

I. INTRODUCTION

A. Historical Background

The Healthy Start Initiative was implemented on April 1, 1992 to reduce infant mortality and morbidity, to improve pregnancy outcomes and to enhance the health and development of children birth to age three. Healthy Start offers universal prenatal and infant risk screening, care coordination, wraparound services, and increases access to comprehensive maternity and well-child care.

Healthy Start is funded with state general revenue dollars and a portion of the federal funds from the Maternal and Child Health Block Grant. The 1997 Florida Legislature funded the expansion of Healthy Start services to children up to three years of age. Due to funding limitations, however, communities are only able to expand services to specific target groups or zip codes within a coalition's area. Coalitions may choose to add a service for the 1 to 3-year-old population or to extend services to families already receiving Healthy Start rather than targeting a new geographic area or population.

To oversee the coordination of the Healthy Start system, which includes planning, fund allocation, quality assurance, contract management, and advocacy, the Healthy Start prenatal and infant healthcare coalitions were formed. From 1992-1999, the South Florida Perinatal Network (SFPN) acted as the coalition for Miami-Dade County. During that time, the lead agency was responsible for the oversight of all Healthy Start services including universal prenatal and infant risk screening, and Healthy Start care coordination and wraparound services in the service delivery area, which is Miami-Dade County.

In 1999, the SFPN was dissolved which resulted in the Miami-Dade County Health Department (MDCHD) having the responsibility for coordinating, and overseeing the Healthy Start care coordination system (2001 Florida Statutes, Title XXIX, Chapter 383.001). To ensure that all women have access to Healthy Start services, the Health Department maintained the contracts with 11 local community health centers and non-profit organizations to provide direct Healthy Start care coordination and wraparound services. As of July 1, 2002, the MDCHD added two community based providers (CBP), totaling 13 CBPs contracted to provide Healthy Start services across the county.

In the year 2000, the Healthy Start Oversight Committee was created to strategically plan for a new Healthy Start Coalition that would be based on scientific research, evidence-based best practices, and community ownership. Since that time, an Executive Director was hired to staff the Coalition. In collaboration with the MDCHD and the Health Council of South Florida, Inc. (HCSF), the Coalition completed the Healthy Start Needs Assessment 2001 which examines the most important maternal and infant outcome indicators for Miami-Dade County. The analysis reviewed every zip code within the county and prioritized geographic areas of most need based upon six critical health indicators which include prenatal care, births to teens, births to unwed mothers, preterm births, low-birth weight, and infant mortality. The Coalition incorporated the findings from the Healthy Start Needs Assessment 2001 and other related analyses into a Service Delivery Plan for Healthy Start services in Miami-Dade County.

B. Infant Mortality and Morbidity

Infant mortality is often considered the primary indicator of a community's health because of its association with a variety of factors such as maternal health, quality of and access to medical care, socioeconomic conditions, and public health practices ¹. The level of infant mortality risk varies markedly based on medically related factors, access to and adequacy of prenatal care, prenatal use of tobacco, alcohol and other drugs, period of gestation, birth weight, APGAR (Activity, Pulse, Grimace, Appearance, Respiration) scores, birth order, and plurality ².

Infant mortality is divided into two time periods: neonatal mortality (death less than 28 days of live birth) and post neonatal mortality (death between 28 and 364 days of life). Neonatal mortality is associated with the events surrounding the prenatal period and the delivery, which include hereditary predisposition, maternal behavior, and access to prenatal care. Post neonatal mortality is associated with the conditions or events that arise after birth, which include sleeping position, smoking by caregivers and second hand smoke, and unintentional and intentional injuries.

The leading cause of infant mortality and morbidity is low birth weight (LBW), which is defined as weighing less than 2,500 grams at delivery. LBW infants who survive are at increased risk for health problems. Direct contributing factors to LBW include substance abuse, tobacco use, poor maternal weight (inadequate or excessive weight), access to prenatal care, infections, and short birth spacing ^{3,4}.

Preterm birth is when a baby is born at less than 37 completed weeks of gestation. In the majority of cases, preterm babies are low birth weight. Preterm LBW babies are at greater risk of morbidity, mortality and disability when compared to full-term LBW babies. Direct contributing factors to preterm births include socioeconomic status, access to prenatal care, maternal health (low weight gain, diabetes, and hypertension), infections, and tobacco and substance abuse ⁵.

II. COMMUNITY NEEDS ASSESSMENT

A. Methodology

The Healthy Start Needs Assessment 2001 is a planning effort by the Healthy Start Coalition of Miami-Dade (HSCMD), MDCDH, and HCSF, Inc. The Needs Assessment Committee served in an advisory capacity and provided oversight to the development of the Needs Assessment.

Sources of Data

Quantitative

- The Agency for Health Care Administration's *Florida Health Insurance Study* provided the insured/uninsured population data.
- The census data was provided by CACI Marketing Systems.
- Florida Department of Health – *Florida Vital Statistics Annual Reports* (1992-1999)
- The Miami Dade County Health Department (MDCHD) Office of Epidemiology provided analyses of the Vital Statistics data

Qualitative

The Needs Assessment Committee took part in a training session conducted by the Director of Program Development and Evaluation at the Center for Health Equity. The training session oriented the group to the goals and strategies of conducting Coalition planning activities for the purpose of developing the Service Delivery Plan. Members were instructed in a Prioritization Process model, in which the main focus was to prioritize indicators of need by geographical planning area.

Subsequent to the training session, the Committee conducted a formal zip code level health problem analysis of Miami-Dade County. The analysis was performed for every health indicator that had been presented in the Healthy Start Needs Assessment 2001. The committee used the county averages (Table 1) for each health indicator as a basis for the prioritization process, which involved focusing on indicators that have the greatest impact on infant mortality, and utilizing a standard measure for determining consistent geographic areas of need.

Table 1

Health Indicators, Miami-Dade County, 1999		
Health Indicators	Number	Percent/Rate
Late/No Prenatal Care	660	2.1 %
Births to Teens	3,549	11.3 %
Births to Unwed Mothers	12,900	41.0 %
Preterm Births	3,087	9.8 %
Low Birth Weight Births	2,490	7.0 %
Infant Mortality	161	5.1*

* Infant Mortality Rate per 1,000 live births

Source: Miami-Dade County Health Department (MDCHD), November 2000

The standard measures for identification within indicators of need were the ten highest ranking zip codes within the county. The Committee designated six health indicators as critical factors for use in identifying geographical areas of need within the county:

- Late/no prenatal care
- Births to teens
- Births to unwed mothers
- Preterm births
- Low birth weight births
- Infant mortality

The Committee determined that these six indicators would capture a greater number of contributing factors and mothers and babies at risk. For example, “births to teens” was selected since it included both first and “repeat births” to teens. Finally, the health indicator of “birth to unwed mothers” was selected since this group is disproportionately less educated; thereby frequently limiting them to low paying jobs. The children of these mothers are also less likely to have a healthy start in life due to the family’s socioeconomic status.

A zip code level analysis of these six critical indicators was performed allowing 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 2

Primary Priority Areas		
<u>South Miami-Dade</u>	<u>Central Miami-Dade</u>	<u>North Miami-Dade</u>
33030 Homestead	33128 Downtown	33054 Opa-locka
33034 West Homestead	33136 Overtown	33147 Liberty City
33035 Florida City		33150 Miami Shores/El Portal
Secondary Priority Areas		
33157 Richmond/Perrine/Cutler Ridge	33130 Downtown	33127 Little Haiti/Wynwood/Miami
33170 Goulds-West		33137 Little Haiti/Morningsire/Wynwood/Miami
33190 Goulds-East		33142 Allapattah/Brownsville/Melrose/Liberty City
		33167 Westview/Lakeview/North Miami/Pinewood

B. Demographics

1. Population

Miami-Dade is a large and diverse county with multiple communities contained within its boundaries. It is the most populated county in Florida, with over 2 million residents since 1995. This number is expected to increase to 2,318,135 by 2005. In 2000, there were 465,772 non-Hispanic Whites, representing 20.7% of the population and 427,140 non-Hispanic Blacks, representing 19% of the population. The Black (population data included Hispanics) population rose by 5.3% between 1997 and 1999. Although Asians represented less than 2% of the county population, there was 9.9% growth between 1997 and 1999. Whites (population data included Hispanics) showed the smallest increase at 3.2%.

There were 1,291,737 Hispanics, representing 57.3% of the population. The Hispanic population represented the largest ethnic group in Miami-Dade, with a growth of 6.2% between 1997 and 1999. The Hispanic population itself is very diverse with new residents coming from areas throughout the Latin American and Caribbean countries. A portion of the new Hispanic residents may be undocumented, although there is no current existing data to support this observation.

Table 3

Miami-Dade County Population by Race/Ethnicity, 2000		
Race/Ethnicity	Number	Percent (%)
Non-Hispanic White	465,772	20.7
Non-Hispanic Black	427,140	19.0
Hispanic	1,291,737	57.3
Non-Hispanic Multi-Racial	31,636	1.4
Asian	30,537	1.3
Other	6,540	0.3
Total Miami-Dade Population	2,253,362	100.0

Source: United States Census Bureau, 2000, August 2001.

The age distribution in Miami-Dade was consistent between 1997 and 2000. The following age groups represented approximately 7% of the county population: 0-4, 5-9, 10-14, and 15-19. The 25-44 age group had the largest representation with 29.4% followed by the 45-64 age group at 22.2%.

Table 4

AGE GROUPS											
Year	Population	0-4	5-9	10-14	15-19	20-24	25-44	45-64	65-84	85+	18+
1997	2,100,128	7.4	7.1	6.8	6.4	6.1	32.4	20.3	11.8	1.7	75.0
1998	2,054,297	7.1	7.1	6.6	6.7	6.3	30.4	21.6	12.3	1.8	75.2
1999	2,180,128	7.0	7.2	7.0	6.8	6.4	29.4	22.1	12.4	1.8	74.8
2000	2,198,826	7.0	7.1	7.3	7.0	6.5	29.4	22.2	11.8	1.8	74.6

Source: Sourcebook America, 1998-2000 Editions, CACI Marketing Systems.

Women of childbearing age (15-44) numbered 448,732 or 20.4% of the total population in 2000. There was a 1.2% increase in the population of childbearing women between 1997 and 2000.

Table 5

Year	Population	Females	15-44 YRS
1997	2,100,128	1,070,718	443,440
1998	2,054,297	1,080,078	443,915
1999	2,180,128	1,097,945	447,546
2000	2,198,826	1,209,919	448,732

Source: Bureau of Business and Economic Research, 2000 Edition

2. Geographic Regions

The county is divided into the following three planning regions:

South Miami-Dade

South Miami-Dade is located at the southern corridor of Miami-Dade County. Its boundaries are 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 the CACI Marketing Systems, the region has an estimated 410,237 residents, representing 18.7% of the total county population.

Central Miami-Dade

For Central Miami-Dade, the North to South boundaries are from Okeechobee Road (SR27) to South Dixie Highway and Kendall Drive (S.W. 88 Street). The East to West boundaries are from the Atlantic Ocean to Krome Avenue (179th Avenue). The area encompasses a 32 zip code region. The region has an estimated 766,320 residents, representing 34.9% of the county population. It has a high concentration of people with Hispanic origins at 78.2% compared to 46.3% in the remainder of the county.

North Miami-Dade

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

3. Household Size and Income

In 2000 there were 782,447 households in Miami-Dade County. This number is expected to rise to an estimated 822,975 in 2005, growing at a rate of 1.5% per year. The average household size was 2.77. The total number of households with incomes under \$15,000 is 160,402 or 20.5%. North Miami had the most zip codes with high percentages (26.1% to 56%) of households with low incomes.

4. Insured/Uninsured Under Age 65

According to the Agency for Health Care Administration *Florida Health Insurance Study*, 25.2% (448,505) of the county's under 65 year old population were uninsured in 1999. North Miami had the most zip codes with high percentages (33.1% to 43.1%) of people under 65 years who were uninsured.

5. Medicaid Population

There were 440,853 Medicaid recipients in 1999, according to data provided by the Medicaid Area 11 office. Twenty-six percent or 114,711 of the recipients are females ages 12-55. Another 14% or 60,491 of the County's Medicaid recipients are children ages 0-3 years. The largest numbers of Medicaid recipients are concentrated in portions of North Miami.

6. Impact on Maternal and Infant Health

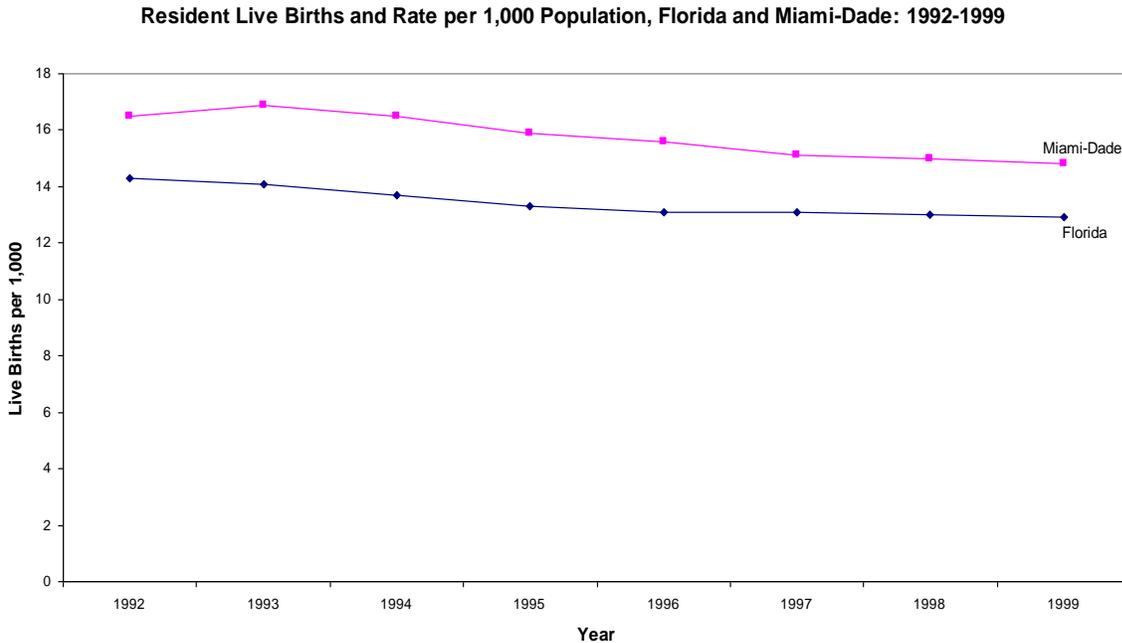
Infant mortality is considered the primary indicator of a community's health because of its association with a variety of factors such as maternal health, quality of and access to medical care, socioeconomic conditions, and public health practices⁶. Miami-Dade County has key socioeconomic and demographic factors that impact on maternal and infant health and service delivery. Miami-Dade County is one of the largest and highly diverse counties in the state of Florida. In 2000, over 2 million people resided within Miami-Dade County; the population is expected to rise to 2.3 million in 2005. Seven percent of those were children under the age of five, another 20.4% were women of childbearing age, creating a broad population base for the Coalition's target groups. Furthermore, more than 50% of the county's population was Hispanic and 19% was non-Hispanic Black, emphasizing the need for the Coalition to provide its services in a linguistically and culturally competent manner. Approximately one fifth of the total households in Miami-Dade County were at the poverty level in 2000. Additionally, a quarter of the people who were 65 years and younger in Miami-Dade had no health insurance in 1999. Low income levels and lack of insurance coverage directly affect access to medical care. North Miami-Dade region had the highest number of poor households, uninsured individuals, and Medicaid recipients, which impact the allocation of services and resources.

III. MATERNAL AND CHILD HEALTH INDICATORS AND TRENDS

A. Total Live Births

Miami-Dade County has the highest number of births in the state. In 1999, there were over 31,000 live resident births. The birth rate in Miami-Dade has been consistently higher than the state as a whole from 1992 to 1999, although the rate was steadily declining from 1993 to 1999.

Figure 1



Source: State of Florida Department of Health, Office of Vital Statistics.
Bureau of Economic and Business Research, University of Florida

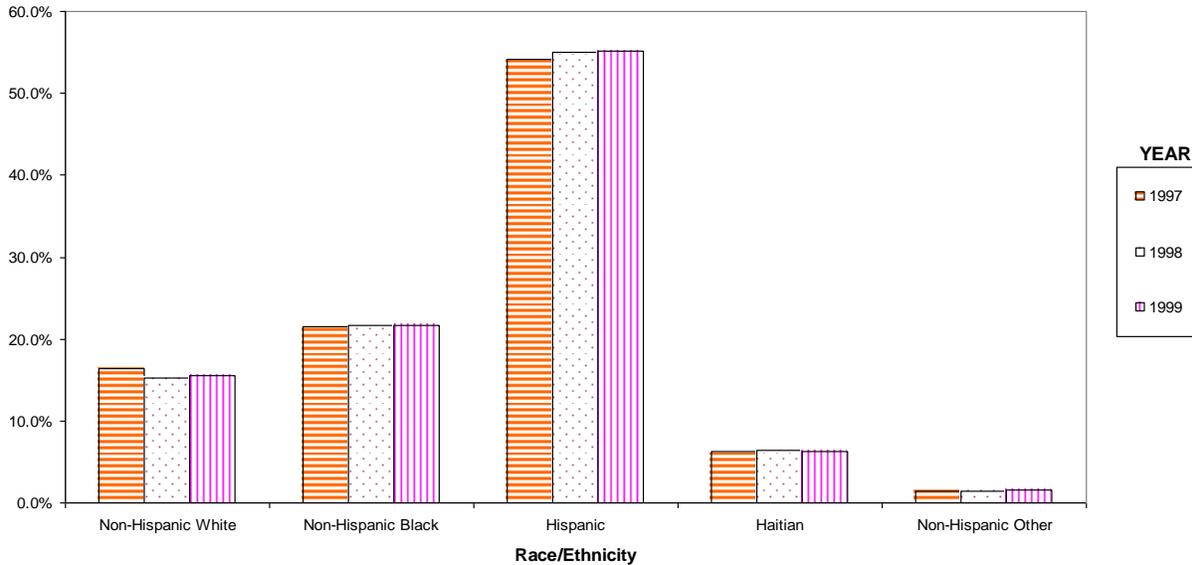
The majority of the births were to Hispanic women, followed by non-Hispanic Black, non-Hispanic Whites, Haitians, and non-Hispanic Others. Most of the births occurred among women ages 20-34 years. An increasing proportion of women ages 35 years and older in Miami-Dade are also giving births.

B. Births by Race/Ethnicity

In 1999 Hispanics accounted for 55.1% of the live births, followed by non-Hispanic Blacks (21.7%), non-Hispanic Whites (15.5%), Haitians (6.2%), and non-Hispanic Others (1.5%). Within each racial/ethnic group, the number of births has been consistent over a three year period.

Figure 2

Percent of Live Births by Race/Ethnicity Miami-Dade County 1997-1999



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

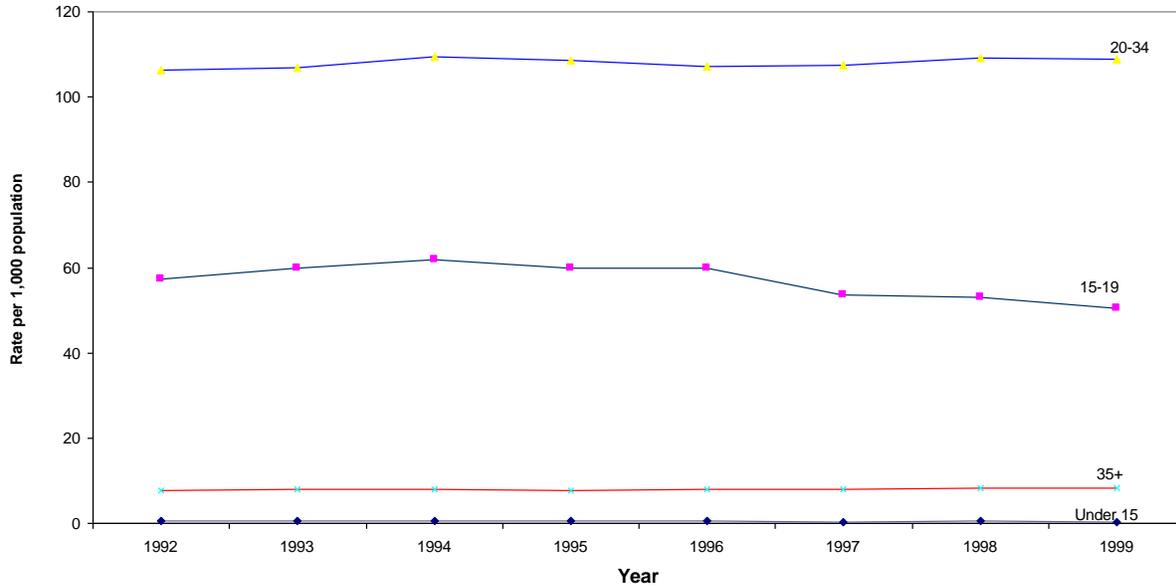
C. Births by Maternal Age

Between 1992 and 1999, most births occurred among women ages 20-34 years, ranging from a birth rate of 106.3 in 1992 to 108.9 in 1999. An increasing proportion of women ages 35 years and older in Miami-Dade are giving birth; the rate increased from 7.6 in 1992 to 8.4 (per 1,000 population) in 1999. Birth rates among women 35 years and older are increasing throughout Florida although the proportion is lower at 5.9 in 1999.

In age group 15-19, the birth rates declined slightly from 1997 to 1999. The birth rates in age group 15 years and under was the lowest compared to the other age groups.

Figure 3

**Resident Live Birth Rate by Maternal Age (per 1,000 population)
Miami-Dade County, 1992-1999**



Source: MDCHD Office of Epidemiology, 1999.

Rates of births to teens have declined over the past eight years in Miami-Dade County and in Florida. In Miami-Dade County the rate of births to teens under 15 years declined from 0.59 in 1992 to 0.42 in 1999, representing a 29% decrease. For teens aged 15-19, the rate declined 11.9% from 57.3 in 1992 to 50.5 in 1999.

Births by teenagers aged 10-14 years accounted for 0.3% (97) of total births in 1999. Non-Hispanic Blacks had the highest percent of births at 0.7% in the 10-14 age group. Live births in the 15-19 age group accounted for 11% (3,452) of total births in 1999. Non-Hispanic Blacks had the highest percent of births by teens with 21.5% in the 15-19 age group.

Among the 10-17 years age group, the percent of repeat births had declined from 14% in 1997 to 10.9% in 1999. Among the 18-19 year olds, the percent of repeat births (28.5%) was the same in the 3 year period.

The percent of non-Hispanic Black repeat births by teens has declined over the past 3 years among 10-17 years old, from 17.4% in 1997 to 12.4% in 1999. The Haitian percent of repeat births has declined from 18.8% to 6.5% during the same period.

Table 6
Repeat Births to Teens by Maternal Age and Race/Ethnicity, Miami-Dade County, 1997-1999

Age of Mother	Race/Ethnicity	1997			1998			1999		
		Live Births	Repeat Births	%	Live Births	Repeat Births	%	Live Births	Repeat Births	%
10-17	Non-Hispanic White	173	13	7.5	172	11	6.4	179	11	6.1
	Non-Hispanic Black	660	115	17.4	659	105	15.9	621	77	12.4
	Hispanic	564	66	11.7	606	63	10.4	592	66	11.1
	Haitian	48	9	18.8	60	7	11.7	31	2	6.5
	Non-Hispanic Others	5	--	--	5	--	--	4	--	--
	Unknown	2	1	50.0	--	--	--	--	--	--
	All	1452	204	14.0	1502	186	12.4	1427	156	10.9
18-19	Non-Hispanic White	220	62	28.2	223	40	17.9	239	57	23.8
	Non-Hispanic Black	829	290	35.0	860	325	37.8	891	303	34.0
	Hispanic	928	220	23.7	918	212	23.1	896	226	25.2
	Haitian	84	18	21.4	90	19	21.1	86	15	17.4
	Non-Hispanic Others	11	--	--	5	1	20.0	9	2	22.2
	Unknown	3	1	33.3	1	1	100.0	1	1	100.0
	All	2075	591	28.5	2097	598	28.5	2122	604	28.5

Source: MDCHD Office of Epidemiology, 1999.

Teenage mothers are more likely than older women to receive inadequate prenatal care and to experience health problems such as inadequate weight gain, maternal anemia, and pregnancy related hypertension. Babies born to teen mothers are at increased risk of being low birth weight and preterm.

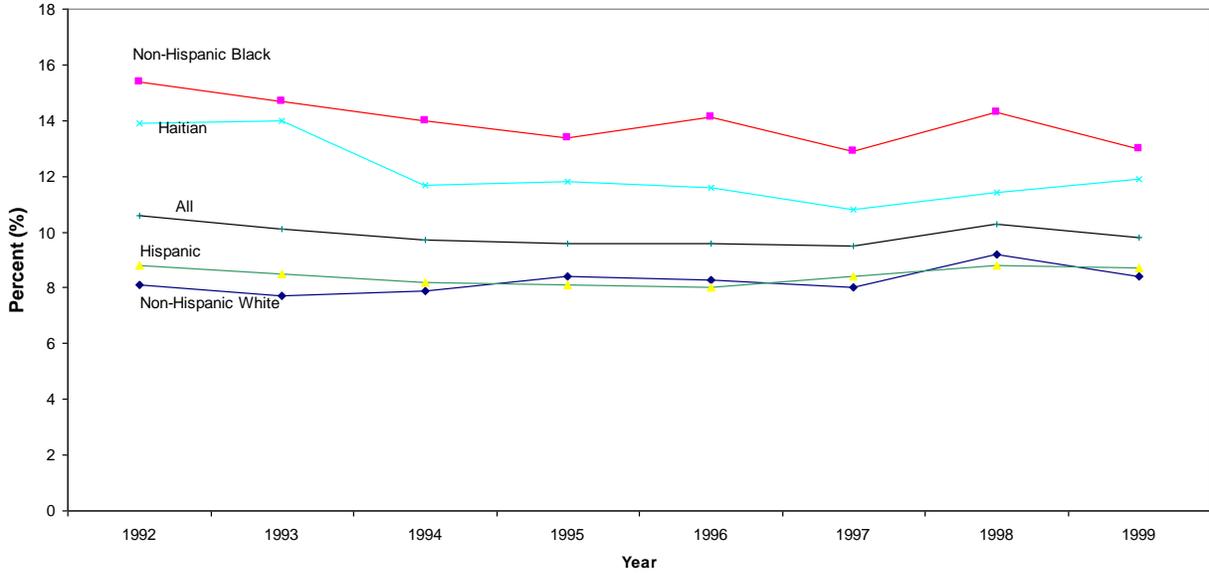
D. Preterm Births

In Miami-Dade County, nearly 10% of all mothers giving birth in 1999 experienced a preterm birth. The overall percent of preterm births had hovered between a low of 9.5% to a high of 10.6% during the period from 1992 to 1999.

By racial/ethnic groups, the percentage of preterm births for non-Hispanic Blacks decreased from 15.4% in 1992 to 13% in 1999. The percentages for Haitians also decreased, from 13.9% in 1992 to 11.9% in 1999. There were no drastic changes in the percentages of preterm births for both Hispanic and non-Hispanic women from 1992-1999.

Figure 4

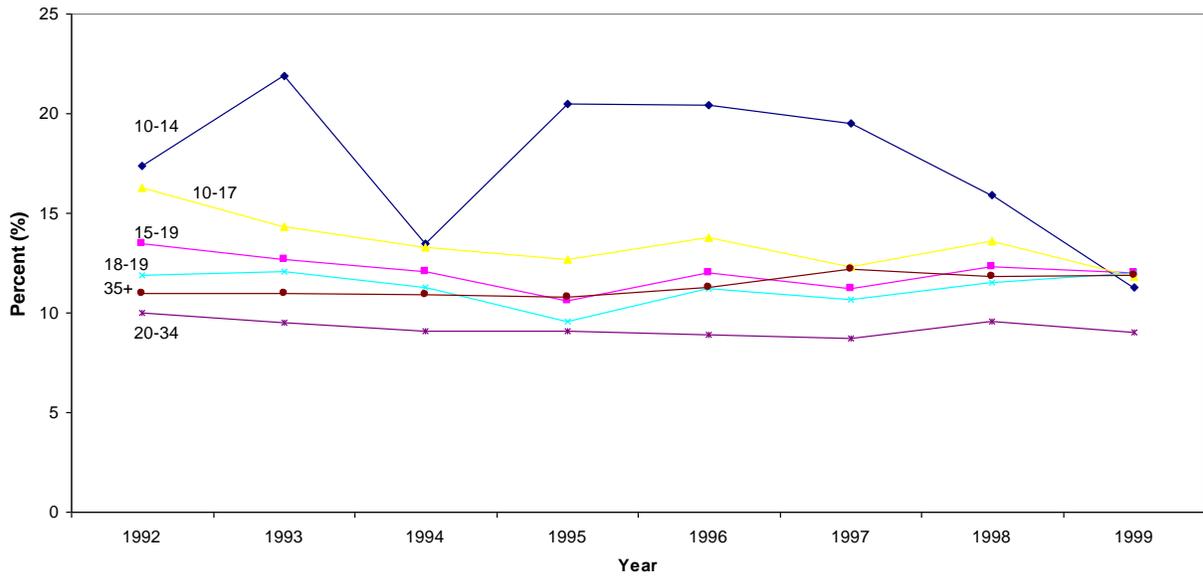
Preterm Live Births by Race/Ethnicity, Miami-Dade County, 1992-1999



Source: MDCHD Office of Epidemiology, 1999.

Figure 5

Preterm Live Births by Maternal Age, Miami-Dade County, 1992-1999



Source: MDCHD, Office of Epidemiology, 1999.

Due to the very low number of births to teens aged 10-14 years, the percent of preterm births in this age group is statistically unreliable. However, the percent of preterm births in this age group had been decreasing from 1992 to 1999. Preterm births to teens 10-17 years had been steadily decreasing from 16.3% in 1992 to 11.8% in 1999. The percentages of preterm births for women in age groups 15-19 years, 18-19 years, and 35+ years had been increasing from 1992 to 1999.

Even though the percentages of preterm births for non-Hispanic Blacks and Haitian women, as well as teens 10-17 years, had decreased, they were still high compared to those of non-Hispanic White and Hispanic women. In an analysis of the 1998-2000 Miami-Dade County vital records, it was found that the percentage of preterm births among non-Hispanic Black (12.1%), Hispanic (7.4%), Haitian (11%) and other women (8.8%) was significantly higher than the percentage (6.7%) of non-Hispanic white women. The percent of preterm births was significantly higher among women younger than 19 and older than 35 years compared with women aged 20-34 years (Attachment C: Determinants of Preterm Birth during 2000 in Miami-Dade County).

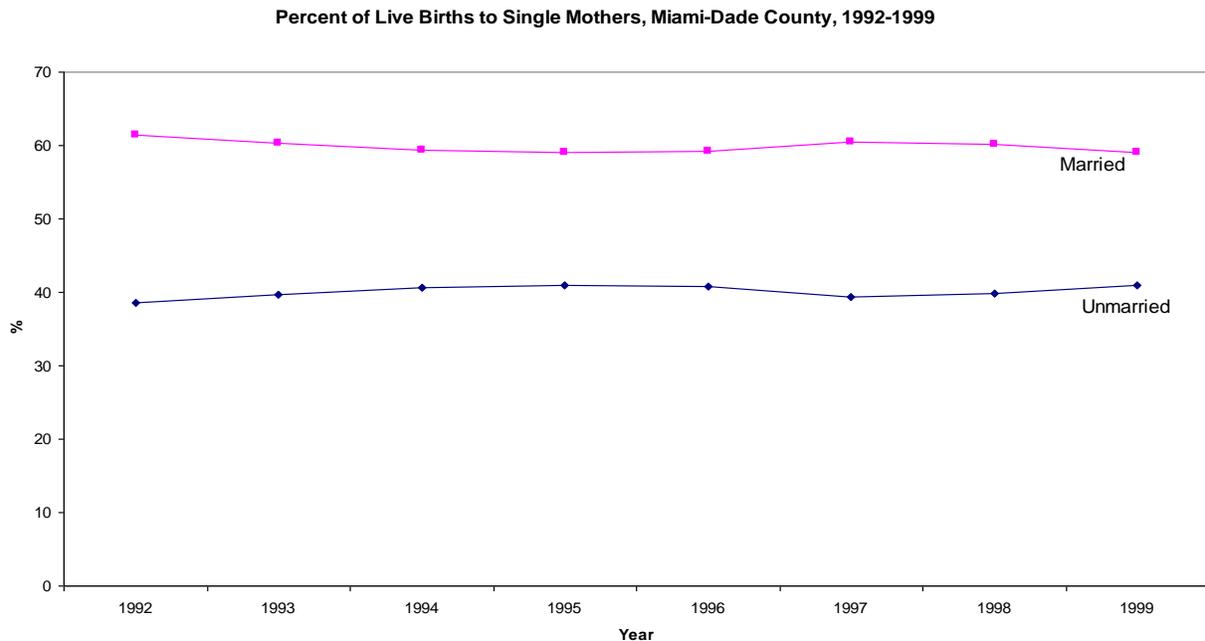
According to the health problem analysis, there are several risk factors that are prevalent among non-Hispanic Black and Haitian women that contribute to the higher percent of preterm births. Some of the direct and indirect contributing factors include infections, diabetes, access to prenatal care, socioeconomic status, and cultural barriers. There needs to be more effort in reaching women in the African American and Haitian communities and pregnant teens.

Maternal age is another risk factor of preterm births regardless of race/ethnicity. Contributing factors include advanced reproductive technology use among older women and short baby spacing among teens.

E. Births to Unwed Mothers

Forty-one percent of the women who gave birth in 1999 were unwed mothers, delivering a total of 12,900 babies. The percent of live births to single mothers appeared to slightly increase in 1999, although the percentage is consistently lower than births to married women.

Figure 6



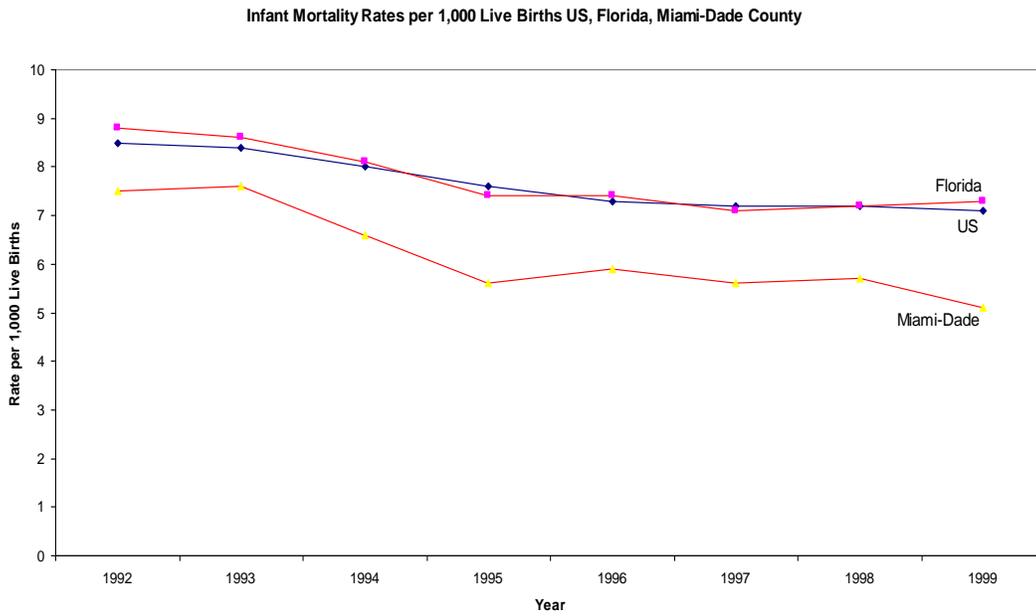
Source: MDCHD Office of Epidemiology, 1999.

Unmarried women are at increased risk of experiencing preterm births. Unmarried women are more likely to get late/no prenatal care, experience more stress, lack the social and financial support systems than married women.

F. Infant Mortality

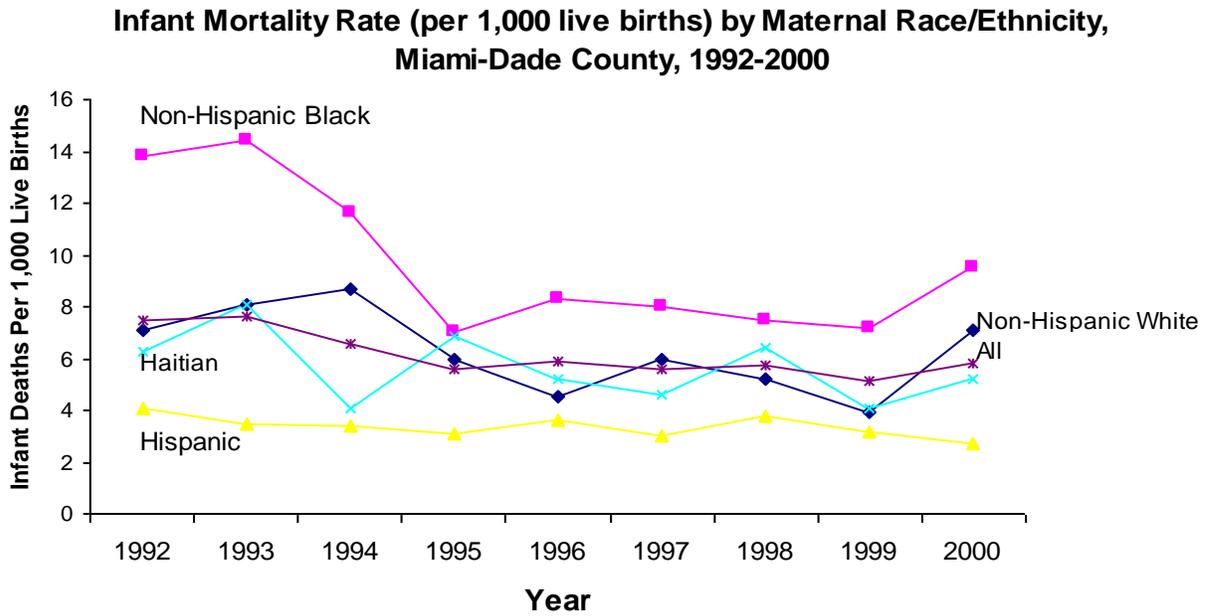
The infant mortality rate for all races and ethnic groups was 5.1 per 1,000 live births in 1999, lower than both Florida and the US rates. The rate in Miami-Dade had been decreasing steadily from 7.5 in 1992 to 5.1 in 1999.

Figure 7



Source: Florida Vital Statistics 1993-1999. Statistical Abstract of the United States 2000. MDCHD Office of Epidemiology.

Figure 8



Source: MDCHD Office of Epidemiology, 1999.

The infant mortality rates decreased among non-Hispanic Blacks, Haitians, Hispanics, and non-Hispanic Whites from 1992 to 1999. Non-Hispanic Black women, in particular, had experienced a drastic decrease in infant mortality from 1992 to 1995; however, the rate had been rising again since 1995. Except for the Hispanic rate, all the other racial/ethnic groups had experienced a rise in their infant mortality rates in 2000. Despite higher poverty and lower education rates, Hispanic infant mortality rate is comparable to the rate of Whites ².

Although the infant mortality rate among non-Hispanic Black women had decreased, the racial disparity is apparent when comparing the infant mortality rates by race/ethnicity. A multivariate analysis of the Miami-Dade County 1995-1998 linked birth and infant death files found that infant mortality rates were higher among non-Hispanic Blacks, Haitians, and other non-Hispanic groups (Attachment C: Risk Factors Associated with Infant Mortality in Miami-Dade County, 1996-1998). Some indirect contributing factors related to maternal race include infections, hypertension, stress, lack of available resources, barrier to prenatal care, and low socioeconomic status.

One way to investigate why the birth outcomes of Hispanic and non-Hispanic Black population are different is to use the Perinatal Periods of Risk (PPOR) approach ⁷. This tool is used to monitor and investigate fetο-infant mortality and to focus work aimed at defining and eliminating disparities ⁸.

G. Neonatal Mortality

Table 7 shows the three-year average neonatal mortality rates of the different racial/ethnic groups in Miami-Dade County. Overall the neonatal mortality rate decreased from 3.84 per 1,000 live births to 3.64. The White and Hispanic average rates were consistent. The Black rates decreased from 6.05 to 5.29. Neonatal mortality is associated with the events surrounding the prenatal period and the delivery.

Table 7. Three year rolling average neonatal mortality rates (per 1,000 live births).

<i>Race/Ethnicity</i>	<i>1996-1998</i>	<i>1997-1999</i>	<i>1998-2000</i>
White	2.96	2.93	2.94
Black	6.05	5.28	5.29
Hispanic	2.26	2.23	2.20
Miami-Dade	3.84	3.60	3.63

Source: Florida Department of Health, Office of Planning, Evaluation and Data Analysis, September 2002.

H. Post Neonatal Mortality

Table 8 shows the three year rolling average post neonatal mortality rates of the different racial/ethnic groups in Miami-Dade County. Overall there had not been any significant increases in the average rates in Miami-Dade. The White and Hispanic groups showed decreases in their average rates, while the Black rates increased. Sudden Infant Death Syndrome (SIDS), injuries, infections, and congenital anomalies are some of the contributing factors to post neonatal mortality.

Table 8. Three year rolling average post neonatal mortality rates (per 1,000 live births).

<i>Race/Ethnicity</i>	<i>1996-1998</i>	<i>1997-1999</i>	<i>1998-2000</i>
White	1.45	1.33	1.33
Black	3.22	3.43	3.51
Hispanic	1.28	1.21	1.11
Miami-Dade	1.94	1.92	1.94

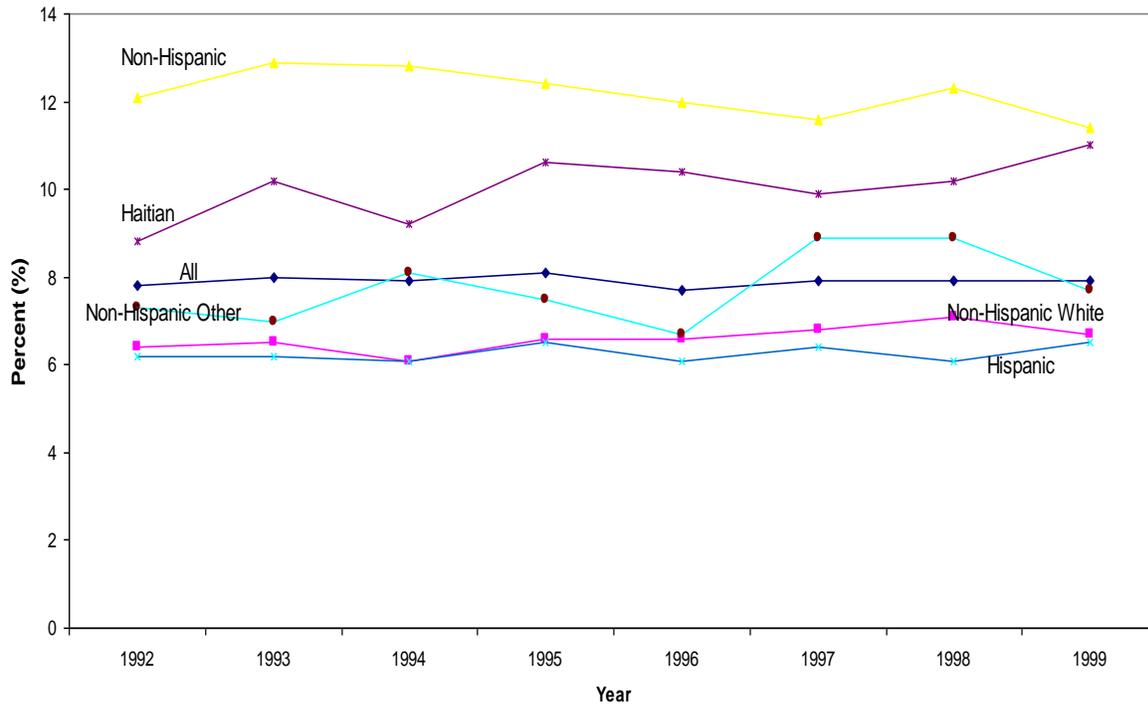
Source: Florida Department of Health, Office of Planning, Evaluation and Data Analysis, September 2002.

I. Low Birth Weight Births

In 1999, non-Hispanic Blacks and Haitians have the highest percent of low birth weight babies of the known population groups at 11.4% and 11.0%, respectively. The percent among Haitian women was increasing; indicating a need to conduct outreach or discussions in the Haitian community to find out about health issues and barriers. The lowest rates are among Hispanics, reporting in at 6.1% overall.

Figure 11

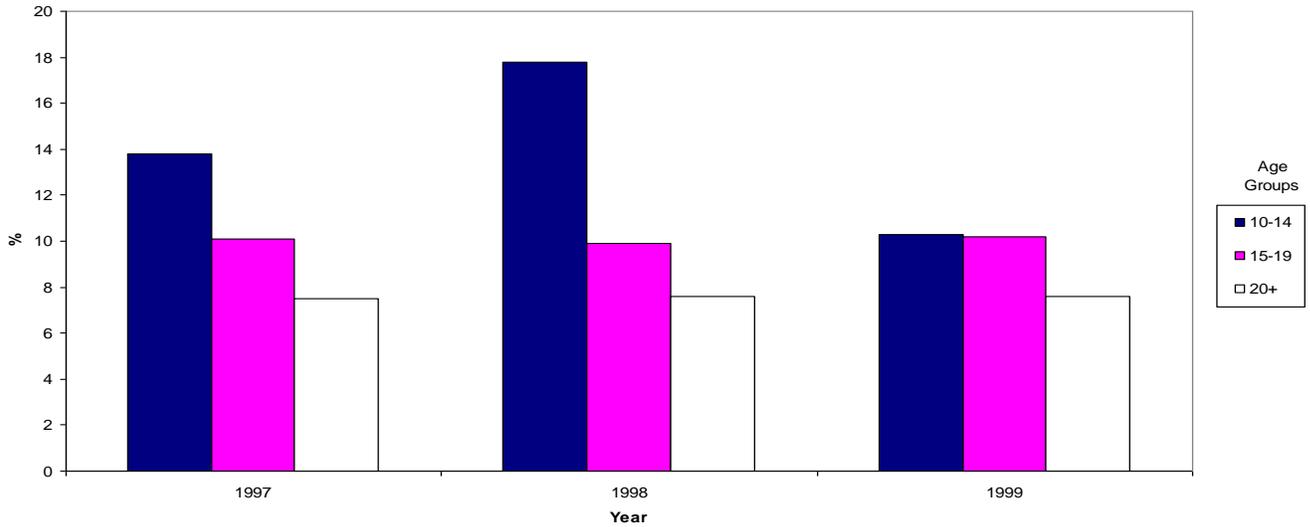
Percent of Low Birth Weight Live Births (<2,500 gm) by Maternal Race/Ethnicity, Miami-Dade County, 1992-1999



Source: MDCHD Office of Epidemiology, 1999.

Figure 12

Percent of Low Birth Weight by Age of Mother, Miami-Dade, 1997-1999



Source: MDCHD Office of Epidemiology, 1997-1999.

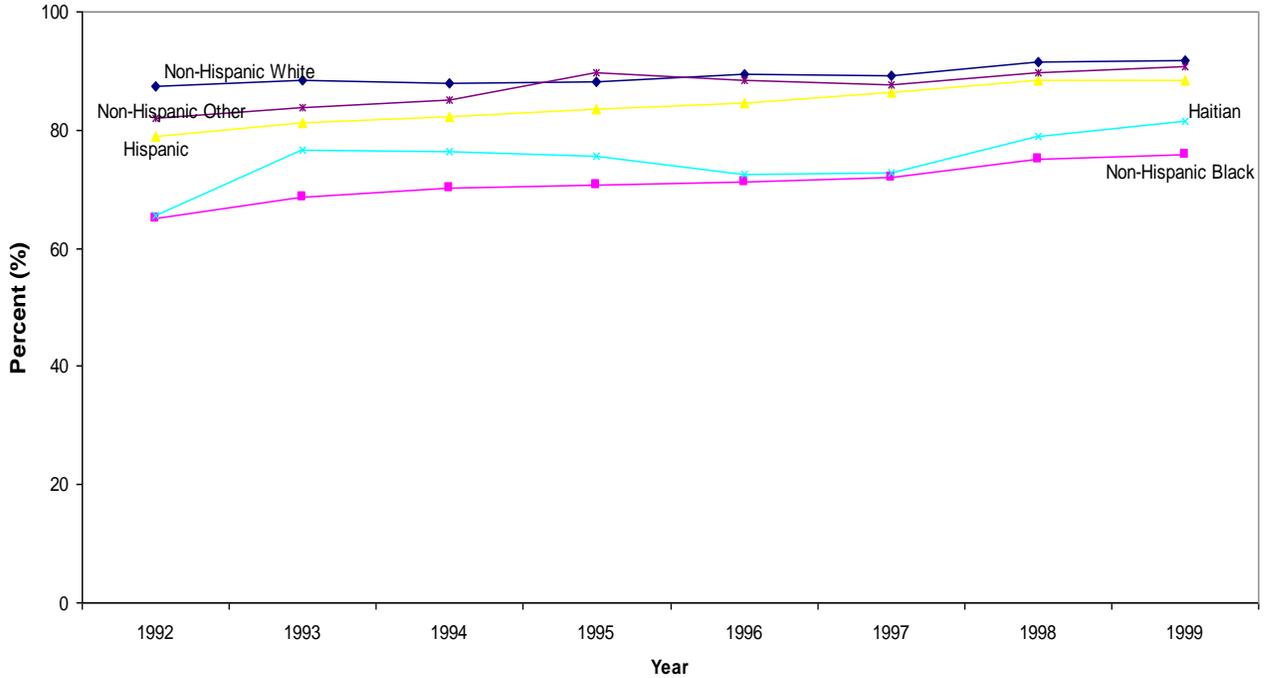
Adolescent mothers had the greatest proportion of low birth weight infants compared to any other maternal age group. Among adolescent mothers, those between the ages of 10 to 14 have a greater proportion of low birth weight infants than 15 to 19 year old mothers. However, low birth weight to teens under 15 years dropped dramatically between 1998 and 1999, from 17.8% to 10.3%.

J. Prenatal Care

Miami-Dade experienced an overall improvement in the utilization of prenatal services from 1992-1999. In 1999, the proportion of non-Hispanic White women accessing prenatal care within the first trimester was 91.9% and non-Hispanic Blacks 75.9%. Among Hispanic groups, Cubans are the most likely to enter prenatal care at 93.6%. The percentage of Haitian women seeking prenatal care increased from 65.5% in 1992 to 81.6% in 1999.

Figure 13

**Percent of All Births Where Mother Reported Prenatal Care Within the First Trimester
by Race/Ethnicity, Miami-Dade County, 1992-1999**



Source: MDCHD, Office of Epidemiology, 1999

In 1999, the number of adolescent mothers who sought prenatal care within the first trimester was 2,445 or 68.9% of all births to teens. The percent of very young mothers getting early prenatal care climbed from 39.7% in 1992 to 47.4% in 1999.

Getting early and ongoing prenatal care is important for reducing the risk of infant mortality, low birth weight, and preterm births.

IV. FINDINGS AND CONCLUSIONS

The following findings are concluded from the Healthy Start Needs Assessment 2001:

1. Miami-Dade County had the highest number of births in the state, with more than 50% of the births born in Miami-Dade to Hispanic women.
2. In 1999, Miami-Dade County had a lower infant mortality rate than the state of Florida. Factors that contributed to lower infant mortality rate statewide, not just Miami-Dade, included access to early prenatal care, advances in medical technology, and availability of health services through the Healthy Start Program and/or other programs. One factor that is unique in Miami-Dade is a higher proportion of Hispanic population in the county. The Prenatal Periods of Risk methodology can be used to investigate why Hispanic women experience better birth outcomes.
2. Non-Hispanic Black women experienced poorer birth outcomes than non-Hispanic White and Hispanic women. Some factors include the inability of these women to gain access to prenatal care, maternal socioeconomic status, and a higher percentage of teenage and unwed mothers.
3. Non-Hispanic Black and Haitian women have higher proportions of low birth weight babies, compared to Hispanic women. Low birth weight births to teens under 15 years dropped dramatically between 1998 and 1999.
4. The percentages of preterm births in Miami-Dade have fluctuated over eight years. Non-Hispanic Black and Haitian women experienced the higher percentages of preterm births countywide.
5. The rates of births to teens have declined over the past eight years in Miami-Dade County and in Florida. The percent of repeat births had declined among those ages 10 to 17 years, and non-Hispanic Black and Haitian teens between 1997 and 1999.
6. Miami-Dade experienced an overall improvement in the utilization of prenatal services from 1992-1999. However, there continues to be disparities among certain ethnic groups receiving prenatal care in the first trimester.
7. Several zip code areas, particularly in the northern and southern regions of Miami-Dade County, have high infant mortality rates, low birth weight births, preterm births, number of households at the poverty level, number of uninsured individuals, and number of Medicaid recipients. Any projects funded by Healthy Start dollars will be incorporated in high-risk zip codes.

V. CATEGORY A
Miami-Dade County

A. Introduction

The Healthy Start Coalition of Miami-Dade, under its state charge to reduce infant mortality, lower the number of low birth weight babies, and improve health and development outcomes, 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. The Coalition is faced with the challenge of how to effectively allocate limited service dollars in areas of greater need. Adding to the challenge is the Coalition's need to gain a comprehensive understanding of the Healthy Start system in order to effect changes. In this cycle of the service delivery plan, the Coalition will focus on the following issues:

- 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 the community's awareness and involvement regarding the Healthy Start Program as well as the Fetal and Infant Mortality Review (FIMR) project;
- increasing the screening percentages among medical providers;
- increasing the number of enhanced services by Healthy Start providers;
- developing the Healthy Start Board of Directors, general membership, and 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 (QI/QA) (Exhibit A).

B. County Priorities

Targeting for this service delivery plan cycle will be on population risk factors as well as geographic areas. Based on information from the needs assessment and the health problem analysis, the three health issues that the Healthy Start Coalition will target will be infant mortality, low birth weight, and preterm births.

As discussed in the 'Methodology' section, the zip code areas below were chosen by the Needs Assessment Committee and endorsed by the Service Delivery Plan Committee as priority areas of concern. Of these zip codes, any enhanced efforts are recommended to be conducted in those that were designated by the Committees as 'primary priority areas'.

Table A1. Priority zip codes and rates and percentages of health indicators, 1999

Zip Codes by Region	Total Number of Live Births	Infant Mortality Rate***	Late/No Prenatal Care %	Preterm Births %	Low Birth Weight %	Births to Teens %	Births to Unwed Mothers %
North Miami-Dade							
33054 * Opa-Locka	462	13.0	3.2	10.6	10.6	21.2	76.2
33147 * Liberty City	967	8.3	4.6	12.8	11.4	24.5	74.8
33150 * Miami Shores/El Portal	458	2.2	3.7	13.3	11.8	22.5	67.9
33127 ** Little Haiti/Wynwood/Miami	504	5.9	3.6	13.1	9.7	23.6	74.8
33137 ** LH/Morningside/Wynwood/Miami	251	15.9	1.6	14.7	11.6	14.7	54.6
33142 ** Allapattah/Brownsville/Melrose/Liberty City	858	7.0	3.8	12.6	10.1	24.9	75.8
33167 ** Westview/Lakeview/N. Miami/Pinewood	332	9.0	2.4	15.1	10.8	16.3	61.4
Central Miami-Dade							
33128 * Downtown	95	0	5.3	14.7	3.2	15.8	71.6
33136 * Overtown	234	12.8	4.3	10.7	9.4	21.4	79.5
33130 ** Downtown	279	7.2	3.6	8.6	4.7	19.7	62.0
South Miami-Dade							
33030 * Homestead	826	7.3	4.6	7.7	6.7	17.6	60.9
33034 * West Homestead	283	0	4.6	8.5	7.8	22.6	61.1
33035 * Florida City	55	18.2	0	16.4	12.7	5.5	20.0
33157 ** Richmond/Perrine/Cutler Ridge	897	13.4	2.5	9.8	7.2	12.7	39.7
33170 ** Goulds-East	171	5.8	3.5	9.9	7.6	21.6	68.4
33190 ** Goulds-West	100	0	2.0	13.0	12.0	9.0	33.0
North Miami	14,964	5.3	2.5	10.6	8.8	13.3	48.8
Central Miami	9,382	5.9	1.4	8.9	6.8	8.1	31.0
South Miami area	6,823	5.9	2.1	4.2	3.4	11.3	37.4
Miami-Dade County	31,487	5.1	2.1	9.8	7.9	11.3	41.0
Florida	196,963	7.3	3.4	10.2	8.2	N/A	37.5

* Primary priority areas ** Secondary priority areas ***Infant Mortality Rate (per 1,000 live births)

Rates and percentages in **bold** type are higher than the county rate and percentages.

Source: MDCHD Office of Epidemiology, November 2000.

1. Infant Mortality (Neonatal and Postnatal)

a. Target Areas

The infant mortality rate for Miami-Dade County has declined from 1992 to 1999. At 5.1 infant deaths per 1,000 live births in 1999, it was lower than both the state (7.3) and US rates (7.1). However, analysis of key indicators of maternal and infant health showed several zip code areas as having higher infant mortality rates than the county rate; in some cases, higher than the state rate (Table A1).

According to the health problem analysis (Attachment A), direct contributing factors to infant mortality include hereditary predisposition, maternal behavior, access to prenatal care, sleeping position, smoking and second hand smoke, and injuries. Some indirect contributing factors that result from being non-Hispanic Black and teen include lack of a social support system, lack of knowledge regarding nutrition, getting early prenatal care, preventing injuries (unintentional and intentional), and family planning.

The North Miami-Dade region had the highest number of live births in 1999. Six zip codes in this area had infant mortality rates that were higher than the county rate. These same zip codes also had higher percentages of women getting late/no prenatal care, births to teens, and births to unwed mothers. Furthermore, this region had a high concentration of non-Hispanic Blacks at 31.6% compared to 9.8% in the rest of the county. Non-Hispanic Black women are more likely to experience infant mortality than other racial/ethnic groups.

The Central Miami-Dade region had the second highest number of live births in 1999. Two zip codes in this area had infant mortality rates that were higher than the county rate. In the Overtown area (33136), all six of the health indicators were higher than the county rates. In the Downtown area (33130), the percentages of birth to teens and births to unwed mothers, as well as late/no prenatal care, were higher than the county. Although there were no infant deaths in the Downtown area (33128), four indicators of infant morbidity were higher than the county rates.

The South Miami-Dade area had the least number of live births in 1999. There were four zip codes that had higher infant mortality rates than the county rate. Due to the relatively low number of births (55) Florida City (33035) area had a disproportionately high infant mortality rate, as well as preterm and low birth weight births. Several of these zip codes also had higher rates of births to teens and unwed mothers.

b. Gaps and Needs

- Death and birth certificates are not always sufficient sources to provide information about the circumstances surrounding an infant death due to SIDS.
- Based on the prenatal screening percentages, there is a need to increase the prenatal screen offer rate and screening rate among medical providers. Efforts should especially focus in the South and Central Miami-Dade regions.
- There is a need for outreach to pregnant teens.

- There is a need to identify the cultural and language barriers that non-Hispanic Black and Haitian women are facing.
- Based on community discussions conducted through the Needs Assessment, the following needs were expressed:

South Miami-Dade

- educate pregnant women on the importance of regular and comprehensive prenatal visits;

Central Miami-Dade

- integrate nutritional information and services with prenatal services; especially information regarding important foods and vitamins for proper prenatal development;

North Miami-Dade

- initiate educational programs to raise awareness of the increased risk for poor health outcomes of teen pregnancy;
- encourage medical staff to consider the economic and cultural background of clients;
- better promotion on the availability of parenting and child birth classes throughout the community including transportation to these events;

Communitywide

- raise the awareness of the value and benefits of the Healthy Start program; the first step should be to clearly communicate to our clients that they are receiving Healthy Start services;
- support cultural competency, consumer friendly services, and high levels of personal interaction between consumers and Healthy Start providers.

2. **Low Birth Weight**

a. **Target Areas**

Despite national and local efforts to reduce the percentage of babies born with low birth weight, the proportion of low birth weight infants has remained constant. Seven zip codes in North Miami-Dade, one in Central Miami-Dade, and two in South Miami-Dade had higher percentages of low birth weight births than Miami-Dade County, which was 7.9% in 1999 (Table A1).

As well documented in the literature, there are many factors that contribute directly to a woman delivering a low birth weight infant. These include tobacco/alcohol/drugs abuse, poor maternal weight gained, maternal age, access to prenatal care, infections (vaginal and urinary track infections, sexually transmitted disease), and birth spacing. These risk factors are more prevalent among non-Hispanic Blacks. Analysis of the Miami-Dade County 2000 birth records confirmed the association between the above risk factors and low birth weight births (Attachment B: Factors Associated with Low Birthweight in Full-term Single Live Births in Miami-Dade County, 2000). It was found that non-Hispanic black, Haitian and other non-Hispanic women were more likely to have

low birth weight babies, compared to non-Hispanic white women. The factors of unmarried, smoking, and medical history during pregnancy were significantly associated with low birth weight. Women aged 10-17 and above 35 years were more likely to deliver low birth weight infants, relative to women aged 20-34 years. Weight gain during pregnancy above 20 pounds and second or third birth could significantly reduce the risk of low birth weight. Intermediate and inadequate prenatal care utilization were significantly associated with low birth weight only in univariate analysis. As shown in Table A1, most of the zip codes with higher percentages of low birth weight births also had higher percentages and/or rates of births to teens, unwed mothers, preterm births, infant mortality, and late/no prenatal care.

b. Gaps and Needs

- There is lack of sufficient screening and identification of infections among pregnant women by prenatal care providers.
- There is a need to address issues of access to care including lack of knowledge regarding available health programs.
- There is a need to educate pregnant and childbearing aged women regarding proper nutrition, harmful effects of tobacco/drugs/alcohol use, and proper birth spacing.

3. Preterm Births

a. Target Areas

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% overall. 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 (Table A1).

Preterm birth and low birth weight have well-known effects on infant morbidity and mortality. Two-thirds of all low birth weight births were from preterm birth during 2000 in Miami-Dade County. An analysis of the Miami-Dade County 2000 vital records was conducted to examine the association between maternal demography, medical history, substance habits, prenatal care utilization and preterm birth (Attachment B: Determinants of Preterm Birth during 2000 in Miami-Dade County). It was found that non-Hispanic black and Haitian women were more likely to experience preterm birth relative to non-Hispanic white women. Being unmarried, smoking during pregnancy, medical history and inadequate prenatal care were factors that significantly increased the risk for preterm birth. Maternal weight gain above 20 pounds and second birth could significantly reduce the risk of preterm birth. Maternal age and alcohol use were significant risk factors in univariate analysis; women aged below 19 and above 34 years were more likely to experience preterm births. However, women aged above 34 years of age had significantly increased risk of preterm birth relative to women aged 20-34 while controlling other risk factors.

b. Gaps and Needs

- There is a need to conduct outreach to pregnant teens, and to link them to appropriate prenatal care and/or other Healthy Start services so that there will be a reduction in repeat births.
- There is a need to educate pregnant women, especially teens, regarding proper weight gain and smoking cessation and/or drugs and alcohol abuse.

4. Healthy Start System

a. Prenatal Screens

Table A2 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 Downtown area (33128) had an especially low offer rate (44.6%) and screening rate (43.6%). Several zip codes in South Miami-Dade had lower percentages of prenatal screen offer than the county percent; with the Florida City area (33035) having the lowest offer percent, as well as the consent percent, than all the other zip codes. The Downtown (33128), Florida City (33035), and Richmond/Perrine/Cutler Ridge (33157) areas had the screening rates below the county average.

Table A2. Live Births and Healthy Start Prenatal Screens Rates ¹, Miami-Dade County, 2000

Zip Codes	Live Births*		Prenatal Screen Offer		Prenatal Screen Consent		Prenatal Screening Rate
	Total	Number	%	Number	%	%	
North Miami-Dade							
33054 *							
Opa-Locka	490	419	85.5	354	84.5	72.2	
33147 *							
Liberty City	1003	716	71.4	657	91.8	65.5	
33150 *							
Miami Shores/El Portal	495	390	78.8	351	90.0	70.9	
33127 **							
Little Haiti/Wynwood/ Miami	532	366	68.8	335	91.5	63.0	
33137 **							
LH/Morningside/ Wynwood/ Miami	260	187	71.9	169	90.4	65.0	
33142 **							
Allapattah/Brownsville/ Melrose/Liberty City	848	567	66.9	522	92.1	61.6	
33167 **							
Westview/Lakeview/ N.Miami/Pinewood	335	279	83.3	251	90.0	74.9	

Central Miami-Dade						
33128 *						
Downtown	101	45	44.6	44	97.8	43.6
33136 *						
Overtown	269	167	62.1	152	91	56.5
33130 **						
Downtown	257	140	54.5	132	94.3	51.4
South Miami-Dade						
33030 *						
Homestead	794	586	73.8	557	95.1	70.2
33034 *						
West Homestead	337	232	68.8	223	96.1	66.2
33035*						
Florida City	51	22	43.1	17	77.3	33.3
33157 **						
Richmond/Perrine/Cutler Ridge	858	465	54.2	389	83.7	45.3
33170 **						
Goulds-East	199	120	60.3	116	96.7	58.3
33190 **						
Goulds-West	90	53	58.9	48	90.6	53.3
Miami-Dade County	32300	19887	61.6	16282	82.7	50.4

¹ Prenatal Screen data only include women who were residents of Miami-Dade County at the date of screening, between January and December of 2000; the number of Live Births is from a different data file (Vital Statistics file from the Florida DOH).

* Primary priority areas ** Secondary priority areas

b. Healthy Start Providers

Healthy Start services in Miami-Dade County are provided by the Miami-Dade County Health Department and Community Based Providers (CBPs). There are currently thirteen CBPs serving in the following regions (Table A3); each having a different system of operation. It will be important to analyze each system through the QI/QA process to examine how Healthy Start services are being delivered.

Table A3

Regions	Providers
North Miami-Dade	<ul style="list-style-type: none"> - Avanti Support - Borinquen Health Center - Catholic Charities - Children's Home Society - Economic Opportunity Family Health Center - Miami Beach Community Health Center, Inc. - North Dade Health Center - The Village - University of Miami Perinatal Care Program
Central Miami-Dade	<ul style="list-style-type: none"> - Avanti Support - Catholic Charities - Children's Home Society - Dr. Raphael A. Penalver Clinic - Helen B. Bentley Family Health Center - Jefferson Reeves Health Center - Miami Beach Community Health Center, Inc. - University of Miami Perinatal Care Program

South Miami-Dade	<ul style="list-style-type: none"> - Avanti Support - Catholic Charities - Children’s Home Society - Community Health of South Dade (CHI) - University of Miami Perinatal Care Program
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c. MomMobile

Also part of the Healthy Start System is the MomMobile, a collaborative project between the March of Dimes, Miami-Dade County Health Department, the Children’s Services Council, and Healthy Start. It is a mobile health unit that serves the underserved, uninsured, and underinsured clients in Miami-Dade area by providing free, comprehensive prenatal care, family planning, laboratory, and educational services. They serve approximately 60+ clients on a weekly basis (Monday through Friday) at four different sites throughout Miami-Dade (Attachment C). Three MomMobile sites are located in zip codes 33030, 33033, and 33177 in South Miami-Dade. One site is in 33184 in Central Miami-Dade. Two of the aforementioned zip codes are deemed primary or secondary Healthy Start priority areas. The QI/QA process will be implemented to analyze how MomMobile delivers its services.

d. MomCare

A relatively recent addition to the Healthy Start System is the MomCare program. It is a Medicaid-funded program through a waiver from the federal government. The program was developed in partnership with the Florida Association of Healthy Start Coalitions, Florida Department of Health, Florida Agency for Health Care Administration, and the U.S. Centers for Medicare and Medicaid Services. In December 2001, MomCare was implemented in Miami-Dade County by the MDCHD. The primary goal of MomCare is to improve birth outcomes and infant health by providing services to pregnant women who are eligible for Medicaid due to their pregnancy. MomCare provides the following services to pregnant women:

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

Medicaid eligibility is determined and Consultec submits a list notifying the local Healthy Start coalitions of eligible participants. MomCare Medicaid-eligible women who are identified 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, but does not utilize Healthy Start services, she will be case managed by a Maternity Care Advisor (MCA) who will assist her in:

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

Currently, the Miami-Dade County Health Department is managing the program. Once the Coalition has the MomCare contract, it will implement a quality assurance and quality

improvement plan (QI/QA) that will allow for ongoing monitoring and evaluation of MomCare services (Attachment D). The Florida Association of Healthy Start Coalitions (FAHSC) has commissioned an assessment (Attachment E) of the Miami-Dade MomCare implementation as part of a broader Technical Assistance contract between the Florida Department of Health, The Healthy Start Coalition of Miami-Dade County and the Healthy Start Coalition of Hillsborough County. The Coalition will incorporate the assessment and the corresponding recommendations into its operation of the MomCare Program.

e. Gaps and Needs

There is a need to analyze where the services are and if they are going to the area and population of greater need.

- Although the majority of the zip codes had higher screening percentages than the county, there are still a lot more women who are not getting the Healthy Start screenings. Improvements are still needed to increase the offer and the screening rates. Targeted and enhanced in-service training needs to be conducted to medical providers in these zip codes.
- There is a need to increase the general community's awareness of the Healthy Start Program.
- There is a need to have Healthy Start funded initiatives targeted at the primary and secondary priority areas.
- There is a need to analyze the level of Healthy Start services by region and providers.
- There is a need to analyze the various indicators of the MomMobile.
- There is a need to analyze the various indicators of MomCare.

5. Quality Improvement/Quality Assurance

The gaps in services will be identified as part of the QI/QA plan. Improving the quality of the programs funded by the Healthy Start Coalition requires a coordinated effort by the organization. As the Coalition assumes oversight and management of the Healthy Start program, it will be the Coalition's responsibility to guarantee that all pregnant women and children birth to age three continue to receive quality Healthy Start services. The Coalition will implement a QI/QA plan (Exhibit A) that will examine the processes of service provision, address customer satisfaction, be data driven, monitor achievement of performance measures and desired outcomes, and focus on continuous improvement. The Coalition will abide by the performance measures specified for the Healthy Start System under the Medicaid Waiver. The plan will ensure that Healthy Start services are delivered in a manner complying with the current *Healthy Start Standards and Guidelines* developed by the State of Florida, Department of Health and the contract indicators.

The QI/QA plan will help the Coalition to clearly define an overall funding strategy, identify providers in need of technical assistance after funds are disbursed and offer assistance. Finally, the Coalition's compliance activities outlined in this document will identify areas where funded providers have or should improve service quality.

6. Transition Plan

The Coalition is expecting to receive final authority over the Healthy Start service dollars during the October/November 2002 time period. Advertisement for the unfilled positions (Quality Improvement and Assurance Manager, Community Liaison and Accountant) shall be posted during the September/October 2002 time period. Once the Coalition has final authority from the Florida Department of Health, it shall complete the hiring of its staff. The following positions will initially be the Coalition's full-time staff: Executive Director, Health Planner, Quality Improvement and Assurance Manager, Contract Manager, Community Liaison, Accountant and Office Manager/Administrative Assistant. Included as Attachment G are the job descriptions for the aforementioned positions. Currently, the Health Planner, Contract Manager and Office Manager/Administrative Assistant positions are employed by the Miami-Dade County Health Department. Upon receiving authority, the Health Planner and Contract Manager positions shall transition into Coalition employees. The Office Manager/Administrative Assistant position shall remain a Miami-Dade County Health Department employee subcontracted and outsourced to the Coalition. It has been mutually agreed upon by the Miami-Dade County Health Department and the Coalition to have an overlap with the Contract Manager position until the end of December 31, 2002. This will assure a smooth transition in the development and execution of the contracts between the Coalition, Miami-Dade County Health Department and the thirteen Healthy Start community-based providers. At the beginning of January 2003, Healthy Start funds will be used to support only the Coalition's Contract Manager position. During the October/November 2002 time period, the existing Coalition staff will start the process of implementing the specific Category A and B Activities (Sections V and VI), the processes for the Quality Improvement and Assurance Plan (Exhibit A) and completion of the current Action Plan (Attachment I) that is part of the current Florida Department of Health contract for the administrative dollars.

C. PLANNING SUMMARY SHEET FOR THE HEALTHY START SYSTEM

Jackson Health System is a major provider of medical care in Miami-Dade County. The Healthy Start System depends on prenatal and postnatal screens conducted by medical providers, which are unfunded by Healthy Start dollars. This link between Healthy Start System and medical providers is crucial for the continuation of services for at-risk women and infants.

Healthy Start System Components Provision of ...	Provider(s)	Y	N	Begin and End Date of MOA or Contract
Outreach services for pregnant women	Public Health Trust/Jackson Health System		√	10/02-9/03
	- All the federally qualified Community Health Centers		√	10/02-9/03
Outreach services for children	Public Health Trust/Jackson Health System		√	10/02-9/03
Process for assuring access to Medicaid (PEPW & ongoing)	Department of Children and Family		√	10/02-9/03
	Public Health Trust/Jackson Health System		√	10/02-9/03
Clinical prenatal care for all unfunded women	Public Health Trust/Jackson Health System		√	10/02-9/03
	MDCHD MomMobile	√		10/02-6/03
Clinical well-child care for all unfunded infants	Public Health Trust/Jackson Health System		√	10/02-9/03
	MDCHD MomMobile	√		10/02-6/03
Funding to support the CHD Vital Statistics Healthy Start screening infrastructure	MDCHD	√		10/02-6/03
Ongoing training for providers doing screens and referrals	MDCHD	√		10/02-6/03
Initial contact after screening	* 13 Healthy Start providers	√		10/02-6/03
Assessment of service needs	* 13 Healthy Start providers	√		10/02-6/03
Ongoing care coordination	* 13 Healthy Start providers	√		10/02-6/03
Childbirth education	* 13 Healthy Start providers	√		10/02-6/03
Parenting support and education	* 13 Healthy Start providers	√		10/02-6/03
Nutritional counseling	* 13 Healthy Start providers	√		10/02-6/03
Provision of psychosocial counseling	* 13 Healthy Start providers	√		10/02-6/03
Smoking cessation counseling	* 13 Healthy Start providers	√		10/02-6/03
Breastfeeding education and support	* 13 Healthy Start providers	√		10/02-6/03
Data entry into CIS/HMS	MDCHD	√		10/02-6/03

* 13 Healthy Start providers can be found in Table A3, pages 27 and 28.

D. Funding Allocation

Included in Attachment H is the formal correspondence dated August 13, 2002 submitted to the Florida Department of Health with the projected Coalition's total operating budget. The distribution is broken down by the Healthy Start Administration and Core Dollars. A partial requested amount of \$79,919.00 of the \$493,950.20 from the Healthy Start Core Dollars had been approved for use from July 1, 2002 – December 31, 2002. Also included is the budget allocation summarized by the Miami-Dade County Health Department for all Healthy Start services, Medicaid Waiver and the MomCare Program. Once the Coalition obtains funding authority, it shall maintain all existing contracts at the same terms and conditions as outlined in the Miami-Dade County Health Department budget distribution schedule.

VI. CATEGORY B

<p><u>Activity 1</u> Provider Development and Education</p>

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?

1) There is a low screening rate among medical providers. In 2000, only 61.6% of pregnant women in Miami-Dade were offered the Healthy Start screens by their medical providers. Of those women who were offered screens, 82% consented. The county screening rate for 2000 was only 50.4%. Several zip codes designated as “priority areas of concern” had lower screen offer and screening rates than the county rates. These zip codes also had higher infant mortality rates, preterm births, and low birth weight births.

2) There is a need to evaluate the number of enhanced Healthy Start services offered by Healthy Start providers. The services include classes in childbirth, breastfeeding, nutrition, parenting, safety (household and transportation), family planning, smoking cessation counseling, and alcohol/drug counseling. In the community discussions, participants suggested that the availability of parenting and childbirth classes needed to be better advertised. Furthermore, there needs to be awareness in the community of the values and benefits of Healthy Start services.

3) There is a need to have consistency among the 13 Healthy Start providers regarding enhanced services training and curriculum used.

4) Once the Coalition has the contract, there is a need for both medical providers and Healthy Start providers to be educated regarding the MomCare Program and the Medicaid Simplified eligibility program.

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

- Analysis of the 2000 Prenatal screening data provided by MDCHD Office of Epidemiology
- Health Problem Analysis
- Community discussions documented in the Healthy Start Needs Assessment 2001
- Healthy Start Provider contracts
- MomCare/SIS system reports
- GH 330 forms

2. PLANNING PHASE QUESTIONS

A. What strategy has been selected to address this?

1) Coalition staff will review with the MDCHD Healthy Start Program Office the current schedule of outreach efforts for the Healthy Start screening process. An analysis will be done on the major prenatal service providers and their screening rates. In-service trainings will be conducted to medical providers and hospitals.

Coalition staff will also work with MDCHD Healthy Start Program Office to identify ways to decrease the time it takes for medical providers to submit screen forms to MDCHD. According to a July 2002 Status report for the Healthy Start Prenatal Upload to Central Registry (Attachment F), the average number of days from screening until received at the Miami-Dade County Health Department was 20 days.

Coalition staff will provide reports of screening rates to medical providers.

2) Coalition staff will review current Healthy Start providers' services' report to determine the current number, frequency, and location of enhanced services being offered. Based on the findings, recommendations will be made on the best efforts with the enhanced services that meet the clients' needs.

3) Coalition staff will work with MDCHD Healthy Start Program Office and the Quality Improvement/Quality Assurance (QI/QA) Committee to identify training needs and to select curriculum. Furthermore, staff will collaborate with community organizations and other Healthy Start Coalitions to identify existing trainings and to exchange resources.

4) Once it has the contract, the Coalition will provide in-services to medical and Healthy Start providers regarding the MomCare Program and the Medicaid Simplified eligibility.

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

- Summary of meetings with MDCHD Healthy Start Program Office, providers, and other community organizations
- Screening reports of individual providers
- Prenatal screen offer rate and screening rate reports
- Contracts to reflect the increase in enhanced services
- Training curriculum and materials
- Infant screening rate

3. STRATEGIES

Action Step	Person Responsible	Start Date	Completion Date
1) Coalition staff will review with the MDCHD Healthy Start Program Office the current schedule of outreach efforts for the Healthy Start screening process. An analysis will be done on the major prenatal service providers and their screening rates.	QI/QA Manager, MDCHD HS Program Office	10-02	1-03
Conduct in-services to providers	MDCHD HS Program Office	Training schedule – TBD	On-going
Conduct Outreach/in-services to hospitals	MDCHD HS Program Office	Training schedule – TBD	On-going
Monitor screening data and provide feedback	Health Planner	10-02	On-going
2) Coalition staff will review current Healthy Start providers’ service reports to determine the current number, frequency, and location of enhanced services being offered. Based on the findings, recommendations will be made on the best efforts with the enhanced services that meet the clients’ needs.	QI/QA Manager	10/02	7/03
3) Coalition staff will work with MDCHD Healthy Start Program Office and the Quality Improvement/Quality Assurance (QI/QA) Committee to identify training needs	QI/QA Manager, MDCHD HS Program Office	10/02	On-going
Select training curriculum and materials	QI/QA Manager, MDCHD HS Program Office, QI/QA Committee	12-02	3-03
Collaborate with community organizations to identify existing trainings and to exchange resources.	Community Liaison	10-02	On-going
4) Conduct MOM Care and Simplified Medicaid eligibility in-services to medical and HS providers	MomCare Manager	TBD	

Activity 2 Community Development

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?

1) There is a need to raise awareness about the Healthy Start services in the community, particularly among non-Hispanic Blacks. Non-Hispanic Black women experience poorer birth outcomes, tend to not seek early prenatal care, have higher percentages of unwed mothers and teenage births. Although the percentage of prenatal care use increased from 65.1% in 1992 to 75.9% in 1999, it was still low compared to non-Hispanic White women (91.9%) and Hispanic women (93.6%).

2) The Coalition needs to collaborate with community organizations that address issues regarding maternal and infant health.

3) There is a need for outreach in the community in the Haitian community. In 1999, 6.2% of the live births in Miami-Dade County were by Haitian women. The percentage of preterm births (11.9%) was higher than both non-Hispanic Whites (8.4%) and Hispanics (8.7%).

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

- Healthy Start Needs Assessment 2001
- Health Problem Analysis 2002– Developed using the Assessment Protocol for Excellence (APEX, 1991 model)
- Community meetings and discussions

2. PLANNING PHASE QUESTIONS

A. What strategy has been selected to address this?

1) The Coalition will launch a marketing campaign in zip code areas where there are high rates of infant mortality, low birth weight, and preterm births. Coalition staff will work with committee members to develop a marketing campaign targeting specific geographic areas and women of childbearing age, specifically non-Hispanic Blacks and Haitians.

The Coalition will work with the Healthy Start providers to assure that they display the Healthy Start logo and include the logo in related printed educational/informational materials.

The Coalition will work with the Healthy Start providers to assure that they participate in educational activities on Healthy Start in their community.

The Coalition will work with other Healthy Start Coalitions around the state to look at their current marketing activities and adapt for use in Miami-Dade.

2) The Coalition will collaborate with organizations that will address issues relating to maternal and infant health; with particular emphasis on those working on breastfeeding, nutrition, domestic violence, child abuse, smoking cessation, SIDS, alcohol/drug abuse, and teenage pregnancy.

3) The Coalition will conduct meetings with community organizations such as the Miami-Dade Breastfeeding Taskforce, Infant Mental Health Coalition, the Miami-Dade Immunization Coalition, etc. to learn more about their health issues and barriers to accessing services. The information will be used to plan appropriate services.

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

- Marketing plan
- 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
- Screening rate report
- Coalition membership roster
- Meeting summaries with community organizations

3. STRATEGIES

Action Step	Person Responsible	Start Date	Completion Date
1) Develop marketing plan (message, media – newspaper, billboard, park benches, etc., materials – brochures, posters, pens, T-shirts, etc.)	Coalition staff HS providers HSC members	10-02	3-02
Consult with other HS Coalitions regarding their marketing plan	Coalition staff	10-02	3-02
Implement campaign	Coalition staff HS providers HSC members	2004	On-going
Monitor screening rate	Health Planner	On-going	
Create and monitor dissemination log of	Health Planner Administrative	On-going	

materials	Assistant		
Use of HS logo and materials	CBPs, HSC	10-02	On-going
Participate in community events to increase visibility of the HS Program	HSC, CBPs	10-02	On-going
2) Work with community organizations that address maternal and infant health issues	Coalition staff	10-02	On-going
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	10-02	On-going

Activity 3 Planning and Research

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?

1) According to the Needs Assessment, the infant mortality rate in Miami-Dade was lower than the state rate, although there are still zip codes that have rates higher than the state. Furthermore, non-Hispanic Black women have consistently higher infant mortality rates than non-Hispanic White and Hispanic women. More information and research are needed to understand the factors that contribute to the higher infant mortality rate among non-Hispanic Black women.

2) The health problem analysis revealed many indirect contributing factors to infant mortality, low birth weight, and preterm births. These issues include teen pregnancy and repeat births, vaginal infections, insufficient folic acid intake, Sudden Infant Death Syndrome (SIDS), and smoking. The Coalition and the community need to gather more information in the areas of data and best practices. The community will prioritize strategies. Services will then be planned and dollars effectively allocated.

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

- Health problem analysis 2002
- Healthy Start Needs Assessment 2001

2. PLANNING PHASE QUESTIONS

A. What strategy has been selected to address this?

1) The Executive Director, Health Planner, and Epidemiologist are currently participating in the Perinatal Periods of Risk (PPOR) Florida Practice Collaborative. PPOR is a methodology used to analyze linked infant birth-death data. PPOR data results will be used for planning and evaluation, and to stimulate examination of additional local data. The PPOR analysis will provide more in-depth information surrounding an infant's death than the conventional infant mortality data based on death records. The Coalition will be using the PPOR methodology to examine the racial disparity in the infant mortality rate in Miami-Dade County.

2) The Coalition will convene a Data Committee made up of the Coalition's general membership so that the Committee can provide direction in the analysis of data, research, planning, and prioritizing of strategies. The following activities will be conducted:

Year 1 and 2: Planning and Prioritizing

- Participate in the Florida Practice (PPOR) Collaborative;
- Gather and analyze primary data (FIMR and linked birth-death files) needed for the PPOR methodology;
- Conduct on-going analysis of Vital Statistic data;
- Consult with providers and medical community regarding the magnitude of maternal infections and what strategies are being implemented to address the issue;
- Conduct literature review to learn about best practices that address SIDS, SBS, alcohol/substance abuse, smoking cessation;
- Contact community organizations to collaborate with their folic acid campaign;
- Communicate literature findings, focus group and data results to appropriate committees;

Year 3

- Implement strategies;

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

- Documentation of literature search and best practices
- Meeting summaries regarding maternal infections
- Meeting summaries of committees to prioritize strategies
- Action plan to implement strategies
- Data analysis of linked birth-death file using the PPOR methodology

3. STRATEGIES

Action Step	Person Responsible	Start Date	Completion Date
Analyze linked birth-death files using the PPOR methodology	MDCHD Epidemiologist, Health Planner	10/02	On-going
Analyze vital statistics, FIMR	MDCHD Epidemiologist, Health Planner	10/02	On-going
Consult with providers, MDCHD STD Program Office, and medical community regarding the magnitude of maternal infections and what strategies are being implemented to address the issue;	ED, Health Planner MDCHD Epidemiologist Data Committee	1/03	TBD
Contact organizations that addresses issues relating to maternal and infant health to research and plan strategies	ED, Health Planner	2003	
Communicate literature findings and data results to appropriate committees of the Board;	ED Health Planner Data Committee	2003	
Prioritize strategies with Executive Committee based on finding;	ED Health Planner Data Committee MDCHD Epidemiologist	7/03	
Implement strategies;	TBD	2004	On-going
Update SDP	Health Planner	Annually	
Participate in the Florida Practice Collaborative	ED, Health Planner, MDCHD Epidemiologist	On-going	

Activity 4

Fetal Infant Mortality Review (FIMR) Program Development

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?

In May 1995 the Board of Directors of the Dade County Medical Association voted to support and co-sponsor the Fetal Infant Mortality Review (FIMR) for Dade County. Case abstraction began in January 1996 with the full support and cooperation of the Vital Statistics Office of the Dade County Department of Health. Fetal and infant death certificates are compiled and matched with available birth certificates on a monthly basis. The nurse abstractor then completes monthly reporting data, de-identifies and randomly selects cases based upon abstraction parameters set forth by the Case Review Team (CRT). Homicide and cases in litigation are excluded. Maternal interview and bereavement support are conducted by MDCHD Healthy Start professional staff. ACOG/NFIMR abstracting tools are used to document available information. Monthly CRT meetings are held at the Dade County Medical Association with 2-3 completed case presentations at the meeting.

Abstraction parameters chosen during the November 1995 CRT meeting included: weight criteria greater than 2,500 grams in all categories (fetal, neonatal, post-neonatal); Miami-Dade County residents only; nonwhite case, if available; and one case abstraction per category for presentation to the CRT. On May 28, 1996, the CRT agreed to change the weight criteria to a minimum of 750 grams for fetal death abstraction cases; the neonatal and post-neonatal weight criteria remain at 2,500 grams.

The following are needs identified in the Health Problem Analysis, CRT, and work group discussions:

- 1) Incomplete medical records, medical record discrepancies, and inaccurate and incomplete vital statistics data;
- 2) Low level of awareness among medical providers regarding data quality issues; and
- 3) Lack of a Community Action Group.

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

- FIMR Case Review Team
- Health Problem Analysis 2002
- Work group discussions

2. PLANNING PHASE QUESTIONS

A. What strategy has been selected to address this?

1. The Community Action Group (CAG) will be developed to address data quality and completeness issues by disseminating FIMR information to medical providers and hospitals. The CAG will review the Case Review Team’s recommendations for change, develop action steps and strategies for implementing necessary changes in the health care system, identify potential resources, identify appropriate change agent, and to evaluate the results of changes made. The CAG will be made up of members of the Healthy Start and other interested groups.

2. Collaborate with medical providers on the process for the collecting and recording of data.

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

- Creation of CAG
- Meeting summaries
- On-going analysis of FIMR data

3. STRATEGIES

Action Step	Person Responsible	Start Date	Completion Date
1) Participate in the monthly FIMR Reviews	ED, HP, FIMR Coordinator, MDCHD Epidemiologist	On-going	
Convene CAG to formally establish the group	ED, HP, FIMR Coordinator, Epidemiologist	1/03	On-going
Disseminate information based on CAG’s recommendations	CAG	3/03	On-going
2) Collaborate with medical providers on the process for collecting and recording of data	CAG	10/04	On-going

Activity 5

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

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 to also 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 the pressing local issues concerning maternal and infant health.

B. What information, if any, was used to identify the issue/problem (ie. 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?

Board of Directors (BOD)

- 1) Develop BOD recruitment package;
- 2) Appoint a nomination committee to recruit new members based upon unfilled membership categories of the Board;
- 3) Develop and implement Board orientation; and
- 4) Develop on-going process to provide continuous Board member training.

General Membership (GM)

- 1) Develop GM recruitment package;
- 2) Meet with community organizations that represent the targeted areas and population to recruit new GM members;
- 3) Participate in community events; serve in task forces, work groups, and other appropriate community initiatives to establish the Coalition's presence in the community and to recruit GM new members;
- 4) Develop and implement GM orientation; and
- 5) Develop on-going process to provide continuous GM member training.

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

- Increased GM membership
- Meeting summaries
- Diverse BOD and GM
- Meeting attendance of BOD and GM

3. STRATEGIES

Action Step	Person Responsible	Start Date	Completion Date
Board of Directors (BOD)			
1) Develop BOD recruitment	ED, Community Liaison	10/02	1/03
2) Appoint a nomination committee to recruit new members based upon unfilled membership categories of the Board	ED, Board of Directors, Community Liaison	10/02	12/02
3) Develop and implement Board orientation	ED	10/02	On-going
4) Develop on-going process to provide continuous Board member training	ED, Community Liaison, BOD		
General Membership			
1) Develop GM recruitment package;	ED, Community Liaison	10/02	1/03
2) Meet with community organizations that represent the targeted areas and population to recruit new GM members;	ED, Community Liaison	10/02	On-going
3) Participate in community events; serve in task forces, work groups, and other appropriate community initiatives to establish the Coalition's presence in the community and to recruit GM new members;	ED, Community Liaison, HSC staff	10/02	On-going
4) Develop and implement GM orientation	ED, Community Liaison	10/02	On-going
5) Develop on-going process to provide continuous GM member training	ED, Community Liaison	10/02	On-going

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