HEALTHY START COALITION
OF
MIAMI-DADE

SERVICE DELIVERY PLAN

Fiscal Years 2011-2015

Submitted: May 2012
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ACCOMPLISHMENTS: HEALTHY START COALITION OF MIAMI-DADE, 2006-2011

OUR HISTORY:
The Healthy Start Coalition of Miami-Dade (HSCMD) was incorporated on April 1, 2001 as a community-based non-profit organization. Our mission is to ensure that all children in Miami-Dade County get a healthy start in life. To achieve our mission, we partner with a network of local community-based organizations and healthcare professionals to plan, coordinate and provide high quality health and education services to women of childbearing age, children to age 3, and their families. Our primary goals are to reduce infant mortality, reduce the number of low birth weight and pre-term births, improve maternal health and improve child health and developmental outcomes.

CELEBRATING A DECADE OF SERVICE...THE HEALTHY START PROGRAM
The Healthy Start Program is funded by the State of Florida Department of Health. Florida statute mandates that all pregnant women are offered the Healthy Start Prenatal Risk Screen at their first prenatal visit and that the Healthy Start Infant (Postnatal) Risk Screen is offered to parents or guardians of all infants born in Florida before leaving the delivery facility. The screens identify risk factors that may jeopardize birth and developmental outcomes. They are the primary entry point for the Healthy Start and Healthy Families programs. All pregnant women and infants are eligible to receive a free healthy start risk screen and services regardless of socioeconomic or immigration status.

Since its inception, HSCMD has worked closely with prenatal care providers to ensure they comply with Florida statute by offering prenatal screens to all pregnant women. Our efforts have been increasingly successful over the past 10 years, raising the number of women screened annually by more than 10,000 from 2001 to 2010.

Once pregnant women and infants are screened and determined to be eligible for the Healthy Start Program, they are assigned to one of the Healthy Start contracted providers who serve the Northern, Central and Southern regions of Miami- Dade County. After screening, eligible women receive care coordination, which links them to those services which most appropriately meet their needs.

Naturally, as the numbers of women screened increases, so does the number of women who qualify for services. In addition, the recent economic downturn has increased the need for services among at-risk families, as well as the number of women scoring above the risk threshold. From 2001 to 2010, the number of women served by The Healthy Start Program increased by 76%.

Through increasing efficiencies and a focus on providing interconception care services (women’s health before, between and beyond pregnancy), HSCMD has seen more than a five-fold increase in the number of services provided to pregnant women between 2001 and 2010, as shown in the following chart.
In partnership with local hospitals, the Healthy Start Coalition of Miami-Dade has been working diligently to ensure that every newborn is screened for risk factors, and referred for Healthy Start services if they qualify. In July 2005, the HSCMD began a comprehensive initiative to improve the Healthy Start Postnatal screening rate. Since August 2005, an HSCMD staff member has visited each hospital/birthing facility quarterly to provide education about the benefits of Healthy Start and other available resources. As a result, the number of infants screened for Healthy Start has increased after 2005, compared to the levels of screening attained prior to this initiative.

Similarly, the numbers of infants served increased during the time period of 2006-2010, with a significant jump in infants served in 2010.

In the past 10 years, there has been a steady upward trend in the number of infant services provided through Healthy Start, with major increases in the five years since 2006. As of 2010, The Healthy Start Program provided more than 273,000 services to infants and their mothers in Miami-Dade County.
THE HEALTHY START COALITION OF MIAMI-DADE

Source: Florida Department of Health, Healthy Start Reports

A DECADE OF INNOVATION...
In addition to providing Healthy Start services required by Florida statute, over the past ten years (and particularly in the last five) HSCMD has pioneered several innovative programs to further our mission. The following are some highlights of HSCMD’s accomplishments:

THE JASMINE PROJECT: The Jasmine Project represents a joint collaboration between the University of Miami’s Starting Early Starting Smart Program (SESS) and the Healthy Start Coalition of Miami-Dade. A federal Healthy Start Project funded by the Health Resources and Services Administration (HRSA) for a five-year period, the program focuses on reducing racial disparities in Black infant mortality and improving health among infants, pregnant women, and women who are between pregnancies. The Jasmine Project provides services in the Miami-Dade communities of Miami Gardens, Opa Locka, and North Miami (ZIP codes 33054, 33055, 33167), where on average from 2005-2007, Black infants died in the first year of life at a rate more than 2 times that of White infants.

MIAMI-DADE COUNTY’S ROSE PROJECT: The Rose Project was so named because it reflects the growth and blossoming of new families. Funded by Miami-Dade County in 2010, the program offers interconception care, childbirth, and breastfeeding education classes and other needed health education and support to pregnant women and their male partners.

HEALTHCONNECT IN THE EARLY YEARS: This voluntary home visitation program funded by The Children’s Trust focuses on health, education, promotion and support to improve maternal health, pregnancy outcomes and child health and development. HealthConnect In The Early Years guides expectant teen moms, first-time mothers, infants and toddlers to live healthier lives by providing practical support and resources to ensure their physical, mental and emotional well-being.

THE HEALTHY START COALITION OF MIAMI-DADE
MOMMOBILE is a mobile medical vehicle providing free regular prenatal, pregnancy testing, family planning, and postpartum care to indigent women in South Dade. A partnership between the March of Dimes, the Miami-Dade County Health Department, The Children's Trust and the Healthy Start Coalition of Miami-Dade, it has been in operation for over 12 years. The MOMmobile serves thousands of pregnant women who otherwise might not seek care or have access to services, thereby delaying necessary medical treatment during pregnancy. Birth outcomes for MOMmobile clients have been consistently better than the County average.

BLACK INFANT HEALTH PRACTICE INITIATIVE: In 2007, the Legislature passed and Governor Charlie Crist signed House Bill 1269, creating the Black Infant Health Practice Initiative (BIHPI), a statewide practice collaborative to address the issue of racial disparity in infant deaths in Florida. HSCMD was responsible for administering BIHPI, but this community-based effort was designed to be driven by community needs and preferences. As a result of this project, information on maternal and infant health indicators and risk factors was used to develop a report that has been widely distributed to Fetal and Infant Mortality Review (FIMR) committee members and other key stakeholders in Miami-Dade County to educate the community about health disparities.

TOUCHPOINTS: The Healthy Start Coalition of Miami-Dade is a Touchpoints Site. The Brazelton Touchpoints Center® partners with local coalitions of multidisciplinary providers to make and sustain change on behalf of children and families. The Touchpoints Approach is a strengths-based intervention that activates and supports the expertise and capacity of families to provide sensitive and nurturing caregiving. Using the Touchpoints Approach, providers identify opportunities to work together with families to bring about better health and readiness to learn outcomes for children.

FIMR (FETAL INFANT MORTALITY REVIEW PROJECT): This project is a countywide effort to better understand the issues associated with fetal and infant mortality and morbidity (when a fetus or an infant dies during the first year of life) and to develop strategies that improve perinatal systems of care, locally and statewide. Funded in the State of Florida by the Department of Health, FIMR began in 1990 as a collaborative effort between the American College of Obstetricians and Gynecologists and the Federal Maternal and Child Health Bureau. From 2008-2010, FIMR investigated more than 100 infant deaths to develop a better understanding of how to prevent such deaths in the future.

SHARE: Share Pregnancy and Infant Loss Support., Inc. is a national organization whose mission is to serve those whose lives are touched by the tragic death of a baby through pregnancy loss, stillbirth or in the first few months of life. The Healthy Start Coalition of Miami-Dade is now a Share Site. Share is a support group for families who have suffered a miscarriage, stillbirth or infant loss. It is an open group facilitated by a trained therapist. Share enables families to share in their sadness, find support and rebuild their hope through connections, comfort and care.
1. DESCRIPTION OF PROCESS USED TO UPDATE THE SERVICE DELIVERY PLAN

The 2011-2015 Service Delivery Plan is driven by data from the 2011 Needs Assessment, which examined 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 critical health indicators which include preterm and low-birth weight births, and fetal and infant mortality. The majority of data were collected for the years 2005 (the last Needs Assessment/Service Delivery Plan) to 2009 (the most recent data available at the end of 2010, when the Needs Assessment occurred.) These findings were then incorporated into a Health Problem Analysis process to identify critical health issues and develop strategies that will drive services of HSCMD for fiscal years 2011-2015.

Model Used for Needs Assessment and Planning

The 2011-2015 Needs Assessment and Service Delivery Plan was driven by two theoretical models of maternal child health: the Ecological Model (Brofenbrenner, 1979) and the Life Course Model (Lu & Halfon, 2003). The Ecological Model of health states that individual health status occurs in social context, and depends on a variety of health exposures and risk factors, including social determinants of health. The Life Course Model expands on this theory to incorporate the effect of prenatal and early childhood exposures on one’s lifelong health trajectory.

Using these models, the Needs Assessment and Service Delivery Plan focused on the HSCMD’s core focus of infant mortality and its most proximal determinants, preterm birth and low birth weight. The Needs Assessment then expanded to include other risk factors for poor birth outcomes, including social and demographic characteristics of County residents. HSCMD solicited data from numerous local and state sources. In addition, the Needs Assessment incorporated formal and informal research conducted as part of HSCMD’s ongoing initiative. A special contracted provider and stakeholder survey was initiated to provide local perspective on quantitative data. These quantitative and qualitative data were then incorporated into formal planning process to identify key health problems and related strategies for implementation over the next five fiscal years.

Committee Participation

The most recent Needs Assessment and Service Delivery Plan were spearheaded by HSCMD in collaboration with the Data Committee and the Board of Directors. Please see the Acknowledgements for a list of all members. The Data Committee, comprised of Contracted Providers, community partners and interested stakeholders, provided oversight for the process and reviewed drafts of the documents developed by HSCMD staff and contractors. Service Delivery Planning was conducted by HSCMD staff and contractors and was guided and approved by the Board of Directors.
Timeline for Needs Assessment and Service Delivery Process
The Data Committee was first convened in October 2010 to guide HSCMD staff and contractors in the development of the 2011 Needs Assessment. During 2011, the Needs Assessment document was developed via online collaboration among HSCMD staff, a contracted data analyst, and the Data Committee, with two in-person meetings conducted to discuss and review data, content and presentation.

Sources of Data

Quantitative
• Agency for Health Care Administration
• Florida Association of Healthy Start Coalitions
• Florida Department of Children and Families, District 11
• Florida Department of Health and Vital Statistics
• Florida Department of Health, Bureau of HIV/AIDS
• 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
• Florida Department of Health: Healthy Start Reports
• Florida Department of Law Enforcement: Domestic Violence Arrests
• Florida Department of Transportation
• Florida Poison Information Center-Miami
• Health Foundation of South Florida
• Miami-Dade County Health Department
• The Children’s Trust

Qualitative
• Black Infant Health Practice Initiative focus groups
• Provider and stakeholder survey
2. SUMMARY OF ALL FINDINGS FROM THE UPDATED NEEDS ASSESSMENT

Executive Summary
This section provides an overview of the Executive Summary of the 2011 Needs Assessment. It highlights the key findings of the assessment in critical areas such as maternal and infant health, child health, social determinants of health, and community perspectives and resources.

Strengths and Successes

Maternal and Infant Health
- A decrease in the overall infant mortality rate in the county in the past five years, with infant, neonatal, and post neonatal mortality rates that are below state averages.
- An infant mortality rate in the County that is statistically lower than expected for population demographics.
- SIDS rates in the County that are lower than the state average.
- A decrease in the fetal death (stillbirth) rate in the County since the last Needs Assessment/Service Delivery Planning process.
- A lower proportion of high-risk pregnancies in the County than the State average.
- A lower proportion of births to obese mothers in the County than the State average.
- A lower incidence of chlamydia and gonorrhea in the County than the State average.
- Decreasing proportions of women who have no or late prenatal care and inadequate prenatal care since the last Needs Assessment/Service Delivery Planning process.

Child Health
- Rates of breastfeeding initiation that are higher than State rates.
- The proportion of fully immunized two year-olds is greater in the County than across the State of Florida.
- Lower rates of fatal injuries (including motor vehicle crashes) than State averages for children ages 1-5.

Social Determinants of Health
- Decreasing rates of births to teens.

Community Perspectives and Resources
- Providers and community members cite high numbers of effective community resources that can be focused and aligned to increase the health status of mothers, infants and young children.
Challenges:

Maternal and Infant Health

- Racial and ethnic disparities in infant mortality, particularly among Non-Hispanic Black/African-Americans.
- Racial and ethnic disparities in SIDS rates, particularly among Non-Hispanic Black/African-Americans.
- Racial and ethnic disparities in preterm birth rates, particularly among Non-Hispanic Black/African-Americans and Haitians.
- In 2009, there was an increase in the preterm birth rate among White Hispanic women, a possible trend that bears surveillance.
- Racial and ethnic disparities in low birth weight rates, particularly among Non-Hispanic Black/African-Americans.
- Increase in the postneonatal (after the first month of life but before the first birthday) mortality rate in 2007-2009; a potential trend that bears surveillance.
- Racial and ethnic disparities in maternal mortality (death during pregnancy or within 42 days after birth), particularly among Haitian mothers.
- An increasing proportion of births occurring to high-risk and obese mothers.
- Racial and ethnic disparities in high-risk and obese mothers, particularly among non-Hispanic Black/African-Americans.
- An elevated incidence of syphilis cases compared to state averages.
- Although the incidence of chlamydia and gonorrhea is lower in the County than in the state, the rates of these two STIs have increased in recent years.
- An elevated prevalence of HIV cases in the County compared to the state, particularly among African-American women of childbearing age.
- An increasing proportion of women who do not access prenatal care in the first trimester of pregnancy.
- A C-section rate that is higher than the state average and has increased each year from 2005-2009.
- Low levels of mothers achieving the breastfeeding duration recommended by leading health and professional agencies; in 2009, there was a slight decrease in breastfeeding initiation from prior years; a potential trend that bears surveillance.
- Racial/ethnic disparities in breastfeeding initiation.

Child Health:

- A proportion of fully immunized Kindergarteners lower than the State average.
- An elevated and increasing rate of low-income children who are obese or overweight.
- Low consumption of fruits and vegetables, particularly among Hispanic children.
- High levels of “screen time” (e.g., television and video games) among children in the County, particularly among low-income children.
- High levels of pediatric asthma hospitalizations, suggesting challenges in community-level pediatric asthma management.
- Higher rates of pediatric hospitalizations for non-fatal accidents than the State average for children ages 1-5.
• Lower rates of child automobile safety practices (i.e., car seat safety) than the State average.

Social Determinants of Health:

• Increasing rate of repeat births to teens.
• Lower proportion of families with adequate insurance coverage than the State average.
• Increasing number of births to unmarried women; in 2009, for the first time, the majority of births in the County were to unmarried mothers. This change mirrors trends at the state and national levels.
• Decreasing proportion of births where the father is listed on the birth certificate.

Community Perspectives and Resources:

• Providers and community members cite underinsurance and lack of health education as main barriers to health for pregnant women and women of childbearing age.
• The health of a mother before, during and after pregnancy was cited as the most important factor in infant mortality by providers and community members. However, many providers feel that women of childbearing age do not have adequate knowledge, skills or resources to maintain health.
• Providers and community members believe that mothers of children ages 0-3 would benefit from education about navigating the health care system and the benefits of breastfeeding. They also state that many families have deficits in knowledge and resources that prevent them from optimal parenting.
3. 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 Committee designated numerous health indicators to be reviewed, with an emphasis on seven: late/no prenatal care, births to teens, births to single mothers, preterm births, low birth weight births, fetal mortality, and infant mortality, among others. The Committee determined that a comprehensive exploration of indicators would capture the greatest number of contributing factors, and mothers and babies at risk

Out of the numerous 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 2011 Needs Assessment, the mission of the HSCMD, 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 (e.g., late/no prenatal care) can affect all three outcomes. Targeting these three indicators enables the HSCMD 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 HSCMD also decided to focus on indicators of performance for the HSCMD, including screening rates.

COMPARISON WITH 2006 NEEDS ASSESSMENT/SERVICE DELIVERY PLAN

The major health indicators selected for this Service Delivery Plan (SDP) are virtually identical to those in the previous SDP, as these major health issues remain a serious concern for the Miami-Dade community.

Miami-Dade’s infant mortality rate has declined since the last SDP. However, racial and ethnic disparities remain an issue. As reported in the 2006 SDP, as of 2003, 10.1% of births in the County were preterm. From 2005-2009, more than 15% of births in the County were preterm.

In 2003, 8.6% of births were low birth weight (LBW). This proportion increased to an average of 9.0% from 2005-2009.

**Infant Mortality**

Infant mortality is the primary indicator that reflects the health of a community. All infants experience the risk of death at birth. However, the risk varies based on medical and biological factors including the following: previous maternal history of infant or fetal loss; access to and adequacy of prenatal care; prenatal use of tobacco, alcohol and other drugs; period of gestation; birth weight; infant gender; birth order; and plurality.

Additionally, infant mortality varies significantly in relation to demographic variables such as maternal age, education, family income, race and marital status. As such, infant mortality is the "tip of the iceberg" of child health problems, according to the American Academy of Pediatrics.
Infant Mortality, Three-Year Discrete Averages, 2001-2009

According to the Florida Department of Health, Division of Family Health Services, Bureau of Family and Community Health, the infant mortality rate is lower in Miami-Dade County than would be expected for its population demographics, and is lower than the State rate. However, much progress still needs to be made in reducing racial/ethnic and geographic disparities, as the charts in this section will demonstrate.

Infant Mortality by Race/Ethnicity
According to the Department of Human Services, Office of Minority Health, African-Americans in the United States have 2.4 times the infant mortality rate as non-Hispanic Whites. They are four times as likely to die as infants due to complications related to low birth weight as compared to non-Hispanic White infants.

From 2005-2009, the infant mortality rate for Black/African-American infants was consistently higher than that of White infants. The Black infant mortality rate dipped briefly in 2008 after a 2007 high of 12.4 per 1,000 births. However, for the 2009 reporting period, the Black infant mortality rate was 2.8 times higher than the White infant mortality rate.
Population demographics in Miami-Dade County are different from the rest of the state; specifically, the majority of the White population are Hispanic Whites, and the Black population includes African-Americans, Haitians and other Caribbeans of African descent. A simple Black versus White comparison may not be finely tuned enough to highlight the extent of racial and ethnic disparities in the county. Therefore, additional analyses were conducted using de-identified Linked Birth-Death Certificate data from Vital Statistics.

Infant mortality rates were calculated for the discrete three-year period 2006-2008 for the four major racial/ethnic groups in the County: White Hispanic, White Non-Hispanic, Black/African-American, and Haitian. Race-level data for 2009 were not available to HSCMD at the time this document was developed. Infant deaths are a relatively rare event; therefore infant mortality rates were calculated on a three-year average basis to avoid unstable estimates due to small sample sizes.
Infant Mortality by Race/Ethnicity, 2006-2008 Average

Over the discrete three-year period, the highest average infant mortality rate was seen among Black/African-Americans, at 10.1 per 1,000 live births. White Hispanics experienced the lowest infant mortality rate, at 4.0 per 1,000 live births. The rate for Haitians was elevated, at 6.8, per 1,000 births. For this period, the infant mortality ratio between non-Hispanic Blacks and Hispanic Whites was 2.5 to 1.

**Geographic Disparities**
Consistent with the legislative charge to Florida Healthy Start Coalitions to identify targeted geographic areas with maternal child health problems, a geographic analysis of infant mortality was undertaken by ZIP code.

As with race/ethnicity, infant mortality rates by ZIP code were calculated on a three-year average basis to avoid unstable estimates due to small sample sizes. In all infant mortality data presented in the Needs Assessment or Service Delivery Plan, ZIP codes that experienced fewer than five infant deaths in a three-year period are suppressed. ZIP-code level infant mortality data for 2009 were not available to HSCMD at the time this document was developed.

The 10 ZIP codes with the highest infant mortality rates are presented in the table below. Rates for the entire county are mapped in the Needs Assessment. The Technical Appendix of the Needs Assessment provides a full analysis of all ZIP codes in the County. The ZIP codes refer to the residence of the mother as noted on the birth certificate.
Top 10 ZIP Codes* With The Highest Infant Mortality Rates, Three-Year Average, 2006-2008

<table>
<thead>
<tr>
<th>ZIP Code</th>
<th>Infant Mortality Rate per 1,000 Live Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>33136</td>
<td>24.3</td>
</tr>
<tr>
<td>33189</td>
<td>15.9</td>
</tr>
<tr>
<td>33170</td>
<td>13.8</td>
</tr>
<tr>
<td>33056</td>
<td>12.2</td>
</tr>
<tr>
<td>33167</td>
<td>11.9</td>
</tr>
<tr>
<td>33145</td>
<td>11.3</td>
</tr>
<tr>
<td>33137</td>
<td>10.6</td>
</tr>
<tr>
<td>33054</td>
<td>10.1</td>
</tr>
<tr>
<td>33127</td>
<td>9.9</td>
</tr>
<tr>
<td>33147</td>
<td>9.8</td>
</tr>
</tbody>
</table>


* ZIP code of mother’s residence as recorded on the birth certificate

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 Healthy People 2020 objectives.
Infant Mortality by ZIP Code*, Three-Year Average, 2006-2008

Note: ZIP codes in White represent areas where data are suppressed due to small sample sizes.
* ZIP code of mother’s residence as recorded on the birth certificate.
Causes of Infant Mortality
To further investigate the issue of infant mortality, an analysis of causes of infant deaths for the same three year period of 2006-2008 was undertaken. The top five causes of death listed on infant death certificates in Miami-Dade were extreme immaturity, bacterial sepsis, heart defects, chromosomal abnormalities, accidental suffocation in bed, and unknown causes (i.e., causes that were undetermined on the death certificate).

In addition to information on the death certificate, more in-depth information is available from the Healthy Start Coalition of Miami Dade’s FIMR project. The goal of the Fetal and Infant Mortality Review (FIMR) Program is to prevent infant mortality and morbidity through the review of fetal and infant deaths. The FIMR process is used as a "warning system" and method for improving birth outcomes and systems of care surrounding pregnancy, childbirth and infancy. FIMR assesses how infant morbidity and mortality occur in specific local communities and creates an action-oriented process for change.

Leading Risk Factors for Infant Deaths, HSCMD FIMR Analysis, 2008-2010

For the most recent years available, the FIMR Case Review Team (CRT) identified the mother’s medical/obstetrical history prior to the current pregnancy as a contributing factor in 89% of infant or fetal deaths. The most common issues found were obesity and pre-existing conditions such as hypertension and diabetes. In 72% of cases, fetal health issues, such as prematurity and infection, contributed to the death. Medical or social service issues contributed in 80% of cases; the most common issue cited was poverty and age under 18 or over 35. Because multiple causes could be implicated in one death, the percentages in the chart add up to more than 100%.

Birth Defects
According to the Florida Birth Defects Registry, one out of every 33 babies is born with a major birth defect in the United States. Birth defects are the leading cause of infant mortality and the 5th leading cause of years of potential life lost. They contribute to life-long disability and developmental delays and account for 30% of pediatric hospital admissions. However,
researchers have found that only about 35% of birth defects have a known cause. Surveillance activities are important for identifying trends and risk factors, developing and evaluating prevention programs, and helping families access services.

Health care providers can help women prevent birth defects by encouraging them to plan their pregnancy and access health care prior to becoming pregnant to discuss family history, use of medications, or chronic health conditions such as obesity, diabetes or epilepsy. Women who are pregnant or planning to become pregnant should avoid tobacco, illicit drugs, and chemicals that may cause harm.

### Rate Of Selected Birth Defects, 1998-2007

<table>
<thead>
<tr>
<th>Birth Defect</th>
<th>Miami-Dade County Rate *</th>
<th>Florida Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neural Tube Defects</td>
<td>3.8</td>
<td>4.5</td>
</tr>
<tr>
<td>Congenital Heart Defects</td>
<td>81.4</td>
<td>73.5</td>
</tr>
<tr>
<td>Chromosomal Anomalies</td>
<td>15.0</td>
<td>15.4</td>
</tr>
<tr>
<td>Orofacial Clefts</td>
<td>9.3</td>
<td>13.6</td>
</tr>
<tr>
<td>Abdominal Wall Defects</td>
<td>4.3</td>
<td>6.7</td>
</tr>
<tr>
<td>Limb Reduction Defects</td>
<td>2.3</td>
<td>3.0</td>
</tr>
</tbody>
</table>

* rate per 10,000 live births

The rate of congenital heart defects is higher in the County than in the State of Florida as a whole. Maternal factors that may increase the risk of having a pregnancy affected by a heart defect include contracting a viral infection, exposure to tobacco smoke, taking anti-seizure or anti-depressant medications, pre-pregnancy obesity and/or diabetes that is not well-controlled and low folic acid levels in blood during the prenatal period.

### Preterm Births

Preterm births occur when a baby is born prior to 37 completed weeks of gestation. The Centers for Disease Control and Prevention (CDC) estimates that 1 out of every 8 infants in the United States is born preterm. Preterm births occur for a number of reasons, but are associated with race, maternal age, marital status and socioeconomic status. 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.

Preterm birth is a serious health problem and is one of the proximal causes of infant mortality. Babies born too early are at increased risk for newborn health complications, such as breathing problems, and even death. Many premature babies require care in a newborn intensive care unit (NICU). Premature babies also face an increased risk of lasting disabilities, such as cognitive and developmental delays, cerebral palsy, lung problems, vision impairment and hearing loss.
Just as with Infant Mortality, racial and ethnic disparities were also seen in preterm birth, with Black/African-American infants at highest risk for preterm birth in the County.

From 2005-2009, 15.6% of all infants were born preterm, with highest rates seen in mothers 14 and younger or 45 and older.

**Geographic Disparities**
Examining community needs in terms of geographic area is essential in identifying areas that require targeted Healthy Start services. Socioeconomic and environmental factors that place women and infants at higher risk for preterm births may readily cluster within geographic neighborhoods. Once identified, appropriate strategies can be implemented to serve these areas.
The 10 ZIP codes with the highest percentage of preterm births are presented in the table below. Rates for the entire County are mapped in the Needs Assessment. The Technical Appendix in the 2011 Needs Assessment provides a full analysis of all ZIP codes in the County.

**Top 10 ZIP Codes* with the Highest Rates of Preterm Birth, Miami-Dade County, 2009**

<table>
<thead>
<tr>
<th>ZIP Code</th>
<th>Percentage of Births that Were Preterm</th>
</tr>
</thead>
<tbody>
<tr>
<td>33156</td>
<td>26.3%</td>
</tr>
<tr>
<td>33136</td>
<td>25.0%</td>
</tr>
<tr>
<td>33127</td>
<td>23.6%</td>
</tr>
<tr>
<td>33173</td>
<td>22.2%</td>
</tr>
<tr>
<td>33196</td>
<td>20.4%</td>
</tr>
<tr>
<td>33150</td>
<td>20.0%</td>
</tr>
<tr>
<td>33170</td>
<td>20.0%</td>
</tr>
<tr>
<td>33135</td>
<td>19.5%</td>
</tr>
<tr>
<td>33176</td>
<td>19.4%</td>
</tr>
<tr>
<td>33132</td>
<td>19.3%</td>
</tr>
</tbody>
</table>

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

* ZIP code of mother’s residence as recorded on the birth certificate

ZIP code 33156 represents the Pinecrest area of Miami-Dade County, with higher-than-median family income and housing values. Although preterm births rates are high in the ZIP code, rates of infant mortality and low birth weight are not, suggesting that some of these births are in the 34-37 week “late preterm” birth range, possibly due to early elective inductions or cesarean deliveries. Some births may also be preterm as a consequence of pregnancies achieved via assisted reproductive technology.

Several of the other high-ranking preterm birth ZIP codes demonstrate more common sociodemographic risk factors for poor birth outcomes, including a primarily Black/African American population and low socioeconomic status.

A map showing preterm birth rates by ZIP code is provided on the next page.
Map of Preterm Births by ZIP Code*, Miami-Dade County, 2009

Note: ZIP codes in White represent areas where data are suppressed due to small sample sizes
* ZIP code of mother’s residence as recorded on the birth certificate
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. 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 by Race/Ethnicity

Despite national and local efforts to reduce the prevalence of babies born with low birth weight, the proportion of low birth weight infants has remained high, particularly among racial and ethnic minorities.

Low Birth Weight Births, by Race/Ethnicity, 2005-2009

![Graph showing low birth weight births by race/ethnicity from 2005 to 2009]

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

Between 2005 and 2009, Non-Hispanic Black/African-Americans and Haitians had the highest rate of low birth weight babies in the County. The lowest rate of low birth weight babies were among Hispanic Whites.

Low Birth Weight by Maternal Age

The risk of low birth weight is elevated among adolescents and then decreases after the age of 20 until increasing again after the age of 35, with a sharp increase over the age of 45. In Miami-
Dade, the highest rate of low birth weight was found in teens under the age of 14 and women over the age of 45.

**LBW Births by Maternal Age, 2005-2009 Average**

![Diagram showing LBW births by maternal age]

**Geographic Disparities**

The 10 ZIP codes with the highest percentage of LBW births are presented in the table below. Rates for the entire County are mapped in the Needs Assessment. The Technical Appendix of the Needs Assessment provides a full analysis of low birth weight for ZIP codes in the County.

**Top 10 ZIP Codes* With Low Birth Weight, 2009**

<table>
<thead>
<tr>
<th>ZIP Code</th>
<th>Percentage of LBW Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>33136</td>
<td>17.7%</td>
</tr>
<tr>
<td>33122</td>
<td>14.3%</td>
</tr>
<tr>
<td>33127</td>
<td>13.5%</td>
</tr>
<tr>
<td>33147</td>
<td>13.5%</td>
</tr>
<tr>
<td>33150</td>
<td>13.5%</td>
</tr>
<tr>
<td>33138</td>
<td>13.4%</td>
</tr>
<tr>
<td>33167</td>
<td>13.4%</td>
</tr>
<tr>
<td>33132</td>
<td>13.3%</td>
</tr>
<tr>
<td>33142</td>
<td>13.3%</td>
</tr>
<tr>
<td>33054</td>
<td>13.2%</td>
</tr>
</tbody>
</table>

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

* ZIP code of mother’s residence as recorded on the birth certificate
Note: ZIP codes in White represent areas where data are suppressed due to small sample sizes.
* ZIP code of mother’s residence as recorded on the birth certificate
4. TARGET POPULATION OR AREA FOR RECEIPT OF SPECIAL EMPHASIS

The primary goals of the Healthy Start Coalition of Miami-Dade as documented in the 2011-2015 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.

Priority #1 – Countywide Race/Ethnicity Disparities Reduction

The mission of HSCMD is to reduce infant mortality in the County, and to that end, we will continue to serve all childbearing women. However, 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.

Priority #2- Geographic Priorities

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 2011 process has therefore included an analysis of health outcome indicators by ZIP code.

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

The chart below cross-references ZIP codes with high infant mortality rates with other maternal and infant health indicators, to identify ZIP codes with persistent health issues. The ZIP codes refer to the residence of the mother as noted on the birth certificate.
<table>
<thead>
<tr>
<th>ZIP Code</th>
<th>Infant Mortality</th>
<th>Low Birth Weight</th>
<th>Pre-Term Birth</th>
<th>High Risk Births</th>
<th>Teen Births</th>
<th>Short Inter-pregnancy Interval</th>
<th>Inadequate Prenatal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>33136</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
</tr>
<tr>
<td>33189</td>
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<td>X</td>
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<tr>
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<td></td>
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<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>33054</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>33127</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
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<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* ZIP code of mother’s residence as recorded on the birth certificate

ZIP code 33136, representing the Overtown neighborhood, has higher-than-average rates of infant mortality, low birth weight, preterm birth, high-risk births and births with inadequate prenatal care.

Opa-Locka/Carol City, ZIP codes 33054 and 33056, experiences high rates of infant mortality and teen births. ZIP code 33054 has some of the highest inadequate prenatal care rates in the County, while 33056 has a high number of high-risk births.

ZIP code 33127, representing Wynwood, demonstrates challenges in the area of infant mortality, low birth weight, preterm birth, and teen births.

Goulds, the neighborhood with ZIP code 33170, has experienced high rates of infant mortality, preterm birth and teen births.

ZIP code 33147, representing the West Little River/Liberty City neighborhoods, has higher-than-average rates of infant mortality, teen births and short interpregnancy intervals.

Consistent with statistics about racial/ethnic disparities in birth outcomes, the neighborhoods noted have large proportions of non-Hispanic Black/African-American residents.

**Comparison with 2006 Needs Assessment/Service Delivery Plan**

In the 2006 Needs Assessment, HSCMD also identified the ZIP codes of 33136, 33170, 33056, 33167, 33137, 33054 and 33147 as neighborhoods where infant mortality was a concern. These findings suggest that persistent social and demographic risk factors for infant mortality exist in these areas. On the other hand, ZIP codes 33189, 33145, and 33127 appear in the top ten ZIP codes for the years 2006-2008. This change may reflect the dynamic demographic and economic changes Miami’s neighborhoods undergo across time. Given the recent economic downturn, and
the lag in availability of vital statistics, other areas with high infant mortality rates may be discovered in the next few years.

Racial/ethnic disparities in birth outcomes continue to remain a challenge for the County, the State of Florida, and the nation. Therefore, HSCMD will continue to focus its efforts on eliminating these disparities in this SDP, just as it did in the previous one.
5. FACTORS CONTRIBUTING TO THE HEALTH STATUS INDICATORS IN THE TARGET POPULATION

Maternal child health researchers, providers and policy makers recognize increasingly that the health of woman and her infant is determined well before pregnancy begins.

“One of the best protections available against low birth weight and other poor pregnancy outcomes is to have women actively plan for pregnancy, enter pregnancy in good health with as few risk factors as possible, and be fully informed about her reproductive and general health” Institute of Medicine [IOM], 1985

Prior to the first pregnancy, and between subsequent pregnancies, all women are encouraged to access health care services, maintain a healthy weight, get good nutrition, and avoid tobacco, alcohol and other drugs that can act as teratogens.

Increase the proportion of women delivering a live birth who received preconception care services and practiced key recommended preconception health behaviors
Healthy People 2020

This section reviews the direct and indirect contributing factors to infant mortality, preterm birth and low birth weight.

Comparison with 2006 Needs Assessment/Service Delivery Plan
As reported in the 2006 SDP, as of 2003, 89% of mothers in the County initiated prenatal care in the first trimester. By 2009, only 69.1% of mothers initiated prenatal care in the first trimester. While the adequacy of prenatal care has increased since the last SDP, efforts are needed to raise awareness about the importance and accessibility of prenatal care.

In 2003, 0.2% of births occurred to mothers over 45 and 3.1% were to mothers ages 40-44. By 2009, those proportions have increased slightly, to 0.3% and 3.4%, respectively. During that same time period, birth to single mothers increased. For the first time, in 2009, the proportion of single mothers was greater than married mothers in the County.

The indicators of obesity and high-risk pregnancy were not tracked in the 2006 SDP. However, they were included in the 2011-2015 SDP due to research and stakeholder perspectives on the impact of poor pre-pregnancy health birth outcomes. These indicators reflect HSCMD’s increased investment in interconception health.

High-Risk Pregnancy
The Florida Department of Health defines a high-risk pregnancy as one where the mother had a history of gestational or pre-pregnancy diabetes, chronic or gestational hypertension, previous preterm delivery or other previous poor birth outcome.
In Miami-Dade County, there has been a trend of increasing proportions of high-risk pregnancies since 2007. Nevertheless, Miami-Dade County experiences a smaller proportion of high-risk pregnancies than the rest of the State.

**High-Risk Births by Race/Ethnicity**
County high-risk births were examined by the race/ethnicity of the mother.

In Miami-Dade County, White non-Hispanic women had the lowest rate of high-risk pregnancy, while nearly 12% of births to Haitian mothers were categorized as high risk.
Geographic Disparities
To identify areas of the county where women enter pregnancy in less-than-optimal health, an analysis of high-risk birth rates was undertaken by ZIP code.

Top 10 ZIP codes* with High-Risk Births, 2009

<table>
<thead>
<tr>
<th>ZIP Code</th>
<th>Percent of Births that Were High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>33136</td>
<td>14.6%</td>
</tr>
<tr>
<td>33016</td>
<td>14.0%</td>
</tr>
<tr>
<td>33056</td>
<td>13.7%</td>
</tr>
<tr>
<td>33138</td>
<td>12.7%</td>
</tr>
<tr>
<td>33142</td>
<td>12.7%</td>
</tr>
<tr>
<td>33023</td>
<td>12.5%</td>
</tr>
<tr>
<td>33179</td>
<td>12.3%</td>
</tr>
<tr>
<td>33169</td>
<td>12.2%</td>
</tr>
<tr>
<td>33128</td>
<td>12.1%</td>
</tr>
<tr>
<td>33141</td>
<td>11.7%</td>
</tr>
</tbody>
</table>

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS
* ZIP code of mother’s residence as recorded on the birth certificate

Maternal Obesity
According to the CDC, maternal obesity [Body Mass Index (BMI) >30] is associated with complications such as cesarean delivery, macrosomia, gestational hypertension, pre-eclampsia, gestational diabetes mellitus, fetal death, and birth defects.

Children born to obese mothers are twice as likely to be obese as other children and to develop Type 2 diabetes later in life. Obesity during pregnancy is also associated with greater use of health care services and longer hospital stay.

Births to Obese Mothers, 2005-2009

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS
The prevalence of maternal obesity has increased in both Miami-Dade County and the State of Florida from 2005-2009. Although the maternal obesity rate is lower in the County compared to the State, the rate is rising. An examination of obesity rates by race/ethnicity was undertaken to identify racial/ethnic disparities in obesity rates. Non-Hispanic Black/African-American mothers were most likely to be obese prior to pregnancy, followed by Haitian women.

**Births To Obese Mothers, By Race/Ethnicity, Average For 2005-2009**

![Bar chart](chart.png)

- **White Hispanic**: 15.4%
- **White Non-Hispanic**: 13.4%
- **Black/AA**: 24.1%
- **Haitian**: 23.7%
- **All Races**: 17.4%

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

**Interpregnancy Interval**

Interpregnancy Interval is the amount of time between pregnancies and is calculated as the number of months between the date the last pregnancy ended and the date of the last menstrual period in the target pregnancy. Women with short interpregnancy intervals are at nutritional risk and more likely to experience adverse birth outcomes; specifically, women with an interpregnancy interval less than 18 months are at greater risk of delivering a low birth weight infant compared to women with interpregnancy intervals of 24 to 36 months.
The decrease in second or later births with a short interpregnancy interval from 2007 to 2009 corresponded with a significant increase in HSCMD’s efforts in interconception education and care during that period. Interconception education and counseling services provide comprehensive information and education related to the optimal health status needed by any eligible woman of reproductive age to improve the birth outcome of a potential pregnancy. This service includes information on access to care, baby spacing, nutrition, physical activity, maternal infections, chronic health problems, substance abuse, smoking, mental health and environmental risk factors.

In Miami-Dade County in 2009, 37.1% of African-American mothers having a second or subsequent birth had an Interpregnancy interval of less than 18 months.
Interpregnancy Interval by Age
To identify whether there were disparities in interpregnancy by maternal age, data were examined by various age groups. The highest proportion of short interpregnancy interval births occurred among teens age 14-19, which suggests that teen mothers have difficulty with baby spacing. Unfortunately, each birth to a teen mother increases her risk of preterm birth and low birth weight and jeopardizes her ability to complete school and/or gain and maintain employment.

2nd Or Later Births With Interpregnancy Interval <18 Months, By Maternal Age, 2009

![Chart showing interpregnancy interval by maternal age]

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

Additional analyses were conducted to identify whether a mother’s education made a difference in interpregnancy interval, but there was no difference between women with a high school education or higher and those who did not graduate from high school.

In addition, a geographic analysis was conducted. The following chart lists ZIP code areas of concern for interpregnancy interval.
Top 10 ZIP Codes* With Short Interpregnancy Interval, 2009

<table>
<thead>
<tr>
<th>ZIP Code</th>
<th>Percent of Births with IPI &lt;18 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>33132</td>
<td>46.20%</td>
</tr>
<tr>
<td>33180</td>
<td>40.90%</td>
</tr>
<tr>
<td>33129</td>
<td>40.70%</td>
</tr>
<tr>
<td>33154</td>
<td>40.70%</td>
</tr>
<tr>
<td>33139</td>
<td>40.50%</td>
</tr>
<tr>
<td>33147</td>
<td>40.40%</td>
</tr>
<tr>
<td>33133</td>
<td>39.40%</td>
</tr>
<tr>
<td>33158</td>
<td>39.10%</td>
</tr>
<tr>
<td>33140</td>
<td>38.90%</td>
</tr>
<tr>
<td>33054</td>
<td>38.60%</td>
</tr>
</tbody>
</table>

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS
* ZIP code of mother’s residence as recorded on the birth certificate

**Prenatal Care**

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 greatest among socially disadvantaged women. Prenatal care should be initiated as early as possible and continue throughout pregnancy. Two commonly accepted measures for monitoring prenatal care utilization are the number of prenatal visits an expectant mother makes and the month or trimester of the first prenatal care visit. The Adequacy of Prenatal Care Utilization (APNCU) Index combines these two measures into one index that measures the sufficiency of prenatal care once it begins. Inadequate prenatal care is defined as too few prenatal care visits for the amount of time the woman was in care.

Analyses of the timing of prenatal care initiation (early, late or none) and the adequacy of that care were conducted to identify opportunities to increase women’s utilization of care, as shown in the charts that follow.
From 2007 to 2009, the proportion of women seeking prenatal care late (in the third trimester) or not at all declined in both the County and the State, although the County rate has historically been lower. This finding suggests that more women understand the importance of accessing prenatal care or that barriers to care have been reduced.

From 2007 to 2009, there was a decrease in the proportion of women who had inadequate prenatal care, suggesting that more women were adhering to the recommended schedule for prenatal care.
Births Where Mothers Accessed Prenatal Care In The First Trimester, 2005-2009

![Chart showing percentage of births where mothers accessed prenatal care in the first trimester from 2005 to 2009.](chart)

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

Although progress has been made in reducing the numbers of women who enter prenatal care late, there is a decreasing proportion of women who access prenatal care in the first trimester.

**Prenatal Care by Race/Ethnicity**

For the most recent year data were available, an analysis was conducted to identify variation in rates of inadequate prenatal care by race/ethnicity.

**Pregnancies With Inadequate Prenatal Care, By Race/Ethnicity, 2009**

![Chart showing percentage of pregnancies with inadequate prenatal care by race/ethnicity in 2009.](chart)

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

Of the four main racial/ethnic groups in the County, Haitian women were most likely to experience inadequate prenatal care, followed by non-Hispanic Black/African-American women. Further research may be necessary to identify whether inadequate prenatal care among Haitian
mothers is due to immigration status, lack of insurance coverage, cultural factors, or some combination of sociodemographic factors.

**Prenatal Care by Maternal Age**
Teens that become pregnant, particularly if they are concerned about their parents’ reactions, may access prenatal care late in their pregnancy or attend too few visits. To understand patterns of prenatal care access by maternal age, these data were examined.

### Inadequate Prenatal Care by Age, 2009

![Graph showing percentage of inadequate prenatal care by age group.](image)

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

Overall, in 2009, 19.7% of mothers had inadequate prenatal care. Among mothers 14 and under, 40.6% had inadequate prenatal care. Teen mothers ages 15-19 also had high rates of inadequate care.
Geographic Disparities

TOP 10 ZIP CODES* WITH INADEQUATE PRENATAL CARE, 2009

<table>
<thead>
<tr>
<th>ZIP Code</th>
<th>Percent of Births with Inadequate Prenatal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>33054</td>
<td>28.2%</td>
</tr>
<tr>
<td>33161</td>
<td>28.0%</td>
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<tr>
<td>33056</td>
<td>27.7%</td>
</tr>
<tr>
<td>33162</td>
<td>26.9%</td>
</tr>
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<td>33136</td>
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<td>33169</td>
<td>25.8%</td>
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<td>24.6%</td>
</tr>
<tr>
<td>33128</td>
<td>24.3%</td>
</tr>
</tbody>
</table>

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS
* ZIP code of mother’s residence as recorded on the birth certificate

Breastfeeding
Breastfeeding provides numerous health benefits for mother and baby. Breast milk is easily digestible, contains antibodies that protect infants from illness, and changes with a baby’s needs. Some studies suggest that breastfeeding helps mothers shed pregnancy weight gain faster than formula-feeding mothers and provides protection against breast and ovarian cancer.

Pediatricians and parents should be aware that exclusive breastfeeding is sufficient to support optimal growth and development for approximately the first 6 months of life and provides continuing protection against diarrhea and respiratory tract infection. Breastfeeding should be continued for at least the first year of life and beyond for as long as mutually desired by mother and child. –American Academy of Pediatrics

Breastfeeding Initiation
Healthy People 2020 goals for breastfeeding include having at least 81.9% of mothers initiate breastfeeding in the United States and have at least 60.6% of mothers still breastfeeding at six months.
Overall, mothers in Miami-Dade County initiate breastfeeding at a higher rate than in the State of Florida.

In 2009, consistent with national data, White non-Hispanic mothers were most likely to initiate breastfeeding while non-Hispanic Black women were least likely to initiate breastfeeding.

**Breastfeeding Duration**

In a phone survey of parents in Miami-Dade County, parents reported that 74% of children were ever breastfed (for any time frame, any amount of breast milk). Three out of 10 children were
breastfed for six or more months. White, non-Hispanic mothers were most likely (37%) to breastfeed their infants for six months or longer. Hispanic mothers were next most likely to breastfeed for six months or longer, while non-Hispanic Black/African-American mothers were least likely to have a longer breastfeeding duration. However, foreign born children were more likely to have been breastfed for six months or more than U.S.-born children.
Source: The Children’s Trust, Child Health and Well-Being in Miami-Dade County: 2007 Parent Survey Results

Social Determinants of Health
Researchers have documented disparities in health status and health outcome that vary by age, sex, education, income, race/ethnicity, disability status, and geographic location. While individual genetics and behavior play a large role in health, health is also influenced by these psychosocial and socioeconomic factors. In an effort to explore the role of these factors in maternal, infant and child health, HSCMD performed a scan of County demographics and social issues.

The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness.
World Health Organization

Family Stress
When families are under stress, child well-being can suffer. Economic stressors and interpersonal conflicts can create an environment where the needs of children become secondary to the daily survival of the family. Frequent residential moves, parental divorce, and changes in family composition can also create stress, as well. In a 2007 phone survey of parents in the County, the Children’s Trust identified several family stressors that were common in families with children. In this context, it should be noted that the economic downturn of 2008 and 2009 may have exacerbated these stressors.

As of 2007, 40% of parents experienced one or more of the stressors listed, with 16% reporting two or more of the stressors over the past year:

Trouble paying rent or mortgage: In 2007, 17% of children in Miami-Dade County lived in families that had trouble paying their rent or mortgage in the prior year. This problem is more common among Hispanic and Black, non-Hispanic children than among White, non-Hispanic children. Trouble paying the rent or mortgage is reported more frequently for children in single-parent families, poor families, families with incomes of $25,000 or less, families in which parents are foreign born, families where the parent has lower levels of educational attainment, or the parent is unemployed.

Residential moves: Seven percent of children moved more than once during the past year. Ten percent of children ages birth to 5 experienced multiple moves, compared with six percent for children ages 6 to 11 and four percent for adolescents ages 12 to 17. Residential moves are more
common for children in families living in poverty or with an unemployed parent than for children not living in poverty or with an employed parent.

**Insurance Status**

In 2009, 60.2% of adults in the County-Dade had some type of health coverage, as compared to 71.4% statewide. The adult insurance coverage rate decreased from 63.4% in 2008. More females tend to be insured than males. Non-Hispanic Whites had higher rates of insurance coverage than non-Hispanic Blacks and Hispanics, at 80.2%, 60.9%, and 54.0%, respectively.

81.9% of children between the ages of 0 and 17 years of age living in Miami-Dade had some type of health insurance, as compared to 85.2% statewide. This rate has increased from 79.2% in 2008.

Source: Health Council of South Florida, Miami-Dade County Community Health Report Card 2010

Children with health insurance coverage are more likely than uninsured children to access preventive health care and to receive care when sick or injured. As of 2007, one out of four children in Miami-Dade was not fully insured (i.e., not currently insured and/or not insured over the last 12 months).

Insurance coverage varies by geographic region and the age and race of the child. Children living in the Northeast, Northwest, and Far South regions of the County are more likely to lack full coverage than their peers in Kendall and Near South areas.

Children ages 6 to 17 are more likely to lack full insurance coverage than children from birth to age 5. Hispanic or Black, non-Hispanic children are more likely to lack full insurance coverage than White, non-Hispanic children.

Children who are foreign born, have a foreign born parent, or speak English less than very well are more likely to lack full coverage than children who are U.S.-born, whose parents are U.S.-born, or who speak English very well. Children who have a parent with less than a bachelor’s degree, whose family income is $47,500 or less, or who live in poverty are more likely to lack full insurance coverage. Children with a parent who is unemployed are more likely to lack full insurance coverage than children with a parent who is either employed or not in the labor force.

Source: The Children’s Trust, Child Health and Well-Being in Miami-Dade County: 2007 Parent Survey Results

**County Demographics**

The 2005-2009 American Community Survey and the US Census Bureau estimate the total population of Miami-Dade County to be 2,457,044 as of 2009, of whom 6.9% are children ages 5 and younger. According to the Florida Department of Health, there were slightly more than half a million women of childbearing age (15-44) living in the county. The population of Miami-Dade County is unique and diverse relative to the demographics of Florida and the United States. Although the majority of the population is White, approximately 1,507,000 individuals (61.4% of the population) are Hispanic or Latino. One fifth of the population is of African ancestry. Miami-Dade County is also characterized by high levels of immigration and mobility. Sixty-one
percent of residents (more than 1.4 million individuals) speak a language other than English at home; 588,044 are foreign born naturalized citizens and 626,851 are foreign born non-citizens.

**County Population by Race, 2009 Estimate**

Source: United States Census Bureau

The map on the next page provides an overview of racial/ethnicity population by zip code.
County Population By Race/Ethnicity And ZIP Code, 2010

Legend
- Black Population over 75%
- Black Population 50-74%
- Hispanic Population over 75%
- Hispanic Population 50-74%
- White Non-Hispanic Population over 75%
- White Non-Hispanic Population 50-74%
- Under 49% (all races)
- ZIP Code Boundaries

Race/Ethnicity Population by Census Block Group (2010)

Data Source: US Census Bureau
Location: Miami-Dade County, Florida
Created by: Serrin Buffkin
February 2012
The Children’s Trust
2555 OKE Third Ave
Miami, FL 33137
www.thechildrenstrust.org
**Education, Employment & Income**
Among females age 25 and over, 23.1% have less than a high school education. Twenty-four percent of males in the same age group have not attained a high school diploma. Nearly 28% of people with less than a high school education live below the poverty level. Eighteen percent of households with children live under the federal poverty level, and the likelihood of being poor increases with the number of children in the family.

The median income for individuals is $28,000, while the median household income is $42,929 in 2009 inflation-adjusted dollars. However, Miami-Dade County is also noted for disparity in income brackets, with pockets of the population having an income substantially above the median, and others with an income below the median.

**Births**
Trends in births can reveal information about current and future demographic trends, as well as social issues such as teen pregnancy and single parenthood that may affect maternal and infant health.

**Births by Maternal Race/Ethnicity, 2009**

As of 2009, the majority of births (58.8%) occurred to White Hispanic mothers. The next highest proportion (18%) occurred to non-Hispanic Black/African-American mothers, consistent with current County demographics.

**Births By Maternal Age**
Certain health risks are associated with giving birth at either end of the range of childbearing years (i.e. teens and mothers over the age of 35). To identify the age profile of childbearing mothers in the County, the HSCMD examined the age distribution of mothers giving birth in the time period of 2005-2009.
Overall, the majority of infants were born to mothers between the ages of 25 and 34. However, more than 8% of infants were born to teen mothers, and more than 18% were born to older mothers.

Focus on Older Mothers
Currently, one in five women in the United States has her first child after the age of 35. While most women over 35 can expect a healthy pregnancy, advanced maternal age places a fetus at increased risk for certain chromosomal abnormalities. In addition, older mothers are more likely to have chronic health conditions such as diabetes and hypertension that put them in the high-risk pregnancy category. Women who give birth after the age of 35 are more likely to experience miscarriage, preterm birth, stillbirth and cesarean delivery.
Since 2005, the proportion of births to women ages 35-39 has increased slightly, while the birth rate to women ages 40 and over has remained relatively stable.

**Focus on Teen Mothers**

The adverse health and socioeconomic consequences of pregnancy and childbearing among teenagers have been well documented. 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. Infants born to teen mothers face an increased possibility of being born at a low birth weight or preterm.

Teen mothers are more likely to drop out of high school than girls who delay childbearing. With her education cut short, a teenage mother may lack job skills, making it hard for her to find and keep a job. A teenage mother may become financially dependent on her family or on public assistance. Teen mothers are more likely to live in poverty than women who delay childbearing until adulthood.

In 2009, the birth rate among females aged 15 to 19 in Miami-Dade County was 31.5 live births per 1,000 females, compared to a statewide rate of 37.4. This rate has improved from 36.6 in 2003. Black teens in Miami-Dade County had higher birth rates than Hispanic teens and White teens, at 51.1, 27.8, and 25.2 live births per 1,000 females, respectively.

Source: Health Council of South Florida, Miami-Dade County Community Health Report Card 2010

### BIRTHS TO TEENS, 2005-2009

Since 2005-2007, the proportion of overall live births to teens has decreased, a positive trend. However, geographic disparities still exist, as shown in the table that follows.

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS
Top 10 ZIP Codes* With The Highest Teen Birth Rates, 2009

<table>
<thead>
<tr>
<th>ZIP Code</th>
<th>Percent of Births to Teen Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>33170</td>
<td>22.2%</td>
</tr>
<tr>
<td>33127</td>
<td>17.6%</td>
</tr>
<tr>
<td>33147</td>
<td>17.5%</td>
</tr>
<tr>
<td>33034</td>
<td>17.2%</td>
</tr>
<tr>
<td>33054</td>
<td>16.6%</td>
</tr>
<tr>
<td>33142</td>
<td>16.0%</td>
</tr>
<tr>
<td>33056</td>
<td>15.9%</td>
</tr>
<tr>
<td>33167</td>
<td>15.8%</td>
</tr>
<tr>
<td>33030</td>
<td>15.5%</td>
</tr>
<tr>
<td>33150</td>
<td>14.7%</td>
</tr>
</tbody>
</table>

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

* ZIP code of mother’s residence as recorded on the birth certificate

Repeat births to teens are defined as second or higher-order births to teens that already have had one or more births. Repeat births are an important indicator because each successive birth decreases a teen’s chances to fulfill her education and career goals. Consequences of repeat births to teens include poor birth outcomes, increased risk of the family remaining on public assistance, and increased risk of contact with the child welfare and juvenile justice system for children. These data are generally indicative of the access, utilization and provision of family planning education and direct services to parenting teens.

Repeat Births To Teens, 2005-2009

In 2009, there was an increase in repeat births to teens. This is a one-year increase, which should be interpreted with caution. However, this may be the beginning of a trend that bears further surveillance in the coming years.
The greatest proportion of repeat births to teens occurred among Black/African-American adolescents, followed by White Hispanic teens.

**Births by Marital Status**

In recent years, there has been an increase in the proportion of births to unmarried mothers. While many single-parent families can provide a healthy family environment, statistically, unmarried mothers have lower incomes, lower education levels, and greater dependence on public assistance than do married mothers. Children born to unmarried mothers are more likely to grow up in a single-parent household, experience instability in living arrangements, live in poverty, and have social/emotional problems.

**Births By Marital Status, 2005-2009**
Since 2005, there has been a steady decrease in the proportion of births to married mothers and a complementary increase in births to unmarried mothers. In 2009, the proportion of births to unmarried mothers exceeded that of births to married mothers.

**Father Listed on Birth Certificate**

Fathers who are involved in their children’s lives can have positive effects on their social, cognitive, and academic achievement. Children with involved fathers tend to do better in school, have better grades, and have less involvement with the legal system. Although data on father involvement are not widely available, HSCMD analyzed a proxy variable— the percent of fathers named on the child’s birth certificate, as shown in the next chart.

**Births Where Father Is Listed On The Birth Certificate, 2005-2009**

![Bar chart showing the percentage of births where the father is listed on the birth certificate from 2005 to 2009.]

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

Between 2005 and 2009, there was a small but consistent decrease in the percentage of birth certificates where the father was listed, suggesting decreasing paternal involvement.
5A. 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, HSCMD 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 HSCMD. 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.

HSCMD took a community-based approach to the Needs Assessment process, engaging providers, community partners and clients in the process of identifying MCH problems and assets in the Miami-Dade community. In addition, HSCMD reached out to partners and providers with an online survey conducted in February 2011.

Provider and Partner Survey
Healthy Start Contracted Providers and community partners were invited to take an online survey during the month of February 2011. Prior to launching the survey, the Needs Assessment Data Committee pilot tested the online version of the questionnaire. Sixty-eight providers and partners completed the survey. Providers and partners indicated that lack of insurance coverage and health knowledge are the main challenge to good health for pregnant women/women of childbearing age.

Barriers To Health Of Pregnant And Childbearing Women

<table>
<thead>
<tr>
<th>Factor</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsurance/underinsurance</td>
<td>1.5</td>
</tr>
<tr>
<td>Lack of health knowledge</td>
<td>1.56</td>
</tr>
<tr>
<td>Availability of maternity care providers</td>
<td>1.63</td>
</tr>
<tr>
<td>Lack of fathers’ involvement</td>
<td>1.83</td>
</tr>
<tr>
<td>Distrust of health care system</td>
<td>2.0</td>
</tr>
<tr>
<td>Difficulty navigating the health care system</td>
<td>2.0</td>
</tr>
</tbody>
</table>

Source: HSCMD Provider and Partner Survey 2011

Stakeholders ranked a mother’s health prior to pregnancy as a major contributing factor to infant mortality in the County, suggesting a need for greater preconception care.
When asked about issues affecting infants and children ages 0-3, providers and partners said that difficulty navigating the health care system was the most critical issue, followed by breastfeeding, availability of pediatricians, deficits in parental knowledge of child development, and poor family living conditions.

**Issues Affecting Health Of Children 0-3**

- **Difficulty navigating the health care system**: Promote interconceptional education to raise mother’s awareness of contraception and health behavior before and between pregnancies.
• **Prenatal care:** Increase access to care; raise awareness about the importance of early and continuous prenatal care, where women can go to obtain it; the dangers of not receiving care early. Promote healthy choices such as quitting smoking and risks associated with infant mortality.

• **Parenting classes:** Promote parenting classes before leaving the hospital with a newborn. Create more awareness about infant mortality and the risks associated with it.

• **Postpartum care:** Increase access to mental health care providers.

• **Breastfeeding:** Increase initiation and duration through support and increased awareness of risks associated with not breast feeding.

• **Insurance/Health Care:** Teach immigrant mothers how to access programs such as Medicaid and Federally Qualified Health Centers.

• **Collaborations:** Link maternity and pediatric care providers together in collaborative partnerships to ensure continuity of care for mothers and children.

The majority of survey respondents (87%) were direct service providers. Most responses came from agencies providing services to more than 500 women each year. Survey respondents reported that a significant proportion of their clients were African-American (48%) living in the north region of the County.

**Black Infant Health Practice Initiative Focus groups**

HSCMD was the recipient of a State of Florida grant to conduct outreach and education about the issues of Black infant mortality. In a series of focus groups held after the last Needs Assessment/Service Delivery Plan process, for the Black Infant Health Practice Initiative (BIHPI), Black mothers and their families reported the following issues:

• **Access to Care:** Each of the participating communities had a number of health facilities to choose from, and at least one facility within their neighborhood that provided affordable health care. Yet many of the participants complained about perceived discrimination towards them on the part of clinics, and in some cases this impacted 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 community clinics. 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, individuals are single or male; they are even less likely to have health coverage. Also of concern is the number of young men and women who lose their Medicaid coverage after eighteen years of age and are not working in jobs which provide them with health benefits.

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

• **Maternal Health:** All communities expressed concern over the increasing rates 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. For women who are not currently seeking care, participants all 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 is best prevented within their own community.

- **Child Health:** Conversations about child health centered on asthma, nutrition and ADD/depression. Many communities are concerned with the increasing rates of asthma and are confused why these rates are escalating. Parents express 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 about the program and its services. In particular, North Miami and East Little Havana, both communities with high immigrant populations, need to be better informed about Healthy Start.

- **Disparities:** Participants were vocal about the perceived differences in quality of service they received from health care or social service providers that are of a different ethnicity. The majority of the participants in these focus groups were Black/African-American (85%) and reported discrimination from White Hispanic providers (but not non-Hispanic White providers).
6. RESOURCE INVENTORY

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

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:

Service Strengths:
- 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.

Service 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.
- Perceived need among community members for health promotion regarding nutrition/obesity.

HSCMD will use these findings to guide the delivery of services from 2011-2015.
## 7. HEALTH STATUS PROBLEM LINKED TO ACTION PLAN

### Health Problem Analysis - Infant Mortality

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

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Risk Factors</th>
<th>Direct Contributing Factors</th>
<th>Indirect Contributing Factors</th>
<th>Strategies that Will Address the Indirect Contributing Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Neonatal Mortality</strong> (infant death from birth to 28 days)</td>
<td>I.a. Congenital abnormality</td>
<td>I.a.1. Hereditary predisposition</td>
<td>Lack of family planning</td>
<td>Counsel pregnant women on family planning and interconceptional care, and link or refer them to the appropriate resources</td>
</tr>
<tr>
<td></td>
<td>I.b. Preterm birth (See following sections)</td>
<td>I.a.2 Maternal behavior</td>
<td>Insufficient folic acid consumption</td>
<td>Continue to collaborate with March of Dimes to begin local folic acid campaign</td>
</tr>
<tr>
<td></td>
<td>I.c. Low Birth Weight (See following sections)</td>
<td>I.b. Access to prenatal care</td>
<td>Lack of or inadequate prenatal care</td>
<td>Educate potential Healthy Start (HS) clients and link them to appropriate resources</td>
</tr>
<tr>
<td></td>
<td>I.d. APGAR at 5 min (score = 0-3, 4-6)</td>
<td>See I.b. above</td>
<td></td>
<td>Outreach to women of childbearing age, especially non-Hispanic Blacks and Haitians regarding early and ongoing prenatal care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Network with HSCMD community based providers to increase outreach to the non-Hispanic Black and Haitian communities</td>
</tr>
<tr>
<td>II. Post-neonatal Mortality (deaths between 28 - 365 days of life)</td>
<td>II.a. Preterm birth (See following sections)</td>
<td>II.b. Low Birth Weight (LBW) (See following sections)</td>
<td>II.c. Sudden Infant Death Syndrome (SIDS)</td>
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<tr>
<td></td>
<td>II.c.1. Sleeping position</td>
<td>➢ Lack of knowledge</td>
<td>➢ Train individuals who are in direct contact with the child, as part of parenting training</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>➢ Lack of awareness by primary caregivers including grandparents</td>
<td>➢ Outreach to childcare facilities and hospitals to ensure that they are educated on the recommended sleeping and playing positions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>II.c.2. Smoking and second hand smoke</td>
<td>➢ Caregiver/family members smoke around the infant</td>
<td>➢ Continue to work with the SIDS Alliance and other related organizations to promote and educate the community at large about SIDS prevention</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>➢ Encourage HSCMD clients to provide a smoke free environment</td>
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<td></td>
<td></td>
<td></td>
<td>➢ Promote tobacco cessation countywide to pregnant women and families with children in the home</td>
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<tr>
<td>II.d. Injuries (Shaken Baby Syndrome)</td>
<td>II.d.1 Unintentional</td>
<td>Incomplete information captured at the time of death</td>
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<tr>
<td>II.c.3. Circumstances surrounding SIDS death</td>
<td>0-1 year old infants are more likely to die from shaken baby syndrome</td>
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<tr>
<td></td>
<td>Lack of provider training on Shaken Baby Syndrome</td>
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<td></td>
<td>Male partners not being gentle with the baby; lack of parenting skills</td>
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<td></td>
<td>Cultural barriers</td>
<td></td>
<td></td>
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<tr>
<td>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</td>
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<tr>
<td>Provide prenatal care providers and child care providers with training, educational materials and literature</td>
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<tr>
<td>Provide awareness within HSCMD and ensure HSCMD providers receive the appropriate training</td>
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<tr>
<td>Identify one individual to spearhead education to fathers/fatherhood initiative</td>
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<tr>
<td>Educate caregivers (mother, father, boyfriend, grandparents, etc) how to gently hold the baby – don’t shake – via parenting education</td>
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</tr>
<tr>
<td>Identify cultural barriers in parenting and provide sensitivity training and education</td>
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</tr>
<tr>
<td>II.d.2. Intentional</td>
<td>Motor vehicle accidents</td>
<td>Evaluate and promote the correct use of child safety seats among all families with infants and children to age 3</td>
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<tr>
<td></td>
<td>Household safety</td>
<td>Educate parents on age appropriate toys; advocacy for appropriate product labeling</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Postpartum depression</td>
<td>Educate parents and child care providers on baby/child-proofing and safety measures including gun safety, pool safety, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Domestic violence/child abuse</td>
<td>Train providers to watch for signs of depression</td>
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<tr>
<td></td>
<td></td>
<td>Provide knowledge and skills on bonding and attachment</td>
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<td></td>
<td>Collaborate with family support services</td>
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<tr>
<td></td>
<td></td>
<td>Help parents to cope with the frustration of a crying baby, feeding problems, etc</td>
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<td></td>
</tr>
</tbody>
</table>
### Health Problem Analysis: Low Birth Weight

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

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Risk Factors</th>
<th>Direct Contributing Factors</th>
<th>Indirect Contributing Factors</th>
<th>Strategies that Will Address the Indirect Contributing Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Birth Weight (LBW = &lt;2,500 grams)</td>
<td>Intra-uterine Growth Retardation</td>
<td>I.a. Tobacco use/smoking</td>
<td>➢ Lack of education to pregnant women about the effects of tobacco/smoking</td>
<td>➢ Increase awareness through outreach education to pregnant women</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I.b. Drugs and alcohol Abuse</td>
<td>➢ Lack of education to pregnant women about the effects of drugs and alcohol</td>
<td>➢ Increase collaboration with substance abuse treatment providers for pregnant women</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I.c. Poor maternal weight</td>
<td>➢ Lack of screening by the prenatal care providers</td>
<td>➢ Assure that Healthy Start (HS) contracted providers are referring substance abusing pregnant women for the appropriate care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I.d. Access to prenatal care</td>
<td>➢ Nutrition</td>
<td>➢ Continue to address needs and gaps in the provision of nutrition services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>➢ Lack of insurance</td>
<td>➢ Assure that Healthy Start (HS) contracted providers follow-up with women referred to WIC to ensure receipt of services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>➢ Increase awareness of the MomCare Program and simplify eligibility for Medicaid</td>
</tr>
<tr>
<td>II. Infections</td>
<td>II. Vaginal, urinary tract infections, and sexually transmitted infections</td>
<td>Lack of screening, identification and treatment of infections</td>
<td>Increase awareness among prenatal care providers regarding the importance of screening for and treating STIs among pregnant women</td>
<td></td>
</tr>
<tr>
<td>III. Baby spacing</td>
<td>III. Having children closely spaced together</td>
<td>Lack of family planning and interconceptional care education</td>
<td>Ensure HSCMD care coordinators are providing interconceptional care education and referring clients for family planning services</td>
<td></td>
</tr>
</tbody>
</table>
### Health Problem Analysis: Preterm Birth

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

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Article I. Risk Factors</th>
<th>Direct Contributing Factors</th>
<th>Indirect Contributing Factors</th>
<th>Strategies that Will Address the Indirect Contributing Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preterm Birth (&lt;37 weeks)</td>
<td>I. Maternal Age I.a. Pregnancy in girls ages 10 to 17 years old</td>
<td>I.a.1. Socioeconomic status</td>
<td>➢ Lack of adequate family planning services</td>
<td>➢ Link/refer pregnant teens to government assistance programs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I.a.2. Access to prenatal care</td>
<td>➢ Lack of interconceptional care education</td>
<td>➢ Provide parenting and interconceptional care education to pregnant and parenting teens</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>➢ Incomplete or high school education</td>
<td>➢ Refer pregnant teens for GED or the South Florida Workforce Program</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>➢ Lack of/inadequate prenatal care</td>
<td>➢ Utilize the Healthy Start paraprofessionals and social workers to work closely with pregnant teens and assist them in accessing available services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>➢ Lack of parental/social support</td>
<td>➢ Collaborate with those schools that have a program set-up for pregnant teens</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>➢ Lack of transportation</td>
<td>➢ Explore the possibility of providing free bus tokens to Healthy Start participants; encourage HSCMD contracted providers to establish a formal agreement with the Miami-Dade County Transit Authority</td>
</tr>
<tr>
<td>Issue</td>
<td>Cause</td>
<td>Solution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| I.a.3. Low maternal weight gain and pre-pregnancy or prenatal obesity | Poor nutrition                                                      | ➢ Link pregnant teens to WIC  
➢ Follow-up with teens referred to WIC to ensure receipt of services  
➢ Develop a nutrition/education campaign targeting this group |
| I.a.4. Smoking                                                       | Lack of knowledge regarding the effects of smoking                   | ➢ Increase awareness through outreach and Healthy Start tobacco cessation program.                                  |
| I.b.1. Diabetes                                                      | Lack of awareness                                                    | ➢ Educate clients about diabetes                                                                                   |
| I.b.2. Hypertension                                                  | Lack of awareness                                                    | ➢ Ensure Healthy Start nurses are the lead case manager where medical conditions are evident  
➢ Assure that Healthy Start staff follow-up with clients and refer them when necessary for chronic medical conditions  
➢ Provide education as needed regarding chronic medical conditions and risks to pregnancy (both mother and infant) |
<table>
<thead>
<tr>
<th>I.b. Pregnancy in women ages 35 and older</th>
<th>I.b.3. Unmarried</th>
<th>I.b.4. Tobacco, alcohol, and drug use</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Non-compliance with doctors’ instruction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Lack of social support</td>
<td></td>
<td></td>
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<tr>
<td>➢ Financial insecurity</td>
<td></td>
<td></td>
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<tr>
<td>➢ Increased stressors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Lack of screening by the prenatal providers office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Lack of education about prenatal substance abuse</td>
<td>➢ Encourage development of rapport between Healthy Start contracted providers and prenatal care providers to share information on clients with high-risk pregnancies and chronic medical conditions</td>
<td></td>
</tr>
<tr>
<td>➢ Refer HSCMD clients to support groups for single mothers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Ensure that contracted HSCMD providers are referring women to social services such as food assistance, WIC, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Encourage parenting education for single mothers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Initiate discussions with providers who are doing the Healthy Start screens to determine what is needed to address problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Educate and encourage prenatal care providers to effectively utilize Healthy Start screening instruments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Distribute brochures and other educational materials</td>
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</tbody>
</table>
8. INTERNAL QUALITY IMPROVEMENT/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, HSCMD 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.

HSCMD 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 HSCMD. 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 HSCMD 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 HSCMD.

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 CEO 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. HSCMD 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 HSCMD’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 Specialist) 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 Specialist will structure the audits
  - Provide reports to the Executive Committee regarding the status of all contracts. The QI/QA Specialist 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 HSCMD objectives and providing evidence of established indicators, which allow the HSCMD 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 HSCMD activities
F. Maternal Infant and Child Health Provider Committee (MIC). 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
9. FUNDING ALLOCATION PROCESS

HSCMD has been given authority under Florida Statues to solicit, select and monitor local service providers, and to determine the allocation of available federal, state and local resources to promote Healthy Start services in the community. HSCMD is held accountable for monitoring the use of these Healthy Start funds in accordance with the requirements of the State of Florida, Department of Health.

HSCMD has partnered with local Healthy Start contracted providers to provide Healthy Start services at an increased level and duration to meet the needs of its clients. Prior to the commencement of each contract year, the Coalition conducts a comprehensive contract negotiation process with each Healthy Start contracted provider to review performance, to determine community needs and to evaluate program expenses. All Healthy Start contracted providers are required to submit the following documents for contract negotiation:
1) Proposed Scope of Services – detailing the number of clients to be served, type of services, and intensity or complexity of services being provided;
2) Proposed budget and budget narrative – detailing potential expenses by line items associated with the above Scope of Service;
3) Staffing Pattern Analysis – listing all staff supported under contract and identifying all enhanced services certifications for each staff;
4) Analysis of Healthy Start Contracted Providers GH350 report on service units- listing all Healthy Start services codes by types and quantities of services by provider and as well as by county and state levels;
5) Contractual Performance Measures from the monitoring visits - identifying positive and negative program performances, outcomes and contract deliverables based on record reviews;
6) Providers’ current fiscal year expenditures – reporting on year-to-date expenses by line items; and
7) Providers’ current audited financials - to assess the operating effectiveness of internal controls and fiscal soundness of the contracted providers

Funding recommendations are presented to the Board of Directors for those providers that are consistent with meeting contractual performance, consistent with addressing community needs and fiscally accountable for Healthy Start funds as required by the State of Florida, Department of Health.

To close the gap in Healthy Start services, the Coalition continues to identify strong local organizations that have the capacity to provide services in accordance with the Coalition’s funding allocation process.
10. EXTERNAL QUALITY IMPROVEMENT/QUALITY ASSURANCE PLAN

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 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 Healthy Start Contracted Providers (HSCPs).

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. There are currently 17 HSCPs:

Avanti Support & Services  
555 Biltmore Way, Suite 204  
Coral Gables, FL 33134  
Phone: (305) 255-5363

Borinquen Health Care Center  
3601 Federal Highway  
Miami, FL 33137  
Phone: (305) 576-6611  
www.borinquenhealth.org

BrainHeart Guidance  
Katja von Elbe, MS Ed, President  
E mail: katja@brainheartguidance.com

Children's Home Society of Florida  
17501 SW 117 Avenue  
Miami, FL 33177  
Phone: (305) 755-6500  
www.chsfl.org

Community Health of South Florida Inc.  
13805 SW 264 Street  
Naranja, FL 33032  
Phone: (786) 264-5747  
www.chisouthfl.org

Institute for Child and Family Health, Inc.  
9380 SW 72nd Street (Sunset Drive)  
Suite 245  
Miami, FL 33173  
Phone: (305) 722-5648  
www.icfhinc.org

Jessie Trice Community Health Center  
5361 NW 22 Avenue  
Miami, FL 33142  
Phone: (305) 637-6400  
www.jtchc.org

Miami Beach Community Health Center  
710 Alton Road  
Miami Beach, FL 33139  
Phone: (305) 538-8835 Ext. 1172  
www.miamibeachhealth.org

Miami-Dade County Health Department  
Healthy Start Data Management Office  
18255 Homestead Avenue  
Miami, Florida 33157  
Phone (305) 278-1074  
www.dadehealth.org

Miami-Dade Family Learning Partnership  
10800 Biscayne Boulevard, Suite 500  
Miami, FL 33161  
Phone: (305) 891-7323
HSCMD 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 HSCMD. 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 HSCMD 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.

**Reporting Requirements**

**Quarterly Reports**

Reports to HSCMD 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 HSCMD. These reports must be data driven and indicate the comprehensiveness and duration of the services being offered. HSCMD staff determines data elements to be included in quarterly reports.

- The QI/QA Specialist will review the quarterly reports and submit written questions on information contained in the reports.
The QI/QA Specialist 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, HSCMD will examine local data and compare with the Department of Health Executive Summary Reports and the GH330/GH350 Reports.

**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 HSCMD.

- 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. HSCMD 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 HSCMD.

**Financial Reports**

- Financial reports submitted by each contracted provider are monitored by HSCMD’s designated staff.

**Program Audit**

HSCMD 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 Specialist coordinates the audit and typically invites the Quality Improvement Review Committee (QIRC) to participate. In addition, HSCMD coordinates the annual audit with the State of Florida, Department of Health.

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

**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 Specialist 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 HSCMD no later than 10 days upon receipt of the audit report. The QIRC will review the corrective action plan and approve as necessary.

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 Specialist 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 Specialist 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 Specialist 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 HSCMD, 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

Performance Based Contracts
To promote fairness, objectivity, and impartiality in the selection and funding of contract service providers, HSCMD 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 HSCMD will incorporate performance standards as an integral part of the contracting process. As part of the funding decision, the HSCMD 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.
11. NEW ACTION PLAN

Planning Summary Sheet

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.

<table>
<thead>
<tr>
<th>Healthy Start System Components</th>
<th>Provider</th>
<th>Y</th>
<th>N</th>
<th>Begin and End Date of MOA Or Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach services for pregnant women</td>
<td>- 17 Healthy Start Contracted Providers - Public Health Trust/Jackson Health System - All federally qualified Community Health Centers</td>
<td>Y</td>
<td>N</td>
<td>01/12-12/12</td>
</tr>
<tr>
<td>Outreach services for children</td>
<td>-11 Healthy Start Contracted Providers of care coordination and wraparound services - Public Health Trust/Jackson Health System - All federally qualified Community Health Centers</td>
<td>Y</td>
<td>N</td>
<td>01/12-12/12</td>
</tr>
<tr>
<td>Process for assuring access to Medicaid (PEPW &amp; ongoing)</td>
<td>Department of Children and Families</td>
<td>N</td>
<td>01/12-12/12</td>
<td></td>
</tr>
<tr>
<td>Clinical prenatal care for all unfunded women</td>
<td>- Public Health Trust/Jackson Health System - Miami-Dade County Health Department,</td>
<td>N</td>
<td>01/12-12/12</td>
<td></td>
</tr>
<tr>
<td>Service Description</td>
<td>Provider</td>
<td>Funding</td>
<td>End Date</td>
<td></td>
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<td>---------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Clinical well-child care for all unfunded infants</td>
<td>Public Health Trust/Jackson Health System</td>
<td>N</td>
<td>01/12-12/12</td>
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</tr>
<tr>
<td>Funding to support the Miami-Dade County Health Department (MDCHD) Vital Statistics Healthy Start screening infrastructure</td>
<td>Miami-Dade County Health Department</td>
<td>N</td>
<td>01/12-12/12</td>
<td></td>
</tr>
<tr>
<td>Ongoing training for providers doing screens and referrals</td>
<td>Miami-Dade County Health Department, Healthy Start Data Management Office and HSCMD</td>
<td>Y</td>
<td>01/12-12/12</td>
<td></td>
</tr>
<tr>
<td>Initial contact after screening</td>
<td>17 Healthy Start Contracted Providers</td>
<td>Y</td>
<td>01/12-12/12</td>
<td></td>
</tr>
<tr>
<td>Assessment of service needs</td>
<td>17 Healthy Start Contracted Providers</td>
<td>Y</td>
<td>01/12-12/12</td>
<td></td>
</tr>
<tr>
<td>Ongoing care coordination</td>
<td>17 Healthy Start Contracted Providers</td>
<td>Y</td>
<td>01/12-12/12</td>
<td></td>
</tr>
<tr>
<td>Interconceptional education and counseling</td>
<td>17 Healthy Start Contracted Providers</td>
<td>Y</td>
<td>01/12-12/12</td>
<td></td>
</tr>
<tr>
<td>Childbirth education</td>
<td>17 Healthy Start Contracted Providers</td>
<td>Y</td>
<td>01/12-12/12</td>
<td></td>
</tr>
<tr>
<td>Parenting support and education</td>
<td>17 Healthy Start Contracted Providers</td>
<td>Y</td>
<td>01/12-12/12</td>
<td></td>
</tr>
<tr>
<td>Nutritional counseling</td>
<td>17 Healthy Start Contracted Providers</td>
<td>Y</td>
<td>01/12-12/12</td>
<td></td>
</tr>
<tr>
<td>Provision of psychosocial counseling</td>
<td>17 Healthy Start Contracted Providers</td>
<td>Y</td>
<td>01/12-12/12</td>
<td></td>
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<tr>
<td>Smoking cessation counseling</td>
<td>11 Healthy Start Contracted Providers</td>
<td>Y</td>
<td>01/12-12/12</td>
<td></td>
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<tr>
<td>Breastfeeding education and support</td>
<td>17 Healthy Start Contracted Providers</td>
<td>Y</td>
<td>01/12-12/12</td>
<td></td>
</tr>
<tr>
<td>Data entry into Client Information System/ Health Management Clinic (CIS/HMC)</td>
<td>Miami-Dade County Health Department</td>
<td>Y</td>
<td>01/12-12/12</td>
<td></td>
</tr>
<tr>
<td>MomCare Program (SOBRA)</td>
<td>HSCMD</td>
<td>Y</td>
<td>01/12-12/12</td>
<td></td>
</tr>
</tbody>
</table>
## Category A – subcontracted providers, QA/QI components of direct services

### QI/QA Work Plan 2011-2015

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>HSCMD Staff Responsible</th>
<th>Date Initiated</th>
<th>Date Completed</th>
</tr>
</thead>
</table>
| 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% | CEO, Provider Liaisons, QI/QA Specialist | January-11 | December-15 |
<p>| a. Set up functional linkage between screening providers and maternal, infant, and child health (MICH) programs overseen by the HSCMD | CEO, Provider Liaisons, QI/QA Specialist | January-11 | December-15 |
| b. Establish greater involvement of principal birthing facilities in the MICH care system | CEO, Provider Liaisons, QI/QA Specialist | January-11 | December-15 |
| 2. Collaborate with one or more initiatives aimed at reducing infant mortality and improving birth outcomes | CEO &amp; staff | January-11 | December-15 |
| 3. Convene the Quality Improvement and Review Committee (QIRC) as needed to address issues/concerns relevant to the Healthy Start system | QI/QA Specialist | March-11 | December-15 |
| 4. Recruit volunteers to participate on the Quality Improvement and Review Committee (QIRC) | CEO and QI/QA Specialist | February-11 | December-15 |
| 5. Conduct annual monitoring visits to Healthy Start Contracted Providers to ensure quality and quantity of service delivery | QI/QA Team | February-11 | December-15 |
| 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-11 | December-15 |</p>
<table>
<thead>
<tr>
<th></th>
<th>Activity</th>
<th>Responsible Parties</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Implement monitoring visit schedule annually</td>
<td>QI/QA Team</td>
<td>February-11</td>
<td>Annually</td>
</tr>
<tr>
<td>8</td>
<td>Identify programmatic challenges as they relate to the Healthy Start system and problem solving</td>
<td>QI/QA Team</td>
<td>February-11</td>
<td>December-15</td>
</tr>
<tr>
<td></td>
<td>a. Assess supervisors’ knowledge of the requirements of the Healthy Start standards and guidelines and identify training needs</td>
<td>QI/QA Team</td>
<td>March-11</td>
<td>December-15</td>
</tr>
<tr>
<td></td>
<td>b. Assess tools needed for supervisors and staff to provide Healthy Start services</td>
<td>QI/QA Team</td>
<td>March-11</td>
<td>December-15</td>
</tr>
<tr>
<td>9</td>
<td>Identify challenges in using work related or Healthy Start forms</td>
<td>QI/QA Team</td>
<td>March-11</td>
<td>December-15</td>
</tr>
<tr>
<td>10</td>
<td>Develop a training plan that addresses the training needs for contracted providers that relates to service delivery</td>
<td>QI/QA Team and Education &amp; Training Manager</td>
<td>March-11</td>
<td>December-15</td>
</tr>
<tr>
<td>11</td>
<td>Coordinate with contracted providers and MomCare staff to develop cultural competence training</td>
<td>QI/QA Team and Education &amp; Training Manager</td>
<td>July-11</td>
<td>December-15</td>
</tr>
<tr>
<td>12</td>
<td>Coordinate customer service training and make available to contracted providers, MomCare staff and MICH service providers in Miami-Dade County, if funding is available</td>
<td>Education &amp; Training Manager</td>
<td>August-11</td>
<td>December-15</td>
</tr>
<tr>
<td>13</td>
<td>Identify appropriate facilitator to train staff</td>
<td>Director of Education and Training</td>
<td>April-11</td>
<td>December-15</td>
</tr>
<tr>
<td>14</td>
<td>Provide technical assistance to the Healthy Start Providers on programmatic issues as Needed</td>
<td>QI/QA Team</td>
<td>Upon execution of contract</td>
<td>December-15</td>
</tr>
<tr>
<td>15</td>
<td>Provide technical assistance to the contracted providers on contractual issues as needed</td>
<td>Finance Manager</td>
<td>Upon contract execution</td>
<td>December-15</td>
</tr>
<tr>
<td>16</td>
<td>Make recommendations to the Executive Committee regarding renewal of contracts</td>
<td>Quality Improvement and Review Committee (QIRC)</td>
<td>May-11</td>
<td>December-15</td>
</tr>
<tr>
<td>17</td>
<td>Develop contracts</td>
<td>Finance Manager/Contract Manager</td>
<td>May-11</td>
<td>December-15</td>
</tr>
<tr>
<td></td>
<td>Activity Description</td>
<td>Responsible Party</td>
<td>Frequency</td>
<td>Duration</td>
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<tr>
<td>18.</td>
<td>Orient contracted providers on the signed contracts</td>
<td>Finance Manager and QI/QA Team</td>
<td>July-11</td>
<td>December -15</td>
</tr>
<tr>
<td>19.</td>
<td>Collaborate with MICH organizations and develop agreements (MOA/MOU) for coordination of services</td>
<td>CEO &amp; staff</td>
<td>January-12</td>
<td>December -15</td>
</tr>
<tr>
<td>20.</td>
<td>Track performance indicators and prenatal and postnatal screening data</td>
<td>QI/QA Team</td>
<td>Quarterly</td>
<td>December -15</td>
</tr>
<tr>
<td>21.</td>
<td>Track service data on the GH330/GH350 reports</td>
<td>QI/QA Team</td>
<td>Quarterly</td>
<td>December -15</td>
</tr>
<tr>
<td>22.</td>
<td>Track the Medicaid Waiver billable service data</td>
<td>QI/QA Team</td>
<td>Monthly</td>
<td>December -15</td>
</tr>
<tr>
<td>23.</td>
<td>Monitor contracted providers’ monthly expenditures</td>
<td>Finance Manager</td>
<td>Monthly</td>
<td>December -15</td>
</tr>
</tbody>
</table>
Category B – community initiatives, coalition operations

Community Awareness

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/HSCMD 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 2011
      - Community discussions (Healthy Start Needs Assessment)

      - Health Problem Analysis 2011

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 HSCMD contracted providers, Miami-Dade County Health Department Data Management Office (MDCHD DMO) and HSCMD 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?
   – HSCMD staff will develop a marketing plan that incorporates feedback from HSCMD contracted providers, MDCHD Healthy Start Data Management Office and HSCMD members.
   – The CEO will contract with public relations and marketing firms, promotional and educational materials vendors and local graphics design companies, to produce marketing materials. The Director of Education and Training 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.
   – HSCMD membership rosters will track changes in number of new members.
   – Meeting summaries with community organizations will be documented by HSCMD staff
   – CIS/HCMS will be utilized to gather information on contracted HSCMD 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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THE HEALTHY START COALITION OF MIAMI-DADE
### 3. ACTION STEPS

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Person Responsible</th>
<th>Start Date</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Marketing Strategies</strong></td>
<td></td>
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</tr>
<tr>
<td>1. Develop new educational messages and slogans, and design promotional materials.</td>
<td>Communications and Program Specialist; Director of Education and Training</td>
<td>1/12</td>
<td>12/12</td>
</tr>
<tr>
<td>2. Continue to share marketing and media ideas and concepts with other Healthy Start HSCMDs</td>
<td>CEO, Communications and Program Specialist; Director of Education and Training</td>
<td>1/12</td>
<td>12/12</td>
</tr>
<tr>
<td>3. Keep and monitor a log of distributed materials to track progress of media campaign</td>
<td>Director of Education and Training, QI/QA Specialist, HSCMD Staff</td>
<td>1/12</td>
<td>12/12</td>
</tr>
<tr>
<td>4. Monitor number of hits and questions submitted to website.</td>
<td>HSCMD Staff</td>
<td>06/12</td>
<td>12/12</td>
</tr>
<tr>
<td>5. Identify funding to conduct an evaluation of internal marketing strategies.</td>
<td>CEO, HSCMD Staff</td>
<td>12/12</td>
<td>12/07</td>
</tr>
<tr>
<td><strong>Healthy Start Contracted Providers Participation</strong></td>
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</tr>
<tr>
<td>1. Through contract, the HSCMD 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</td>
<td>HSCMD Staff, HSCPs</td>
<td>1/12</td>
<td>12/12</td>
</tr>
<tr>
<td>2. Through contract, the HSCMD will continue to assure that Healthy Start Contracted Providers (HSCPs) participate in community events on its behalf</td>
<td>HSCMD Staff, HSCPs</td>
<td>1/12</td>
<td>12/12</td>
</tr>
<tr>
<td><strong>HSCMD Efforts</strong></td>
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</tr>
<tr>
<td>1. Make presentations at least quarterly at health fairs, public forums, etc. to increase visibility of the Healthy Start Program, raise awareness of Healthy Start services, and recruit HSCMD members</td>
<td>HSCMD staff</td>
<td>1/12</td>
<td>12/12</td>
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</tbody>
</table>
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. HSCMD staff | 1/12 | 12/12

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. HSCMD staff | 1/12 | 12/12

4. Monitor screening rate quarterly, analyze trends, identify problem areas, and select strategies. Re-evaluate to ensure strategies are working. HSCMD Staff/Contracted Data Analysts, Director of Education and Training, QI/QA Specialist | 1/12 | 12/12

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. Director of Education and Training | 1/12 | 12/12

6. Develop educational materials on issues relevant to Healthy Start services and maternal and child health best practices. HSCMD Staff/Contracted Data Analysts, Director of Education and Training, CEO | 1/12 | 06/12

7. Distribute educational materials on issues relevant to healthy start services and maternal and child health best practices. HSCMD Staff | 1/12 | 12/12
Enhanced Services

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/HSCMD 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.

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? HSCMD documents.

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3. ACTION STEPS

<table>
<thead>
<tr>
<th>ACTION STEPS</th>
<th>Person Responsible</th>
<th>Start Date</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify training needs of HSCPs during monitoring visits</td>
<td>Director of Education and Training &amp; QI/QA Specialist</td>
<td>01/12</td>
<td>12/12</td>
</tr>
<tr>
<td>2. Continue to review national and local curricula for any updates, revision or upcoming trainings and workshops</td>
<td>Director of Education and Training</td>
<td>01/12</td>
<td>12/12</td>
</tr>
<tr>
<td>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</td>
<td>Director of Education and Training, HSCMD Staff</td>
<td>01/12</td>
<td>12/12</td>
</tr>
<tr>
<td>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</td>
<td>Director of Education and Training</td>
<td>01/12</td>
<td>12/12</td>
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Screening Rates

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 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. Therefore, there is a need for continuous improvement in screening rates and reducing the number of days from screening to initial contact.
   
   b. What health status indicator/HSCMD 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.
   
   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 HSCMD summary of activities.

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3. ACTION STEPS

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<th>Action Steps</th>
<th>Person Responsible</th>
<th>Start Date</th>
<th>End Date</th>
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</thead>
<tbody>
<tr>
<td>1. Monitor and review on a quarterly basis the prenatal and postnatal screening rate.</td>
<td>QI/QA Specialist, QIRC Team</td>
<td>01/12</td>
<td>12/12</td>
</tr>
<tr>
<td>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.</td>
<td>QI/QA Specialist, QIRC Team, MDCHD Healthy Start Data Management Office</td>
<td>01/12</td>
<td>12/12</td>
</tr>
<tr>
<td>3. Monitor and review the submission of the prenatal risk screening instrument for:</td>
<td>QI/QA Specialist, MDCHD Healthy Start Data Management Office</td>
<td>01/12</td>
<td>12/12</td>
</tr>
<tr>
<td>• The average number of days from screening date until screen receipt at the Healthy Start Data Management Office at the MDCHD</td>
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<tr>
<td>• Assignment and transfer of accurate risk screens to contracted Healthy Start Contracted Providers</td>
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</tr>
<tr>
<td>4. Review the current schedule of outreach efforts by Healthy Start contracted providers and HSCMD staff</td>
<td>QI/QA Specialist, QIRC Team</td>
<td>01/12</td>
<td>12/12</td>
</tr>
<tr>
<td>5. Conduct in-service training and outreach to prenatal care providers and birthing facilities who have low screening rates on an ongoing basis</td>
<td>QI/QA Specialist, Provider</td>
<td>01/12</td>
<td>12/12</td>
</tr>
</tbody>
</table>
6. Monitor screening data to track progress monthly. Analyze *Healthy Start Executive Summary Report* to evaluate the following outcomes related to Healthy Start screening:

- Percentage of potential participants offered screens (compared to estimated number of pregnant women/number of births for same time period)
- Percentage of potential participants consenting to and receiving screens; total percentage of positive screens and screens referred for other factors
- Percentage of potential participants (or their families) consenting to participate

| Liaisons, MDCHD Healthy Start Data Management Office | QI/QA Specialist | 01/12 | 12/12 |
Board and Membership 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?
      HSCMD needs to develop an active Board of Directors and general membership. The Board of Directors serves not only to provide direction to the HSCMD’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 HSCMD on pressing local issues concerning maternal and infant health.

   b. What health status indicator/HSCMD 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?
      HSCMD staff will track the progress of the Board of Directors by monitoring participation in scheduled meetings and participation of General Members in HSCMD 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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### 3. ACTIONS STEPS

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<th>Action Steps</th>
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<th>Start Date</th>
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<tbody>
<tr>
<td><strong>Board of Directors (BOD)</strong></td>
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<tr>
<td>1. Review and conduct Board orientation as needed, such as with the addition of a new member</td>
<td>CEO</td>
<td>1/12</td>
<td>12/12</td>
</tr>
<tr>
<td>2. Provide Board member training as needed, such as with the addition of a new member</td>
<td>CEO, HSCMD Staff, QI/QA Specialist, Director of Education and Training</td>
<td>1/12</td>
<td>12/12</td>
</tr>
<tr>
<td>3. Increase consumer and community participation and diversity by asking current Board members to identify at least one potential member per year.</td>
<td>CEO, Board Members</td>
<td>1/12</td>
<td>12/12</td>
</tr>
<tr>
<td><strong>General Membership (GM)</strong></td>
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</tr>
<tr>
<td>1. Continue to meet with community organizations that represent the targeted areas and population to recruit new GM members</td>
<td>CEO, QI/QA Specialist, Director of Education and Training</td>
<td>1/12</td>
<td>12/12</td>
</tr>
<tr>
<td>2. Participate in community events; serve on task forces, work groups, and other appropriate community initiatives to establish the HSCMD’s presence in the community and to recruit new General Members. Distribute newsletters with membership forms at community events.</td>
<td>HSCMD Staff, Board Members</td>
<td>1/12</td>
<td>12/12</td>
</tr>
<tr>
<td>3. Review and conduct general membership (GM) orientation as needed</td>
<td>CEO, QI/QA Specialist, Director of Education and Training</td>
<td>1/12</td>
<td>12/12</td>
</tr>
<tr>
<td>4. Provide GM member training as needed</td>
<td>QI/QA Specialist, Director of Education and Training</td>
<td>1/12</td>
<td>12/12</td>
</tr>
<tr>
<td>5. Expand geographic representation of general members and their organizations by asking members to identify other potential members</td>
<td>CEO, Board Members</td>
<td>1/12</td>
<td>12/12</td>
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</tbody>
</table>
Infant Mortality

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/HSCMD 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 2011
   - Healthy Start Needs Assessment 2011
   - 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?

   HSCMD 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 and Haitian 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 HSCMD to different community groups and publications prepared by HSCMD staff.

f. Where/how will you get the information? HSCMD documents and reports.
### 3. ACTION STEPS

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Person Responsible</th>
<th>Start Date</th>
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<tbody>
<tr>
<td><strong>PPOR</strong></td>
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</tr>
<tr>
<td>1. Continue to participate in Perinatal Periods of Risk initiative.</td>
<td>CEO</td>
<td>1/12</td>
<td>12/12</td>
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<tr>
<td><strong>Research and Planning</strong></td>
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<tr>
<td>1. Present the PPOR methodology and data results from Phase II analyses to</td>
<td>CEO</td>
<td>1/12</td>
<td>12/12</td>
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<tr>
<td>the Data Committee quarterly</td>
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<tr>
<td>2. Analyze and review vital statistics data as made available by the Florida</td>
<td>HSCMD Staff/Contracted Data Analysts</td>
<td>1/12</td>
<td>12/12</td>
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<tr>
<td>Department of Health quarterly</td>
<td></td>
<td></td>
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<tr>
<td>3. Present updated FIMR data results to the Data Committee quarterly</td>
<td>HSCMD Staff/Contracted Data Analysts</td>
<td>1/12</td>
<td>12/12</td>
</tr>
<tr>
<td>4. Identify underlying causes of infant mortality and develop recommendations</td>
<td>CEO, HSCMD Staff/Contracted Data Analysts, Data Committee, FIMR Case Review Team</td>
<td>1/12</td>
<td>12/12</td>
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<tr>
<td>for reducing the infant mortality rate in Miami-Dade County.</td>
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<tr>
<td>5. Communicate results of data analysis to Board of Directors annually; to</td>
<td>CEO, HSCMD Staff/Contracted Data Analysts</td>
<td>06/12</td>
<td>12/12</td>
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<tr>
<td>health care providers annually via a written report and on as-needed basis</td>
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<td>through educational sessions.</td>
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<tr>
<td>6. Evaluate infant mortality rate annually to determine effectiveness of</td>
<td>CEO, HSCMD Staff/Contracted Data Analysts, Data Committee</td>
<td>06/12</td>
<td>12/12</td>
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<td>strategies.</td>
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<tr>
<td><strong>FIMR Program</strong></td>
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<tr>
<td>1. Review 29 fetal death cases per year</td>
<td>HSCMD Staff/Contracted Data Analysts, Nurse Abstractor, FIMR Case Review Team</td>
<td>1/12</td>
<td>12/12</td>
</tr>
<tr>
<td>2. Conduct monthly Case Review Team (CRT) meetings and report findings to</td>
<td>CEO, Director of Education &amp; Training, Abstractors</td>
<td>1/12</td>
<td>12/12</td>
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<td>Community Action Group</td>
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<tr>
<td>3. Establish linkages and relationships with hospitals and other</td>
<td>CEO, Director of Education &amp; Training</td>
<td>1/12</td>
<td>12/12</td>
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<tr>
<td>organizations that might provide insight and expertise to the CRT, for</td>
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<td>example DCF, MEs Office, Funeral Home Directors,</td>
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<tr>
<td>Emergency Response, First Responders, Fire Department, Police Department, etc.</td>
<td>HSCMD Staff</td>
<td>1/12</td>
<td>12/12</td>
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<tr>
<td>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</td>
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<tr>
<td>5. Conduct two (2) CAG meetings per year</td>
<td>HSCMD Staff</td>
<td>1/12</td>
<td>12/12</td>
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<tr>
<td>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)</td>
<td>CEO, HSCMD Staff</td>
<td>1/12</td>
<td>12/12</td>
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</tbody>
</table>
**Fund Allocation**

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/HSCMD 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 HSCMD 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 HSCMD. Also during site visits, the QI/QA Specialist 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 HSCMD
   
   f. **Where/how will you get the information?** HSCMD fiscal reports, contracted providers fiscal audit reports.
### 3. ACTION STEPS

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

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/HSCMD 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 HSCMD monitoring and review activities.

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</table>
| 1. Monitor screening data to track progress quarterly. Analyze Healthy Start Executive Summary Report to evaluate the following outcomes related to Healthy Start service provision:  
- Women who received initial contact  
- Women determined as needing an initial assessment  
- Women who received an initial assessment  
- Women determined to need ongoing care coordination  
- Total number of women who received a Healthy Start (HS) service  
- Total number of women attempt to contact only  
- Total number of women who received an initial contact and/or initial assessment only  
- Total number of women who received only initial contact and/or initial assessment with "other Healthy Start services"  
- Total number of women who received services through care coordination-tracking or not face to face with or without "other Healthy Start services"  
- Total number of women who received services through care coordination face to face with or without "other Healthy Start services" without FSP  
- Total number of women who received services through care coordination face to face with or without "other Healthy Start services" with FSP  
- Total number of women unable to locate  
- Total number of women unable to complete initial contact  
- Total number of women unable to complete initial assessment | CEO, QI/QA Specialist, Director of Education and Training | 01/12 | 12/12 |
| 2. Analyze the monthly CIS/HCMS reports to identify which services are not being offered | CEO, QI/QA Specialist, Director of Operations, Director of Education and Training | 01/12 | 12/12 |
| 3. Review current Healthy Start Contracted Providers’ service reports to determine the current number, frequency, and location of enhanced services being offered | CEO, QI/QA Specialist, Director of Operations, Director of Education and Training | 01/12 | 12/12 |
| 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 | CEO, QI/QA Specialist, Director of Operations, Director of Education and Training | 01/12 | 12/12 |
| 5. Develop performance improvement plans for providers who are not in compliance. | CEO, QI/QA Specialist, Director of Operations, Director of Education and Training | 01/12 | 12/12 |
| 6. Develop corrective action plans for Providers who do not satisfactorily complete Performance Improvement Plans. | CEO, QI/QA Specialist, Director of Operations, Director of Education and Training | 01/12 | 12/12 |
**Interconception Care for Teens and Other At-Risk Mothers**

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 HSCMD’s efforts, and our policies assure all pregnant teenagers immediate access to services.

   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.

   b. What health status indicator/HSCMD 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 2011, 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 and other high-risk mothers, as will the Jasmine Project and HealthConnect in the Early Years.

   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 HSCMD summary activities. Vital Statistics will be used to obtain outcome measure, self-referral reports from the Miami-Dade County Health Department Data Management Office

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<tr>
<td>1. Monitor the rates of teen pregnancy and repeat teen pregnancy in Miami-Dade County.</td>
<td>CEO, Director of Education and Training, HSCMD Staff/Contracted Data Analysts, QI/QA Specialist</td>
<td>01/12</td>
<td>12/12</td>
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<tr>
<td>2. Identify Healthy Start wraparound services that promote baby spacing on an annual basis</td>
<td>HSCMD Staff, QI/QA Specialist</td>
<td>01/12</td>
<td>12/12</td>
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<tr>
<td>3. Identify methods to increase teen engagement in interconceptional services.</td>
<td>Director of Education and Training</td>
<td>06/12</td>
<td>12/12</td>
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<tr>
<td>4. Identify and collaborate, on an ongoing basis, with agencies in the target areas that provide services to teens.</td>
<td>HSCMD Staff</td>
<td>01/12</td>
<td>12/12</td>
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<tr>
<td>5. Provide interconceptional education services to parenting teens</td>
<td>Healthy Start Contracted Providers</td>
<td>01/12</td>
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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 HSCMD will implement a quality improvement and quality assurance plan (QI/QA) that will allow for ongoing monitoring and improvement of MomCare service delivery. The HSCMD will assess performance through the use of administrative records, MomCare Information System (MIS) data reports, MomCare record review form, self-reports from clients regarding the services received, and other assessment methods. The HSCMD 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, HSCMD 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, HSCMD shall provide follow-up services to recipients

8. HSCMD shall work with prenatal care providers to provide them with information on the Healthy Start program serviced available to recipients

9. HSCMD shall encourage prenatal care providers to refer recipients into Healthy Start in the HSCMD’s service delivery area

10. HSCMD shall compile information about language skills of prenatal care providers and their office staff and provide recipients with this information when requested

11. HSCMD shall submit reports to the contract manager of the Department of Health

Performance Specifications
Outcomes and Outline. HSCMD shall submit a quarterly report of these measures using the “All Clients” report from the MIS. In addition, the fourth quarter report, HSCMD will include a year-end performance measure report for the entire contract period.

1) 75% of enrollees shall receive an attempt to contact within 5 working days of referral.
2) 85% of auto assigned enrollees shall receive three documented attempts to contact
3) 85% of the enrollees shall be enrolled with a prenatal care provider within 30 days
4) 85% of enrollees successfully contacted shall receive, or shall have already received, WIC information
5) 70% 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 31st 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. 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 HSCMD
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.

HSCMD will compile the following data from MIS and report that data to the Department of Health each month:

- Number of women referred by the fiscal agent
- Number of women who received an attempt to contact within 5 working days of referral
- Number of women successfully contacted
- Number of women who chose a prenatal care provider
- Number of women who choose not to participate
- Number of women referred to the Healthy Start program
- Number of women receiving follow-up from the Maternity Care Advisor
- Number of women receiving follow-up from the Healthy Start program

**Quarterly Reports**

1) HSCMD shall compile the following data from the MIS “New Clients” report and submit this data, along with an invoice and the MIS Remittance Voucher Comparison, to the Department of Health 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) HSCMD is required to compile the following additional information and submit with the quarterly reports to the Department of Health:
   - Any difficulties encountered by recipients or prenatal care providers
   - Summary of problems HSCMD is experiencing with their no-show reporting system
   - Internal or external QI/QA of the prenatal care counseling system using the Department of Health MomCare Record Summary Review Form
   - A summary of the results of recipient surveys. It is the responsibility of HSCMD to inform the contract manager when, and how often, survey results will be reported to the Department if the frequency is less than quarterly
   - 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 HSCMD’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.

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
- MomCare Information System
- 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.