056), Opa Locka (33054) Little Haiti/Wynwood (33172 and 33137), Liberty City (33147), North Miami (33167) in North Miami-Dade.

Please Note: that the above areas have been selected from our geographic priority areas which exclude zip codes with less than 200 births and with less than 4 of the seven (7) health indicators.

## 2. Gaps and Needs

- Socioeconomic status greatly impacts on tendency to seek prenatal care. As a result pregnant women of a relatively lower socio-economic status are less informed and less likely to appreciate the importance of prenatal care
- Lack of insurance and ineligibility for Medicaid, prevent many women from accessing prenatal care
- Factors such as domestic abuse and stress, drugs and alcohol consumption, and chronic medical conditions, often result in low maternal weight gain
- Lack of knowledge about the effects of smoking on fetal development and birth outcome
- Lack of knowledge about the effects of diabetes and failure to seek appropriate surveillance and care throughout pregnancy
- Lack of knowledge about the effects of hypertension and failure to seek appropriate surveillance and care throughout pregnancy
- Unmarried women are more predisposed to delivering premature and low weight babies because they often lack the support system afforded to married women
- Lack of knowledge about the negative effects of tobacco, alcohol, and drug use on fetal development
- Lack of adequate family planning services often lead to repeat births among teens
- Lack of interconceptional care education often results in preterm and low weight babies because women do not get the opportunity to recover from previous pregnancies
- Incomplete or high school education often reduces the earning power of women thus, creating barriers to accessing proper pre and post natal care, such as inflexible job schedule and inability to access child day care services
- Lack of parental/social support often leads to stress which subsequently increases the risk of a poor birth outcome
- Lack of transportation prevents many pregnant women from attending prenatal care appointments
- Poor nutrition due to ignorance about the nourishment needed to sustain healthy pregnancies as well as an inability to purchase the appropriate food
- Lack of awareness about the general life styles changes needed to sustain a healthy pregnancy
- Cultural norms and behaviors as well as ignorance often cause women to neglect the instructions given by doctors
- Inappropriate dietary habit often among obese pregnant women increases the risk of a poor birth outcome
- Financial insecurity acts as a barrier to seeking proper health care throughout pregnancy
- Lack of screening by the prenatal providers contributes to infant mortality, since risks are not identified and preemptive measures; Healthy Start services are not administered

## D. Healthy Start System

### 1. Prenatal Screen Offer Rates

Table 14 lists the Healthy Start prenatal screening rates by the priority zip codes. Medical providers in North Miami-Dade region were doing a better job of offering prenatal screens to pregnant women than their counterparts in the regions of Central and South Miami-Dade. As a result, the screening rates were higher than the county rate in 2000. In Central Miami-Dade, the Coconut Grove/Coral Gables (33133) had an especially low offer rate (29.1%) as did the Kendall/South Miami/Sunset area (33173, 26.6%). Several zip codes in South Miami-Dade had lower than average prenatal screen offer rates, with both Kendall/Crossings (33186) and Kendall/Hammocks (33196) having the lowest in South Miami with 30.5% and 30.4% respectively.

**Table 14. Live Births and HS Prenatal Screen Offer Rates <sup>1</sup>, Miami-Dade County, 2003**

Zip Codes	Live Births	Prenatal Screens Offered	Prenatal Screen Offer Rate
<b>North Miami-Dade</b>	<b>Total</b>	<b>Number</b>	<b>%</b>
33054 Opa-Locka	493	367	74.4%
33147 Liberty City	824	565	68.6%
33127 Little Haiti/Wynwood	518	340	65.6%
33137 Little Haiti/Morningside/ Wynwood	236	166	70.3%
33167 Westview/Lakeview/ N.Miami/Pinewood	297	184	62.0%
<b>Central Miami-Dade</b>			
33125 Allapattah/Melrose	655	357	54.5%
33130 Downtown	278	164	59.0%
33133 Coconut Grove/Coral Gables	368	107	29.1%
33135 Little Havana	422	251	59.5%
33136 Overtown	261	162	62.1%
33173 Kendall/South Miami/Sunset	369	98	26.6%
33174 Sweetwater	350	127	36.3%
33193 Kendall/Sunset	636	206	32.4%

<b>South Miami-Dade</b>			
33030 Homestead	788	649	82.4%
33032 Homestead/Redland/Princeton/Naranja	432	246	56.9%
33033 Homestead/Leisure City/Naranja	555	287	51.7%
33034 West Homestead	351	181	51.6%
33157 Richmond/Perrine/Cutler Ridge	898	398	44.3%
33176 Kendall	598	212	35.5%
33177 South Miami Heights/Perrine	771	294	38.1%
33186 Kendall/Crossings	885	270	30.5%
33187 Perrine	213	70	32.9%
33189 Cutler Bay (Ridge)	323	160	49.5%
33196 West Kendall/Hammocks	647	197	30.4%
<b>Miami-Dade County</b>	<b>32,277</b>	<b>22,809</b>	<b>70.7%</b>

<sup>1</sup> Prenatal Screen data only include women who were residents of Miami-Dade County at the date of screening, between January and December of 2004; the number of Live Births is from Section II.B.

## 2. Gaps and Needs

- Conduct a secondary database evaluation of Healthy Start services to compare the risk factors and birth outcomes of participants vs. non-participants
- Increases in the prenatal risk screen and postnatal risk screen rates are still needed to achieve the 100% required by Florida statute
- Targeted and enhanced in-service training, outreach, and education and marketing need to be conducted with prenatal care providers and birth facilities in these zip codes
- Increase the general community's awareness of the Healthy Start Program, its availability and benefits
- There is a need to analyze the level of Healthy Start services by region and providers
- Closer examination of certain risk factors, specifically but not limited to, births to unwed mothers to determine what indirect factors are associated with being unwed during pregnancy
- Closer review of the zip code areas with 6 or 7 of the critical risk factors and examination with health service issues in communities that the Healthy Start Program can impact positively

## E. Overall County Priorities - Race/Ethnicity Disparities Reduction

Overall, it is evident from the data prepared for the SDP that Non-Hispanic Black and Haitian women have a higher rate of almost all of the risk factors designated as critical for evaluating risk among a given population. Furthermore these two groups also have disproportionately higher rates of births to teens, low birth weight, preterm birth, fetal mortality and infant mortality. In order to address these racial/ethnic disparities the Coalition has developed two new strategies included in Category B. Furthermore, any subsequent strategies or expansion of

current strategies will focus on decreasing the current racial/ethnic disparities among these critical health indicators among these populations in Miami-Dade County.

In an attempt to address these racial/ethnic disparities among Non-Hispanic Black and Haitian communities we will be guided by both the data presented earlier in this document, the results from the community perspectives and the Health Problem Analysis below. Please note that the Health Problem Analysis was developed for the 2002-2005 Service Delivery Plan, and included substantial time and labor investments from staff and SDP Committee members. Although significant improvements have been made in the rates of infant mortality among non-Hispanic Blacks, the problems identified below which are associated risks and contributing factors, are still relevant to the current needs of the County. Coalition staff has modified the activities recommended for addressing the contributing factors to more closely reflect the maturity and capacity of the Coalition and HSCPs. Furthermore, a cross-reference with the strategies and activities in Category B denote that the majority, if not all of these activities are addressed in those sections.

#### IV. TARGET POPULATION /AREAS OF SPECIAL EMPHASIS

The primary goals of the *Healthy Start Coalition of Miami-Dade* as documented in the 2002-2005 SDP are to:

- reduce infant mortality
- reduce the number of low birth weight and pre-term births
- improve maternal and child health developmental outcomes.

Furthermore, the populations with the highest percentage of risk factors and poor birth outcomes, including infant deaths, continue to be non-Hispanic Blacks and Haitians, although notable improvements have been made in the infant mortality rate among the former. Zip code specific data tables at the end of this section have been used for designating and identifying the primary target areas.

A review of data and health indicators by geographic area is essential when determining how and where to focus additional services in any given community. Socioeconomic and environmental factors that place women and infants at greater risks and lead to significantly poorer health outcomes may readily cluster within geographic neighborhoods. The Healthy Start Needs Assessment 2005 process has therefore included an analysis of health outcome indicators by zip code.

A zip code level analysis of these seven critical indicators was performed to allow the Committee to apply the standard of measure in order to identify geographic priority areas of need. Based on their analysis of the data, the Committee designated the following zip codes as priority areas of concern:

**Table 15. Top Ten (10) Priority Areas**

Priority Areas		
	Zipcode	Neighborhood
NORTH	33054	Opa Locka
	33056	Carol City
	33147	Liberty City
	33162	North Miami Beach/North Miami
	33167	Liberty City/Opa Locka
	33168	Miami Shores/Little Haiti
CENTRAL	33128	Little Havana
	33136	Overtown
SOUTH	33032	Homestead
	33034	Florida City
	33170	Goulds

**NOTE: Zip Codes 33032 and 33034 are being considered as one geographic area for the purpose of this report.**

These zip code areas/neighborhoods were subsequently designated to be included in the community perspectives section of this document, which included the completion of a focus group, collection of a standard questionnaire at each focus group and a summary of the findings as presented in the section on consumer and provider perspectives. Coalition staff identified community-based organizations or facilities in nine of the above listed zip code areas, since some of the neighborhoods had significant overlap.

The tables on the following pages show the prevalence of risk factors in priority communities, as well as their relative rank.

In North Miami, the previous Service Delivery Plan showed zip code 33054 (Opa-Locka) as having the highest infant mortality rate. The current plan prioritizes zip code 33167 (Westview/Lakeview/N. Miami/Pinewood) with the highest Infant Mortality rate in North Miami-Dade.

In Central Miami, zip code 33136 (Overtown) had the highest infant mortality rate in both 2001 and 2005; it has been designated a priority area in both the 2002-2005 and 2006-2011 SDPs.

For South Miami, the previous SDP established zip code 33035 (Florida City) as a priority area with the highest infant mortality rate. Currently, zip code 33032 has the highest infant mortality rate in the southern part of the county.

**Table 16. Geographic Priority Areas in North Miami-Dade County**

N o r t h			Births to Unwed Mothers	Rank	Births to Mothers Age 10-19	Rank	Low Birth Weight Births (<2,500 grams)	Rank	Gestation <37 Weeks (PTD)	Rank	Late/No PNC	Rank	Fetal Mortality Rate	Rank	Infant Mortality Rate	Rank	Total Risk Factors (Out of 7)
	Zip Code	Total Live	Percent		Percent		Percent		Percent		Percent		Rate		Rate		
	33054	493	72.8%	3rd	21.9%	2nd	15.8%	1st	18.3%	5th	3.7%	3rd	16.2	5th	8.1		6
	33055	686	54.8%	9th	12.0%	8th	10.1%		8.6%		2.8%	8th	14.6	10th	5.8		4
	33056	547	71.7%	5th	16.1%	6th	13.3%	4th	19.9%	4th	2.2%		14.6	9th	16.5	2nd	6
	33127	518	72.2%	4th	17.6%	4th	12.5%	7th	13.3%		2.7%	9th	23.2	1st	9.7	8th	6
	33137	236	53.0%	10th	7.6%		14.0%	2nd	33.1%	1st	2.1%		12.7		12.7	3rd	4
	33147	824	76.2%	1st	22.0%	1st	11.5%	9th	11.3%		3.3%	5th	13.3		12.1	5th	5
	33161	910	50.1%		8.7%		11.1%	10th	11.4%		3.1%	6th	17.6	4th	8.8	10th	4
	33167	297	63.0%	7th	17.2%	5th	13.5%	3rd	31.0%	2nd	3.0%	7th	*		16.8	1st	6
	33168	398	52.3%		10.3%		12.6%	6th	13.8%	10th	2.3%		15.1	8th	12.6	4th	4
	33169	620	61.1%	8th	9.8%		13.2%	5th	6.8%		4.2%	1st	17.7	3rd	11.3	6th	5
	33181	299	36.5%		5.4%		7.0%		14.7%	9th	2.7%	10th	20.1	2nd	*	7th	4

**Table 17. Geographic Priority Areas in Central Miami-Dade County**

C e n t r a l	Zip Code	Total Live Births 2003	Births to Unwed Mothers	Rank	Births to Mothers Age 10-19	Rank	Low Birth Weight Births (<2,500 grams)	Rank	Gestation < 37 weeks (PTD)	Rank	Late/No PNC	Rank	Fetal Mortality Rate	Rank	Infant Mortality Rate	Rank	Total Risk Factors (out of 7)
			Percent		Percent		Percent		Percent		Percent		Rate		Rate		
	33125	655	57.7%	4th	12.7%	2nd	6.7%		9.2%		1.8%	2nd	9.2	6th	7.6	6th	5
	33130	278	60.4%	2nd	11.9%	3rd	4.7%		11.2%	6th	1.8%	3rd	*		*		4
	33133	368	32.3%	9th	5.2%		6.3%		10.1%	10th	1.4%	5th	13.6	1st	*	4th	5
	33135	422	58.8%	3rd	11.6%	4th	6.2%		9.2%		1.4%	4th	*		*	10th	4
	33136	261	73.9%	1st	20.3%	1st	16.9%	1st	20.7%	1st	3.4%	1st	*		26.8	1st	6
	33173	369	24.9%		4.6%		10.8%	3rd	12.2%	4th	*		10.8	4th	*	9th	4
	33174	350	37.4%	7th	8.3%	5th	7.7%	8th	9.4%		*		*	8th	*	3rd	5
	33193	636	28.9%		5.8%	10th	7.5%	10th	10.5%	9th	1.1%	7th	*		*		4

**Table 18. Geographic Priority Areas in South Miami-Dade County**

S o u t h	Zip Code	Total Live Births 2003	Births to Unwed Mothers	Rank	Births to Mothers Age 10-19	Rank	Low Birth Weight Births (<2,500 grams)	Rank	Gestation < 37 Weeks (PTD)	Rank	Late/No PNC	Rank	Fetal Mortality	Rank	Infant Mortality	Rank	Total Risk Factors (Out of 7)
			Percent		Percent		Percent		Percent		Percent		Rate		Rate		
	33030	788	66.1%	1st	19.3%	2nd	7.7%	8th	7.7%	10th	4.1%	1st	6.3	9th	*	8th	7
	33032	432	57.6%	4th	17.1%	4th	9.3%	2nd	9.3%	7th	1.4%	7th	13.9	2nd	9.3	1st	7
	33033	555	58.7%	3rd	17.5%	3rd	7.4%	9th	10.3%	2nd	1.4%	6th	7.2	6th	7.2	4th	7
	33034	351	65.5%	2nd	20.2%	1st	10.8%	1st	9.7%	5th	3.1%	2nd	*	5th	8.5	2nd	7
	33157	898	43.1%	5th	10.4%	5th	9.0%	3rd	9.8%	4th	2.0%	4th	8.9	4th	7.8	3rd	7
	33176	598	30.3%	8th	6.9%	9th	8.0%	6th	7.9%	9th	1.2%	8th	6.7	7th	*	10th	7
	33177	771	37.1%	7th	9.2%	8th	5.8%		6.9%		1.6%	5th	6.5	8th	*		4
	33186	885	21.2%	10th	3.7%	10th	7.9%	7th	9.6%	6th	0.5%	9th	*		*	9th	6
	33187	213	23.9%	9th	9.9%	7th	7.0%	10th	10.3%	1st	0.0%		18.8	1st	*	7th	6
	33189	323	39.3%	6th	10.2%	6th	8.4%	4th	9.9%	3rd	2.2%	3rd	12.4	3rd	*	5th	7
	33196	647	19.9%		2.8%		8.0%	5th	9.0%	8th	*	10th	6.2	10th	6.2	6th	5

## V. FACTORS CONTRIBUTING TO THE HEALTH STATUS INDICATORS IN THE TARGET POPULATION

### A. Prenatal Care

#### 1. Quantity: Accessing Prenatal Care Services

A positive correlation between the use of prenatal services and birth outcomes has been widely documented. Many researchers have suggested that the beneficial impact of adequate prenatal care is strongest among socially disadvantaged women. Prenatal care should be initiated as early as possible and should continue throughout pregnancy. In fact, since 1965, the American College of Obstetricians and Gynecologists has recommended that pregnant women receive at least 13 visits during a full-term pregnancy.

#### 2. Timing: Prenatal Care within the First Trimester

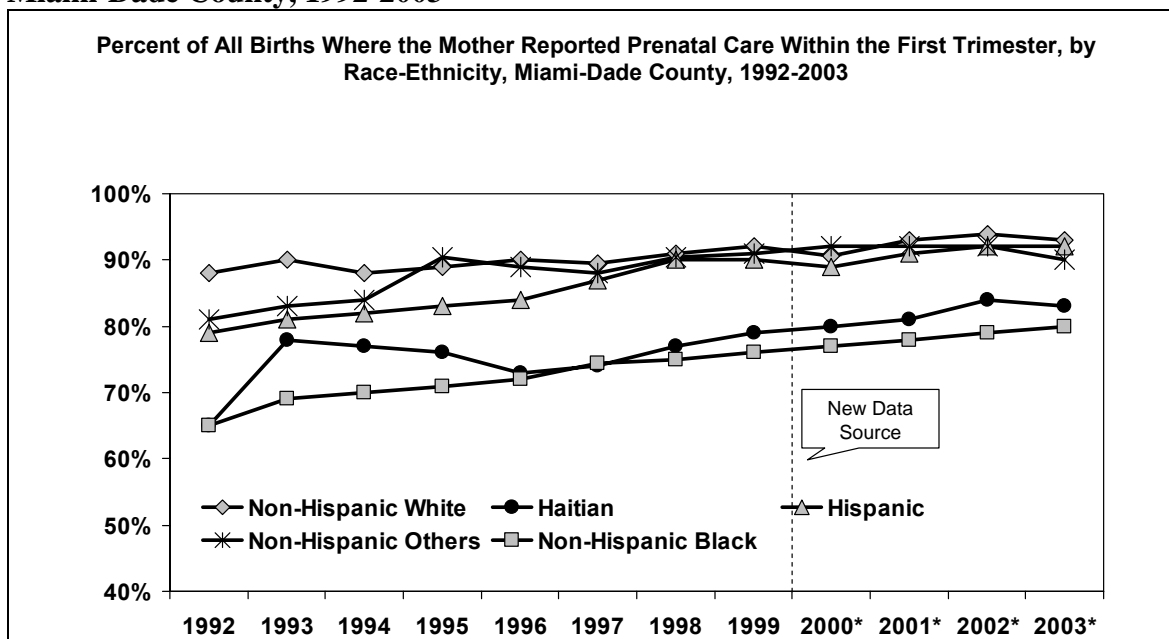
The Florida Department of Health reported that in 2000, 90.6% of the population of pregnant women who sought prenatal care in the first trimester was non-Hispanic White. By 2003, this rate increased to 93.2% and was closely followed by the rate for Hispanics, which increased from 89.2 to 91.6% in the same period. Within the Hispanic population, Cubans had the highest rate of timely initiation: 94.8% in 2003. Timely initiation within the Haitian population increased from 80.0% in 2000 to 83.4% in 2003.

**Table 19. Percent of All Births in which Mother Reported Prenatal Care Within the First Trimester by Race-Ethnicity, Miami-Dade County 2000-2003**

RACE-ETHNICITY OF MOTHER	2000	2001	2002	2003
	Percent	Percent	Percent	Percent
Non-Hispanic White	90.6%	92.6%	93.6%	93.2%
Non-Hispanic Black	77.0%	78.0%	78.9%	79.9%
Hispanic	89.2%	90.8%	91.7%	91.6%
Cuban	94.2%	95.0%	95.1%	94.8%
Puerto Rican	87.5%	89.6%	89.3%	87.4%
Central/South American	86.9%	89.4%	90.6%	90.8%
Mexican/Other Hispanic	85.7%	79.0%	83.3%	83.3%
Haitian	80.0%	80.7%	83.6%	83.4%
Non-Hispanic Others	92.2%	93.2%	91.9%	90.3%
All	86.2%	87.8%	88.9%	89.0%

Source: Florida Department of Health, Office of Vital Statistics. These data correspond to those published in the Florida Vital Statistics Annual Reports for 2000-2003.

**Figure 6. Percent of all Births with Prenatal Care in First Trimester by Race-Ethnicity, Miami-Dade County, 1992-2003**



Source (1992-1999 data): Miami-Dade Department of Health, Office of Epidemiology, 1999. \*Source: Florida Department of Health, Office of Vital Statistics. These data correspond to those published in the Florida Vital Statistics Annual Reports for 2000-2003.

### 3. Special Needs: Prenatal Care among Teens

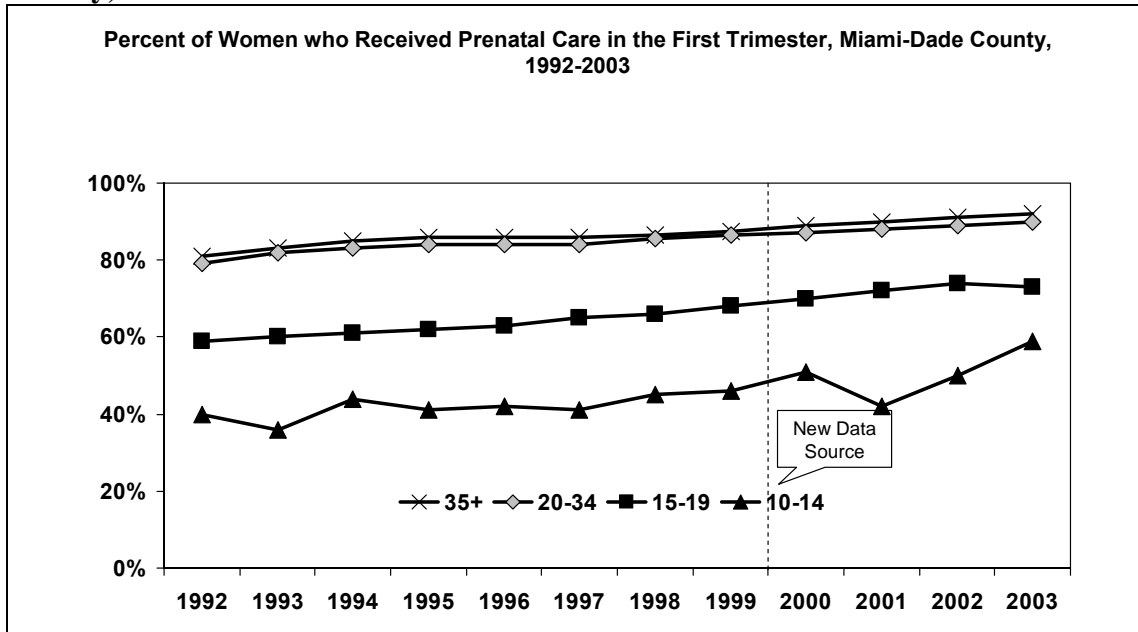
In 2000, the number of adolescent mothers who sought prenatal care within the first trimester was 2,531. By 2003, a total of 2,280 received prenatal care. The 18-19 year old group accounted for the highest percentage in the first trimester because the group also accounted for the highest number of live births within the teen population. There are many reasons that may account for the failure of teens to obtain prenatal care. Understandably, teens often deny to themselves the reality of their pregnancy until a number of weeks have already passed, thus delaying access to appropriate care. Fear of notifying a parent, denial and lack of knowledge about the institutions that provide help are only some of the reasons. In other cases, the youngest mothers, (ages 10-14) may also be subject to sexual abuse, which can lead to psychosocial needs that should be addressed.

**Table 20. Percent of Women who Received Prenatal Care in the 1st Trimester, Miami-Dade County, 2000-2003**

AGE OF MOTHER (YRS)		2000	2001	2002	2003
<= 14	Number	46	28	34	37
	Percent	55.4%	45.9%	54.8%	62.7%
15-17	Number	871	818	761	704
	Percent	65.5%	70.5%	71.1%	68.7%
18-19	Number	1,614	1,660	1,635	1,539
	Percent	74.1%	76.3%	78.8%	80.0%
20-24	Number	5,816	5,921	5,818	5,840
	Percent	81.9%	83.0%	84.9%	84.4%
25-29	Number	7,727	7,941	7,851	7,853
	Percent	88.7%	90.5%	90.8%	90.9%
30-34	Number	7,116	7,241	7,540	7,810
	Percent	91.7%	92.3%	93.3%	93.1%
35-39	Number	3,811	3,927	4,024	4,206
	Percent	90.8%	92.5%	92.7%	92.9%
40-44	Number	803	866	844	916
	Percent	89.4%	90.3%	91.0%	90.6%
45+	Number	31	61	65	56
	Percent	91.2%	89.7%	92.9%	94.9%
Unknown	Number	3	0	2	0
	Percent	50.0%	0.0%	66.7%	0.0%
All	Number	27,838	28,463	28,574	28,961
	Percent	86.2%	87.8%	88.9%	89.0%

Source: Florida Department of Health, Office of Vital Statistics. These data correspond to those published in the Florida Vital Statistics Annual Reports for 2000-2003.

**Figure 7. Percent Women Receiving Prenatal Care in the First Trimester, Miami-Dade County, 1992-2003**



Source: Miami-Dade Department of Health, Office of Epidemiology, 1999. Source (2000-2003): Florida Department of Health, Office of Vital Statistics. These data correspond to those published in the Florida Vital Statistics Annual Report for 2003.

The table below shows that in 2000, 88.7% women within the 25-29 year old age group received prenatal care. This proportion increased to 90.09% in 2003. In total, a slight increase in the rate of women receiving prenatal care was recorded: 86.2% in 2000 to 89.0% in 2003.

**Table 21. Resident Live Births, Percent and Rate (per 1,000 women in specified group), by Maternal Age, Miami-Dade County, 2000-2003**

MATERNAL AGE		2000	2001	2002	2003
<= 14	Number	83	61	62	59
	Percent	0.3%	0.2%	0.2%	0.2%
	Rate	1.1	0.8	0.8	0.7
15-17	Number	1,330	1,160	1,071	1,025
	Percent	4.1%	3.6%	3.3%	3.1%
	Rate	28.6	24.3	22.2	20.5
18-19	Number	2,178	2,175	2,074	1,924
	Percent	6.7%	6.7%	6.5%	5.9%
	Rate	73.3	71.6	67.6	60.3
20-24	Number	7,105	7,138	6,855	6,919
	Percent	22.0%	22.0%	21.3%	21.3%
	Rate	97.9	95.9	91.1	87.9
25-29	Number	8,708	8,774	8,646	8,638
	Percent	27.0%	27.1%	26.9%	26.5%
	Rate	106.1	107.9	108.3	107.1
30-34	Number	7,759	7,841	8,084	8,387
	Percent	24.0%	24.2%	25.2%	25.8%
	Rate	89.4	91.4	95.4	96.3
35-39	Number	4,199	4,247	4,339	4,527
	Percent	13.0%	13.1%	13.5%	13.9%
	Rate	43.4	45.0	46.8	49.1
40-44	Number	898	959	927	1,011
	Percent	2.8%	3.0%	2.9%	3.1%
	Rate	10.3	10.7	10.1	10.7
45+	Number	34	68	70	59
	Percent	0.1%	0.2%	0.2%	0.2%
	Rate*	0.17	0.32	0.32	0.27
Unknown	Number	6	2	3	2
	Percent	---	---	---	---
	Rate	---	---	---	---
<b>Total Births</b>	<b>Number</b>	<b>32,300</b>	<b>32,425</b>	<b>32,131</b>	<b>32,551</b>

Source: Florida Department of Health, Office of Vital Statistics. These data correspond to those published in the Florida Vital Statistics Annual Report for 2003.

Source: Florida Department of Health, Office of Vital Statistics. These data correspond to those published in the Florida Vital Statistics Annual Report for 2003. \* Denominator consists of women aged 45-59 years.

## B. Special Circumstances: Age and Marital Status

### 1. Births By Maternal Age

Between 2000 and 2003, the highest percentages of live births occurred among women ages 25-29 years old. Rates were relatively stable with the highest rate within this age group.

An increasing proportion of women ages 35-39 in Miami-Dade gave birth at a rate of 49.1 per 1000 of the population in 2003, an increase from 43.4 in 2000. This trend is significant, because mothers of advanced maternal age are more likely to experience complications of pregnancy that can lead to preterm birth, low birth weight and neonatal mortality.

Rates of births to teens declined over the past four years in Miami-Dade County and Florida. In Miami-Dade County the birth rate per 1,000 of the population for teenagers less than 15 years, declined from 1.1 in 2000 to 0.8 between 2001 and 2002 then further to 0.7, in 2003. For teens

aged 15-17 the rate declined from 28.6 in 2000 to 20.5 in 2003 and among 18-19 year olds, from 73.3 in 2000 to 60.3 in 2003.

## 2. Births to Single Mothers

In general, children of single mothers are at higher risk for poor health outcomes than children from two-parent homes. In 1999, unwed mothers who accounted for 41% of all women who gave birth delivered a total of 12,900 babies. This rate fluctuated with only a slight variation throughout 1992-2003 and was recorded at 13,741 in 2003. The highest geographic concentrations of unwed mothers were found in Homestead/Leisure City (33030), West Homestead (33034) and Goulds-West (33170) in South Miami-Dade; Central's Downtown (33128, 33130 and 33132), and Overtown community (33136), have the highest rates; and Opa-Locka (33054), Carol City (33056), Little Haiti/Wynwood/Miami (33127), Allapattah/Brownsville/Melrose/Liberty City (33142), Liberty City (33147), Miami Shores/El Portal (33150) and Westview/Lakeview/North Miami/Pinewood (33167) in North Miami-Dade are the highest ranking areas with rates ranging from 56.8% or higher for all births.

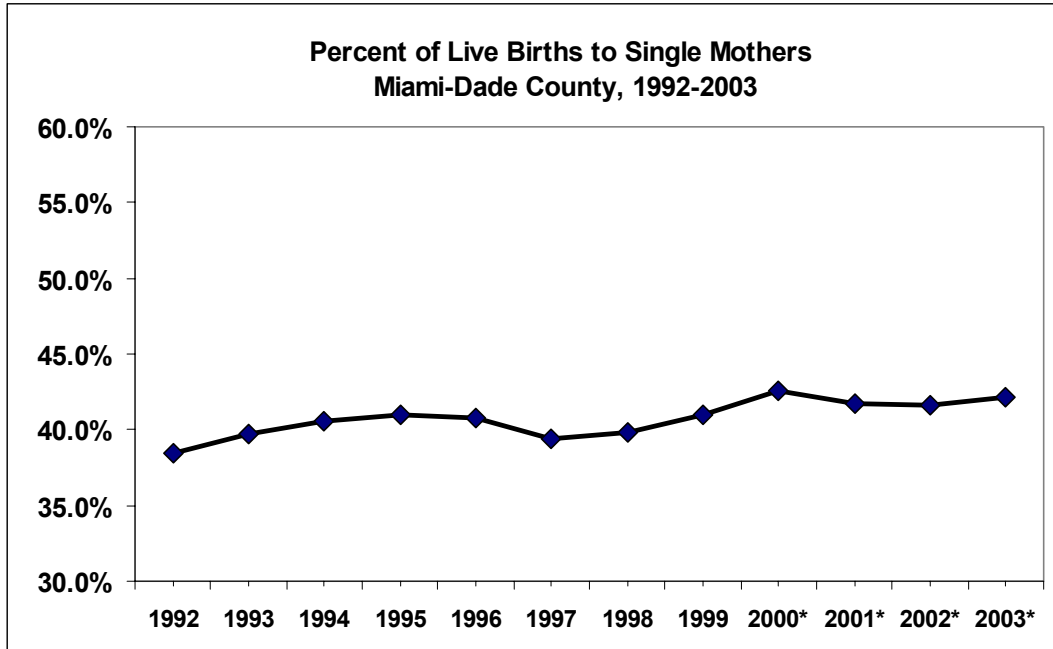
**Table 22. Percent of Live Births by Marital Status Miami-Dade County, 1992-2003**

MARITAL STATUS		1997	1998	1999	2000*	2001*	2002*	2003*
Unmarried	Number	12,344	12,580	12,900	13,742	13,522	13,362	13,741
	Percent	39.4%	39.8%	41.0%	42.5%	41.7%	41.6%	42.2%
Married	Number	18,956	19,048	18,586	18,548	18,893	18,769	18,809
	Percent	60.5%	60.2%	59.0%	57.4%	58.3%	58.4%	57.8%
Not Classified	Number	7	4	1	10	10	---	1
	Percent	---	---	---	---	---	---	---

Source: Miami-Dade County Health Department, Office of Epidemiology, 1999

\*Source: Resident Births from the Florida Department of Health, Office of Vital Statistics. These data correspond to those published in the Florida Vital Statistics Annual Reports for 2000-2003.

**Figure 8. Percent of Live Births to Single Mothers Miami-Dade County, 1992-2003**



Source: Miami-Dade County Health Department, Office of Epidemiology, 1999.

\*Source: Resident Births from the Florida Department of Health, Office of Vital Statistics.

These data correspond to those published in the Florida Vital Statistics Annual Report for 2000-2003.

To develop action plans, the Coalition used the Health Problem Analysis model in examining underlying risk factors for the three core health indicators: infant mortality, preterm birth, and low birth weight. In the Health Problem Analysis, the committee focused on target populations and identified potential strategies to be incorporated into Action Plans.

Items in boldface denote strategies incorporated in the Action Planning Process

**1. Health Problem Analysis - Infant Mortality**

**Target Population: Non-Hispanic Blacks and Haitians**

<b>Health Problem</b>	<b>Risk Factors</b>	<b>Direct Contributing Factors</b>	<b>Indirect Contributing Factors</b>	<b>Strategies that Will Address the Indirect Contributing Factors</b>
<b>I. Neonatal Mortality (infant death for birth to 28 days)</b>	I.a. Congenital abnormality	I.a.1. Hereditary predisposition	➤ Lack of family planning	➤ Counsel pregnant women on family planning and interconceptional care, and link or refer them to the appropriate resources
		I.a.2 Maternal behavior	➤ Insufficient folic acid consumption	➤ Continue to collaborate with March of Dimes to begin local folic acid campaign
			➤ Lack of or inadequate prenatal care	➤ Educate potential Healthy Start (HS) clients and link them to appropriate resources
	I.b. Preterm birth (See following sections)	I.b. Access to prenatal care		➤ Outreach to women of childbearing age, especially non-Hispanic Blacks and Haitians regarding early and ongoing prenatal care
	I.c. Low Birth Weight (See following sections)	See I.b. above		➤ Network with the HS community based providers to increase outreach to the non-Hispanic Black and Haitian communities
	I.d. APGAR at 5 min (score = 0-3, 4-6)			



	<p>II.d. Injuries (Shaken Baby Syndrome)</p>	<p>II.c.3. Circumstances surrounding SIDS death</p> <p>II.d.1 Unintentional</p>	<ul style="list-style-type: none"> <li>➤ Incomplete information captured at the time of death</li> <li>➤ 0-1 year old infants are more likely to die from shaken baby syndrome</li> <li>➤ Lack of provider training on Shaken Baby Syndrome</li> <li>➤ Male partners not being gentle with the baby; lack of parenting skills</li> <li>➤ Cultural barriers</li> </ul>	<ul style="list-style-type: none"> <li>➤ Collaborate with medical examiners to collect accurate information regarding the infant’s sleeping position or to clearly state, “undetermined” on the death certificate. Track specifics regarding other siblings in the home</li> <li>➤ Provide prenatal care providers and child care providers with training, educational materials and literature</li> <li>➤ Provide awareness within HS and ensure HS providers receive the appropriate training</li> <li>➤ Identify one individual to spearhead education to fathers/fatherhood initiative</li> <li>➤ Educate caregivers (mother, father, boyfriend, grandparents, etc) how to gently hold the baby – don’t shake – via parenting education</li> <li>➤ Identify cultural barriers in parenting and provide sensitivity training and education</li> </ul>
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		II.d.2. Intentional	<ul style="list-style-type: none"> <li>➤ Motor vehicle accidents</li> <li>➤ Household safety</li> <li>➤ Postpartum depression</li> <li>➤ Domestic violence/child abuse</li> </ul>	<ul style="list-style-type: none"> <li>➤ Evaluate and promote the correct use of child safety seats among all families with infants and children to age 3</li> <li>➤ Educate parents on age appropriate toys; advocacy for appropriate product labeling</li> <li>➤ Educate parents and child care providers on baby/child-proofing and safety measures including gun safety, pool safety, etc.</li> <li>➤ Train providers to watch for signs of depression</li> <li>➤ Provide knowledge and skills on bonding and attachment</li> <li>➤ Collaborate with family support services</li> <li>➤ Help parents to cope with the frustration of a crying baby, feeding problems, etc</li> </ul>
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## 2. Health Problem Analysis: Low Birth Weight

### Target Population: Non-Hispanic Blacks and Haitians

Health Problem	Risk Factors	Direct Contributing Factors	Indirect Contributing Factors	Strategies that Will Address the Indirect Contributing Factors
<b>Low Birth Weight (LBW = &lt;2,500 grams)</b>	Intra-uterine Growth Retardation	I.a. Tobacco use/smoking  I.b. Drugs and alcohol Abuse  I.c. Poor maternal weight  I.d. Access to prenatal care	<ul style="list-style-type: none"> <li>➤ Lack of education to pregnant women about the effects of tobacco/smoking</li> <li>➤ Lack of education to pregnant women about the effects of drugs and alcohol</li> <li>➤ Lack of screening by the prenatal care providers</li> <li>➤ Nutrition</li> <li>➤ Lack of insurance</li> </ul>	<ul style="list-style-type: none"> <li>➤ Increase awareness through outreach education to pregnant women</li> <li>➤ Increase collaboration with substance abuse treatment providers for pregnant women</li> <li>➤ Assure that Healthy Start (HS) contracted providers are referring substance abusing pregnant women for the appropriate care</li> <li>➤ Continue to address needs and gaps in the provision of nutrition services</li> <li>➤ Assure that Healthy Start (HS) contracted providers follow-up with women referred to WIC to ensure receipt of services</li> <li>➤ Increase awareness of the MomCare Program and simplify eligibility for Medicaid</li> </ul>

			<ul style="list-style-type: none"> <li>➤ Issue with undocumented clients</li> <li>➤ Lack of transportation</li> </ul>	<ul style="list-style-type: none"> <li>➤ Collaborate with community organizations to advocate for services to undocumented HS clients</li> <li>➤ Explore the possibility of providing bus tokens and continue to refer women to the closest HS provider when possible</li> </ul>
	II. Infections	II. Vaginal, urinary tract infections, and sexually transmitted disease	<ul style="list-style-type: none"> <li>➤ Lack of screening, identification and treatment of infections</li> </ul>	<ul style="list-style-type: none"> <li>➤ Increase awareness among prenatal care providers regarding the importance of screening for and treating STDs among pregnant women</li> </ul>
	III. Baby spacing	III. Having children closely spaced together	<ul style="list-style-type: none"> <li>➤ Lack of family planning and interconceptional care education</li> </ul>	<ul style="list-style-type: none"> <li>➤ Ensure HS care coordinators are providing interconceptional care education and referring clients for family planning services</li> </ul>



		I.a.3. Low maternal weight gain and pre-pregnancy or prenatal obesity	<ul style="list-style-type: none"> <li>➤ Poor nutrition</li> </ul>	<ul style="list-style-type: none"> <li>➤ Link pregnant teens to WIC</li> <li>➤ Follow-up with teens referred to WIC to ensure receipt of services</li> <li>➤ Develop a nutrition/education campaign targeting this group</li> </ul>
		I.a.4. Smoking	<ul style="list-style-type: none"> <li>➤ Lack of knowledge regarding the effects of smoking</li> </ul>	<ul style="list-style-type: none"> <li>➤ Increase awareness through outreach and HS tobacco cessation program.</li> </ul>
		I.b.1. Diabetes	<ul style="list-style-type: none"> <li>➤ Lack of awareness</li> <li>➤ Negligence of doctors' instructions</li> </ul>	<ul style="list-style-type: none"> <li>➤ Educate clients about diabetes</li> <li>➤ Ensure Healthy Start nurses are the lead case manager where medical conditions are evident</li> <li>➤ Assure that Healthy Start staff follow-up with clients and refer them when necessary for chronic medical conditions</li> </ul>
		I.b.2. Hypertension	<ul style="list-style-type: none"> <li>➤ Lack of awareness</li> </ul>	<ul style="list-style-type: none"> <li>➤ Provide education as needed regarding chronic medical conditions and risks to pregnancy (both mother and infant)</li> </ul>



## VI. CONSUMER AND PROVIDER INPUT

### **A. Methodology**

Since its inception in 2000, the Healthy Start Coalition of Miami-Dade has conducted both formal and informal qualitative inquiry related to the population it serves and the environment in which it exists. In fact, throughout its history, the Coalition has collaborated with more than 100 organizations and 250 individuals who have continuously broadened the range of community participation thereby providing vital data reflective of the needs, structure and characteristics of the target population and communities served by the Coalition. In addition, it has benefited from the perspectives of advocates, providers, and community leaders who have been involved in volunteer activities, and gained experience from working in the communities and neighborhoods as well as other social interactions.

The Coalition is also committed to convening and maintaining various committees, councils, and task forces aimed at assuring a continual flow of qualitative data related to the community. In addition to these sources of input, it aspires to recruit the business sector and other key players in the community thereby making them active participants in planning for the health of our children. The potential results are expected to further expand the reservoir information resources while capitalizing on emerging opportunities to effectuate positive change for maternal and child health services within our community.

In creating the Needs Assessment and Service Delivery Plan, the Data Committee conducted a zip code level analysis of seven (7) critical indicators which became the standard of measure in identifying geographic priority areas of need. These included,

- Births to teens
- Births to unwed mothers
- Preterm births
- Low birth weight births
- Infant mortality
- Fetal mortality
- Prenatal care

The ten leading zip codes in each indicator were then applied to a matrix that clearly highlighted zip codes that are disproportionately affected by these areas of need.

**Table 23. Focus Group Matrix**

Priority Areas			
	Zip code	Neighborhood	Facility
NORTH	33054	Opa Locka	North Dade Health Center
	33056	Carol City	
	33147	Liberty City	Teen Pregnancy Prevention Center
	33167	Liberty City/Opa Locka	EOFHC Reeves House
	33162	North Miami Beach/North Miami	North Miami Senior High Adult Education
	33168	Miami Shores/Little Haiti	
CENTRAL	33128	East Little Havana	Regis House Main Office
		Allapattah/Melrose	Team Metro Office
	33136	Overtown	Overtown NET Center
SOUTH	33032	Homestead	Community Health Center of South Dade - Martin Luther King Clinic
	33034	Florida City	
	33170	Goulds	CHI Doris Ison Clinic

In comparison to the last Service Delivery Plan, when five focus groups were conducted, this Service Delivery Plan expanded the focus groups to include a larger number of participants representing a broader geographic region. The committee also formulated specific guidelines to govern the prioritization process and ensure that it possessed a clear knowledge of the county averages for each health indicator; emphasized the indicators that have the greatest impact on infant mortality; and utilized a standard measure for determining consistent geographic areas of need.

**B. Focus Group Planning and Procedures**

In an effort to obtain current information reflective of the communities serviced by the Coalition, focus groups were identified as a highly appropriate method of obtaining information about the communities serviced by the Coalition while substantiating the key health indicators identified.

The groups were created through a collaborative effort that involved the Coalition and community organizations based within the targeted areas. Community meetings in targeted areas were attended by Coalition staff that identified the most suitable organizations that were then recruited to host group sessions. Subsequently, the Coalition provided promotional materials such as flyers that were disseminated by hosting organizations while community members who agreed to participate in group sessions, were given educational and outreach materials.

Group sessions were held between July and September 2005, 90% of which were convened in the evenings and lasted between 1.5 to 2 hours. The topics of discussion were of mutual interest to both the Coalition and hosting organizations and were cultural competent to the extent that discussions were language specific. Hispanic focus groups were therefore moderated in Spanish while the Haitian-Creole group was moderated in Haitian-Creole.

In total, 9 focus groups were conducted throughout the 3-month period. A moderator and co-moderator directed each while the complete session was recorded on tape.

## C. Demographic Information

There were a total of 130 participants in nine focus groups. Of these 130 participants, 90 were female, or 69.2%; 14 were male, or 10.8% and 26 were no response (20%). Participants ranged in age from 17 thorough 71. Participants resided in a range of areas (zip codes) throughout the county.

Participants were asked to self-report their race/ethnicity. The majority of respondents were African-American at 43.8% (57); followed by Hispanic respondents at 25.4% (33); Haitians at 22.3% (29) and Whites at 3.1% (4). 3.1% (4) people identified as Other, describing their ethnicity as Haitian-Dominican (1), Bahamian (1), Native African-Indian Descent (1) and Jamaican (1). Three (3) participants or 2.3% did not respond.

The majority of participants have children; 76.1% (99) have children and 21.4% (28) do not have children. Three (3) participants or 2.3% did not respond. Participants have one to eleven children, with the majority having one or two. There were seven or 5.4% of no respondents to this question.

Female participants were asked “during your pregnancy (or pregnancies), how many times, on average, did you see a doctor?” 79 responded to this question, with the majority (58.2%) visiting a doctor 10 or more times.

Participants were asked if any of their children had problems at birth, 97 of the participants answered this question, with the majority (70.1%) answering that their children had NO problems at birth.

Participants were asked about their access to health care in the past year; particularly, if there was anytime in the past twelve months that they needed health care but could not get it. One-hundred twelve (112) participants responded to this question, with the majority (77) 68.8% answering NO. Thirty-five (35 or 31.2%) participants answered yes, and chose the following as reason why: (Participants could check all answers that applied).

- No health insurance = 19
- Seeing a doctor costs too much = 8
- Did not know where to go = 3
- No transportation = 5
- Could not get an appointment = 2
- No one spoke my language at the facility = 1
- No child care = 2

Participants were then asked the same question about their children, that is, if there was anytime in the past twelve months that they needed health care but could not get it. Ninety-one (91) of the participants responded to this question, with the majority 82.4% (75) responding NO. Sixteen or 17.6% respondents said that YES, and choose all of the following reasons that applied:

- No health insurance = 10
- Seeing a doctor costs too much = 4

- Did not know where to go = 1
- No transportation = 2
- Could not get an appointment = 1
- No one spoke my language at the facility = 0
- No child care = 0

Only 8 participants responded YES to BOTH of the previous questions, that is, 6% said that there was a time in the past twelve months that either they or their child needed health care but could not get it.

Of those who responded YES that either they, or their child had unmet health needs (n=42), had an average age of 32.

Of those who responded YES that either they, or their child had unmet health needs (n=42), 69% (29) had children and 31% (13) did not and the mean number of children was 2.6.

Of those who responded YES that either they, or their child had unmet health needs (n=42), were predominantly Haitian (38%) or African American (33%).

Of those who responded YES that either they, or their child had unmet health needs (n=42), most (24%) coming from zip codes 33142 and 33161 (19%):

Fifty-three percent (53.0%) or 69 of participants have some form of health insurance coverage, with the majority of respondents covered by Medicaid. Almost 44% (57) of respondents do not have any health insurance. (4 participants did not respond to this question).

- Private = 21 (30.4%)
- Medicaid = 29 (42.0%)
- JMH CareCard = 9 (13%)
- Medicare = 4 (5.8%)
- Other = 0
- Did not designate = 6 (8.7%)

Seventy-two percent (72.7% or 72) of participants' children have some form of health insurance coverage, and similarly to their parents, most children (63.9%) are covered by Medicaid.

Twenty-five (25.2%) of participants' children have no health insurance (2 participants did not respond).

- Private = 17 (23.6%)
- Medicaid = 46 (63.9%)
- Jackson Memorial Health (JMH) CareCard = 0
- Healthy Kids = 3 (4.2%)
- Other = 1 (1.4%)
- Missing = 5 (6.9%)

Fifteen percent (15%) or 19 of the participants responded that NEITHER they nor their child had health insurance.

Respondents who did not have insurance, or who had children without insurance (n=63) had an average age of 35.

Of the respondents who did not have insurance, or who had children without insurance (n=63), 71% (45) had children and 25% (16) had NO children. (4 did not report.) The average number of children was 2.6.

Respondents who did not have insurance, or who had children without insurance (n= 63) were predominantly Haitian (22) or Hispanic (22).

- African American = 14
- Haitian = 22
- Hispanic = 22
- White = 1
- Other = 3
- Did not report = 1

Respondents who did not have insurance, or who had children without insurance (n= 63) came from 33142 (21%) and 33161 (14%):

## **D. Summary of Qualitative Data Findings**

### **1. Access to Health Care/Insurance**

What health services are available in your community? Are they affordable (sliding scale, low/no cost)?

Participants in each community were able to designate a number of areas in which they could receive health care. Jackson Health System includes a number of satellite clinics used by various communities, including North Dade Health Center; North Miami Health Center; Jefferson Reaves; Juanita Mann; Peñalver Clinic; and Jackson North Specialty and Diagnostic Center. Federally qualified health centers (FQHCs) like Economic Opportunity Family Health Center also has a number of clinics used by various communities; of particular popularity is Jessie Trice Family Health Center in Liberty City. In the South, Community Health of South Dade (CHI's) clinics: Martin Luther King Center (MLK Center), Doris Ison Clinic, Naranja and the Everglades are used by community members who live in that area. Other important community clinics include Borinquen, Helen B. Bentley and Stanley Myers (currently called the Miami Beach Community Health Center). All areas are familiar with Jackson Memorial Hospital, and many of the participants rely on it for emergency and regular care. Other hospitals utilized are Parkway, Baptist South, and Memorial Hospital in Broward and Miami Children's Hospital. Community members also took advantage of a number of One-Stop services in their particular neighborhoods for WIC services and other health screenings.

Many of the health clinics listed above provide health care at either low cost or on a sliding scale. For the most part, participants thought that the sliding scales were comparable to what they could afford. Except for Jackson Memorial Hospital, hospital care was considered prohibitively expensive.

Where do you usually go in order to receive health care?

Participants typically go to the clinics and hospitals listed above. Many complained about their lack of control during emergencies; when they ask to be taken to a particular hospital and the ambulance refuses. Sometimes this preference is based on affordability and at other times, it is based on perceived standard of care. In some cases, participants felt that they are discriminated against because of the neighborhoods in which they live: “[when] *they pick you up from this neighborhood, they are going to assume that they you just got Medicaid or no insurance at all, you are going to go directly to Jackson. And because Jackson is so overwhelmed in the ER already from everything to a small cut to ‘I have a small fever’, you with your emergency are going to be sitting there for hours before you are seen. Unless there is a gunshot wound or you are critical.*”

Have you ever had trouble getting health care?

Many of the participants had delayed seeking preventative or basic health care due to the lack of insurance or inability to pay for health care. In the communities which contained high numbers of undocumented immigrants, people delayed care because they do not “have papers”: “*I know for a fact that there are a lot of people in the community who are sick, but because they don’t have legal papers, they cannot see a doctor.*”

In the case of an emergency, most participants will get care. Yet oftentimes this care comes at a price: “*If you don’t have insurance, they will send you a bill. I had a problem when I went there for an emergency, and at the time I was only working part time. So later on they billed me, and they don’t bill on a sliding scale, they billed me the full price.*”

In most communities, participants shared their experiences with the disrespect they felt at the local clinic. In Liberty City and Overtown, participants complained that doctors at Jackson did not understand them because they spoke English and were not Hispanic. In East Little Havana, participants said they were discriminated against because they were Hispanic and did not speak English. In North Miami, participants noted that they were treated poorly in the clinic because they are Haitian. Finally, in North Dade, participants complained that the clinic staff is rude, and they need to learn to keep their personal business at home. Lack of or poor customer service was a consistent issue countywide and across all race/ethnicity groups.

Another similarity among all the communities is the long wait time to receive care. This was particularly the case for specialty services such as vision or dental. Community members noted that they were forced to wait for months for appointments to access these services.

What would help your family access better health care?

Each community highlighted the lack of affordable health insurance as a problem for accessing quality health care. Many talked about the lack of Medicaid for women and men without children, young adults over the age of eighteen and individuals who lost coverage because they became employed but were not given health insurance by employers. A number of women emphasized the strategy of repeat pregnancies to access health care. “*Yeah I had trouble getting care, but you know, you have to either be*

*pregnant or have kids to get care. I had to get pregnant, now I am getting a little more care.”*

Many communities cited the lack of knowledge about available services. In some cases, participants asked about transportation and others informed them that the local clinic provides free transportation.

Some communities also discussed more convenient hours as a means to access better care. *“Some of the doctors, they stop working at five, they don’t work on a Saturday. And you have to get the time off from work, when you get sick, and it is difficult.”*

Are there any health services that you or your children need that are not available to you? What services are you lacking?

All communities highlighted the lack of affordable dental and vision services in their community. In the communities where they could access dental and vision, participants cited long wait times for appointments. As one woman commented about dental care in her community: *“It takes forever to get an appointment, yet if you walked in that office right now, you aren’t going to see anyone in there [being seen].”* Another participant echoed this comment: *“I called last year to get an appointment and I am still waiting.”*

Do you have health insurance?

Each community expressed opinions about the difficulties in getting affordable insurance. Many participants complained about the fact that programs such as Medicaid and KidCare have strict income requirements. One participant asked: *“Is there any other alternative from Medicaid or KidCare because you need to make no more than \$8/hour to qualify, so If you have high bills you cannot afford to pay for health insurance without these programs.”*

## **2. Community Health**

How would you describe the health of your community?

In general, communities described the health of their community as ‘poor,’ ‘not good,’ ‘awful,’ ‘mediocre’ and ‘terrible.’

What do you think are the biggest health issues within your community?

Health issues of high concern remained relatively similar among the communities. Many expressed concern about obesity, diabetes and hypertension. Additionally, of growing concern are sexually transmitted infections and diseases, and HIV/AIDS. A number of communities also cited depression and anxiety as problems in their area.

Who do you think suffers the poorest health in your community?

The majority of groups agreed that men suffer from the poorest health in their community. This is because men are least likely to visit a doctor in most cases; they need to have a serious health problem in order to seek care. Also, men are perceived to work harder physically and eat more unhealthy food: *“Because most of the time in this community, we eat a lot of fried foods and the men the most in this community, they work harder, mostly in the sun, so they have it really bad. They eat more fried foods than anything.”*

In East Little Havana, participants stated that women have the worst health because they suffer from depression.

Where are the people with the poorest health most likely to live in your community?

Participants pointed to the areas of highest poverty as those with the poorest health. In some cases it was the projects, or in other communities, areas where drug addicts and homeless tended to congregate. Yet one participant astutely commented that it is not just the homeless who have health problems: “[t]hose people who live under the bridge, they ain’t the only sick people. ...because I don’t live under a bridge and I have diabetes, high blood pressure and I ain’t got no air conditioning either!”

Participants from Liberty City designated their entire area as one of poor health.

What would improve the health of your community?

In general, communities agreed that affordable health care would greatly improve the health of their communities. In addition, greater access to health information, including services available in their community would be helpful. Participants also suggested that improving the quality of services they receive; less discrimination, at clinics and hospitals would be an important method.

Where do you get your health information? Who do you trust the most to give you health information?

Communities receive health information from a variety of sources. In communities that enjoy a high rate of internet access, participants use the web as an important source of health information. A large number also relied on their doctor for health information; if they have questions they will either call or visit the clinic to ask questions. In some cases, participants had access to advice lines through their health insurance while others consulted family members for health advice.

In addition to clinics and family, participants also get health information from churches, the radio, health brochures, and schools. However, the majority rely on doctors as the most trusted source of health information. Many also trusted their mothers or other family members as sources of health information.

### **3. Maternal Health**

What are the biggest health issues for women in your community?

Sexually transmitted infections and diseases were often mentioned as big health issues for women in most communities. Participants are concerned about women who get repeat infections: “*somebody who keeps getting STDs, and she keeps going back to the boy, and she keeps getting them. They go get the medicines, but they go back to the boy!*” In addition, diabetes, obesity, heart disease and hypertension were also mentioned. In some communities, women also have problems with alcohol and drugs. In the south part of the county, participants were particularly concerned about the increasing rate of lupus and cancers, thought to be linked to exposure to environmental pollutants. Finally, of greatest concern to all communities was the increasing problems with depression among women.

In many cases, women are seen as carrying the largest emotional burdens in their families, as well as having to remain strong, so they are most susceptible to depression.

Which women in this community are most likely to visit a doctor? Which are they least likely? Why?

In most communities, the women least likely to visit the doctor are teenagers, drug addicts, alcoholics and homeless women. Others least likely to seek care are women who lack insurance and those whose cultures teach them to depend on home remedies as the first line of defense against illness. Some women use prayer before seeking care: *“It depends on the home life, because some people, they say, let’s pray about it first and then I will go to the doctor.”*

Some pregnant women are also less likely to visit a doctor, because previous pregnancies were healthy: *“I am going to speak for the majority because I am from this neighborhood and I have been pregnant eight times, and I can say, if nothing ain’t really wrong with my baby, I ain’t gonna have prenatal care. This is my first prenatal care, I’ve been taking the vitamins. Well shoot, we usually go the whole nine months. We get the pregnancy test at Juanita Mann and then you go have your baby free at Jackson.”*

Where can we find pregnant women who do not visit the doctor? How can we get them to go to the doctor?

The answers to this question tended to vary and be determined by location. In most areas, participants identified Wal-Mart or local grocery stores such as Publix, Sedanos or Winn-Dixie as good places to find pregnant women. In a number of communities, participants recommended high schools as another source of pregnant women who do not visit the doctor. Some communities also recommended flea markets, nail salons, and local clubs.

The most common solution cited, to ensure that women receive prenatal care was making it affordable or free. In some communities, participants recommended that women be transported from their homes, provided lunch and child care while they visit the clinic. Many others recommended gift certificates to local grocery stores or Wal-Mart, or free items for the baby such as clothes, cribs, and strollers.

Have you or anyone you know, experienced a teenage pregnancy? Do you think that teenage pregnancy affects the overall health of families in this community? How?

This question elicited a spirited conversation in each community. All communities agreed that teenage pregnancy negatively affects the community; in most cases participants noting that it’s ‘babies having babies.’ *“The people who are paying the consequences are the babies because we are babies and we are not ready to take care of them.”* Some of the most common effects are endured by the families of teen mothers as they need to worry about another mouth to feed, and another child to raise and nurture. In many cases, teen mothers are less likely to complete their schooling: *“I know a little girl, she had a baby at sixteen. But this girl, she had her baby, she didn’t go back to school because she thought she was going to miss something at home. She didn’t want to go back.”* One community was concerned about providing adequate support for teen mothers without encouraging repeat pregnancies: *“at the same time they don’t want to make it seem like its okay because then the child may go out and get pregnant again because ‘my parents*

*didn't see anything wrong with it.' They try to be there but at the same time discourage them. A lot of people who get pregnant in high school, they get pregnant back to back."*

In all communities, this question inevitably led to a discussion about teen pregnancy prevention. While the majority of communities supported sex education, there was some debate about the best age to begin teaching. Most of the communities agreed that sex education in schools needs to be supplemented by communication within the home, yet all participants agreed that this was easier said than done. Some recommendations were made for community churches to incorporate this teaching or parents and children should take classes together.

#### **4. Child Health**

Would you describe the children in your community as 'healthy'?

Although each of the communities were very vocal on the health issues which plague their children (see question below), the majority agreed that the health of their children is relatively good. This is because children are more likely to have access to health care through KidCare or Medicaid, and in many cases, parents are most likely to ensure that their children get adequate care even if they do not seek preventative care for themselves.

What are the biggest health issues for children in your community?

Most communities identified asthma as one of the biggest health issues in their community. In addition, obesity and nutrition were also seen as problems, particularly as parents could not control the type of food eaten by their children who were inactive at home. One parent complained that there are *"too many reasons to eat junk food—you have Burger King, Mickey D's. Even if you cook them a nice meal, they say 'I want,' 'I want,' 'I want!'"* As a result of these nutritional problems, many children in these communities suffer from diabetes and in some cases, heart problems. Parents also discussed the increasing rates of mental issues such as attention deficit disorder and depression among children. Some parents see a link between nutrition and ADD: *"Because that is the easiest thing to say it is, but maybe their nutrition is bad, so they don't have the attention span they need in school. Or they are not going to sleep on time and children are on drugs they don't need."* Parents also thought that some of the mental issues experienced by children are related to growing up in low-income neighborhoods: *"If you live in a community, like the lady was saying, that you cannot play with friends without a cop driving by, just because a cop sees a bunch of black kids playing together. Or you live in a community which you see people out homeless every single day, or shooting someone in your family, or doing it right there in front of you, how could those kids could be emotionally or mentally healthy? It's impossible."*

If your child was sick, when would you take him or her to the doctor? (i.e. what makes your child 'sick enough' to see a doctor?)

There are many symptoms that would prompt parents to take their child to the doctor. Most common are fever, vomiting, diarrhea, bleeding, and shortness of breath or coughing, runny nose or stomach pains. In some communities, parents also rely on home remedies to treat fevers—this is most common in North Miami (among the Haitian community), Goulds and Liberty City.

## 5. Healthy Start Services

Have you ever heard about Healthy Start services? Where? What have you heard about it?

In some areas, participants were very familiar with Healthy Start, particularly in North Dade, Overtown, Liberty City and Goulds. Other areas had some knowledge but there were a few areas that were completely unaware of the program: North Miami and East Little Havana.

During your pregnancy were you offered a Healthy Start Screening?

In some communities, participants were familiar with the Healthy Start Screen. Yet in many cases, participants had difficulty differentiating it from all the other paperwork they filled out during their initial prenatal exam.

Did anyone tell you about services available to you after your screening?

In the communities where women were familiar with Healthy Start, the majority of them were also informed about Healthy Start services.

Have you ever gotten services from Healthy Start? What did you think about the services? What was most helpful? What would you change?

In those communities familiar with Healthy Start, participants commented that the free classes—both the childbirth and parenting classes—are very useful. In addition, the attention by the Healthy Start provider, the free stuff for the baby and mom were also seen as useful aspects of the program. The only recommendations for change came from women who felt that they had not been adequately informed about the services, although in some cases, it was difficult to tell if this was due to provider issues or client issues.

## 6. Conclusions

What other issues need to be addressed that were not mentioned here today that require action to give all children a healthy start in life?

Most communities had no further comments at the end of the session; however, participants in North Miami asked that more attention be given to the increasing rate of HIV among children.

## 7. Summary of Key Points

**Access to Care:** A number of health facilities were available in each community and at least one provided affordable services. Participants however, complained about perceived discrimination towards them and in some cases this impacted their willingness to seek care.

**Lack of Information:** Many communities are unaware of the services offered near their neighborhood or the range of services offered at the community clinic. Participants expressed surprise that local clinics provided free transportation. Some communities were unaware of where to seek information about needed services

**Health Insurance:** Current regulations about income requirements make subsidized health programs out of reach for many communities. If families do not have children or individuals are single or male, they are less likely to have health coverage. Also of

concern is the number of young men and women who lose Medicaid coverage after eighteen years of age and are working jobs that do not provide them with health benefits.

**Community Health:** All communities described their health as poor. Similar to issues in maternal and child health, the largest concern on a community level, is nutrition/obesity which is linked to diabetes and hypertension.

**Maternal Health:** All communities expressed concern over the increasing rate of depression among women. Yet while each community recognized depression as a problem among women, none of the communities linked depression to other community wide health problems, nor did they talk about the need to seek care for depression.

**Prenatal Care:** For the most part, communities were familiar with the importance of prenatal care and women had utilized the care relatively regularly during their pregnancy. To encourage women who are not currently seeking care, participants recommended financial incentives through gift certificates, access to free care, or gifts of needed baby items.

**Teen Pregnancy:** This is a topic of great concern to each community, and participants were very vocal in how teen pregnancy can be best prevented within their own community.

**Child Health:** Conversations about child health centered on asthma, nutrition and attention deficit disorder/depression. Many communities were concerned about the increasing rate of asthma and confused about the reason for this escalation. Parents expressed concern about the lack of control over their child's eating habits—either because they feel that the child eats poorly at school, or that they themselves are unable to fully control their child at home.

**Healthy Start:** While a number of communities (North Dade, Overtown, Liberty City and Goulds) were familiar with Healthy Start services and screenings, some neighborhoods were under informed. In particular, participants in North Miami and East Little Havana, areas that have high immigrant population, need to be better informed about Healthy Start.

## VII. Resource Inventory and Service Gaps

### A. Resource Directory

The Resource Directory lists all the providers of Healthy Start services in Miami-Dade, and has been provided to the Department of Health as a separate document.

### B. Assets and Gaps

A review of the Resource Inventory, in conjunction with community input, Needs Assessment data, and geographic priority areas, reveals the following strengths and service gaps:

#### **Resource Assets:**

- Miami is a major metropolitan area; a wide variety of high-quality core services are available in the community.
- Clinics for low-income clients are generally available and offer services on a sliding-fee scale

#### **Resource Gaps:**

- Despite the availability of care, clients may be unaware of services in their local communities. This lack of awareness is an opportunity for community awareness and education.
- Perceived discrimination or cultural/language barriers at local clinics. This community perception is an opportunity to conduct provider awareness and training.
- Clients may delay seeking preventative or basic health care due to the lack of insurance or inability to pay for health care. This is a particular problem for undocumented immigrants.
- The availability of enhanced services varies across the region; different providers may not coordinate/refer appropriately, or deliver comprehensive services in a consistent manner. This area is an opportunity for provider education and awareness.
- There is an opportunity for the Coalition to reduce the time from initial screening to care coordination services.
- There is a need for increased awareness and service provision around mental health issues, particularly postpartum depression.
- Perceived need among community members for health promotion regarding nutrition/obesity.
- Lack of affordable health insurance for those without private insurance but unable to qualify for Medicaid.

The Coalition will use these findings to guide the delivery of services from 2006-2010.

## VIII. HEALTHY START SYSTEM

### A. Prenatal and Infant Screening

The Healthy Start Coalition of Miami-Dade, Inc. (HSCMD), is responsible for maintaining an informed and active provider network able to improve screening rates. Currently the HSCMD contracts the Miami-Dade County Health Department (MDCHD) which through its Healthy Start Data Management Office, is responsible for receiving Healthy Start screens from community medical providers, entering the data from the screen (processing the screen) and assigning pregnant women to contracted HSCPs.

The HSCMD is responsible for monitoring the quality and performance of the risk screen management services provided by the MDCHD and the distribution/assignment, in terms of establishing the number of clients and assignment parameters, to each of the contracted HSCPs.

### B. Healthy Start Contracted Providers

Healthy Start services in Miami-Dade County are provided by HSCPs. There are currently fifteen HSCPs serving in the following regions (Table 24).

**Table 24. Healthy Start Contracted Provider by Region**

<b>Regions</b>	<b>Providers</b>
North Miami-Dade	<ul style="list-style-type: none"> <li>- Avanti Support</li> <li>- Borinquen Health Care Center</li> <li>- Catholic Charities</li> <li>- Economic Opportunity Family Health Center</li> <li>- Miami Beach Community Health Center, Inc.</li> <li>- Miami-Dade Family Learning Partnership</li> <li>- North Dade Health Center</li> <li>- The Village</li> <li>- University of Miami/Jackson Memorial Hospital NICU</li> <li>- University of Miami Starting Early Starting Smart (SESS)</li> <li>- Victims Services Center</li> <li>- Wellness for Life, Inc. (Nutrition Only)</li> </ul>
Central Miami-Dade	<ul style="list-style-type: none"> <li>- Avanti Support</li> <li>- Borinquen Health Care Center</li> <li>- Catholic Charities</li> <li>- Dr. Raphael A. Peñalver Clinic</li> <li>- Miami Beach Community Health Center, Inc.</li> <li>- Miami-Dade Family Learning Partnership</li> <li>- The Village</li> <li>- University of Miami Nutrition Division (Nutrition Only)</li> <li>- University of Miami/Jackson Memorial Hospital NICU</li> <li>- University of Miami Starting Early Starting Smart (SESS)</li> <li>- Victims Services Center</li> </ul>

	- Wellness for Life, Inc. (Nutrition Only)
South Miami-Dade	- Avanti Support - Borinquen Health Center - Catholic Charities - Community Health of South Dade (CHI) - Miami-Dade Family Learning Partnership - University of Miami Nutrition Division (Nutrition Only) - University of Miami/Jackson Memorial Hospital NICU - University of Miami Starting Early Starting Smart (SESS)

Contracted providers who receive the screens are responsible for contacting each respective woman. At the initial contact, resources available to the participant to offset their risk status may be discussed and determination made as to whether the participant needs further intervention or simply needs information about community resources.

Participants in need of further intervention are channeled into additional Healthy Start services, depending on the nature of their need. Many clients may need “tracking” for future follow-up, while others may need a thorough initial assessment to determine the full extent of interventions needed to offset their risk. As a result of the initial assessment, some clients may need one or more of the following Healthy Start services: ongoing care coordination, parenting, childbirth, and breastfeeding education, tobacco education/cessation, psychosocial counseling and nutritional counseling. If a participant is in need of a service that is not provided or not within the scope of the Healthy Start Program, she is referred to an appropriate provider (outside of HSCMD) for those services. For example, if a woman does not have shelter, Healthy Start Care Coordinators will expend significant time and effort in order to locate appropriate accommodations. This example also applies for referrals to Medicaid, WIC, emergency cash assistance, HIV/AIDS services, immunization clinics, family planning, etc.

Once the Healthy Start participant agrees to care coordination, the provider will determine the level of services needed. Most communities lack the resources to meet all identified needs, therefore a system of triage and prioritization in service delivery is necessary in order to provide intensive services to those with highest priority needs.

### **C. MomCare**

MomCare is a Medicaid-funded program authorized by a special waiver from the federal government. MomCare was developed through a partnership of the Florida Healthy Start Coalitions, the Florida Department of Health, the Florida Agency for Health Care Administration, and the U.S. Centers for Medicare and Medicaid Services. MomCare seeks to improve birth outcomes and infant health by providing the following services to Medicaid-eligible pregnant women:

- Simplified Medicaid enrollment
- Choice counseling for selection of maternity care providers
- Care management to assist with initiation and use of prenatal care
- Healthy Start services for at-risk women

The purpose of MomCare is:

- To help pregnant women understand their choices and select a primary care provider
- To assist pregnant women in receiving early prenatal care
- To identify at-risk women through the Healthy Start screening process
- To assist at-risk women obtain needed services

The MomCare program is accountable to state and federal agencies for its activities, expenditures, and impact on the health of pregnant women and infants. Therefore, complete and accurate records are critically important. Maternity care advisors will document their activities in local records established for each client and in the statewide SOBRA information system. A description of the SOBRA information system is included in the Appendix. Periodically, each local Coalition will be audited to determine the appropriateness and effectiveness of their MomCare program.

Clients must be pregnant and eligible for Medicaid under income criteria for presumptive eligibility or SOBRA (185% poverty). Early contact with pregnant women encourages and assists them in obtaining prenatal care as soon as possible, complete the Healthy Start screen and access other needed services. The patient's relationship with the provider is established through the enrollment process and the provider agrees to meet specific performance standards.

The types of services provided include choice counseling as the process of providing unbiased information to a Medicaid recipient regarding her options for enrolling with a maternity care provider in order to assist her with the selection of that provider. Prenatal care counseling is broader in scope and includes assistance to Medicaid clients to schedule and keep appointments, follow through on referrals to other services, and identifying and resolving any needs and problems. Care management consists of ongoing activities to follow a client, identify any needs and assist her to access the needed services. Coordination also involves working closely with other providers serving the client to assure services are effective.

The MomCare process includes:

**Medicaid Eligibility Determined**

- Client completes simplified form declaring income and providing proof of pregnancy
- Department of Children and Families (DCF) determines eligibility
- DCF notifies Consultec (fiscal agent)
- Consultec notifies Coalition
- Consultec sends printed information to client about MomCare

**Initial Contact with Client**

- Maternity care advisors explain the program
- A list of provider choices is given to the client
- Maternity care advisors assist the client in selecting a provider
- Assistance is offered in scheduling the first or next appointment

- Clients are encouraged to complete a Healthy Start screen. In some Coalition areas, the screen may be used as a tool in the initial contract and is partially completed
- Maternity care advisors determine the need for WIC
- Clients are informed of their rights to change provider and the procedures to do so

**Enrollment with Provider**

- When chosen within 30 days, the selected provider is recorded in client's record
- If not, the provider is assigned to the client through a random process

**Provider Contact**

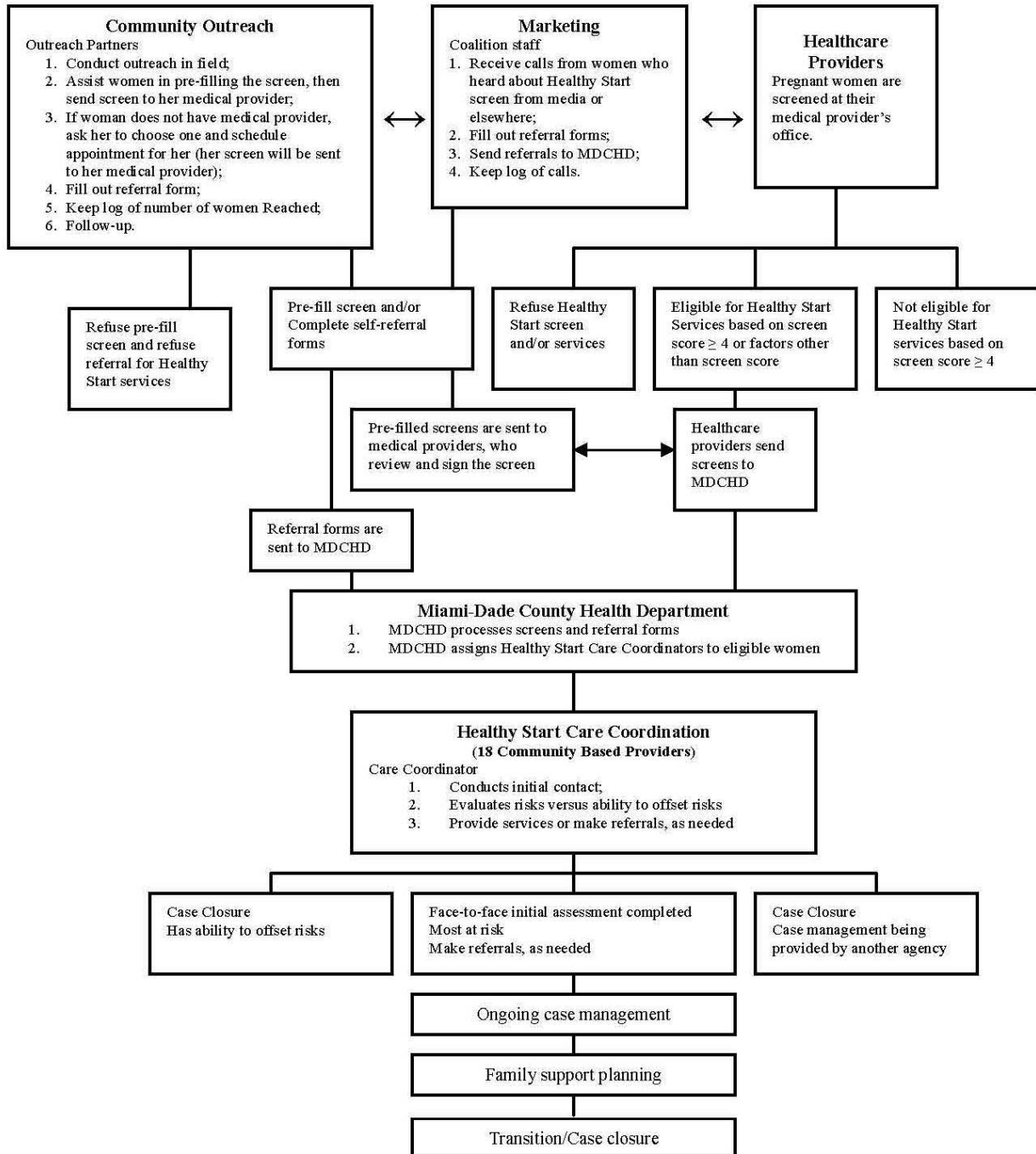
- Maternity care advisors contact the selected provider to enroll the client
- Maternity care advisors determine whether a visit is scheduled
- Providers are reminded to complete the Healthy Start screen. In some Coalition areas they will receive a partially completed screen from the Maternal Care Advisor (MCA)

**Follow-Up**

- Assistance is offered/provided to clients to make/keep appointments
- Maternity care advisors verify that appointments are kept
- Maternity care advisors verify that Healthy Start screen was completed
- Clients receive assistance to access case management and other services
- Problems are resolved as they occur
- Clients receive assistance to change providers if requested and qualifications are met
- Clients are surveyed periodically to determine satisfaction

## D. Three-Pronged Approach to Service Delivery

As described in earlier sections, the Coalition has identified three priorities for action planning: low birth weight, preterm birth, and infant mortality. These issues form the core of the Coalition's mission. Therefore, action plans selected for Fiscal years 2006-2011 will focus on strengthening the Coalition's ability to screen and provide services to qualified women through our three-pronged approach to service delivery.



## IX. FUNDING ALLOCATION PROCESS

The Healthy Start Coalition of Miami-Dade has enlisted contractors to provide Healthy Start services to its clients. In March 2004, the Coalition announced a Request for Proposal (RFI) for its services with a May 5, 2004 deadline. Fifteen proposals were submitted for Healthy Start services in addition to one from the Miami-Dade County Health Department, to process and manage Healthy Start screens and encounter forms. Volunteers, members from the Coalition's Board of Directors, and staff, reviewed all proposals. The results were tabulated and the Coalition called a debriefing session with the reviewers on May 15, 2004 to clarify discrepancies in tabulation and other concerns.

Funding decision for FY 2004-2005 was presented to the Board of Directors on May 27, 2004 and were based on a comprehensive analysis that includes the following: 1) Request for Information (RFI) process; 2) Analysis of Healthy Start Contracted Providers GH350 monthly reports of services; 3) Contractual Performance Measures from the monitoring visits; and 4) Staff recommendations.

As a result of the RFI process, the Coalition selected 11 providers including the Miami-Dade County Health Department that would receive funding for fiscal year July 1, 2004 – June 30, 2005.

With the exception of conducting a RFI for FY2005-06, those 11 providers went through a contract negotiation process similar to that done in 2004. The Coalition met with each organization and reviewed their proposal for services, analyzed the staffing pattern, budget expenditure for the previous fiscal year and proposed budget for FY2005-06, GH350 reports, contractual performance measures and monitoring visit results. The Coalition developed contracts with all the providers that are consistent with the contract requirements of the State of Florida, Department of Health.

To close the gap in Healthy Start services, the Coalition continues to identify local organizations able to provide services to meet the need. All potential service providers are required to submit a proposal and budget narrative that are reviewed by staff. If the providers show strong history and has the capacity to provide a service, Coalition staff would formally meet with the service provider to negotiate a contract. As of January 2006, the Coalition has entered into contractual agreements with three (3) additional service providers who are providing nutrition and parenting education. Currently, the Coalition has 14 contracted providers.

## X. ACTION PLANS: CATEGORY A

### A. Planning Summary Sheet for the Healthy Start System

**Coalition:** Healthy Start Coalition of Miami-Dade

**Coalition Priorities:** To reduce infant mortality and morbidity, improve pregnancy outcomes, and enhance the health and development of children from birth to age three in Miami-Dade County.

**What particular priorities, target groups, or geographic areas are targeted in your Service Delivery Plan?** Healthy Start services are provided countywide.

Check the “Y” column if Healthy Start money is being used.

Check the “N” column if Healthy Start money is not being used.

<b>Healthy Start System Components</b>	<b>Provider</b>	<b>Y</b>	<b>N</b>	<b>Begin and End Date of MOA Or Contract</b>
Outreach services for pregnant women	- 11 Healthy Start Contracted Providers - 2 Outreach organizations funded by the Coalition - Public Health Trust/Jackson Health System -All federally qualified Community Health Centers	Y	N  N  N	01/06-12/10
Outreach services for children	-11 Healthy Start Contracted Providers of care coordination and wraparound services - Public Health Trust/Jackson Health System -All federally qualified Community Health Centers	Y	N  N	01/06-12/10
Process for assuring access to Medicaid (PEPW & ongoing)	Department of Children and Families		N	01/06-12/10
Clinical prenatal care for all unfunded women	- Public Health Trust/Jackson Health System - Miami-Dade County Health Department,		N  N	01/06-12/10

	MomMobile			
Clinical well-child care for all unfunded infants	Public Health Trust/Jackson Health System		N	01/06-12/10
Funding to support the Miami-Dade County Health Department (MDCHD) Vital Statistics Healthy Start screening infrastructure	Miami-Dade County Health Department		N	01/06-12/10
Ongoing training for providers doing screens and referrals	Miami-Dade County Health Department, Healthy Start Data Management Office and Coalition	Y		01/06-12/10
Initial contact after screening	12 Healthy Start Contracted Providers	Y		01/06-12/10
Assessment of service needs	12 Healthy Start Contracted Providers	Y		01/06-12/10
Ongoing care coordination	12 Healthy Start Contracted Providers	Y		01/06-12/10
Interconceptional education and counseling	12 Healthy Start Contracted Providers	Y		01/06-12/10
Childbirth education	12 Healthy Start Contracted Providers	Y		01/06-12/10
Parenting support and education	13 Healthy Start Contracted Providers	Y		01/06-12/10
Nutritional counseling	11 Healthy Start Contracted Providers	Y		01/06-12/10
Provision of psychosocial counseling	11 Healthy Start Contracted Providers	Y		01/06-12/10
Smoking cessation counseling	11 Healthy Start Contracted Providers	Y		01/06-12/10
Breastfeeding education and support	12 Healthy Start Contracted Providers	Y		01/06-12/10
Data entry into Client Information System/ Health Management Clinic (CIS/HMC)	Miami-Dade County Health Department	Y		01/06-12/10
MomCare Program (SOBRA)	Coalition	Y		01/06-12/10

## **B. Internal and External Quality Improvement and Quality Assurance Plan**

The Healthy Start Initiative was implemented by the State of Florida on April 1, 1992 in an attempt to reduce infant mortality, the number of low birth weight babies and to improve the overall health and developmental outcomes of newborns. In order to achieve these objectives, the Coalition offers universal prenatal and infant screening aimed at identifying pregnant women and infants who face the risk of suffering adverse birth, health and developmental outcomes. If found to be at risk for poor birth and developmental outcomes they are offered Healthy Start services such as care coordination, parenting, breastfeeding and childbirth education, smoking cessation, psychosocial and nutritional counseling via Healthy Start contracted providers located throughout Miami-Dade County.

The Coalition is committed to continuously improving the quality of its programs and services, thereby ensuring that all pregnant women and children are offered the screen to determine risk. To this end, a Quality Improvement and Quality Assurance (QI/QA) plan has been designed to monitor and guide the objectives of the Coalition. The QI/QA plan will be used and refined on an ongoing basis to examine the processes of service provision, address customer satisfaction, monitor the achievements of performance measures and desired outcomes, and drive continuous improvements. Additionally, it will help the Coalition to clearly define an overall funding strategy, and identify providers in need of technical assistance after funds are disbursed. Ultimately, the QI/QA plan will ensure that Healthy Start services are delivered in a manner which complies with the current Healthy Start Standards and Guidelines developed by the State of Florida, Department of Health and the contract requirements.

Finally, the compliance activities outlined in this document will identify areas in which funded providers must improve in order to provide the expected level and quality of services mandated by the Coalition.

### **1. Healthy Start Coalition Committees**

As the need arises, the Coalition will convene committees that are responsible for monitoring external contracts and improving the Healthy Start care coordination system. The following is a list of current committees which manage the Healthy Start System:

**A. Board of Directors.** The Board of Directors is responsible for approving all contracts and addressing matters of non-compliance related to contract stipulations as follows:

- Issues of contract compliance, amendments or termination
- The Board of Directors will make the final decision on all contracts

**B. Executive Committee.** This committee is responsible for planning, funding and overseeing the Healthy Start system while providing recommendations to the Board of Directors when necessary. In the area of quality improvement the committee:

- Receives regular reports from the Quality Improvement and Review Committee on audit outcomes and other programmatic issues involved in the contracts
- Recommends continuation/discontinuation of funding with contracted providers

- Makes final recommendations to the Board of Directors regarding newly selected providers, as well as those that are eligible for renewal
- The Executive Director will convene this committee

**C. *Quality Improvement and Review Committee (QIRC).*** The QIRC committee continually monitors and develops procedures for improving Healthy Start service delivery and ensures compliance with the *Healthy Start Standards and Guidelines*. The Coalition recruits members of community organizations who possess the necessary expertise in the area of quality improvement and assurance. A minimum of four (4) people are invited to serve on this committee. The committee will:

- Review the Coalition's quality improvement processes and provide recommendations
- Attend committee meetings on quality improvement efforts when scheduled
- Review quarterly reports submitted by contracted providers and provide feedback/questions to the Quality Improvement/Assurance Manager (QI/QA Manager) regarding the reports, as appropriate. Providers are given the opportunity to respond to feedback/questions
- Conduct annual program audit of all contracted providers. The QI/QA Manager will structure the audits
- Provide reports to the Executive Committee regarding the status of all contracts. The QI/QA Manager will draft the reports for submission to committee members and seek modifications or approval
- Provide annual recommendations to the Executive Committee and the Board of Directors regarding continued funding of the contracts
- Designated staff will convene this committee

**D. *Forms Revision and Improvement Committee.*** A subcommittee of the QIRC will be created to improve and revise forms as the need arises. Healthy Start forms will be used to document clients' information. Contracted providers may select internal staff members to participate on this committee. The committee will:

- Examine the existing Healthy Start forms to ensure user friendliness
- Identify issues that are related to forms and recommend areas in which further training is needed
- Work with contracted providers to implement new forms
- Designated staff will convene this committee

**E. *Data Committee.*** Data is crucial to understanding the direction of the Healthy Start initiative, formulating strategies to achieve Coalition objectives and providing evidence of established indicators, which allow the Coalition to make informed decisions. Designated staff will convene this committee which is responsible for:

- Developing processes to collect and analyze statistical data including performance and outcome objectives for Healthy Start core services
- Addressing data quality issues
- Identifying community and state-wide data sources
- Evaluating the Coalition activities

**F. Maternal Infant and Child Health Provider Committee (MICH).** The Healthy Start Coalition of Miami-Dade is one facet of the Healthy Start system that delivers its services to women and children in Miami-Dade through contracted providers. The MICH Committee will address concerns that arise within the Healthy Start system of care coordination and other maternal, infant and child health systems.

- The committee is composed of Healthy Start contracted providers
- The committee identifies gaps in maternal, infant and child health services as well as barriers in accessing Healthy Start services
- The committee invites maternal, infant and child health providers to address related issues collaboratively
- Healthy Start contracted providers are given the opportunity to dialogue about issues and concerns that impede their ability to provide quality services and receive assistance in developing strategies for improvement
- Designated staff will convene this committee

## **2. Reporting Requirements**

### **a. Quarterly Reports**

Reports to the Healthy Start Coalition are critical to the QI/QA process as these are needed to monitor progress and overall program success, as well as to identify best practices. All contracted providers are required to submit quarterly reports to the Coalition. These reports must be data driven and indicate the comprehensiveness and duration of the services being offered. Coalition staff determines data elements to be included in quarterly reports

- The QI/QA Manager will review the quarterly reports and submit written questions on information contained in the reports
- The QI/QA Manager will track all performance indicators and service data quarterly and compare them to the annual numbers from the previous year as well as the numbers from the previous quarter and program record audits
- As part of the performance data, the Coalition will examine local data and compare with the Department of Health Executive Summary Reports and the GH330/GH350 Reports.

### **b. Monthly Review Reports**

- All Healthy Start contracted providers are required to conduct internal monthly record reviews using the forms included in the contract. A minimum of 10 records are reviewed each month (30 records quarterly) as part of the ongoing internal QI/QA process. A complete summary of the records reviewed and a written status on each outcome and performance measures are included in the quarterly reports submitted to the Coalition.
- Each Healthy Start contracted provider must have an internal QI/QA process in place within their respective organization and is required to report on that process quarterly. The Coalition will offer technical assistance to providers as they develop quality improvement plans and will monitor those plans on a quarterly basis. The internal QI plan may include consumer satisfaction surveys, other types of client surveys, peer

record reviews, and an internal process for problem-solving and addressing issues that affect service provision. All contracted providers must submit a copy of the written internal QI process to the Coalition.

**c. Financial Reports**

Financial reports submitted by each contracted provider are monitored by the Coalition's designated staff.

**3. Program Audit**

The Coalition performs at least one annual audit of each Healthy Start contracted provider. The audit may include, but is not limited to: 1) case record reviews, 2) class observations, 3) home visits, 4) personnel file audits, 5) financial audits, 6) facility audits, 7) client satisfaction surveys, and 7) staff meetings. The QI/QA manager coordinates the audit and typically invites the Quality Improvement Review Committee (QIRC) to participate. In addition, the Coalition coordinates the annual audit with the State of Florida, Department of Health.

Through its audits, the Healthy Start Coalition assesses performance using administrative records, self-reported data from service providers, and client satisfaction surveys. Subject to the availability of funds, the Coalition will contract with independent entities to conduct evaluations of the Healthy Start program components in Miami-Dade.

**a. Annual Audit Format/Procedure**

- Inform Healthy Start contracted providers of scheduled audit at least one month in advance of the date
- Develop and submit an agenda regarding the annual audit in order to outline the areas of focus
- Review the following reports in preparation of the audit:
  - Quarterly reports
  - Last site visit report
  - Financial report
  - Survey or focus group results (when available)

The annual audit will consist of three parts:

- 1) An entrance interview with the provider staff responsible for managing Healthy Start services
- 2) Record review of randomly selected prenatal and postnatal records
- 3) An exit interview with the program manager and other contracted provider staff to discuss the strengths of the services provided, concerns highlighted during the audit and negotiate strategies for improvement

The QI/QA Manager will prepare a report for the QIRC. In addition, the results of the audit will be submitted to the Healthy Start contracted providers. Providers found to be non-compliant with the contract, are required to formulate a corrective action plan which must be furnished to the Coalition no later than 10 days upon receipt of the audit report. The QIRC will review the corrective action plan and approve as necessary.

**b. Other QI/QA Strategies**

- All Healthy Start staff will be trained on the current *Healthy Start Standards and Guidelines* and other areas as necessary. The QI/QA Manager will invite the State of Florida, Department of Health Healthy Start Contract Manager to conduct trainings and provide technical assistance when necessary. In addition, the QI/QA Manager will provide a minimum of two trainings per year on the *Healthy Start Standards and Guidelines* and coding of Healthy Start services. The QI/QA Manager will also work with the Miami-Dade County Health Department and the Healthy Start contracted providers to provide a standard orientation and ongoing training plan for the providers' staff. As mandated by the Coalition, it is the responsibility of each provider to train new staff as needed and maintain records of completed trainings for each staff member who provides Healthy Start services.
- Train prenatal health care providers and hospitals/birthing facilities on a regular basis to encourage Healthy Start services

**4. Performance Based Contracts**

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

**C. QI/QA Work Plan 2006-2010****Year:** 2006-2010

<b>Section 1.01 Action Steps</b>	<b>Coalition Staff Responsible</b>	<b>Date Initiated</b>	<b>Date Completed</b>
1. Implement strategies to increase the prenatal and postnatal screening rate in Miami-Dade County. 2005 Prenatal screen rate: 57.6% 2005 Postnatal screen rate: 75.5%	Executive Director, Provider Liaisons, QI/QA Manager	January-06	December-10
a. Set up functional linkage between screening providers and maternal, infant, and child health (MICH) programs overseen by the Coalition	Executive Director, Provider Liaisons, QI/QA Manager	January-06	December-10
b. Establish greater involvement of principal birthing facilities in the MICH care system	Executive Director, Provider Liaisons, QI/QA Manager	January-06	December-10
2. Collaborate with one or more initiatives aimed at reducing infant mortality and improving birth outcomes	Executive Director & staff	January-06	December-10
3. Convene the Quality Improvement and Review Committee (QIRC) as needed to address issues/concerns relevant to the Healthy Start system	QI/QA Manager	March-06	December-10
4. Recruit volunteers to participate on the Quality Improvement and Review Committee (QIRC)	Executive Director and QI/QA Manager	February-06	December-10
5. Conduct annual monitoring visits to Healthy Start Contracted Providers to ensure quality and quantity of service delivery	QI/QA Team	February-06	December-10
6. Develop a schedule for the annual monitoring visits of contracted providers to review charts, observe wraparound services and/shadow staff on home visits	QI/QA Team	February-06	December-10

Quality Assurance and Quality Improvement Work Plan 2006-2010

7. Implement monitoring visit schedule annually	QI/QA Team	February-06	Annually
8. Identify programmatic challenges as they relate to the Healthy Start system and problem solving	QI/QA Team	February-06	December-10
a. Assess supervisors' knowledge of the requirements of the Healthy Start standards and guidelines and identify training needs	QI/QA Team	March-06	December-10
b. Assess tools needed for supervisors and staff to provide Healthy Start services	QI/QA Team	March-06	December-10
9. Identify challenges in using work related or Healthy Start forms	QI/QA Team	March-06	December-10
10. Develop a training plan that addresses the training needs for contracted providers that relates to service delivery	QI/QA Team and Education & Training Manager	March-06	December-10
11. Coordinate with contracted providers and MomCare staff to develop cultural competence training	QI/QA Team and Education & Training Manager	July-06	December-10
12. Coordinate customer service training and make available to contracted providers, MomCare staff and MICH service providers in Miami-Dade County, if funding is available	Education & Training Manager	August-06	December-10
13. Identify appropriate facilitator to train staff	Education and Training Manager	April-06	December-10
14. Provide technical assistance to the Healthy Start Providers on programmatic issues as Needed	QI/QA Team	Upon execution of contract	December-10
15. Provide technical assistance to the contracted providers on contractual issues as needed	Finance Manager	Upon contract execution	December-10
16. Make recommendations to the Executive Committee regarding renewal of contracts	Quality Improvement and Review Committee (QIRC)	May-06	December-10
17. Develop contracts	Finance Manager/Contract Manager	May-06	December-10

Quality Assurance and Quality Improvement Work Plan 2006-2010

18. Orient contracted providers on the signed contracts	Finance Manager and QI/QA Team	July-06	December-10
19. Collaborate with MICH organizations and develop agreements (MOA/MOU) for coordination of services	Executive Director & staff	January-06	December -10
20. Track performance indicators and prenatal and postnatal screening data	QI/QA Team	Quarterly	December -10
21. Track service data on the GH330/GH350 reports	QI/QA Team	Quarterly	December -10
22. Track the Medicaid Waiver billable service data	QI/QA Team	Monthly	December -10
23. Monitor contracted providers' monthly expenditures	Finance Manager	Monthly	December -10

XI. ACTION PLANS: CATEGORY B

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

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

According to community focus groups, there is a need to increase awareness of the values and benefits of Healthy Start services in the community. Non-Hispanic Black and Haitian women, in particular, tend to experience poorer birth outcomes, tend to delay prenatal care, account for a higher percentage of unwed mothers and teenage births compared to non-Hispanic White women and would benefit greatly from receiving information regarding Healthy Start services.

Marketing/community awareness:

- increases public awareness of risk behaviors associated with adverse birth and health outcomes for mothers and children
- facilitates access to services designed to address those risks
- informs community members, particularly women of childbearing age, of the benefits of the Healthy Start program
- empowers pregnant women to request the Healthy Start screen if it is not offered by the prenatal care provider

**b. What health status indicator/Coalition administrative activity is being addressed by this strategy?** Community awareness, screening rates

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

- Healthy Start Needs Assessment 2005
- Community discussions (Healthy Start Needs Assessment)
- Health Problem Analysis 2004

**2. PLANNING PHASE QUESTIONS**

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

Community Education, with an emphasis on Non-Hispanic Black and Haitian women

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

- Development of a marketing plan with feedback from the HS providers, Miami-Dade County Health Department Data Management Office (MDCHD DMO) and Coalition members
- Marketing materials
- Log of distribution of materials (where, who, what, how many, how will the materials be used)
- Community Based Provider (CBP) site visits and reports
- Changes in screening rates and number of self-referrals
- Number of membership forms submitted

- Number of website “hits” and questions submitted
- Meeting summaries with community organizations
- CIS/HCMS reports.
- Number and venue of presentations made to community-based and professional organizations.

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

- Coalition staff will develop a marketing plan that incorporates feedback from HS providers, MDCHD HS Data Management Office and Coalition members.
- The Executive Director will contract with public relations and marketing firms, promotional and educational materials vendors and local graphics design companies, to produce marketing materials. The Education and Training Manager will create a log to track the distribution of marketing materials (where, who, what, how many, how will the materials be used).
- Healthy Start Contracted Providers’ reports will document how many community events were attended.
- Prenatal Risk Screen Executive Summary Reports will be used to access information on changes in screening rates and number of self-referrals.
- Coalition membership rosters will track changes in number of new members.
- Meeting summaries with community organizations will be documented by Coalition staff
- CIS/HCMS will be utilized to gather information on contracted HS Providers’ community outreach efforts.

**d. What do you expect will be the observed impact of the strategy on the system or community-wide problem/need?** There will be an increase in the awareness of the availability, values and benefits of Healthy Start services in the community. Greater awareness will lead to greater usage

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

- Community perceptions of awareness and benefits
- Screening rates

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

- Community focus groups
- Quarterly executive summary reports

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**3. ACTION STEPS**

Action Steps	Person Responsible	Start Date	Completion Date
<b>Marketing Strategies</b>			
1. Develop new educational messages and slogans, and design promotional materials.	Communications and Program Specialist; Education and Training Manager	1/06	12/06
2. Continue to share marketing and media ideas and concepts with other Healthy Start Coalitions	Executive Director, Communications and Program Specialist; Education and Training Manager	1/06	12/06
3. Keep and monitor a log of distributed materials to track progress of media campaign	Education and Training Manager, QI/QA Manager, Research and Planning Manager,	1/06	12/06
4. Monitor number of hits and questions submitted to website.	Coalition Staff	06/06	12/06
5. Identify funding to conduct an evaluation of internal marketing strategies.	Executive Director, Coalition Staff	12/06	12/07
<b>Healthy Start Contracted Providers Participation</b>			
1. Through contract, the Coalition will continue to assure that Healthy Start Contracted Providers (HSCPs) display the Healthy Start logo and include the logo in related printed educational/informational materials	Coalition Staff, HSCPs	1/06	12/06
2. Through contract, the Coalition will continue to assure that Healthy Start Contracted Providers (HSCPs) participate in community events on its behalf	Coalition Staff, HSCPs	1/06	12/06
<b>Coalition Efforts</b>			
1. Make presentations at least quarterly at health fairs, public forums, etc. to increase	Coalition staff	1/06	12/06

**MARKETING/COMMUNITY AWARENESS**

visibility of the HS Program, raise awareness of Healthy Start services, and recruit Coalition members			
2. Work with community organizations that address maternal and infant health issues to raise awareness of Healthy Start Program and to identify opportunities for collaboration. Ongoing communication with community service providers and community groups is critical to support the education outreach function	Coalition staff	1/06	12/06
3. Conduct meetings with community organizations to learn more about their health issues and barriers to accessing services. The information will be used to plan appropriate services	Coalition staff	1/06	12/06
4. Monitor screening rate quarterly, analyze trends, identify problem areas, and select strategies Re-evaluate to ensure strategies are working.	Research and Planning Manager, Education and Training Manager, QI/QA Manager	1/06	12/06
5. Make training and workshops available to key maternal, infant and child health (MICH) community stakeholders to address issues identified by Step 3 and 4.	Education and Training Manager	1/06	12/06
6. Develop educational materials on issues relevant to Healthy Start services and maternal and child health best practices	Research and Planning Manager, Education and Training Manager, Executive Director	1/06	06/07
7. Distribute educational materials on issues relevant to healthy start services and maternal and child health best practices	Coalition Staff	1/06	12/06

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

**a. What is the requirement or system/community-wide problem or need identified to be addressed by a strategy?** For the past three (3) years, from October 2002 – September 2005 the Coalition had received funding from the United Way in Miami-Dade to conduct street-level outreach in zip codes 33147 and 33142, where a disproportionate number of maternal risk factors and adverse birth outcomes occur in Miami-Dade County. The funding for this initiative ended in September 2005. Since the initiative proved successful in increasing Healthy Start program awareness and increasing the number of women screened and referred to the Healthy Start program, the Coalition decided to expand this outreach initiative to the zip codes listed below. These zip codes are within the geographic scope of the outreach partners with whom we have worked for the past three years, and are also part of these zip codes included in the geographic areas of concern in Section IV. These zip codes also have a high number of Haitian-American residents, which is one of the target populations.

**Table 25. Zip codes of Priority Areas in Miami-Dade**

Zip Code	Total Live Births	Births to Unwed Mothers	Births to Mothers Age 10-19	Low Birth Weight Births (<2,500 grams)	Gestation <37 Weeks	Late/No PNC	Fetal Mortality Rate	Infant Mortality Rate
		Percent	Percent	Percent	Percent	Percent	Rate	Rate
33054	493	72.8%	21.9%	15.8%	18.3%	3.7%	16.2	8.1
33055	686	54.8%	12.0%	10.1%	8.6%	2.8%	14.6	5.8
33056	547	71.7%	16.1%	13.3%	19.9%	2.2%	14.6	16.5
33127	518	72.2%	17.6%	12.5%	13.3%	2.7%	23.2	9.7
33142	841	75.4%	18.7%	10.2%	13.3%	3.7%	11.9	8.3
33147	824	76.2%	22.0%	11.5%	11.3%	3.3%	13.3	12.1
33150	513	67.3%	15.4%	9.7%	11.1%	3.3%	11.7	7.8
33167	297	63.0%	17.2%	13.5%	31.0%	3.0%	6.7	16.8
33169	620	61.1%	9.8%	13.2%	6.8%	4.2%	17.7	11.3

Source: Florida Department of Health, Office of Vital Statistics

**b. What health status indicator/Coalition administrative activity is being addressed by this strategy?** Community Awareness, Screening Rates

**c. What information, if any, was used to identify the issue/problem (i.e. HPA, FIMR, screening, client satisfaction, interviews, QI/QA)?** Healthy Start Needs Assessment 2005, Community Discussions (Healthy Start Needs Assessment), Health Problem Analysis 2004.

**2. PLANNING PHASE QUESTIONS**

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

Street-level outreach to pregnant women and teens in the targeted zip code aimed at promoting awareness of and increasing participation in the Healthy Start program.

**b. What do you expect will be the observed impact of the strategy on the system or community-wide problem/need?** An increase in prenatal screen offer rates, screening rates and consent rates in the targeted zip code areas. These will subsequently result in a decrease in poor birth outcomes.

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

Prenatal offer and prenatal screening rates.

**d. Where/how will you get the information?** Healthy Start reports website, along with locally developed Coalition summary activities. Vital Statistics will be used to obtain outcome measures as well as self-referral reports from the MDCHD Data Management Office.

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**3. ACTION STEPS**

Action Steps	Person Responsible	Start Date	Completion Date
1. Conduct street-level outreach in target areas on a monthly basis.	Teen Pregnancy Prevention Center (TPPC) and Economic Opportunity Family Health Center (EOFHC)	1/06	6/07
2. Conduct training of the Healthy Start Program and project procedures in target areas	Research and Planning Manager, QI/QA Manager	1/06	6/07
3. Participate in Workshops and Seminars and community health fairs in target areas	Research and Planning Manager, QI/QA Manager, TPPC, EOFHC	1/06	6/07
4. Conduct quarterly meetings with project partners	Research and Planning Manager, QI/QA Manager	1/06	6/07
5. Monitor number of self-referrals from target areas on a quarterly basis to evaluate effectiveness	Research and Planning Manager, QI/QA Manager	1/06	6/07

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

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

1) There is a need to evaluate the amount and schedule of enhanced Healthy Start services offered by Healthy Start Contracted Providers. In community discussions, participants suggested that the availability of parenting and childbirth classes needed to be better advertised.

2) There is a need to have consistency among contracted Healthy Start Contracted Providers regarding enhanced services training and curriculums used.

The Healthy Start enhanced services support pregnant women in reducing the factors and situations that place them and their babies in jeopardy of poor birth outcomes.

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

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

- Community discussions documented in the most recent Needs Assessment

**2. PLANNING PHASE QUESTIONS**

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

Increase the number and improve the quality of enhanced services offered by Healthy Start Contracted Providers; Increase the knowledge and awareness of the Healthy Start program countywide; Contribute to the capacity-building of community-based providers in contact with pregnant women, infants and children.

**b. What information will you gather to demonstrate that you have implemented this strategy as intended?**

- Increase in the number of services as reflected in the CIS/HCMS reports
- Contracts with Healthy Start Contracted Providers that reflect the increase in the number of enhanced services
- Selection and utilization of standard training curriculum and materials

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

- CIS/HCMS monthly report provided by DOH
- Healthy Start Contracted Providers' service reports provided by the providers
- Current Healthy Start Provider contracts provided by the MDCHD Data Management Office

**d. What do you expect will be the observed impact of the strategy on the system or community-wide problem/need? There will be an increase in the consistency and quality of service provision among HSCPs.**

**HEALTHY START PROVIDER DEVELOPMENT**

**e. What information will you gather to demonstrate this change on the system?**  
 QI/QA audit reports and internal evaluations.

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

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**3. ACTION STEPS**

<b>ACTION STEPS</b>	<b>Person Responsible</b>	<b>Start Date</b>	<b>Completion Date</b>
1. Identify training needs of HSCPs during monitoring visits	Education and Training Manager & QI/QA Manager	01/06	12/06
2. Continue to review national and local curricula for any updates, revision or upcoming trainings and workshops	Education and Training Manager	01/06	12/06
3. Give presentations to professional and community-based organizations and providers regarding the Healthy Start Risk Screen process, MomCare Program, the Medicaid Family Planning Waiver and the Medicaid Simplified eligibility, when there is an identified need, such as a new provider or new staff at an existing provider	Education and Training Manager, Coalition Staff	01/06	12/06
4. Provide workshops for Healthy Start Contracted Providers and as resources permit, extend invitations to community based organizations when there is an identified need, such as a new provider or new staff at an existing provider	Education and Training Manager	01/06	12/06

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

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

The prenatal risk screen *offer rate* among prenatal care providers in Miami-Dade was 71.7% in FY04-05 (July 1, 2004 – June 30, 2005). Of those women who were offered screens 75% consented to complete the screen, and 96% consented to participate in the Healthy Start Program. According to a December 2005 Status report for the Healthy Start Prenatal Upload to Central Registry, it takes an average of 25 days from the date pregnant women are screened until the forms are received in the County Health Department. This length of time is long compared to other large counties such as Hillsborough (19 days), Palm Beach (14 days), Orange (16), and Pinellas (12).

The Healthy Start prenatal screening instrument is used to funnel pregnant women most likely to be at risk, into the system of care needed to optimize their birth outcomes. The sooner the at-risk women enter the system of care, the chances of having good birth outcomes increase.

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

- Healthy Start prenatal and postnatal screening rates

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

- Prenatal and Postnatal Executive Summary Reports
- Prenatal Risk Screen Upload Status Report
- Postnatal Risk Screen Upload Status Report

**2. PLANNING PHASE QUESTIONS**

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

Increase prenatal and postnatal risk screen offer rates by providing outreach and in-service training to prenatal care providers and birthing facility (hospital) staff on how to adequately present the Healthy Start screen in a manner that encourages consent, how to explain the concept of Healthy Start, and the benefits of Healthy Start screening and program participation to eligible pregnant women.

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

- 1) Number of in-service trainings to medical providers
- 2) Screening reports of individual providers
- 3) Prenatal screen offer rate and screening rate reports
- 4) Postnatal screen offer rate and screening rate reports
- 5) Amount and type of outreach, for example letters, educational materials distribution, workshops, face-to-face training and review, etc.

**SCREENING RATE MONITORING AND IMPROVEMENT**

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

- 1) Logs and documentation of in-service and outreach methods
- 2) Executive Summary Reports
- 3) Prenatal Upload Status Reports
- 4) Individual prenatal care provider and birthing facility offer and screening rates

**d. What do you expect will be the observed impact of the strategy on the system or community-wide problem/need?** There will be an increase in the offer rates, in the screening rates and a decrease in the average number of days from screening date until screen receipt at the Healthy Start Data Management Office at the MDCHD.

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

- 1) Executive Summary Reports
- 2) Prenatal Upload Status Reports
- 3) Individual prenatal care provider and birthing facility offer and screening rates

**f. Where/how will you get the information?** State of Florida screening reports via the Healthy Start reports website, individual provider performance information from the Healthy Start Data Management Office at the MDCHD, and the locally developed Coalition summary of activities.

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**3. ACTION STEPS**

<b>Action Steps</b>	<b>Person Responsible</b>	<b>Start Date</b>	<b>End Date</b>
1. Monitor and review on a quarterly basis the prenatal and postnatal screening rate.	QI/QA Manager, QIRC Team	01/06	12/06
2. Identify and monitor on a quarterly basis the accuracy and timeliness of the prenatal and postnatal screens that are completed and submitted to the Miami-Dade County Health Department.	QI/QA Manager, QIRC Team, MDCHD Healthy Start Data Management Office	01/06	12/06

**SCREENING RATE MONITORING AND IMPROVEMENT**

<p>3. Monitor and review the submission of the prenatal risk screening instrument for:</p> <ul style="list-style-type: none"> <li>• The average number of days from screening date until screen receipt at the Healthy Start Data Management Office at the MDCHD</li> <li>• Assignment and transfer of accurate risk screens to contracted Healthy Start Contracted Providers</li> </ul>	<p>QI/QA Manager, MDCHD HS Data Management Office</p>	<p>01/06</p>	<p>12/06</p>
<p>4. Review the current schedule of outreach efforts by Healthy Start contracted providers and Coalition staff</p>	<p>QI/QA Manager,</p>	<p>01/06</p>	<p>12/06</p>
<p>5. Conduct in-service training and outreach to prenatal care providers and birthing facilities who have low screening rates on an ongoing basis</p>	<p>QI/QA Manager, Provider Liaisons, MDCHD HS Data Management Office</p>	<p>01/06</p>	<p>12/06</p>
<p>6. Monitor screening data to track progress monthly. <i>Analyze Healthy Start Executive Summary Report</i> to evaluate the following outcomes related to Healthy Start screening:</p> <ul style="list-style-type: none"> <li>• Percentage of potential participants offered screens (compared to estimated number of pregnant women/number of births for same time period)</li> <li>• Percentage of potential participants consenting to and receiving screens; total percentage of positive screens and screens referred for other factors</li> <li>• Percentage of potential participants (or their families) consenting to participate</li> </ul>	<p>QI/QA Manager</p>	<p>01/06</p>	<p>12/06</p>

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

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

The Healthy Start Coalition needs to develop an active Board of Directors and general membership. The Board of Directors serves not only to provide direction to the Coalition's activities but also as an advocate on behalf of maternal and infant health. The general members serve to give on-going feedback to the Board of Directors and Coalition on pressing local issues concerning maternal and infant health.

**b. What health status indicator/Coalition administrative activity is being addressed by this strategy?** Board and membership development

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

- Florida Department of Health (DOH) contract
- Board of Directors meeting minutes

**2. PLANNING PHASE QUESTIONS**

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

On-going Healthy Start Board of Directors and General Membership Development

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

- Increase General Membership (GM) membership
- Meeting summaries
- Diverse Board of Directors and General Membership (GM)
- Meeting attendance of Board of Directors and GM

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

Coalition staff will track the progress of the Board of Directors by monitoring participation in scheduled meetings and participation of General Members in Coalition activities.

**d. What do you expect will be the observed impact of the strategy on the system or community-wide problem/need?** There will be an active Board of Directors and general membership.

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

Board of Director meeting minutes, specific recommendation from activities held by the Board of Directors and the General Membership (GM).

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

Board of Directors minutes, general membership and public meeting minutes

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**BOARD AND GENERAL MEMBERSHIP DEVELOPMENT**

**3. ACTIONS STEPS**

<b>Action Steps</b>	<b>Person Responsible</b>	<b>Start Date</b>	<b>Completion Date</b>
<b>Board of Directors (BOD)</b>			
1. Review and conduct Board orientation as needed, such as with the addition of a new member	Executive Director	1/06	12/06
2. Provide Board member training as needed, such as with the addition of a new member	Executive Director, Research and Planning Manager, QI/QA Manager, Education and Training Manager	1/06	12/06
3. Increase consumer and community participation and diversity by asking current Board members to identify at least one potential member per year.	Executive Director, Board Members	1/06	12/06
<b>General Membership (GM)</b>			
1. Continue to meet with community organizations that represent the targeted areas and population to recruit new GM members	Executive Director, Research and Planning Manager, QI/QA Manager, Education and Training Manager	1/06	12/06
2. Participate in community events; serve on task forces, work groups, and other appropriate community initiatives to establish the Coalition's presence in the community and to recruit new General Members. Distribute newsletters with membership forms at community events.	Coalition Staff, Board Members	1/06	12/06
3. Review and conduct general membership (GM) orientation as needed	Executive Director, Research and Planning Manager, QI/QA Manager, Education and Training Manager	1/06	12/06

**BOARD AND GENERAL MEMBERSHIP DEVELOPMENT**

4. Provide GM member training as needed	Executive Director, Research and Planning Manager, QI/QA Manager, Education and Training Manager	1/06	12/06
5. Expand geographic representation of general members and their organizations by asking members to identify other potential members	Executive Director, Board Members	1/06	12/06

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

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

According to the Needs Assessment, the infant mortality rate (IMR) in Miami-Dade was lower than the State rate. However, there are zip code areas in Miami-Dade County that have higher IMRs than the State. Moreover, Non-Hispanic Black women and Haitian women in Miami-Dade County has consistently accounted for higher infant mortality rates than non-Hispanic White and Hispanic women. Further research is needed to understand and address these factors.

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

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

- Health Problem Analysis 2004
- Healthy Start Needs Assessment 2005
- FIMR Case Review Team

**2. PLANNING PHASE QUESTIONS**

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

Ongoing data and collection and analysis, with feedback of results to healthcare providers and key community stakeholders.

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

- Data analysis of official linked birth-death files
- Data analysis of FIMR data
- FIMR Meeting summaries
- MCH Indicators and Surveillance Data

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

Coalition staff will obtain data from the Department of Health, the FIMR Case Review Team, and other sources as needed and identified.

**d. What do you expect will be the observed impact of the strategy on the system or community-wide problem/need?** There will be more information and available research to understand and decipher the factors that contribute to the higher infant mortality rate among non-Hispanic Black women in Miami-Dade County.

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

Copies of data updates, copies of presentations made by the Coalition to different community groups and publications prepared by Coalition staff.

**f. Where/how will you get the information?** Coalition documents and reports.

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**3. ACTION STEPS**

<b>Action Steps</b>	<b>Person Responsible</b>	<b>Start Date</b>	<b>Completion Date</b>
<b>PPOR</b>			
1. Continue to participate in Perinatal Periods of Risk initiative.	Executive Director	1/06	12/06
<b>Research and Planning</b>			
1. Present the PPOR methodology and data results from Phase II analyses to the Data Committee quarterly	Research and Planning Manager	1/06	12/06
2. Analyze and review vital statistics data as made available by the Florida Department of Health quarterly	Research and Planning Manager	1/06	12/06
3. Present updated FIMR data results to the Data Committee quarterly	Research and Planning Manager	1/06	12/06
4. Identify underlying causes of infant mortality and develop recommendations for reducing the infant mortality rate in Miami-Dade County.	Executive Director, Research and Planning Manager, Data Committee, FIMR Case Review Team	1/06	12/06
5. Communicate results of data analysis to Board of Directors annually; to health care providers annually via a written report and on as-needed basis through educational sessions.	Executive Director, Research & Planning Manager	06/07	12/06
6. Evaluate infant mortality rate annually to determine effectiveness of strategies.	Executive Director, Research and Planning Manager, Data Committee	06/07	12/06
<b>FIMR Program</b>			
1. Review 29 fetal death cases per year	Research and Planning Manager, Nurse Abstractor, FIMR Case Review Team	1/06	12/06
2. Conduct monthly Case Review Team (CRT) meetings and report findings to Community Action Group	Executive Director, Research and Planning Manager, Nurse Abstractor	1/06	12/06
3. Establish linkages and relationships with hospitals and other organizations that might provide insight and expertise to the	Executive Director, Research and Planning Manager	1/06	12/06

**INFANT MORTALITY**

<p>CRT, for example DCF, MEs Office, Funeral Home Directors, Emergency Response, First Responders, Fire Department, Police Department, etc.</p>			
<p>4. Continue to identify interested individuals and organizations with expertise in the area of maternal infant health to serve on the Community Action Group (CAG); recruit members via invitation letter, followed up by in-person visit.</p>	<p>Coalition Staff</p>	<p>1/06</p>	<p>12/06</p>
<p>5. Conduct two (2) CAG meetings per year</p>	<p>Research and Planning Manager</p>	<p>1/06</p>	<p>12/06</p>
<p>6. Update, as needed, the mission and goals for the CAG Points of discussion to include:          - Purpose of the CAG          - Responsibility of members          - FIMR findings (present data)          - Strategies based on data findings          - Operations of CAG          - Future meetings (CAG may meet quarterly or semi-annually)</p>	<p>Executive Director,          Research and Planning Manager</p>	<p>1/06</p>	<p>12/06</p>

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

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

It is the responsibility of the Healthy Start Coalition to monitor the use of Healthy Start funds.

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

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

- Florida Department of Health (DOH) contract.

**2. PLANNING PHASE QUESTIONS**

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

Ensure fiscal accountability for contracted providers through appropriate fund allocation procedures.

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

- Expenditure reports from providers
- Service reports from providers
- Itemized list of HS funded staff by portion of Full Time Employment (FTE) and expenditures for staff during report period.

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

Healthy Start Contracted Providers will submit the above listed reports to the Coalition. Also during site visits, the QI/QA Manager and Director of Operations will review the above listed reports.

**d. What do you expect will be the observed impact of the strategy on the system or community-wide problem/need? There will be improved accountability for the use of Healthy Start funds.**

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

Fiscal reports submitted to the Coalition.

**f. Where/how will you get the information? Coalition fiscal reports, contracted providers fiscal audit reports.**

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**3. ACTION STEPS**

Action Steps	Person Responsible	Start Date	Completion Date
1. Conduct contract negotiations annually, and contract revisions and amendments as needed during the contract year	Executive Director, QI/QA Manager, Director of Operations	01/06	07/06
2. Determine the total amount of expenditures per community based provider	Executive Director, QI/QA Manager, Director of Operations, Bookkeeper	01/06	08/06
3. Determine the number of unduplicated clients who received the services or encounters provided per community based provider	QI/QA Manager, Director of Operations, Bookkeeper	01/06	7/06
4. Determine the number of full time employed personnel funded with HS dollars (in FTEs) at what cost or at what negotiated rate per community based provider	Executive Director, QI/QA Manager, Director of Operations, Bookkeeper	01/06	07/06
5. Verify that Healthy Start (HS) dollars are spent only on authorized services per community based provider monthly	Executive Director, QI/QA Manager, Director of Operations, Bookkeeper	01/06	12/06
6. Conduct annual internal fiscal audit	Executive Director, QI/QA Manager, Director of Operations, Bookkeeper	01/06	12/06
7. Require copies of annual financial audits of all Healthy Start contracted providers	Executive Director, QI/QA Manager, Director of Operations, Bookkeeper	01/06	12/06
8. Establish future funding levels annually based on programmatic and fiscal performance.	Executive Director, QI/QA Manager, Director of Operations, Bookkeeper	01/06	07/06

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

- a. What is the requirement or system/community-wide problem or need identified to be addressed by a strategy?**  
Performance improvement of contracted Healthy Start Providers
  
- b. What health status indicator/Coalition administrative activity is being addressed by this strategy?**
  - QI/QA
  
- c. What information, if any, was used to identify the issue/problem (i.e. HPA, FIMR, screening, client satisfaction, interviews, QI/QA)?**
  - Prenatal and Postnatal Executive Summary Reports
  - Prenatal Risk Screen Upload Status Report

**2. PLANNING PHASE QUESTIONS**

- a. What strategy has been selected to address this?**  
Ensure that HSCPs provide quality service through annual QI/QA audits, service audits, reviews of quarterly reports and GH350 reports.
  
- b. What information will you gather to demonstrate that you have implemented this Strategy as intended (who, what, how many, where, etc.)?**  
Changes in the rates and numbers of the indicators listed in section 1b.
  
- c. Where/how will you get the information?**  
Client Information System/Health Client Management System (CIS/HCMS) Reports, GH330/GH350 reports, performance review results and summaries, and Executive Summary reports.
  
- d. What do you expect will be the observed impact of the strategy on the system or community-wide problem/need? There will be an increase and improved distribution in the indicators listed in 1b.**
  
- e. What information will you gather to demonstrate this change on the system?**  
Executive Summary reports, performance measures, chart review summaries.
  
- f. Where/how will you get the information? State of Florida screening reports via the Healthy Start reports website, along with local Coalition monitoring and review activities.**

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**3. ACTION STEPS**

Action Steps	Person Responsible	Start Date	Completion Date
<p>1. Monitor screening data to track progress quarterly.  <i>Analyze Healthy Start Executive Summary Report</i> to evaluate the following outcomes related to Healthy Start service provision:</p> <ul style="list-style-type: none"> <li>• Women who received initial contact</li> <li>• Women determined as needing an initial assessment</li> <li>• Women who received an initial assessment</li> <li>• Women determined to need ongoing care coordination</li> <li>• Total number of women who received a Healthy Start (HS) Service</li> <li>• Total number of women attempt to contact only</li> <li>• Total number of women who received an initial contact and/or initial assessment only</li> <li>• Total number of women who received only initial contact and/or initial assessment with "other Healthy Start services"</li> <li>• Total number of women who received services through care coordination-tracking or not face to face with or without "other HS services"</li> <li>• Total number of women who received services through care coordination face to face with or without "other HS services" without FSP</li> <li>• Total number of women who received services through care coordination face to face with or without "other HS services" with FSP</li> <li>• Total number of women unable to locate</li> <li>• Total number of women unable to complete initial contact</li> <li>• Total number of women unable to complete initial assessment</li> </ul>	<p>Executive Director,                      QI/QA Manager,                      Director of Operations,                      Education and Training Manager</p>	<p>01/06</p>	<p>12/06</p>
<p>2. Analyze the monthly CIS/HCMS reports to identify which services are not being offered</p>	<p>Executive Director,                      QI/QA Manager,                      Director of Operations,                      Education and Training Manager</p>	<p>01/06</p>	<p>12/06</p>
<p>3. Review current Healthy Start Contracted</p>	<p>Executive</p>		

<p>Providers' service reports to determine the current number, frequency, and location of enhanced services being offered</p>	<p>Director, QI/QA Manager, Director of Operations, Education and Training Manager</p>	<p>01/06</p>	<p>12/06</p>
<p>4. Recommendations will be made on best practices for enhanced services that meet clients' needs; these will be based on the findings from the Client Information System/Health Management Clinic (CIS/HCMS) and providers' service reports</p>	<p>Executive Director, QI/QA Manager, Director of Operations, Education and Training Manager</p>	<p>01/06</p>	<p>12/06</p>
<p>5. Develop performance improvement plans for providers who are not in compliance.</p>	<p>Executive Director, QI/QA Manager, Director of Operations, Education and Training Manager</p>	<p>01/06</p>	<p>12/06</p>
<p>6. Develop corrective action plans for Providers who do not satisfactorily complete Performance Improvement Plans.</p>	<p>Executive Director, QI/QA Manager, Director of Operations, Education and Training Manager</p>	<p>01/06</p>	<p>12/06</p>

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**1. IDENTIFIED COMMUNITY-WIDE/SYSTEM ISSUE:**

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

Pregnant and parenting teens are a key focus of the Coalition's efforts, and our policies assure all pregnant teenagers immediate access to services.

Overall, births to teens declined over the past four years in Miami-Dade County and Florida. In Miami-Dade County the percent of births to teens 15-19 years declined from 10.9 in 2000 to 9.1 in 2003. However, births to teens in some zip code areas are nearly twice the percentage for the County overall. In South Miami-Dade, percentages above 17.1 are found in Homestead (33030), Homestead/Redland/Princeton/Naranja (33032), Homestead/Naranja (33033), and Florida City (33034). Central Miami-Dade has one zip code with a notably high rate of births to teens, Overtown (33136). North Miami-Dade has several areas with high percentages including Opa-Locka (33054), Carol City 33056), Little Haiti/Wynwood (33127), Liberty City (33147), and Miami Shores/North Miami (33167). These zip codes are part of the community outreach expansion described under the HSCMD Outreach Initiative.

Furthermore, a comparison of live births among teens in all ethnic groups showed that the non-Hispanic Black population accounted for the highest percentage throughout the period.

There were also notable discrepancies in the repeat births to teens categories in many zip code areas. Homestead (33030) and West Homestead (33034) in South Miami-Dade have exceedingly high rates in this category with 25.1 to 35.3% repeat births to teens, respectively. In Central Miami-Dade, similarly high rates can be found in Downtown (33128), Coral Gables (33134), Overtown (33136), Tamiami (33175) and Kendall Lakes/Horse Country (33183). In North Miami-Dade, Opa-Locka (33054), Little Haiti/Wynwood/Miami (33127), Miami Shores/El Portal/Little Haiti/Miami (33138), Allapattah/Brownsville/Melrose/Liberty City (33142), Liberty City (33147) and Miami Shores/El Portal/Little Haiti/Miami (33150) are most affected by high percent of repeat births to teens.

**b. What health status indicator/Coalition administrative activity is being addressed by this strategy?** Teen pregnancy rates, teen repeat pregnancy rates.

**c. What information, if any, was used to identify the issue/problem (i.e. HPA, FIMR, screening, client satisfaction, interviews, QI/QA)?** Healthy Start Needs Assessment 2005, Community Discussions (Healthy Start Needs Assessment), Florida CHARTS.

**2. PLANNING PHASE QUESTIONS**

**a. What strategy has been selected to address this?** Healthy Start Contracted Providers will offer interconceptional education to teenagers.

**TEEN PREGNANCY PREVENTION/INTERCONCEPTIONAL CARE**

- b. What information will you gather to demonstrate that you have implemented this strategy as intended? (who, what, how many, where, etc.).** Number of direct contacts with pregnant teens; Number of direct contacts with parenting teens; Number of units of interconceptional education services provided
  - c. What do you expect will be the observed impact of the strategy on the system or community-wide problem/need?** A decrease in the teen pregnancy and teen repeat pregnancy rates in Miami-Dade County.
  - d. What information will you gather to demonstrate this change on the system?** Teen pregnancy and teen repeat pregnancy rates.
  - e. Where/how will you get the information?** Healthy Start reports website, along with locally developed Coalition summary activities. Vital Statistics will be used to obtain outcome measure, self-referral reports from the Miami-Dade County Health Department Data Management Office
- \*\*\*\*\*

**3. ACTION STEPS**

<b>Action Steps</b>	<b>Person Responsible</b>	<b>Start Date</b>	<b>Completion Date</b>
1. Monitor the rates for teen pregnancy and repeat teen pregnancy in Miami-Dade County on an annual basis	Executive Director, Education and Training Manager, Research and Planning Manager, QI/QA Manager	01/06	12/06
2. Identify Healthy Start wraparound services that promote baby spacing on an annual basis	Research and Planning Manager, QI/QA Manager	01/06	12/06
3. Increase teen engagement with interconceptional care by identifying curricula specifically designed for teens, and provide training to HSCPs as needed, such as with the addition of a new provider, or new staff at an established provider	Education and Training Manager	06/06	12/06
4. Identify and collaborate, on an ongoing basis, with agencies in the target areas that provide services to teens.	Coalition Staff	01/06	12/06
5. Provide interconceptional education services to parenting teens	Healthy Start Contracted Providers	01/06	12/06

# ATTACHMENT A

## ATTACHMENT A

### MOMCARE PROGRAM QI/QA PLAN

The MomCare program is a Medicaid-funded program implemented through a 1915(b) waiver from the federal government to provide Medicaid coverage for pregnant women under the Sixth Omnibus Budget Reconciliation Act (SOBRA). MomCare is a partnership between the Florida Healthy Start Coalitions, Department of Health, Agency for Health Care Administration, and the U.S. Centers for Medicare and Medicaid Services. On October 1, 2001, the Healthy Start Coalitions assumed responsibility for assuring that all Medicaid eligible women receive choice counseling and case management services to assure their access to continuous and ongoing prenatal care and other services as appropriate.

MomCare was implemented in Miami-Dade County on December 1, 2001. The major program goals are to improve birth outcomes and infant health for enrollees and to enroll eligible pregnant women within 30 days of notification from the fiscal agent with the selected prenatal care provider and facilitate having a Healthy Start screen completed.

The Medicaid fiscal agent, Consultec submits a weekly list notifying the local Healthy Start Coalitions of client eligibility. Medicaid-eligible women who are identified as at-risk through the Healthy Start screen and consent to the Healthy Start program will receive ongoing Healthy Start care coordination and other wraparound services. If a woman qualifies for MomCare, she will be case managed by a Maternity Care Advisor (MCA) who will assist her with:

- Scheduling and keeping appointments
- Following through on referrals to other services
- Identifying needs and accessing needed services

To guarantee that the MomCare program goals are achieved, the Coalition will implement a quality improvement and quality assurance plan (QI/QA) that will allow for ongoing monitoring and improvement of MomCare service delivery. The Coalition will assess performance through the use of administrative records, SOBRA Information System (SIS) data reports, MomCare record review form, self-reports from clients regarding the services received, and other assessment methods. The Coalition will work with frontline staff to ensure that performance measures are achieved and will be reviewed monthly.

#### **A. Performance Measures**

1. Attempt to contact the enrollee by telephone within five working days of receiving notification from the fiscal agent
2. Register the enrollee within 30 days of notification from the fiscal agent with the selected prenatal care provider and facilitate the completion of the Healthy Start screen. Make at least three attempts to make contact within the first thirty days of notification by the fiscal agent of eligibility. In the event that reaching the enrollee by phone is not successful, then at least 25% shall receive one attempted face to face contact with priority given to those with no phone
3. Assign a prenatal care provider if the enrollee has not made a decision within 30 days by selecting from a list of providers within a thirty-minute drive of the enrollee's

- residence. Coalitions with more than one prenatal care provider who meet this requirement shall assign a prenatal care provider to the enrollee based upon a locally established unbiased protocol. The selection process shall be weighted for those group practices with more than one prenatal care provider
4. Inform the recipient that her prenatal care provider can be changed for up to 60 days from provider enrollment
  5. For all recipients that have been auto-assigned, or have not been verbally contacted but their provider choice registered, the Coalition shall provide one additional attempt to communicate. Communication may be by letter, telephone call or face-to-face encounter
  6. Provide follow-up services to recipients as needed
  7. After enrollment, between the sixth and ninth month of her pregnancy, the Coalition shall provide follow-up services to recipients
  8. The Coalition shall work with prenatal care providers to provide them with information on the Healthy Start program serviced available to recipients
  9. The Coalition shall encourage prenatal care providers to refer recipients into Healthy Start in the Coalition's service delivery area
  10. The Coalition shall compile information about language skills of prenatal care providers and their office staff and provide recipients with this information when requested
  11. The Coalition shall submit reports to the contract manager of the Department of Health

### **Performance Specifications**

***Outcomes and Outline.*** The Coalition shall submit a quarterly report of these measures using the "All Clients" report from the SOBRA Information System. In addition, the fourth quarter report, the Coalition will include a year-end performance measure report for the entire contract period.

- 1) 80% of enrollees shall receive an attempt to contact within 5 working days of referral.
- 2) 90% of auto assigned enrollees shall receive three documented attempts to contact
- 3) 90% of the enrollees shall be enrolled with a prenatal care provider within 30 days
- 4) 90% of enrollees successfully contacted shall receive, or shall have already received, WIC information
- 5) 60% of recipients that have been auto-assigned, or not verbally contacted but their provider choice registered, shall receive an additional attempt to communicate (by letter, phone or face-to-face) between the 31<sup>st</sup> day and the fifth month

### **Performance Review and Reports**

Reviews will be designed to 1) improve quality of service delivery and 2) meet the information and technical assistance needs of the staff. Such needs will be addressed quickly and professionally.

- (a) A. ***Monthly Review Reports***
  - The MomCare program manager or designated representative responsible for administration of the program will conduct monthly record reviews using the forms included in the contract. A minimum of 10 records will be reviewed monthly (30

records quarterly) as part of the ongoing internal QI process. A complete summary of the records reviewed and a written status on each outcome and performance measures will be included in the quarterly reports submitted to the Coalition

- The MOMCARE program manager or designated representative responsible for administration of the program will report on consumer satisfaction surveys, and other types of evaluation techniques
- The Coalition will compile the following data from SIS and report that data to the Department of Health each month:
  - a) Number of women referred by the fiscal agent
  - b) Number of women who received an attempt to contact within 5 working days of referral
  - c) Number of women successfully contacted
  - d) Number of women who chose a prenatal care provider
  - e) Number of women who choose not to participate
  - f) Number of women referred to the Healthy Start program
  - g) Number of women receiving follow-up from the prenatal care counselor
  - h) Number of women receiving follow-up from the Healthy Start program

### **Quarterly Reports**

- 1) The Coalition shall compile the following data from the SIS “New Clients” report and submit this data, along with an invoice and the SIS Remittance Voucher Comparison, to the Department each month, on the number of women who:
  - Receive an attempt to contact
  - Not successfully contacted
  - Enrolled with a prenatal care provider within 30 days of referral
  - Auto-assigned
  - Facilitated WIC
  - No-shows
- 2) The Coalition is required to compile the following additional information and submit with the quarterly reports to the Department:
  - a) Any difficulties encountered by recipients or prenatal care providers
  - b) Summary of problems the Coalition is experiencing with their no-show reporting system
  - c) Internal or external QI/QA of the prenatal care counseling system using the Department of Health MomCare record summary review form
  - d) A summary of the results of recipient surveys. It is the responsibility of the Coalition to inform the contract manager when, and how often, survey results will be reported to the Department if the frequency is less than quarterly
  - e) A report on performance outcomes and outputs

### **Meetings**

**A. MomCare Meetings.** The program supervisor and Maternal Care Advisors (MCAs) will have monthly staff meetings to:

- Coordinate the assignment of new enrollees
- Address and resolve programmatic issues
- Determine quality and flexibility of workload
- Assess technical assistance needs

**B. *Maternal Infant and Child Health Provider Committee (MICH)*.** MomCare staff participates in the Coalition’s MICH meetings. The MICH Committee addresses concerns that arise within the Healthy Start system of care coordination and other maternal, infant and child health systems.

The MomCare program supervisor or designated representative responsible for administration of the program will attend Healthy Start program meetings, telephone conferences, and the Department of Health’s trainings where appropriate.

#### **IV. Trainings**

MomCare staff will receive appropriate training to efficiently provide services to all enrollees. MomCare staff will be trained on the programmatic components of MomCare services, as well as the maternal infant and child health system. Trainings will include but not be limited to the following:

- Healthy Start Medicaid Waiver
  - Simplified Medicaid Eligibility
  - MomCare services
  - Healthy Start wraparound services
- MomCare program components
  - Initial contact
  - Enrollment
  - Provider contact
  - Follow-up services
  - Grievance procedures
- SOBRA Information System (SIS)
- MomCare performance measures
- Healthy Start system of service provision
- Maternal and child health resources available in the community
- Sensitivity to culture, language, and education
- Other training as needed.

# **ATTACHMENT B**

## ATTACHMENT B. REFERENCES

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