HEALTHY START COALITION OF HARDEE, HIGHLANDS AND POLK COUNTIES, INC.

SERVICE DELIVERY PLAN 2021-2026

A plan for providing community-based services that promote and support healthy pregnancies, babies, and families.

Presented to the Board of Directors on May 20, 2021

Approved by Service Delivery Plan Committee June 23, 2021

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Florida Healthy Start

Healthy Start Coalition of Hardee, Highlands and Polk Counties

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ACKNOWLEDGMENTS

We extend our sincere thanks to leaders in this community, as without their true dedication to this process, this plan would not be possible. They devoted their time and talent to assist the Healthy Start Coalition of Hardee, Highlands & Polk Counties, Inc. in developing this maternal and child health service delivery plan.

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INTRODUCTION

The Healthy Start Coalition of Hardee, Highlands, & Polk Counties, Inc. was organized to reduce Florida's high infant mortality and improve the lives of pregnant women and their families. The coalition is governed by a volunteer board of various professionals. The coalition covers Hardee, Highlands, and Polk counties. The coalition is comprised of numerous members representing consumers, physicians, nutritionists, midwives, doula, local government, businesses, health care payors, social services, education, civic organizations, public health, nurses, mental health, hospitals, local health planning agencies, and more.

Mission:

The coalition's mission is to promote and support healthy pregnancies, babies, and families by providing a maternal and child health system of care through community partnerships.

Vision:

The coalition's vision is to be the leader for linking community resources to maximize the health and wellness of childbearing women and their families.

The coalition's commitment in the tri-county area:

1. To establish partnerships among private and public sector, state and local governments, community groups and organizations, and maternal and child health care providers to offer coordinated, community-based care for pregnant women and infants.
2. To promote and protect the health and well-being of all pregnant women and children through the provision and accessibility of health care programs to fully meet the health requirements of this population.

The projects, programs, and initiatives at the coalition are:

- Coordinated Intake & Referral Program (Connect)
- Nurse Family Partnership Program
- Healthy Start Program
- Fetal Infant Mortality Review (FIMR) Project
- Teen Pregnancy Prevention Alliance/Youth Leadership Team
- Beds 4 Babies Project
- Safe Haven for Newborns
- Plan of Safe Care

PURPOSE

The coalition has worked extensively alongside the board and community partners by ensuring a community-wide health needs assessment for maternal and child health was available, implementing a comprehensive non-duplicative referral system for home visiting agencies, reducing barriers to access of care for both prenatal and infant care, and increasing community awareness of maternal and child health issues.

This Service Delivery Plan was developed to track the progress of the last 6 years addressing maternal and infant health needs in the tri-county area of Hardee, Highlands & Polk Counties, to guide the development of Healthy Start Services through 2026. The plan was developed to align with the Coalition's pillars of advocacy, education, and partnerships. The pillars use social determinants of health, health equity, and the centered goal of reducing infant mortality. As the area served by our coalition continues to expand and diversify, this plan acknowledges the improvement for the health of children, childbearing women, fathers, and families in our community.

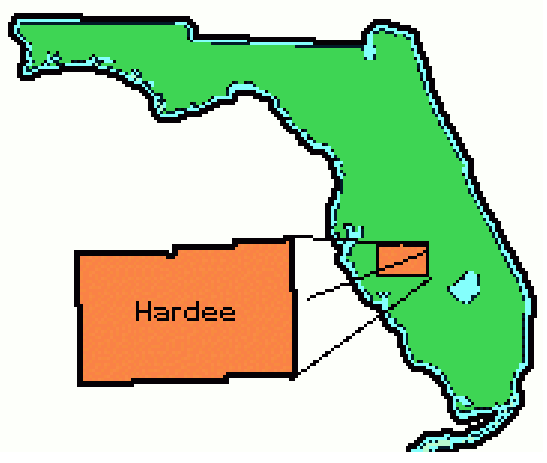
However, women continue to be of advanced maternal age, opioid use during pregnancy has increased, and the teen pregnancy rate remains a concern. Committee members recognized these key findings based on their review of the data. The data utilized was obtained through Florida CHARTS, Community Needs Assessment, and Surveys. The strategies listed throughout this Service Delivery Plan will highlight the goals and related strategies for the next five years.

The plan aligns with the foundational principles of reducing infant mortality and improving maternal and child health outcomes through advocacy, education, and partnerships. The pillars of the coalition help ensure communities and the families that live in them are healthy and thriving. The data will show that infant mortality is an entire community problem. This huge maternal and child health problem will need the community to solve it!

CHARACTERISTICS OF THE COALITION AREA

HARDEE COUNTY

Hardee County is a very rural county and has an estimated 2018 population of 27,245 residents, which reflects a 0.8% decrease since the 2015 estimated census. Hardee County's population is comprised of 88.4% white, 7.5% black or African American, 1.7% two or more races and 2.4% of the population identify themselves as American Indian, Asian or Native Hawaiian/Pacific Islander. Approximately 44% of Hardee County residents identify themselves as of Hispanic or Latino origin. Forty-five percent (45%) of individuals age five and above speak a language other than English at home. In 2018, almost one in four (23.3%) of the county's population lived below the poverty level, and 39% of the county's children live below the poverty level. Thirty-four (34%) of the population are women ages 15-44. Sixty-eight percent (68%) of the residents are under the age of fifty. Eighty-four and one-half percent (84.5%) of the population has health coverage with 38.1% of residents on Medicaid.



There is no childbirth/delivering facility in the county, therefore all births to residents of Hardee County occur in other counties. The majority of these women deliver in neighboring Highlands, Polk, and Sarasota Counties. Only two hospitals, Lakeland Regional Health and Sarasota Memorial, have Level 3 Neonatal Intensive Care Units (NICU). There is only one clinic site, Central Florida Health Care, that provides prenatal and well woman (OB/GYN) care to the residents of Hardee County.

Hardee County's major industry is agriculture which includes citrus, cattle and calves, milk from cows, vegetables, melons, potatoes and sweet potatoes.

A summary of Findings from Hardee County's January 2019 Health Needs Assessment

Community Themes, Strengths, and Assessment

The below topics were identified through community surveys and meetings as areas of concern representing opportunities for improvement:

- Focus on expanding community partnerships
- Community commitment to education (high school drop-out rates, continuing education including vocational)
- Chronic disease (overweight and obesity, nutrition education for all ages, diabetes)
- Access to affordable healthcare (limited health care providers)
- Health literacy
- Drug and alcohol abuse
- Teen pregnancy

Forces of Change Assessment

The items below are trends, events, or factors that were identified during the Forces of Change Assessment:

- Trending drug abuse issues (opioids, medical/recreational marijuana, e-cigarettes)
- Natural Disasters
- Immigration (laws/changes)
- Telehealth/Telemedicine
- Mental Health
- Technology advancement (communication)

Local Public Health System Assessment

The Essential Services identified received a low average performance score and received a high priority rating:

- Essential Service #3: Inform, educate, and empower people about health issues
- Essential Service #4: Mobilize community partnerships to identify and solve health problems
- Essential Service #7: Link people to needed personal health services and assure the provision of health care when otherwise available
- Essential Service #8: Assure a competent public health and personal health care workforce
- Essential Service #9: Evaluate the effectiveness, accessibility, and quality of personal and population-based health services

Community Health Status Assessment

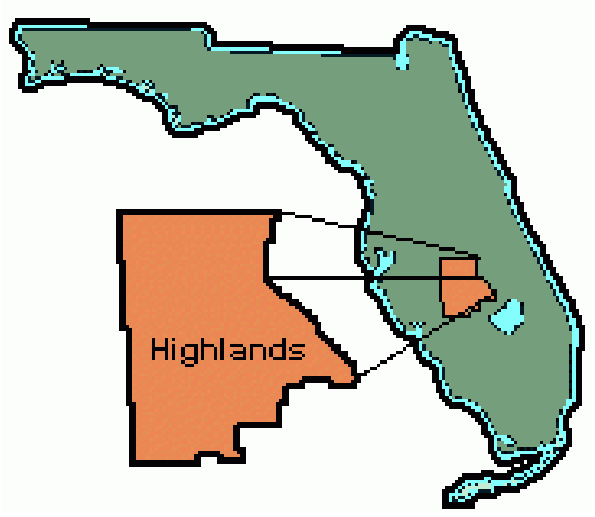
During data review the following were noted areas of concern:

- Education (graduation rates, higher education)
- Chronic Disease (overweight and obesity, heart disease, diabetes)
- Cancer
- Access to care
- Substance Abuse and Mental Health

CHARACTERISTICS OF THE COALITION AREA

HIGHLANDS COUNTY

Highlands County has an estimated 2018 population of 105,424 residents, which is a 0.9% increase from the 2015 estimated census population. Highlands' population is comprised of 84.5% white, 10.5% black or African American, 1.7% two or more races and 3.3% of the population identify themselves American Indian, Asian or Native Hawaiian/Pacific Islander. Approximately 20.8% of Highlands County residents identify themselves as of Hispanic or Latino origin. Slightly more than 19% of the county's population lives below the poverty line. Thirty-one percent (31%) of the county's children live below the poverty line. Sixteen (16%) of the population are women ages 15-49. Forty-two percent (42%) of the residents are under the age of forty-five.



There is one childbirth/delivering facility located in Highlands County. Most women deliver at this hospital; some choose to deliver at neighboring Polk County hospitals. There are five prenatal providers to provide prenatal and well woman care to residents of Highlands County. High-risk women and infants are transferred to neighboring Polk, Hillsborough or Orange Counties for Level 2 and Level 3 Neonatal Intensive Care Unit (NICU) facilities for delivery and/or care.

A summary of Findings from highlands County's January 2019 Health Needs Assessment

Leading Causes of Death

According to 2018 data, the two most frequent causes of death or people in Highland County are cancer followed closely by heart disease. Together they accounted for slightly under half of all deaths. Another quarter of total deaths are represented by (in decreasing order of frequency) chronic lower respiratory disease, unintentional injuries, diabetes and stroke. Comparing the most current 3-year age-adjusted death rates for Highlands County with those for all of Florida shows that, for the majority of categories listed, county rates are higher than Florida as a whole. Most significantly, rates for black residents are much higher than the state's black population averages for cancer, lower respiratory disease, and stroke. Among whites, county death rates are also much higher than their state-wide counterparts for the following causes: diabetes, motor vehicle crashes, and pneumonia/influenza.

Overweight/Obesity

Excess weight is considered to be a strong factor and precursor to serious health problems such as diabetes, hypertension and heart disease. Individuals are considered overweight if their Body Mass Index ranges from 25.0 to 29.9. Having a Body Mass Index that is equal to or greater than 30.0 is considered obese. For the purpose of this study, statistics for both conditions are combined.

Prior to 2010, Highlands County rates (and trends) of overweight/obesity roughly mirrored those in Florida as a whole. Since then, while state-wide rates have trended slightly downward, county rates have risen significantly for both men and women. It is noteworthy that men's rates are twenty percentage points higher than women's in Highlands County. The male rate of overweight/obesity in Highlands County (83.2%) ranks in Florida's top quartile.

Communicable Disease Incidence

Communicable diseases include Sexually Transmitted Diseases (STDs), vaccine-preventable diseases and others for which no vaccine has been developed. Highlands county ranks below the state-wide rate for all STDs, as well as AIDS, Hepatitis A and tuberculosis cases.

With regard to vaccine-preventable diseases, recent state and county data is unavailable for measles, mumps and rubella. Pertussis, also known a whooping cough, is a vaccine-preventable but highly contagious bacterial infection for which infants are especially at risk. An increase in pertussis rates is noted beginning around 2011. Highlands County's rate has outpaced the state-wide rate for several years.

Childhood immunization rates in Highlands County compare favorably with Florida as a whole.

A summary of Findings from highlands County's January 2019 Health Needs Assessment

Maternal and Child Health

Approximately 885 babies were born to Highlands County residents in 2018. The health of the babies, the care they received before birth, and the age of the mothers are important factors in determining the state of maternal and child health, which in turn is a large factor in the overall health of the county.

Health data by race illustrates wide disparities between black mothers and infants and their white counterparts in Highlands County. A greater proportion of teen births occur among blacks, as well as infant deaths and extremely low birthweights. Highlands County mothers across all races enter prenatal care later in their pregnancies and are more likely to be unmarried.

Maternal Smoking Rates

Smoking during pregnancy is a known contributor to the risk of premature birth as well as a low or very low birthweight. Mothers' smoking rates during pregnancy in Highlands County have mirrored Florida's state-wide downward trend but remain higher on average.

Infant Mortality

Infant mortality rates are considered a primary indicator of the health of a community. These rates document the deaths of babies between birth and 364 days of life. The leading causes of infant deaths in Florida are perinatal conditions, congenital anomalies, low birth weight and sleep-related deaths. There has been a major decrease in the incidence of sudden infant death syndrome (SIDS) since the American Academy of Pediatrics released its recommendations in 1991 that infants be placed down for sleep in a non-prone position.

It should be noted that the total number of infant deaths in Highlands County each year is so low that one or two such deaths can cause a large statistical variance in the rate. For example, from 2016 to 2018, yearly rates ranged from 3 deaths per year to 7. For this reason, 3-year rolling rates are used to give a longitudinal view.

Family Planning

Fifty percent of females less than 45 years of age or males less than 60 years old reported that they or their partner take measures to prevent pregnancy.

Breastfeeding Rates

Breast milk contains antibodies that boost infants' protection against common childhood illnesses and infections. Breastfeeding lowers babies' risk of developing asthma or allergies. Babies who are breastfed exclusively for the first 6 months, without any formula, have fewer ear infections, respiratory illnesses, and bouts of diarrhea. Researchers have observed a decrease in the probability of Sudden Infant Death Syndrome (SIDS) in bread-fed infants. Another apparent benefit from breastfeeding may be protection from allergies. Breastfeeding is also thought to reduce risks of obesity and of developing Type 1 diabetes. Mother who breastfeed also receive numerous health benefits and advantages.

Rates of breastfeeding initiation among mother in Highlands County have trailed those of Florida as a whole for at least a decade.

A summary of Findings from highlands County's January 2019 Health Needs Assessment

Key Informant Interviews with Community Participants

As an additional component of the Highlands County community health assessment during the fall of 2019, individual interviews were conducted with key informants in the county to elicit their perception of the health status of county residents. Potential interview respondents were identified in conjunction with the Highlands County Community Health Improvement Planning (CHIP) committee. Respondents represented a variety of viewpoints and backgrounds. These interviews were intended to ascertain opinions among key individuals likely to be knowledgeable about the community and who are influential over the opinions of others about health concerns in the county. Respondents were contacted to determine their willingness and availability to participate in the interview process. The interview findings provided qualitative information and reveal factors affecting the views and sentiments regarding healthcare services in Highlands County. A summary of opinions (relevant to this Community Needs Assessment) is reported without judging the veracity of their comments.

Babies and Children:

In general, interviewees described a phenomenon in Highlands County in which the needs of the sizable retiree and senior citizen populations skew healthcare resources and attention away from younger age groups. Specifically, they cite a shortage of pediatric specialty care, as well as adequate dental care, for these youngest residents. They also note that for parents of children with complicated conditions or significant disabilities, for which they may have to travel out of county to get the specialty care needed, there are significant transportation and cost barriers. In other scenarios, when parents utilize the emergency room for their children's primary care, respondents expressed concern that there is often little medical follow-up for their children's conditions. Health challenges noted by respondents for this age group included asthma, Type II diabetes (diagnosed at younger and younger ages), and poor nutrition.

Interviewees familiar with the healthcare needs of the county's migrant farmworker population also commented upon the particular health risks and conditions commonly seen in these families' children. They voiced concern that lack of affordable housing and childcare perpetuated the need to take children into the fields with their parents, risking heat exposure, insect bites and exposure to pesticides and contagious illnesses.

Teens and adolescents:
respondents cited poor nutrition and unhealthy lifestyles, mental health issues (specifically mentioning anxiety, ADD/ADHD, and cutting behaviors), as well as high rates of teen pregnancy as significant health challenges for this age group. Sexual health education and teen pregnancy prevention were mentioned as being given low priority in favor of focus on academics in the schools.

Pregnant women:
several interviewees had current or past experience working directly with this population. One respondent expressed the perception that for family planning and routine prenatal care, Highlands does offer adequate resources if women avail themselves of them. Samaritan's Touch was mentioned as an important resource for low-income women, but in the same breath, it was acknowledged that these clinics are trying to meet the needs of a large rural community where the population is spread out. Other common sentiments included concern that prenatal care is sometimes put off until late in pregnancy especially among uninsured, indigent, or undocumented women. The point in pregnancy at which prenatal care is initiated is, of course, directly correlated with health outcomes of both the infant and the mother. Some respondents also expressed concern about the lack of prenatal providers and facilities serving women with high-risk pregnancies; these women sometimes have to travel out of the county (if they can afford to).

Mental health care and substance abuse treatment:
These combined categories elicited some of the most comments and concerns from interviewees. They differed in their levels of knowledge regarding the availability, cost, and type of treatment options in the county, but overall they expressed that mental health and substance abuse treatment is underfunded, under promoted, and underutilized.

CHARACTERISTICS OF THE COALITION AREA

POLK COUNTY

Polk County is a partially urban and partially rural county. It is the largest in geographical area of the tri-county region and is comprised of 2,010 square miles. Polk County is Florida's 9th most populous county. The 2018 estimate is that Polk County has a population of over 708,009, which is an increase of 8% from 2015. Polk county residents are comprised of 78.9% white, 16.1% black or African American, 2.2% two or more races and 2.8% of the population identifying themselves as American Indian, Asian or Native Hawaiian/Pacific Islander. Approximately 23.6% of Polk County residents identify themselves as of Hispanic or Latino origin. Nearly 17.3% of the county's population lives below the poverty level. Twenty-four percent (24%) of the county's children live below the poverty line. Approximately 36.8% of the population are women ages 15-44. Approximately fifty-five percent (55%) of the residents are under the age of forty-five.

There are three (3) childbirth/delivery facilities located within Polk County, of which Winter Haven Women's Hospital has a Level 2 Neonatal Intensive Care Unit (NICU) and Lakeland Regional Health recently opened a Level 3 Neonatal Intensive Care Unit (NICU). One (1) birthing center is also located in Polk County. Some Polk County women deliver in neighboring Hillsborough, Osceola and Orange Counties. Fourteen (14) providers with 22 clinic sites are available to provide OB/GYN care to residents of Polk County.

POLK COUNTY 2020 COMMUNITY HEALTH ASSESSMENT
RELEVANT KEY THEMES

Relevant Key Themes were re-occurring topics or concerns discovered during the assessment process. These issues were recognized in consumer opinion surveys, in public health community discussions, and in analysis of statistical health data.

POLK COUNTY TEEN PREGNANCY

Risks/Social Determinants

While all mothers experience changes upon the birth of their baby, the social and economic changes experienced with a teen birth have long-lasting impacts on teen parents and their children. Teen pregnancy significantly contributes to high school dropout rates; only half of teen mothers received their high school diploma by the age of 22.

Evidence has found that there are several socioeconomic conditions that contribute to high teen birth rates. These factors include low education levels of a teen's family, low income level of a teen's family, poor opportunities for teens to participate in positive youth involvement, racial segregation within neighborhoods, neighborhood disorder, and neighborhood-level income inequality. In addition to these risk factors, teens in the child welfare system are at an increased risk and are twice as likely to become pregnant as teens not in foster care.

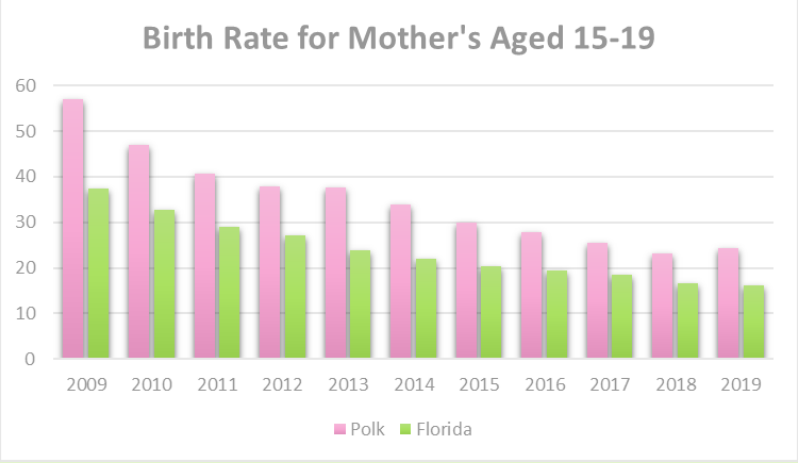
The social and economic impacts extend beyond the teen mother to affect her child/children, as well. Children of teen mothers are statistically more likely to drop out of high school. More likely to be incarcerated, more likely to face unemployment as a young adult, and more likely to become a teen parent themselves.

Fortunately, teen pregnancy rates are on a rate of national decline. A combination of evidence-based prevention programs, clinical services, and a focus on social determinants of health and protective factors has contributed to this national decline.

POLK COUNTY 2020 COMMUNITY HEALTH ASSESSMENT
RELEVANT KEY THEMES

Polk Teen Birth rate percentage

Polk's teen birth rate, births to mothers ages 15-19, has continued to decline, despite still being higher than the State rate. Of the 7,846 Polk births in 2018, only 6.2% of these births (486) were teen births.



Prevention

Teen pregnancies are preventable. Research shows that a combination of evidence-based teen pregnancy prevention programs, access to youth-friendly contraceptive and reproductive health services, and support from parents or other trusted adults play a vital role in decreasing teen pregnancy. Efforts at the community level to address the racial, ethnic, and geographical disparities also play a critical role in the continued decline of teen pregnancy rates.

Engaging Young Men

The teen mother is not the only individual affected by teen pregnancy and birth. Results from the National Survey of Family Growth found that 80% of young men ages 15-19 reported that they would be either very upset or a little upset if they were to get a female pregnant. Furthermore, the social and economic factors affecting the teen mother extend to the teen father; data shows that teen fathers are less like to graduate from high school, have a harder time finding a job, and are more likely to contract a sexually transmitted infection (STI). It is important to impress upon young men the level of importance their involvement is in promoting sexual health and decisions about contraception. Involvement in these processes has increased the effective use of pregnancy and STI prevention.

POLK COUNTY 2020 COMMUNITY HEALTH ASSESSMENT
RELEVANT KEY THEMES

Polk Pregnancy Related Outcomes – 2020

Pregnancy related health outcomes are influenced by a woman's health along with other factors.

Overweight and Obesity

In Polk, 59.2% of births between the years 2016-2018 were to women who were either overweight or obese at the time pregnancy occurred. There are currently more women who are obese or overweight at the time of pregnancy than in the 2015 Community Health Assessment.

According to the American College of Obstetricians and Gynecologists, overweight or obese women are at increased risk of several pregnancy complications such as:

- gestational diabetes
- hypertension
- preeclampsia
- sleep apnea
- miscarriage/pregnancy loss
- cesarean deliver

Similarly, babies born to women who are overweight or obese are at increased risk of complications such as:

- prematurity
- stillbirth
- congenital birth defects, such as heart defects or neural tube defects
- birth injuries
- childhood obesity

It is recommended that a woman who is at a healthy weight at the time she becomes pregnant only gains 25-35 pounds during her entire pregnancy. This number changes for women who may be overweight or obese at the time of conception. A woman who is overweight at the time of pregnancy is advised to only gain 15-25 pounds for the duration of her pregnancy while a woman who is obese at the time of pregnancy is advised to gain only 11-20 pounds during her entire pregnancy to avoid any health risks.

During the second and third trimesters, a pregnant woman needs only 300 extra calories a day – the average amount of calories found in half of a sandwich with a glass of skim milk or two bowls of oatmeal. It is also recommended that pregnant women continue to be active for at least 30 minutes on most, preferably all, days of the week. Some low impact activities that will help pregnant women maintain a healthy weight include walking or swimming.

COLLABORATION

In the process of working to achieve the Coalition's maternal and child health Needs Assessment, community groups and individuals have established productive working relationships.

Key collaborative efforts in partnership with community members, or sponsored by the Coalition, are identified in the Appendix of this Needs Assessment. Listed below are community sources/resources used in this process.

- Community Health data from Hardee, Highlands and Polk's FDOH health assessments
- FDOH Polk Birth Disparity Initiative
- Focused Coordinated Intake & Referral data from clients in all three counties
- Surveys
- Prenatal Providers
- Delivery Facilities
- Pediatric Providers
- Consumer/Client

The Healthy Start Coalition of Hardee, Highlands and Polk Counties, Inc. and partners will continue to analyze the most current data as received, so that the strategies and action plans will be appropriate to achieve the desired outcomes. It will not be a single intervention, but a series of community partnerships that will assist with addressing the identified issues. Four components will exist in our continued planning: 1) early and continued risk assessment, 2) health promotion and counseling, 3) medical and/or psychosocial intervention, 4) identifying substance-abusing mothers and substance-exposed newborns.

The plan is to address the whole family. The desire is to educate the community that change, and improvement can be achieved by working one generation to the next. A healthy mother starts with her grandmother and mother. The cultural practices that may have a significant bearing on our health disparities are generational. These strategies are developed to change the thought process and address behaviors, thus improving outcomes. These ideas will be a part of the overall process to continuously identify risks: medical, environmental, psychosocial and other. The Healthy Start Coalition of Hardee, Highlands and Polk Counties, Inc. is dedicated to improving the outcomes for mothers and babies.

CURRENT COALITION COMMITTEES THAT CONTRIBUTED TO THIS SERVICE DELIVERY PLAN

Service Delivery Plan Committee (SDP)

In October 1997, the Service Delivery Plan (SDP) committee was formed. This was a permanent Coalition committee to develop the Service Delivery Plan and oversee its implementation. In FY 20-21 the committee continues to oversee the implementation of the SDP and contributes to the development of the Needs Assessment. The committee includes members from Central Florida Health Care, Winter Haven Women's Hospital, FDOH – Polk, FDOH – Highlands, Early Steps, Lakeland Regional Health, United Way of Central Florida Success by 6, Healthy Families, Department of Children and Families and Redlands Christian Migrant Association.

The purpose of the committee is to examine primary and secondary data presented by the Coalition, identify barriers to maternal and child health care, and to establish and monitor the effectiveness of Coalition strategies addressing priority maternal and child health issues. The SDP committee reviewed the survey documents, data collected from local health department, and had input into the 2020 Needs Assessment document.

Fetal And Infant Mortality Review Project/Committee (FIMR)

Fetal Infant Mortality Review (FIMR) Project for the Healthy Start Coalition of Hardee, Highlands and Polk Counties, Inc. is a tri-county action-oriented process of community-based fetal and infant mortality reviews aimed at addressing factors and issues that affect infant mortality and morbidity. This process continually assesses, monitors, and works to improve service systems, influence policy, community education, direct planning efforts that will lower mortality rates, and identify resources for women, infants, and families. The Coalition's FIMR project is funded by the Florida Department of Health (FDOH) and is linked to 11 funded initiatives in Florida and nationally with more than 175 projects in 28 states.

Fetal And Infant Mortality Review Project/Committee (FIMR) cont.

There is a multi-disciplinary team of professionals on the Case Review Team (CRT) in our tri-county area. This committee uses patient-blinded and case abstracted information from a variety of records and interviews. The purpose of the review is to discover patterns of contributing factors and develop strategies for system and community change. In each fiscal year, the CRTs review a total of 28 randomly selected fetal and infant deaths. Analysis of year-end data reveals that prematurity, pre-existing medical conditions, obesity, and poverty continue to be the leading causes of death.

In all three counties, FIMR Community Action Groups (CAGs) develop and implement recommendations based on the CRT findings. As a result of these findings, the Coalition, along with the CAGs, have worked to improve Healthy Start screen rates and expand patient and provider education on the value of Healthy Start services. In addition, they have provided community education on the importance of prevention of prematurity, need for early prenatal care, access to care, signs and symptoms of preterm labor, and interconception care.

Highlights of the local CAGs

Provide insight and input to the next phase of the Needs Assessment (i.e., development of the Service Delivery Plan).

Highlands County Community Action Group meets monthly, (currently via Zoom due to COVID -19) CAG members collaborate to provide maternal child health education and resource information about access to care, obesity, and birth spacing to women of childbearing age and families with young children. Past projects include participation in March of Dimes March for Babies Walk, Safe Sleep Awareness, Child Abuse Awareness Prevention, and Prematurity Awareness Month s activities, breastfeeding resource information review, and family planning. The group also shares the responsibility of being the Nurse Family Partnership Advisory Committee.

Hardee County Community Action Group meets every other month. Meetings are currently via Zoom due to COVID 19. FIMR, infant mortality data and Healthy Start updates are given when appropriate at each meeting.

CURRENT COALITION COMMITTEES THAT CONTRIBUTED TO THIS SERVICE DELIVERY PLAN

Teen Pregnancy Prevention Alliance (TPPA)

The Teen Pregnancy Prevention Alliance (TPPA) was initially formed as a small group of individuals interested in preventing teen pregnancy in Hardee, Highlands and Polk Counties. The group expanded and focused their efforts and strategies on program implementation and evaluation. TPPA was formally established in 1994 as an action group of the Healthy Start Coalition of Hardee, Highlands, and Polk Counties. The Polk TPPA evolved into the funded and staffed Polk Teen Pregnancy Prevention Alliance and the Coalition continues to partner with the TPPA's in Hardee and Highlands Counties. In each county, TPPA is comprised of members from sectors of the community including private business, public health, social services, law enforcement, schools, youth, parents, and the faith community.

Hardee County Teen Pregnancy Prevention Alliance (Hardee TPPA)

Since the last Service Delivery Plan, Hardee TPPA has worked closely with many community organizations to continue working with the youth in the county to reduce teen pregnancy. Hardee TPPA works in collaboration with community wide partners distributing information on teen pregnancy and other healthy teen choices. Hardee County receives funding from Heartland for Children, through the coalition, for events and education throughout the county. In 2017-2018 Hardee TPPA worked on a logic model that will help guide them through their efforts in preventing teen pregnancy and encouraging teens to make healthy choices in all aspects of their lives. TPPA members in Hardee County hope to make a shift in their efforts to focus more on changing policy throughout the county. Typically, each May, in honor of Teen Pregnancy Prevention Month, Hardee County offers teens in the middle school a 'Healthy Choices' event, where middle school students receive information on making healthy choices and learn about issues, they face every day. Due to COVID 19, the 2019-2020 event was cancelled. The group is looking at alternative ways to offer teen pregnancy prevention information to the county's youth.

Highlands County Teen Pregnancy Prevention Alliance (Highlands TPPA)

Highlands County TPPA works closely with other community organizations to bring teen pregnancy/STD prevention and making healthy choices education to the youth in the community. Highlands County TPPA receives funding from Heartland for Children, through the Coalition, for education and events throughout the community. Highlands TPPA hosts an annual event for teens in the county to learn about teen pregnancy/STD prevention and making healthy choices. Highlands County also partners with different community organizations to bring awareness to teen pregnancy/STD prevention throughout the county, especially through the use of social media. Due to COVID 19, the 2019-2020 event was cancelled. The group is looking at alternative ways to offer teen pregnancy prevention information to the county's youth.

SUMMARY OF DATA SOURCES AND METHODS OF COMMUNITY INPUT

The Healthy Start Coalition of Hardee, Highlands and Polk Counties, Inc. utilized several data sources to identify existing and emerging maternal and child health issues. The following is a description and the methodology utilized.

Methodology

It is important to have a comparison standard in order to determine favorable versus unfavorable health outcomes. A comparison of various secondary data sources was made based on certain Florida state standards with regards to maternal and child health. A description of the process undertaken to determine the health indicators addressed in this study, along with a list of the secondary data sources that were used follows.

Sources of Secondary Data

The primary source of secondary data was the Community Health Assessment Resource Tool Set, Florida Department of Health –CHARTS 2018 MCH data, Office of Planning, Evaluation and Data Analysis. The CHARTS data analysis consisted of three-year rolling averages for the years 2016 through 2018.

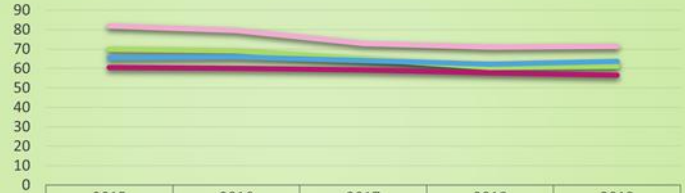
The indicators selected by the committees are represented in the following graphs.

Birth Rates to Women - Less than 37 Weeks Gestation (% of total births)

	2015	2016	2017	2018	2019
Hardee	8.2	9.8	13	11.5	12.4
Highlands	10.3	11.4	10.5	12.4	10.7
Polk	9.1	9.5	10	11.1	10.9
State	10	10.1	10.2	10.2	10.6

Hardee Highlands Polk State

Birth Rates to All Mothers - Ages 15-44 (Rate per 1,000)



	2015	2016	2017	2018	2019
Hardee	81.8	79.6	72.9	70.9	71.3
Highlands	69.9	69.2	65	60.6	61.2
Polk	65.5	66	64	62.1	63.6
State	60.6	60.2	59.2	57.7	56.6

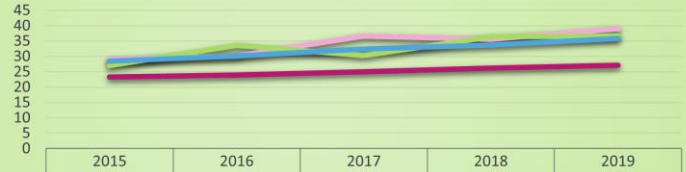
Hardee Highlands Polk State

Birth Rates to Women - Late or No Prenatal Care (% of all mothers - self reported)

	2015	2016	2017	2018	2019
Hardee	9.5	7.4	13.2	9.7	9.3
Highlands	8	11.7	11.2	12.5	14.6
Polk	6.4	6.6	7.2	7.6	7.6
State	5.5	6.1	6.9	7.1	7.5

Hardee Highlands Polk State

Birth Rates to Women - Obese at Time Pregnancy Occured (% of total births)



	2015	2016	2017	2018	2019
Hardee	29	30.1	36.6	35.6	39
Highlands	27	33.6	30.3	36.4	36.6
Polk	28.4	30.1	32.4	33.7	35.8
State	23.3	24	25	26.2	27.1

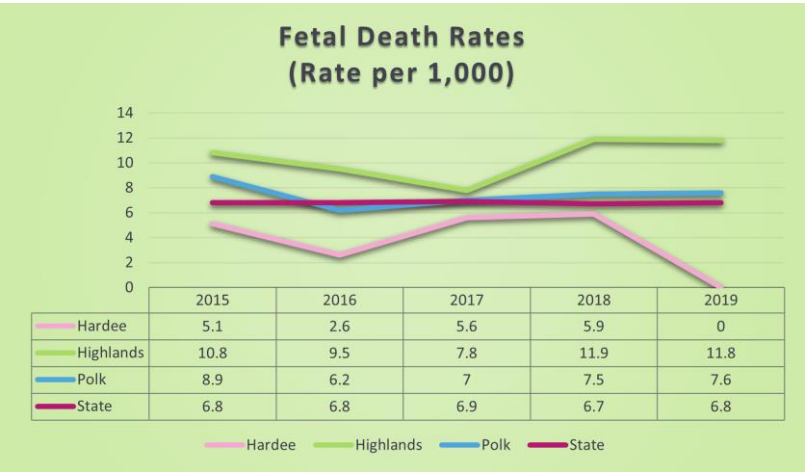
Hardee Highlands Polk State

SUMMARY OF DATA SOURCES AND METHODS OF COMMUNITY INPUT

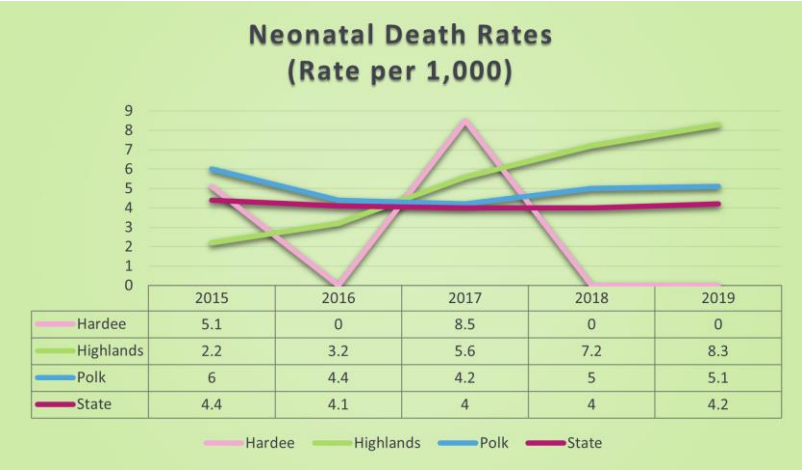
Further analysis of secondary data included analysis of infant mortality and comparison to state averages. Infant mortality data for all three counties was accomplished by using the model of analysis recommended by Dr. William Sappenfield. The model examines root, intermediate and immediate causes of infant mortality including:

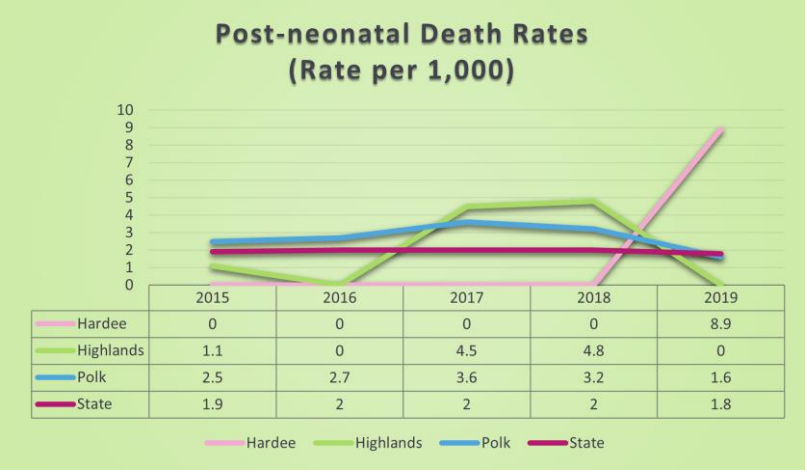
- Economic, educational and access to care factors
- Race/ethnicity and cultural disparities
- Low and very low birthweight and preterm births

Fetal mortality is the death of a fetus or baby after 20 weeks' gestation. The rate is the number of fetal deaths per 1,000 live births. Fetal mortality and the fetal mortality rate reflect the health and well-being of the population's women of reproductive age and their pregnancies, as well as the quality of healthcare available. Fetal mortality information is used by local governments and organizations to identify areas in need and designate available resources.



Neonatal mortality is the death of a live-born baby prior to the 28th day of life. This rate is strongly correlated with low birthweight. Neonatal mortality and the neonatal mortality rate reflect the health and well-being of the population's women of reproductive age and their infants, as well as the quality of the healthcare available. Neonatal mortality information is generally associated with risk factors and issues related to pregnancy and birth and is used by local governments and organizations to identify areas in need and designate available resources.

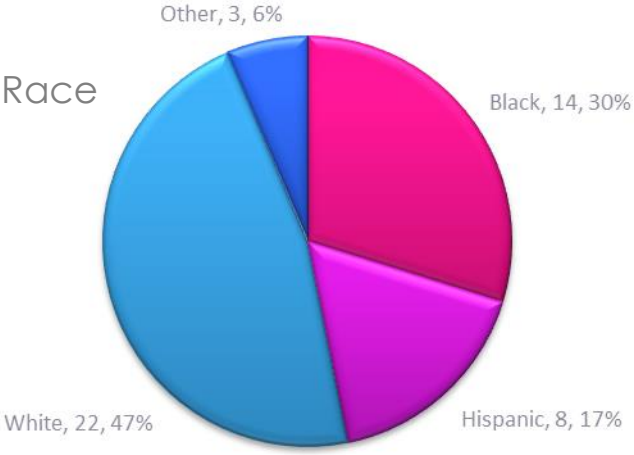




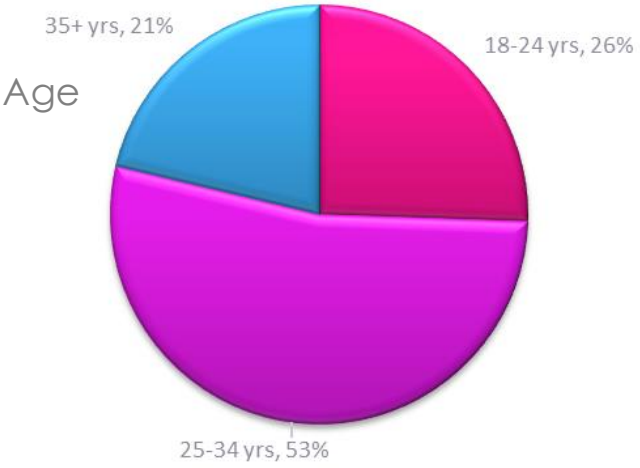
Consumer Client Data

The Needs Assessment process provided a few important findings about the aligned priorities mandated by Florida Department of Health. Unfortunately, the Coronavirus Pandemic (COVID-19) started as we began our initial survey launch. After nearly 4 months of surveying, our responses were minimal, however very reflective of our overall counties' demographics. Because this was an assessment for planning purposes, and not a research project, we must consider some limitations in reviewing the feedback. These limitations include having a relatively small sample size. Therefore, while we can make some assumptions related to these results, we must be mindful that the sample cannot be generalized to the entire populations of Hardee, Highlands and/or Polk Counties. As our coalition's Service Delivery Plan team help to identify and prioritize critical issues for moms, babies, and dads in our coalition area. There were 47 respondents to the Consumer/Client Survey; they reside in the zip codes 33810, 33813,33801,33844, 33809, 33803, 33823, 33880, 33823, 33860, 33870, 33825,33839, 33841, 33812, 33868, 33805, 33815, 33896, 33898 representing a vast area in our tri-county region. A summary of those survey findings are graphed.

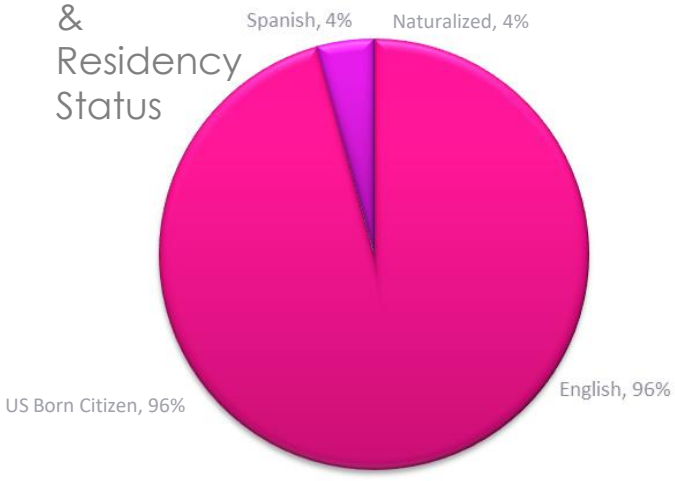
Race



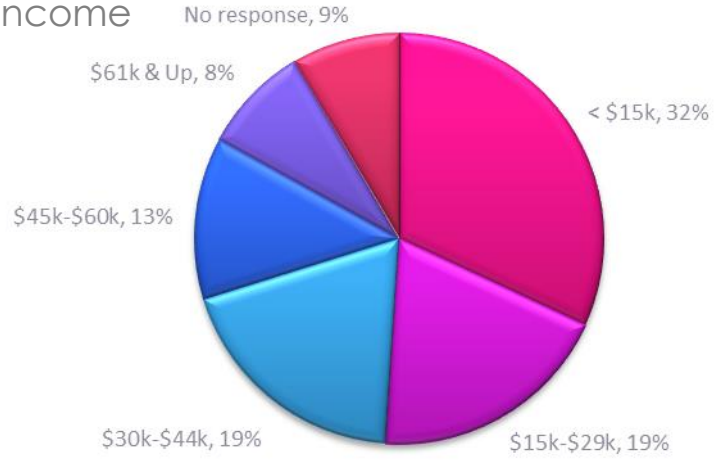
Age



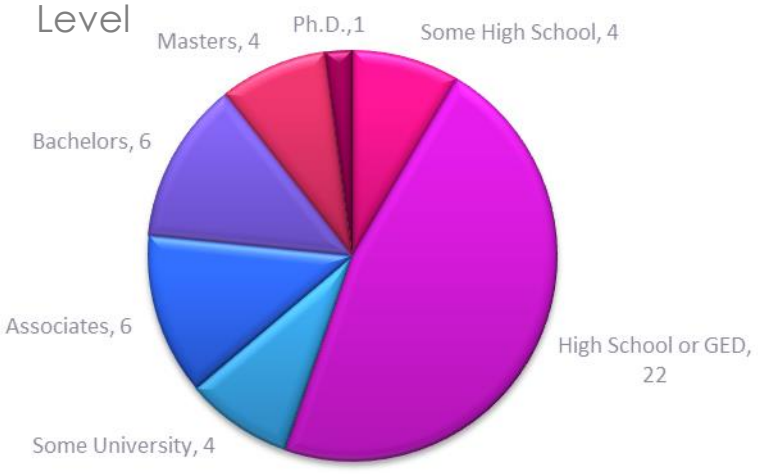
Primary Language & Residency Status



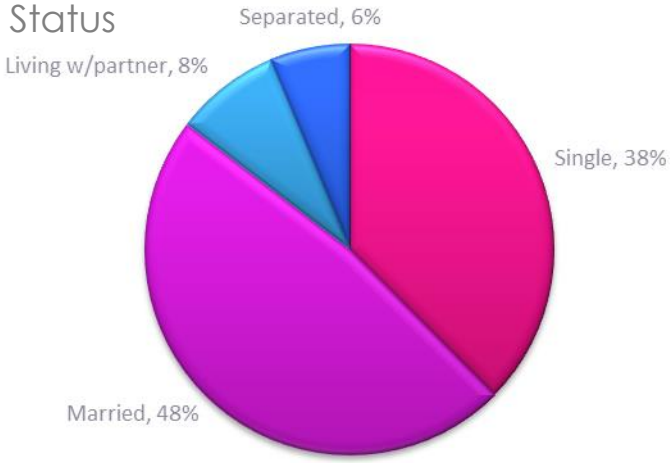
Income



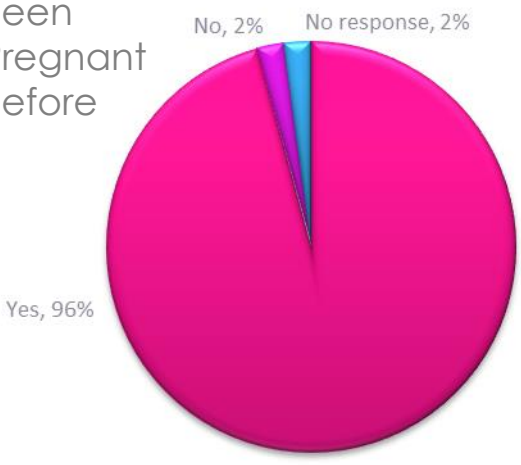
Education Level



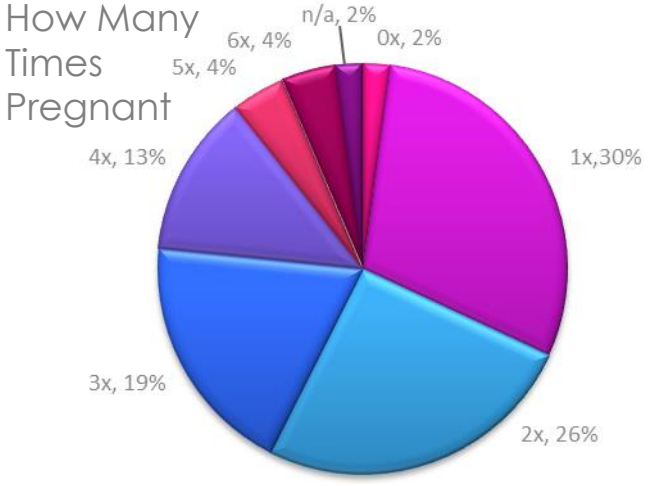
Relationship Status



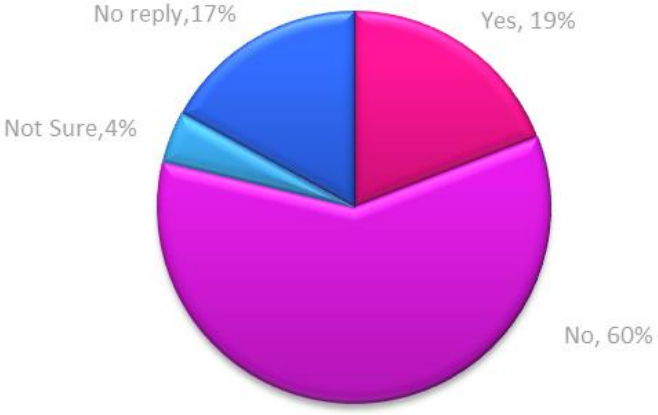
Been Pregnant Before



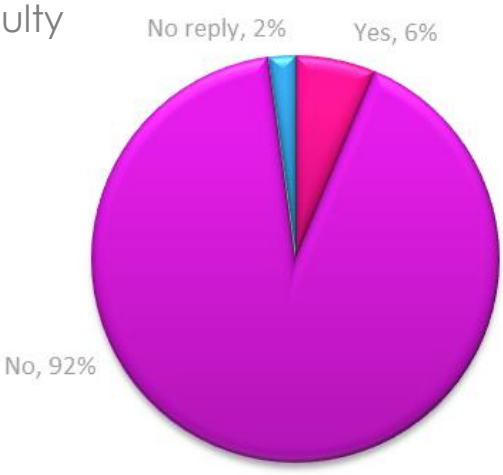
How Many Times Pregnant



Informed on CONNECT Referral System

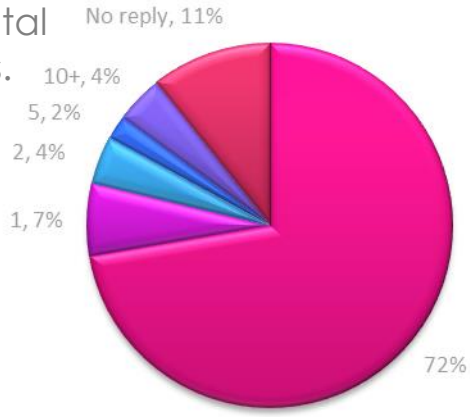


Provider Communication Difficulty



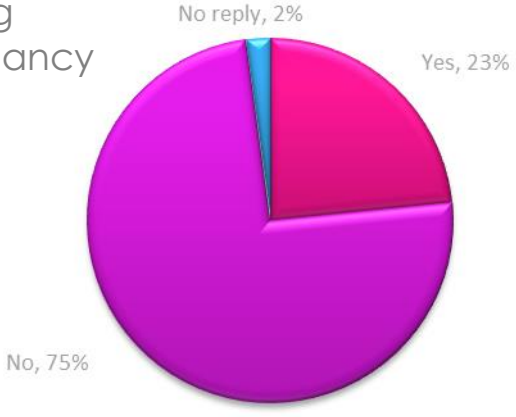
One reason given for difficulty in communication was lacking in quality of care, seemed to have too many patients.

Missed Prenatal Appts.

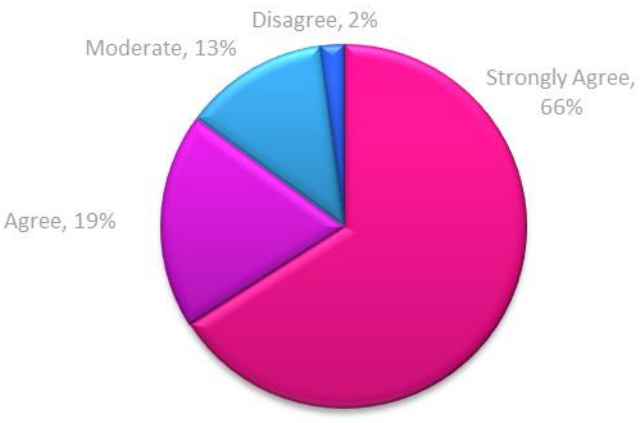


Reasons give for missed prenatal appointments: Some other reason, No one to take care of my children, Could not get off work; Could not get a doctor or nurse to take you as their patient; No appointments were open, Lack of transportation, Insurance, No time off, Inconvenient hours

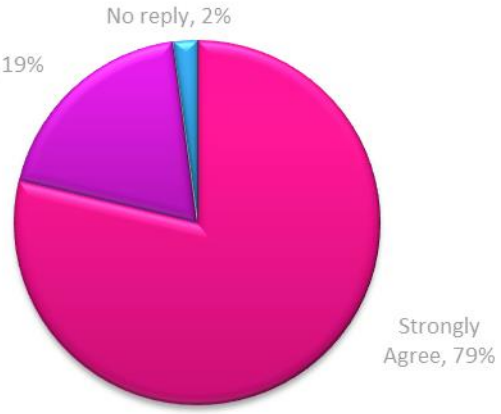
Use of Drugs or Tobacco Before/ During Pregnancy



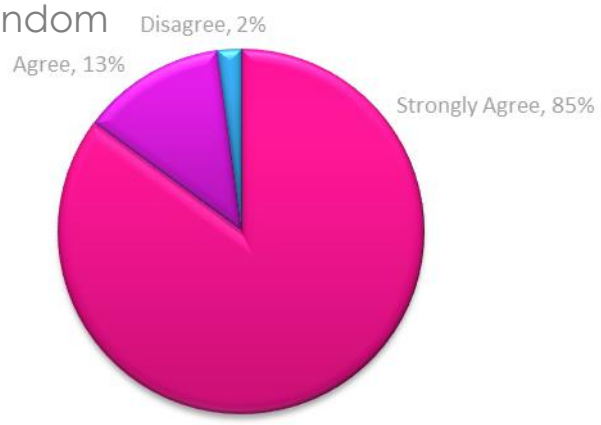
Knowledge of Methods and Effectiveness of Contraception



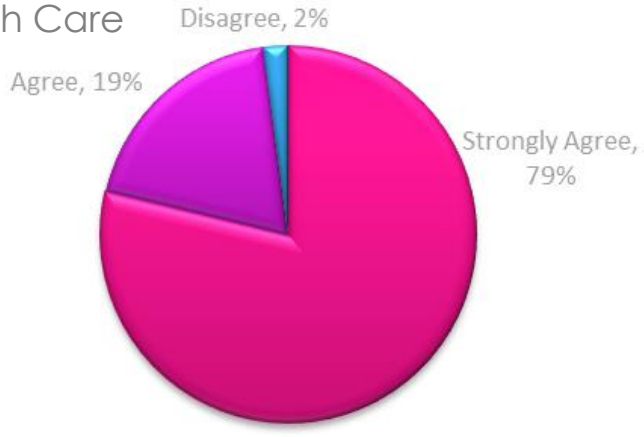
Pregnancy / STI Prevention Access



Know Steps to Put on a Condom



Access to Transportation for Reproductive/Sexual Health Care

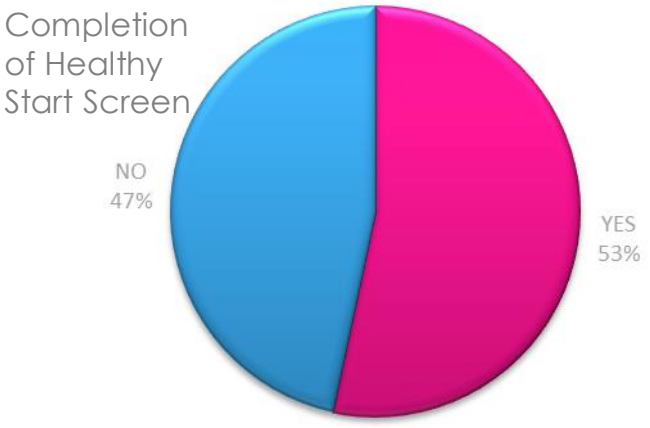


Issues Obtaining Childcare

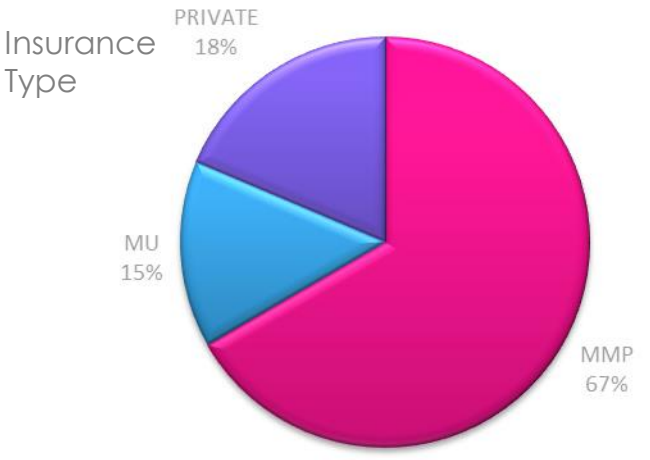
Community Data

The following data represents statistics collected from fiscal year 2019-2020. One hundred forty files, across-the-board, were analyzed and charted to create the graphs.

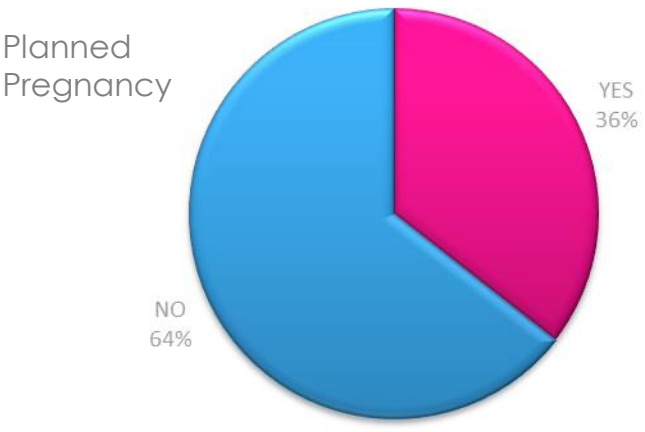
The inception of Coordinated In-take & Referral opened the door to more community-based referrals. Approximately half of our referrals come from the Universal screening process.



Method of payment included more than half with presumptive Medicaid (MU) or Medicaid for Pregnancy (MMP). Private insurance accounts for the remainder.



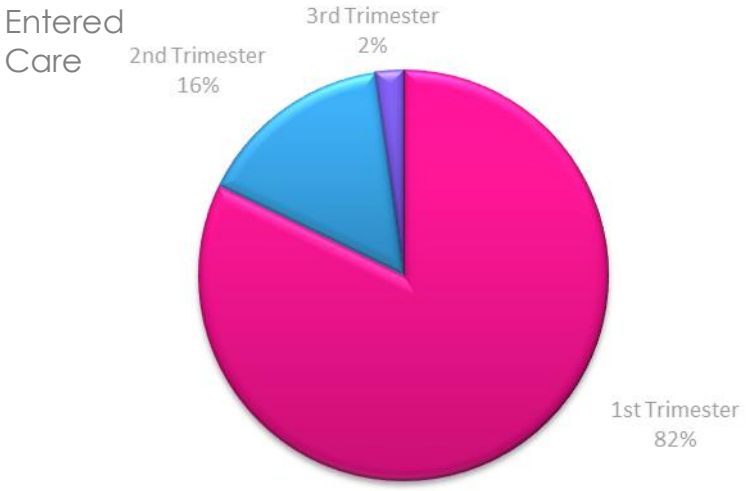
Unplanned pregnancies continue to be problematic. However, most women expressed their acceptance and responded with positivity



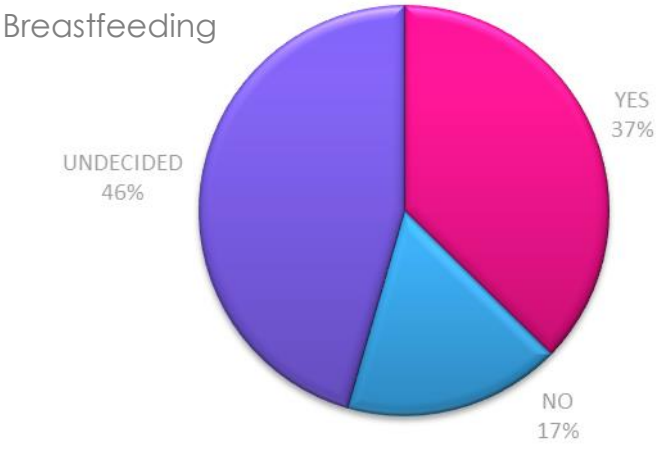
Community Data

The following data represents statistics collected from fiscal year 2019-2020. One hundred forty files, across-the-board, were analyzed and charted to create the graphs.

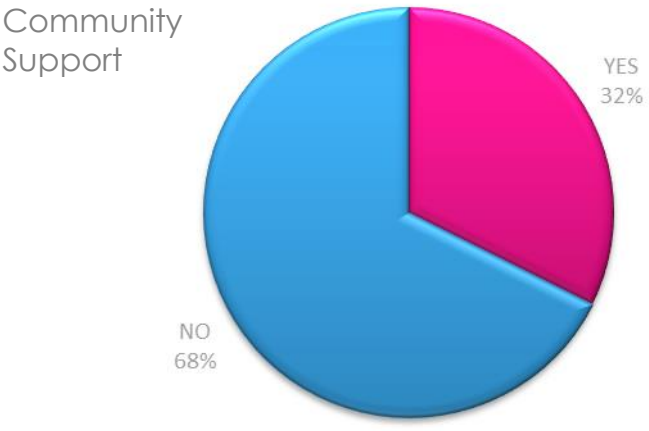
About 20% had late or no prenatal care and more than 80% began care in the first trimester.



More than one-third of women plan to breastfeed. Almost half are undecided, and a small number are planning to exclusively bottle feed.



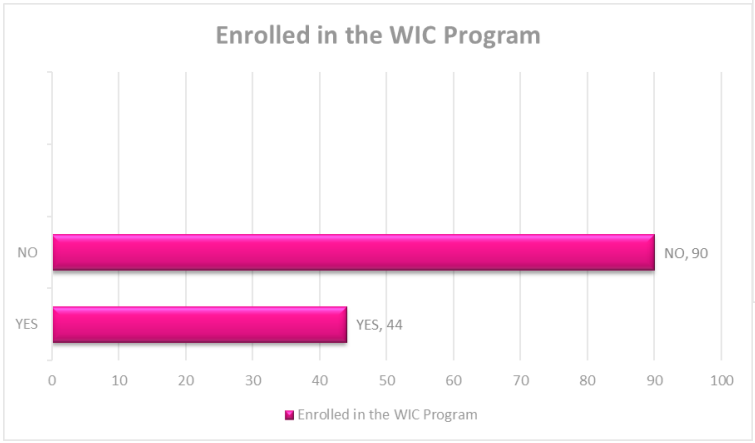
Less than one-third received assistance from a community agency. This refers to any form of support to help the family foundation, i.e. financial, food, household items, etc.



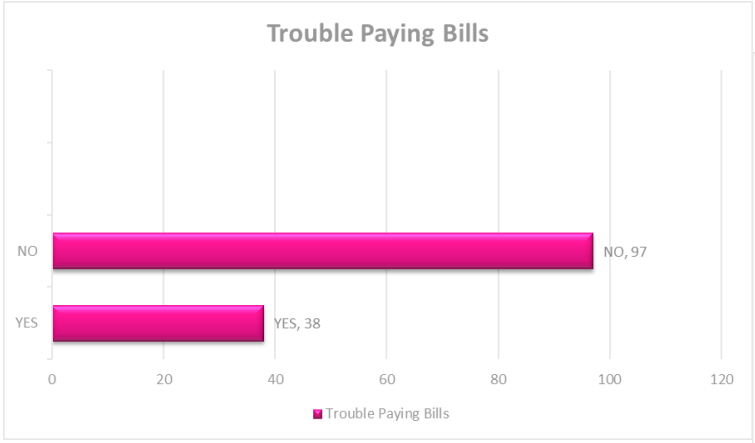
Community Data

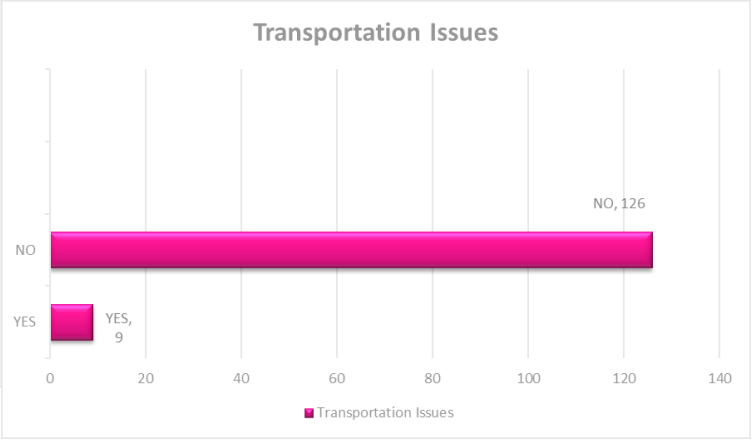
The following data represents statistics collected from fiscal year 2019-2020. One hundred forty files, across-the-board, were analyzed and charted to create the graphs.

Most women knew about the WIC program and about one-third were actively participating.

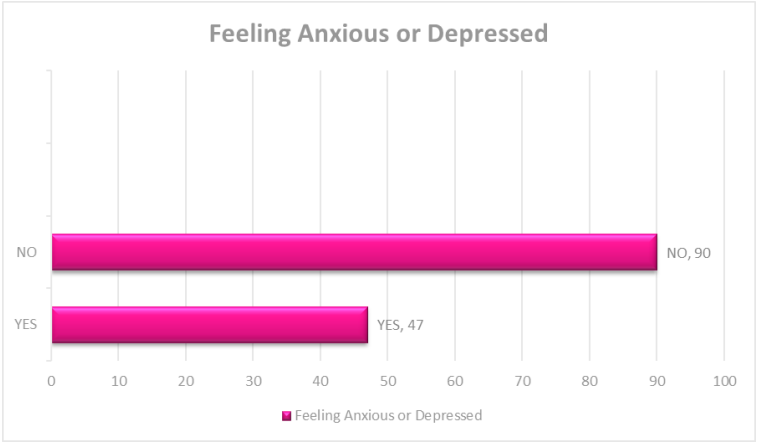


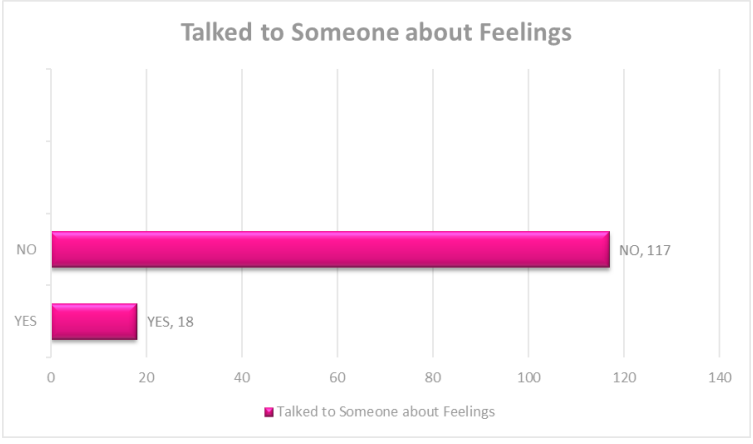
A little more than a quarter of the women indicated having trouble paying their bills and even fewer specified transportation as an issue getting to appointments or otherwise.





About one-third expressed feeling anxious or depressed during pregnancy and very few received counselling or related services prior to screening

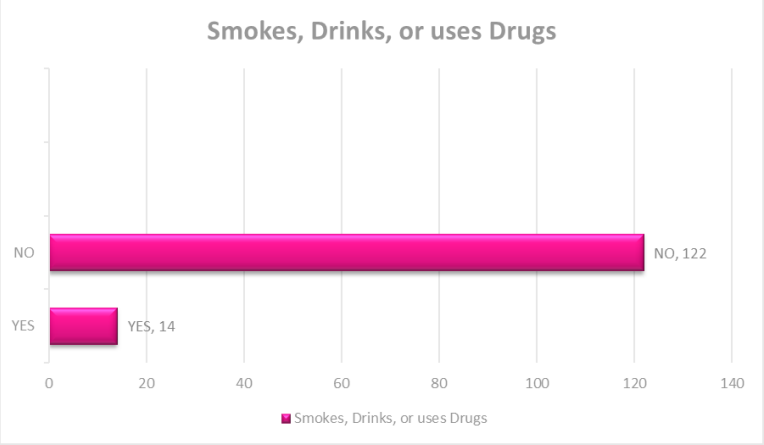




Community Data

The following data represents statistics collected from fiscal year 2019-2020. One hundred forty files, across-the-board, were analyzed and charted to create the graphs.

While any percentage of women with a record of substance use is significant, the number of those reviewed was relatively small at 10%.



Prenatal Provider Data

Source: Prenatal Provider Survey Results

Thirty-five Prenatal Provider surveys were distributed and fifteen (43%) were returned. The results of this survey will enable the Coalition of Hardee, Highlands and Polk counties to determine the scope of service for this plan period with regard to Prenatal Providers.
The following are the results.

- 100% of the respondents, indicated they knew and worked with Healthy Start, were familiar with services and experienced no barriers to working with the program.
- 4%, indicated there were ways Healthy Start could help to better serve their patients including, providing more information of contact made and services, providing more materials in their waiting rooms and more Spanish materials.
- It is important to have an accurate number of new OB patients seen each month to be able to ascertain an accurate screening rate. Among the fifteen responses, new OB patients range from 10 – 55 per month. This is excellent information to better assist providers with screening.
- Approximately 98% of respondents screen every woman for Tobacco, Opioids, Alcohol, and Illicit drugs.
- Another 40% offer/administer MAT options.
- 73% accept Medicaid and 98% accept private pay. These are important factors when conducting CI&R interviews for SOBRA clients.
- When asked about wait time for first OB appointments, lengths vary from less than a week to eight to nine weeks. The majority, 50%, see women within 1-2 weeks of call.
- Thirteen of fifteen were familiar with Coordinated Intake and Referral, available programs for referral and appreciate receiving Provider letters on their patients.

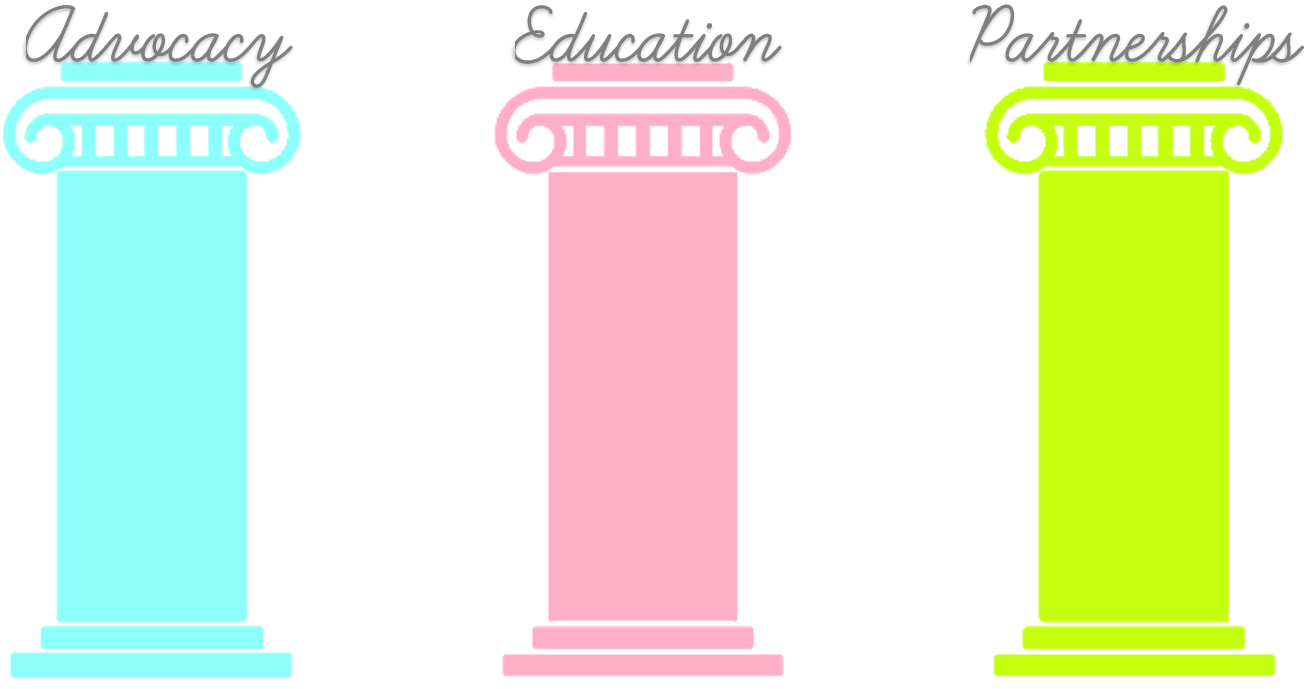
Pediatric Provider Data

Source: Pediatric Provider Survey Results

Forty-eight Pediatric Provider surveys were distributed and twenty-five (52%) were returned. The results of this survey will enable the Coalition of Hardee, Highlands and Polk counties to determine the scope of service for this plan period with regard to Pediatric providers. The following are the results.

- Twenty-two, or 46%, are familiar and work with the Healthy Start program and are familiar with Healthy Start services.
- While offices indicate knowing about Healthy Start services, only 44% submit referrals from their office for their patients. Most say their patients are enrolled right after birth.
- Of the twenty-five responses, the average number of newborns seen range from 5 – 200 per month.
- Twenty-four of twenty-five encounter substance exposed newborns. The approximate number, per year, per provider, ranges from 1 to 48 per month.
- 98% accept Medicaid and indicate they see newborns within 1 week after birth.
- All 25 respondents have no barriers working with Healthy Start. Only 20% were aware of Coordinated Intake and Referral and said the follow up letters were helpful.
- 52% commented on ways Healthy Start could help them better serve their patients. Comments include: Information on how to refer, details of services, and in-service for staff.

Three Pillars



Evaluation Methodology

Our coalition covers 3-diverse counties! We utilized various components to capture both the qualitative and quantitative data to represent all these communities. The issues reflected were obtained via key informant interviews, consumer/client opinion surveys, pediatric providers surveys, prenatal providers surveys, delivery facilities surveys, public health community forum discussions, and statistical health data from Florida Charts and other data custodial relevant sites. In addition, we collaborated with the numerous different community partners such as: Florida Department of Health in Polk, Hardee, & Highlands Counties, Florida Healthy Babies Initiative in Polk, Hardee, & Highlands Counties, and the Community Health Assessments for the tri-county areas that included local health departments, Federally Qualified Health Centers, and local hospitals.

"Research has shown that a web of biological, environmental, economic, social, and psychosocial factors has influence on perinatal health outcomes. To effectively understand, address, and affect these potential casual factors, Healthy Start Coalitions should continuously identify and assess the varied factors within their catchment areas that impact systems of perinatal care and perinatal health outcomes. One way to identify those factors is assessing the community needs and resources."

The coalition and our community partners will continue to analyze all the data to ensure that each pillar's strategies action steps will be appropriate to achieve the desired outcomes. This will address the whole family through educating the community that change and improvement can be achieved by working one generation to the next. For example, a healthy mother starts with her grandmother and her mother. These strategies and action steps are developed to change the thought process and address behaviors, thus improving maternal and child health outcomes. These strategies will be a part of the overall process to continuously identify risks: medical, environmental, psychosocial, and other. Evidently, there will not be a single intervention, but a series of the three pillars: advocacy, education, and partnerships that will assist with addressing all the identified issues. The Healthy Start Coalition of Hardee, Highlands and Polk Counties, Inc. is dedicated to improving the outcomes for all mothers and babies in our tri-county communities.

PILLAR ONE: ADVOCACY

STRATEGY 1

Conduct a minimum of 3 community development activities that utilizes social determinants of health which impact birth outcomes.

Community partners and Healthy Start service providers are informed about perinatal issues and trends, maternal and child health issues that are associated with the tri-county areas. There will be a diverse membership that is representative of the population served. The membership supports the work of the coalition through improved advocacy efforts and funding, increased engagement, and intensity of services amongst providers, and improved consumer awareness regarding all things Maternal and Child Health.

STRATEGY 2

Lead the Coordinated In-take and Referral to connect prenatal women and new mothers to home visiting services.

PILLAR ONE: ADVOCACY – EVALUATION METHODS

Strategy 1: Conduct a minimum of 3 community development activities that utilizes social determinants of health which impact birth outcomes.

The Coalition is required to inform the community providers regarding perinatal issues and trends, develop a membership that is representative of the population served, and provide advocacy regarding Maternal and Child Health issues. The Coalition will utilize trainings and social media campaigns to help inform the various identified issues of importance. This strategy is incorporated from the Healthy Start Standards and Guidelines Chapter 22 and requirements for our coalition provided by our contract with the Florida Department of Health. Furthermore, this strategy will use the 7 social determinants of health (Poverty, Racism, Toxic Stress, Education, Employment, Housing & Transportation) in publishing newsletters, trainings, meetings, and workshops to convey the impact on Maternal and Child Health outcomes that influence the overall quality of life for the communities we serve. Lastly, the coalition will track the production and distribution of newsletters, meetings, workshops, training attendance and evaluations, usage of coalition website, legislative visits, media coverage, and impact of the social media campaigns for all Maternal and Child Health activities. In summation, after completion of all these various action steps the observed impact of this strategy on the system of community wide problem/need are as follows: a diversified coalition membership representative of the population served, improved advocacy efforts and funding, an informed and trained staff, providers, and community partners, increased engagement of services, and improved consumer awareness regarding all maternal and child health issues.

PILLAR ONE: ADVOCACY – EVALUATION METHODS

Strategy 2: Lead the Coordinated In-take and Referral to connect prenatal women and new mothers to home visiting services.

This program has been beneficial in providing services to all clients within the system of care to choose their desired home visiting program. In addition, it has led to the reduction of duplication of home visiting services in our area, and across the entire state of Florida. The data is exemplified in showing a higher need of services for a vastly diversified clientele. This process has improved identifying and engaging more high-risk clients and provided the opportunity for them to engage in a program for a much longer extended duration of participation. Clients that are referred to the Coordinated System of Care (Connect Program) that are at risk of having an early delivery (prematurity), small baby (low birth weight), or previous poor birth outcome (neonatal/infant deaths) receive individualized and appropriate services. This strategy will be continued to improve by the collaboration of multiple agencies within the Home Visiting Advisory Committee, reviewing of the Executive Summary Reports, Well Family System reports, Provider Reports, Chart/Case Reviews, and Fetal Infant Mortality Review Case summaries. Lastly, the Coordinated Intake & Referral Team will continue to use the home visiting protocols, intervention pathways, and trainings to ensure the best delivery system of care for all home visiting agencies.

Action Steps	Responsible Entity	Start Date	End Date
Develop and distribute at least two newsletters per year.	Coalition Staff Community Partners	7/21	6/26
Host a minimum of one annual meeting.	Coalition Staff	7/21	6/26
Recruit a diverse membership at various coalition's events, activities, and meetings	Coalition Staff Provider Staff Home Visiting Advisory Committee Healthy Start Program Providers	7/21	6/26
Present annually to Board of Directors and Service Delivery Plan Committee members key maternal and child health indicators	Coalition Staff	7/21	6/26
Develop a user-friendly website	Coalition Staff Technology Consultant	7/21	6/26
Expand the number of pregnant women/families referred to Coordinated Intake & Referral (Connect) system annually	Coalition Staff Healthy Start Program Providers Community Partners Prenatal Providers Pediatric Providers Delivery Facilities	7/21	6/26
Increase the number of women/families who receive a completed Initial In-take within 25 calendar days of receipt of referral.	CI & R Team Home Visiting Advisory Committee Coalition Staff Healthy Start Program Providers	7/21	6/26
Increase rate of referrals to the Coordinated Intake & Referral system from community agencies, Department of Children & Families, and Managed Care Organizations	CI & R Team Community Partners Home Visiting Advisory Committee Healthy Start Program Providers	7/21	6/26
Conduct an in-service as needed to discuss the purpose of Coordinated Intake & Referral, improve consent to program(s) of choice, and duration in program rates	CI & R Team Coalition Staff Home Visiting Advisory Committee Healthy Start Program Providers	7/21	6/26
Develop Memorandum of Understanding and BAA with home visiting programs	Coalition Staff	7/21	6/26
Increase the number of pregnant women/families that receive an Initial In-take and referral to a home visiting program	CI & R Team, Home Visiting Advisory Committee Healthy Start Program Providers	7/21	6/26

PILLAR TWO: EDUCATION

Education is a core tenet to the improvement of maternal and child health indicators. Safe Sleep, Maternal Chronic Illnesses, Alcohol, Tobacco, and Other Drugs (ATOD) use, and prematurity prevention education is needed for both the consumer and providers. Furthermore, after the COVID-19 pandemic, maternal stress and depression became more prevalent. Maternal stress and Depression are an associated risk factor for prematurity and very low birth weight births which impact neonatal and infant deaths. Mothers, both prenatally and postnatally, have increasing stress and anxiety and referrals to behavioral health agencies has increased exponentially. Moreover, chemically dependent pregnant women and substance-exposed newborns have increased in our tri-county community. Controlled substances include both prescription drugs not prescribed to the parent or not administered as prescribed. All these various risk assessments will help increase the identification and engagement of the higher risk clients and the intensity of the duration of services offered.

STRATEGY 1

Develop and distribute FIMR data about the underlying causes of fetal and infant death and to improve maternal health by addressing chronic health conditions

STRATEGY 2

Address Maternal Stress and Depression though the Healthy Start system of care

STRATEGY 3

Assist chemically dependent pregnant women and substance-exposed newborns

PILLAR TWO: EDUCATION– EVALUATION METHODS

Strategy 1: Develop and distribute FIMR data about the underlying causes of fetal and infant death and to improve maternal health by addressing chronic health conditions.

As one of the twelve funded Fetal Infant Mortality Review Projects in the state of Florida, our coalition recognizes the importance of reducing infant mortality. Our diverse communities each have a unique diversity as it pertains to the death of both their fetal and infants. In one community, there is a huge disparity between the death of white vs. black infants. Contrarily, in another community within our coalition the fetal/infant deaths are low. Moreover, our other community the rate of infant mortality is changed drastically with the death of a minority infant and/or fetal. Therefore, as previously mentioned we understand the severity of this indicator and what it means for our communities in which we serve. This strategy will address numerous causes of deaths that our infants/fetal experience such as Un-Safe Sleep, Prematurity, Blunt Force Trauma, Genetic Issues, Maternal Issues, Cord Issues, Lack of Prenatal Care, Lack of Access, and more. Furthermore, this strategy will utilize the expertise of community partners, case managers, and providers. The best-known value of understanding the death of our infants and/or fetal is to provide information to our consumers by educating and increasing their awareness through educational materials, presentations, social media campaigns, newsletters, coalition website, and focus groups. These things will be captured with agendas, minutes, and assessments. The data will be provided through the Vital Statistics from the Birth & Death Certificates, Florida Charts, Healthy Start Reports, and interviews. In summation, our coalition's FIMR Project will continue to improve the relationships with our community, families, and community partners to have a better understanding of the issues that are presented that affect our overall Maternal and Child health system of care.

PILLAR TWO: EDUCATION– EVALUATION METHODS

Strategy 2: Address Maternal Stress and Depression though the Healthy Start system of care.

Since the onset of the COVID-19 Pandemic, our coalition area has witnessed an increase of maternal stress and depression. The coalition understands these are not just isolated issues, but a community-wide problem. This problem has a huge impact on increasing the risk of prematurity, low birth weight, and neonatal and infant deaths. The coalition has partnered with local Mental and Behavioral Health entities to ensure these key areas of stress and depression for the maternal and child health system of care is a front and center must for our diverse communities to address. By collaborating with other entities, we will use Fetal Infant Mortality Review data, Health Problem Analysis, Community Health Improvement Plan Assessments, and Well Family System and Home Advisory Council reports to help reduce the issue of maternal stress and depression. Also, this strategy will utilize intervention pathways that were developed through the Healthy Start system of Care, increase social awareness and support, address barriers to receiving counseling services, improve the collective impact with community partners that are trained in mental and behavioral health services. Lastly, the effectiveness of this strategy will be able to be actionized in the number of services received, number of referrals, and number of memorandums of understanding agreements between agencies

Strategy 3: Assist chemically dependent pregnant women and substance exposed newborns.

Our coalition is situated along the Interstate 4 corridor for the state of Florida. These areas have seen an exponential increase of moms using opioids during their pregnancy. Our coalition has partnered with the statewide Florida Perinatal Quality Collaborative, Lakeland Regional Health, and Department of Children & Families Services in addressing this important issue. The Plan of Safe Care is a key component that brings the multiple agencies together to evaluate, treat and provide services to both mom and baby. The entire system of care for our coalition area will work cohesively to ensure that community partners, providers, and consumers identify and refer moms who present with a substance abuse problem and/or have a substance exposed newborns to the appropriate service providers. This will ensure our mothers and infants are identified in a timely manner and are provided the assistance needed to have wrap-around support to address contributing factors, cause, and determine their outcomes. The group of community partners focused on this strategy will continue to provide information based upon the Healthy Start data and performance reports, documentation of community and provider referrals, and consumer surveys in ensuring this strategy is implemented as intended. Our coalition understands this issue is complex and vast, but will continue to utilize assessments, education, and awareness to ensure moms, providers, and community partners increase their knowledge on the immediate effects of using substances while pregnant and the impact it will have on the health and outcome of the birth of their child. In summation, the usage of Executive Summary Reports, Healthy Start Prenatal and Infant ADHOC Reports, Consumer Surveys, and Healthy Start Screening data will be able to provide the measure to be effectively executed in decreasing the number of cases of chemically dependent pregnant women and substance exposed newborns.

Action Steps	Responsible Entity	Start Date	End Date
Develop and distribute discharge packets to all parents of newborns. Packets will have strong Healthy Start brand identification	Coalition Staff Community Partners Birthing Facilities	7/21	6/26
Conduct an annual presentation to community partners, consumers, and providers informing about infant mortality	Coalition Staff	7/21	6/26
Implement routine Post-partum Depression Screening and intervention Pathway during Healthy Start services and refer to counseling if necessary	Healthy Start Program Providers	7/21	6/26
Develop Memorandum of Understanding for service provision, priority services and advocacy with community partners: Domestic Violence Coalition, Peace River Center, Tri-county Human Services, and Lakeland Regional Health	Coalition Staff Community Partners	7/21	6/26
Monitor quarterly the results of the Edinburg Screening and the number of sessions completed for the Mothers & Babies Curriculum	Coalition Staff Healthy Start Program Providers	7/21	6/26
Conduct service providers staff training plan for motivational interviewing, cultural competency, relationship of risk factors to outcomes as needed	Coalition Staff Healthy Start Program Providers	7/21	6/26
Provide the following Healthy Start system of care trainings as needed: SCRIPT, Interconception Care, FSU Partners for Healthy Baby, Safe Baby, Edinburgh, Mothers and Babies ASQ 3 and ASQ SE	Coalition Staff Healthy Start Program Providers Community Partners Training Experts	7/21	6/26
Partner with the Florida Perinatal Quality Collaborative's (FPQC) Maternal Opioid Recovery Effort (MORE) Project to help substance use pregnant women	Florida Perinatal Quality Collaborative Community Partners Coalition Staff Advent Health Facility Lakeland Regional Health Facility	7/21	6/26
Provide an update to providers, consumers, and community partners on local statistics, available resources, and treatment facilities	Coalition Staff Community Partners	7/21	6/26
Encourage substance use screening at all provider offices and delivery facilities	Coalition Staff Healthy Start Program Providers Community Partners Birthing Facilities Ob/Gyn Offices	7/21	6/26
Refer mothers to community agencies and treatment facilities that offer services for substance use/exposure	Coalition Staff Healthy Start Program Providers Community Partners Birthing Facilities Ob/Gyn Offices	7/21	6/26
Attend meetings that address substance use and other related service as needed	Coalition Staff Healthy Start Program Providers	7/21	6/26
Conduct Alcohol Tobacco Other Drug Screening and Intervention pathways with Healthy Start clients	Healthy Start Program Providers	7/21	6/26
Conduct SCRIPT curriculum with Healthy Start clients	Healthy Start Program Providers	7/21	6/26

PILLAR THREE: PARTNERSHIPS

STRATEGY 1

Maintain Healthy Start Prenatal Risk Screen Rate of 70% of all women who give birth and Maintain Healthy Start Infant Risk Screen Rate of 75% of all newborns.

Both the prenatal and infant risk screens are vital to the success of families in the tri-county area. The screens are a point of identification and entry into the Coordinated Intake and Referral system of care that offers engagement. Increasing the prenatal and infant risk screening rates continues to be an important aspect of what we do to ensure all women have an opportunity to enter a home visiting program. These screens provide rich data that bridge partnerships amongst various organizations for an increase in resources that are needed for the overall reduction of infant mortality. The screens assist with improving maternal and child health indicators such as low birth weight, preterm birth, and other poor birth outcomes that are addressed on the screen. Mothers in our tri-county communities are not waiting the recommended length of interval time for baby spacing.

STRATEGY 2

Decrease the number of women with an inter-pregnancy interval < 18 month.

PILLAR THREE: PARTNERSHIPS – EVALUATION METHODS

Strategy 1: Maintain Healthy Start Prenatal Risk Screen Rate of 70% of all women who give birth and Maintain Healthy Start Infant Risk Screen Rate of 75% of all newborns.

The Florida Association of Healthy Start Coalitions was created over 30 years ago with the importance of understanding the collaboration of community partners, providers, and consumers of maternal and child health services to work together to ensure a robust system of care for the entire state of Florida. Risk screening is the point of identification and entry into the Healthy Start System of Care and a critical point in the system of care to ensure engagement. As one of the 32 local coalitions, our coalition continues to maintain the importance of screening. The increase of prenatal and infant risk screening is a core outcome measure for the Florida Department of Health contractual requirements. Our coalition's health care providers, community partners, and consumers are provided extensive training on both the prenatal and infant risk screens that provide a better understanding of infant mortality, low birth weight, preterm births, and other poor birth outcomes that are indicated by the screening process. This strategy successful implementation will be shown via the number of providers trained on the risk screening instrument, frequency of visits to provider offices, materials distributed to provider offices, provider screening rates, hospital and birthing centers screens offered and completed, and referrals into the Coordinated Intake & Referral System for home visiting services which include the Healthy Start Program. Summating, there will be a reduction of lag time due to the usage of the rates of both screens being maintained, care coordination for moms and babies receiving appropriate referrals as needed, and the reduction of poor birth outcomes in our coalition's communities.

PILLAR THREE: PARTNERSHIPS – EVALUATION METHODS

Strategy 2: Decrease the number of women with an inter-pregnancy interval < 18 months.

The American College of Obstetrics & Gynecology experts recommend for the best health outcomes for both the mom and baby to wait at least 18 months (1yr. 6mo.). There is a lot of evidence that shows that pregnancies that begin before 18 months after a previous pregnancy are at a higher risk for various complications. Furthermore, the risks increase for pregnancies that occur before 6 months after birth. The coalition's diverse communities have identified there is a higher percentage of women with short-interval pregnancies vs. the overall state rate. As mentioned throughout this plan, birth outcomes are important in reducing the indicators such as prematurity, low birth weight, and infant mortality. Consumer education through Provider and Community Partners is vital. As a coalition we are reminded to address some of the cultural and generational issues and beliefs that clients have as it pertains to family planning, access to family planning, the use of Long-Acting Reversible Contraceptives (LARCs), other birth control, and lack of education from medical providers and community partners on the importance of pregnancy intervals < 18 months. The data gathered will improve this strategy by utilizing the Well Family System reports for interconception care coordination, data on birth control usage, attendance of trainings, and assessments results.

Action Steps	Responsible Entity	Start Date	End Date
Provide Educational Visits to Providers on an as needed basis	Coalition Staff	7/21	6/26
Conduct an annual in-service on Healthy Start with all providers	Coalition Staff	7/21	6/26
Create annually Provider Connection, Mommy Matters and Mommy Knows Best newsletter	Coalition Staff	7/21	6/26
Provide Maternal and Child Health updates to providers on an as needed basis	Coalition Staff Healthy Start Program Providers Community Partners	7/21	6/26
Share written or verbal feedback about screening issues and screening rates to providers quarterly	Coalition Staff Healthy Start Program Providers	7/21	6/26
Provide Healthy Start clients with their provider's information to schedule post-partum appointment as needed	Healthy Start Program Providers Connect Team	7/21	6/26
Collaborate as needed with the Florida Perinatal Quality Collaborative on issues related to long-acting reversible contraception access	Florida Perinatal Quality Collaborative Community Partners Coalition Staff Healthy Start Program Providers	7/21	6/26
Ensure clients with Medicaid are linked to the Family Planning Medicaid Waiver and Title X after birth as needed	Connect Team Healthy Start Program Providers Community Partners	7/21	6/26
Provide training for community partners, service providers, and staff on cultural issues and beliefs about baby spacing intervals and long-acting reversible contraception as needed	Coalition Staff Healthy Start Program Providers	7/21	6/26
Expand Healthy Start relationships with WIC, Nemours Children Specialty Care and prenatal clinics, Central Florida Health Care, hospitals and birthing centers	Community Partners Coalition Staff Healthy Start Program Providers	7/21	6/26
Conduct quarterly Home Visiting Advisory Committee meetings	Coalition Staff Connect Team Home Visiting Advisory Committee	7/21	6/26
Provide data to Home Visiting Advisory committee as needed	Coalition Staff Connect Team	7/21	6/26
Provide education to providers, consumers, and community partners about the Coordinated Intake & Referral System (Connect)	Connect Team Coalition Staff	7/21	6/26

Plan of Safe Care for Prenatal Substance Use (CFOP170-8)

In accordance with the Comprehensive Addiction and Recovery Act (CARA) of 2016, The Coalition will work with local hospitals and child welfare professionals to ensure the development of the Plan of Safe Care at the earliest point of the mothers use or the infant's exposure has been identified. A plan of safe care must be developed, implemented and monitored for infants under one year old who have been affected by exposure to controlled substances or alcohol. Controlled substances include both prescription drugs not prescribed to the parent or not administered as prescribed (CFOP 170-8).

As required by s. 383.14 all attending health care providers are required to refer infants identified as prenatally exposed to alcohol and controlled substances for early intervention, remediation and prevention services. This process will begin with a referral to the Coordinated Intake and Referral unit.

When initiated, the Healthy Start Coalition will collaborate with other stakeholders and partners to provide services for infants and families affected by prenatal exposure to alcohol and controlled substances, including but not limited to:

- Other home visitor programs
- Healthy Families
- ELC
- County Health Departments
- CPT
- CMS
- Substance abuse treatment
- DCF
- Early Steps

When invited by the Child Welfare professionals, the Healthy Start Coalition provider will participate in the 21-day plan of safe care staffing. The staffing participants will discuss the following, including but not limited to: (1) the progress of the parent(s)' substance misuse treatment, (2) any parenting concerns/ parental capacity, (3) victim-child(ren)'s developmental concerns/ needs, if any, (4) any other additional service provider input, (5) any follow up needed prior to closing the DCF investigation, and (6) potential date of DCF case closure.

Conclusion

The qualitative and quantitative data shows that as we make progress, we are reminded there is still lots of work to do. The coalition will continue to inform the community partners, service providers, coalition staff, and others regarding perinatal issues and trends and maternal and child health issues. Over the course of this Service Delivery Plan our tri-county areas will expand the membership to be representative of the populations served. The coalition will adhere to the **three pillars of advocacy, education, and partnerships** to ensure we are the go-to experts in the field of Maternal and Child Health issues.

Every baby deserves a Healthy Start

Community Partners

Lakeland Housing Authority
Winter Haven Housing Authority
Local Coordinating Board for Hardee and Highlands County
Highlands County Board of County Commissioners
Polk County Board of County Commissioners
Hardee Board of County Commissioners
Midwifery Practices
University of South Florida Perinatal Quality Collaborative
Managed Care Organizations
Florida Department of Health
Department of Children & Families
Lakeland Regional Health
Bay Care
Advent Health
Local Ob/Gyns
Local Pediatricians
Coalition Staff
Service Providers Staff
Home Visiting Advisory Committee
Local school boards
United Way of Central Florida
Redlands Christian Migrant Association
Parents As Teachers Program
East Coast Migrant Head Start Program
Central Florida Health Care
Pieces to Peace Counseling Charities
Melanin Families Matter, Inc.
Safe Sleep Task Force
Agency Connection Network
Nurse Family Partnership Program
Teen Pregnancy Prevention Alliance Committee
Planned Parenthood
Polk State College
Florida Southern College
Southeastern University
South Florida State College
Healthy Families (Hardee/Highlands/Polk)

APPENDICES

APPENDIX A
ATTENDEES OF SERVICE DELIVERY PLAN WORKGROUP

Tonya Akwetey Healthy Start Coalition of HHP Public Health	Ermelinda Ceteno Central Florida Health Care Nursing	Heidi Dembrowski Winter Haven Women's Hospital Nursing	Spring Dority Healthy Start Coalition of HHP Admin./Contracts Coord.
Charlene Edwards Healthy Start Coalition of HHP HSC Executive Director	Taylor Freeman Department of Health Community Health	Cynthia Knowles Early Steps Child Intervention	Tracey McKinney Lakeland Regional Health Nursing
Jodi Miller United Way of Central Florida Success By 6 Education	Holly Parker Healthy Start Coalition of HHP Health Education	Heather Recchi Department of Children and Families Health Education	Andrea Rhodes Department of Children & Families Social Work
Jennifer Richards Winter Haven Women's Hospital Nursing	Cynthia Scott Florida Department of Health Highlands	Roselyn Smith Florida Department of Health Polk (Healthy Start)	Amanda Snyder Lakeland Regional Hospital
Amanda Tyner Department of Health Public Health	Amanda Wilson Department of Children & Families Social Work	Nancy Zachary Redlands Christian Migrant Association Public Health	

APPENDIX B
HEALTHY START SURVEYS

SURVEY

Consumer / Client

PART A

1. City/Zip Code: _____ 2. Age: _____ 3. Primary Language: _____ 4. Race: _____
5. Income: ⬭ Less than 15,000 ⬭ $15,000-$29,000 ⬭ $30,000-$45,000 ⬭ $45,000-$60,000 ⬭ Over $60,000
6. Education level: ⬭ Middle or Elementary School ⬭ Some High School ⬭ High School or GED ⬭ Some University
   ⬭ Associate Degree ⬭ Bachelor's Degree ⬭ Master's Degree ⬭ Ph. D. Degree
7. Residency Status: ⬭ US Born Citizen ⬭ US Naturalized Citizen ⬭ Other
8. What is your primary language: ⬭ English ⬭ Spanish ⬭ French ⬭ Haitian Creole ⬭ Other _____
9. Relationship Status: ⬭ Single ⬭ Married ⬭ Divorced ⬭ Living with Partner ⬭ Widowed ⬭ Separated

PART B

1. Are you or have you ever been pregnant? ⬭ Yes ⬭ No, if no, please proceed to Part C
2. How many times have you been pregnant? _____
3. Have you ever been provided information on the CONNECT Referral System? _____
4. I missed _____ (how many) prenatal appointments for the following reasons:
   ⬭No one to take care of my children ⬭No way to get to the clinic or office ⬭Couldn't get time off work
   ⬭Afraid of medical tests ⬭Couldn't get a doctor or nurse to take you as their patient
   ⬭Medicaid transportation wouldn't take your other children ⬭Didn't have enough money or insurance to pay for your visit
   ⬭Inconvenient office hours ⬭No appointments were open ⬭Something else
5. Before or during your pregnancy did you smoke cigarettes and/or marijuana or do other drugs (prescription or street)?
   ⬭Yes ⬭No
6. Have you ever experienced any challenges or issues with obtaining childcare? ⬭Yes ⬭No ⬭N/A
7. Have you ever had difficulty communicating with your provider: ⬭Yes ⬭No, if no, please proceed to Part C
   If yes, please describe: _____
   _____
   _____
   _____

Part C

8. I understand the different types of contraceptives and their effectiveness.
   ⬭ Strongly Agree ⬭ Agree ⬭ Moderate ⬭ Disagree ⬭ Strongly Disagree
9. I understand the steps to correctly put on a condom.
   ⬭ Strongly Agree ⬭ Agree ⬭ Moderate ⬭ Disagree ⬭ Strongly Disagree
10. I feel I have access to the services I need for pregnancy and STI prevention.
    ⬭ Strongly Agree ⬭ Agree ⬭ Moderate ⬭ Disagree ⬭ Strongly Disagree
11. I feel I have access to transportation to visit a doctor for pregnancy prevention/STI prevention/prenatal care.
    ⬭ Strongly Agree ⬭ Agree ⬭ Moderate ⬭ Disagree ⬭ Strongly Disagree

The Healthy Start Coalition of Hardee, Highlands and Polk counties, Inc. would like to THANK YOU for taking the time to complete this survey. Your answers and comments will enable us to structure services to better assist you in providing the very best care for the women and infants. The Coalition's Vision is to: Be the leader for linking community resources in order to maximize the health and wellness of childbearing women and their families.

For information call or email
Holly Parker, Provider Liaison
863.381.0114 or hollyp@healthystarthhp.org

SURVEY

Prenatal Provider

PART A

1. Have you heard of the Healthy Start program? ☐ Yes ☐ No (If no skip to Part B)
2. Which Healthy Start services are you familiar with?

☐ Risk Screen ☐ Home Visiting ☐ Baby Spacing/family Planning ☐ Childbirth Education ☐ Smoking Cessation

☐ Breastfeeding ☐ Women's health ☐ Parenting Education ☐ Postpartum Education ☐ Depression Screening

PART B

1. What is the average number of **new** OB patients seen per month? _____
2. Does your office have bilingual staff or provide interpreter services? ☐ Yes ☐ No ☐ Spanish ☐ Creole ☐ Other _____
3. Do you regularly screen pregnant women for the following? ☐ Tobacco ☐ Alcohol ☐ Opioids ☐ Illicit substances (√ all that apply)
4. Does your office administer/offer substance use treatment options? ☐ Yes ☐ No If yes, what? _____
5. Does your practice accept Medicaid? ☐ Yes ☐ No
6. Does your practice accept private pay patients? ☐ Yes ☐ No
7. How long does it take to get the first OB appointment? Please explain _____
8. Does your office discuss Long Acting Reversable Contraceptives with patients? ☐ Yes ☐ No

   If yes, what does your office recommended? _____
9. What are your greatest barriers in caring for your patients? (Check all that apply) ☐ Medicaid eligibility ☐ Medicaid reimbursement

   ☐ Patient compliance ☐ Under/uninsured ☐ Transportation ☐ Lack of resources

   ☐ Language barrier ☐ Patient understanding plan of care
10. What is the highest priority for you to better address the needs of your patients? _____
11. Are there any barriers to working with the Healthy Start program? ☐ Yes ☐ No _____
12. Are you familiar with the Coordinated Intake & Referral (CI&R) process through the Healthy Start Coalition? ☐ Yes ☐ No
13. Coordinated Intake & Referral refers pregnant women & infants to the following Home Visiting agencies. Which ones are you familiar?

    ☐ Healthy Start ☐ Healthy Families ☐ Nurse Family Partnership ☐ Parents as Teachers ☐ Early Head Start
14. Is the CI&R patient referral follow up letter your office receives helpful? ☐ Yes ☐ No _____
15. How can the Healthy Start Coalition help you better serve your patients? _____
16. Would you be interested in receiving the latest Florida Maternal/Child Health birth Data for your county? ☐ Yes ☐ No

Part C

Provider/Clinic Name: _____

Hours of Operation: _____

Name/Title of Person completing survey: _____

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Holly Parker, Provider Liaison
863.381.0114 or hollyp@healthystarthhp.org

SURVEY

Pediatrician Provider

PART A

1. Have you heard of the Healthy Start program? ☐ Yes ☐ No (If no skip to Part B)
2. Which Healthy Start services are you familiar with?

   ☐ Risk Screen ☐ Home Visiting ☐ Baby Spacing/family Planning ☐ Childbirth Education ☐ Smoking Cessation

   ☐ Breastfeeding ☐ Women's health ☐ Parenting Education ☐ Postpartum Education ☐ Depression Screening

PART B

1. How many newborns do you see, on average, in a typical month? _____
2. Do you have bilingual staff or provide interpreter services? ☐ Yes ☐ No (√ what applies) ☐ Spanish ☐ Creole ☐ Other _____
3. Do you refer infants up to 1 year of age to any of the following? ☐ Healthy Start ☐ Early Steps ☐ Early Head Start (√ what applies)
4. Does your office encounter substance exposed newborns? ☐ Yes ☐ No If yes, about how many per year? _____
5. Does your practice accept Medicaid? ☐ Yes ☐ No
6. Does your practice accept private pay patients? ☐ Yes ☐ No
7. How long does it take to get the first newborn appointment? _____
8. Does your office discuss Long Acting Reversable Contraceptives with parents and/or patients? ☐ Yes ☐ No

   If yes, what does your office recommended? _____
9. What are your greatest barriers in caring for your patients? (√ what applies) ☐ Medicaid eligibility ☐ Medicaid reimbursement

   ☐ Patient compliance ☐ Under/uninsured ☐ Transportation ☐ Lack of resources

   ☐ Language barrier ☐ Patient understanding plan of care
10. What is the highest priority for you to better address the needs of your patients? _____
11. Are there any barriers to working with the Healthy Start program? ☐ Yes ☐ No _____
12. Are you familiar with the Coordinated Intake & Referral (CI&R) process through the Healthy Start Coalition? ☐ Yes ☐ No
13. Coordinated Intake & Referral refers pregnant women & infants to the following Home Visiting agencies; which ones are you familiar with?

    ☐ Healthy Start ☐ Healthy Families ☐ Nurse Family Partnership ☐ Parents as Teachers ☐ Early Head Start
14. Is the CI&R patient referral follow up letter your office receives helpful? ☐ Yes ☐ No _____
15. How can the Healthy Start Coalition help you better serve your patients? _____

    _____
16. Would you be interested in receiving the latest Florida Maternal/Child Health Birth Data for your county? ☐ Yes ☐ No

Part C

Provider/Clinic Name: _____

Hours of operation: _____

Name/Title of Person completing survey: _____

The Healthy Start Coalition of Hardee, Highlands and Polk counties, Inc. would like to THANK YOU for taking the time to complete this survey. Your answers and comments will enable us to structure services to better assist you in providing the very best care for the women and infants. The Coalition's Vision is to: Be the leader for linking community resources in order to maximize the health and wellness of childbearing women and their families.

For information call or email
Holly Parker, Provider Liaison
863.381.0114 or hollyp@healthystarthhp.org

SURVEY

Delivery Facility

PART A

1. Have you heard of the Healthy Start program? ☐ Yes ☐ No (If no skip to Part B)
2. Which Healthy Start services are you familiar with?

☐ Risk Screen ☐ Home Visiting ☐ Baby Spacing/family Planning ☐ Childbirth Education ☐ Smoking Cessation
☐ Breastfeeding ☐ Women's health ☐ Parenting Education ☐ Postpartum Education ☐ Depression Screening

PART B

1. How many deliveries does your facility have, on average, in a typical month? _____
2. How many NICU patients do you serve in a typical month? _____
3. How many NICU patients do you transfer in a typical month? _____
4. How many OB patients present with little or no prenatal care in a typical month? Number_____ or Percent _____
5. What reasons do patients give for not receiving prenatal care? _____
6. Does your office have bilingual staff or provide interpreter services? ☐ Yes ☐ No
   Check those that apply ☐ Spanish ☐ Creole ☐ Other _____
7. Do you routinely screen for the following? ☐ Alcohol ☐ Opioids ☐ Illicit substances ☐ Postpartum depression (check all that apply)
8. Does your facility refer newborns to any of the following?
   ☐ Healthy Start ☐ Healthy Families ☐ Early Steps ☐ Early Head Start (check all that apply)
9. Does your office encounter substance exposed newborns? ☐ Yes ☐ No If yes, about how many per year? _____
10. Is your facility a Medicaid Provider? ☐ Yes ☐ No If Yes, about what percentage of your patients are Medicaid? _____
11. Does your facility accept private pay patients? ☐ Yes ☐ No
12. Does your facility discuss family planning & Long Acting Reversable Contraceptives with patients? ☐ Yes ☐ No
    If yes, what does your office recommended? _____
13. What are your greatest barriers in caring for your patients? (Check all that apply)

☐ Medicaid eligibility ☐ Medicaid reimbursement ☐ Patient compliance ☐ Under/uninsured ☐ Transportation ☐ Lack of resources
☐ Language barrier ☐ Patient understanding plan of care

14. What is the highest priority for you to better address the needs of your patients? _____
15. Are there any barriers to working with the Healthy Start program? ☐ Yes ☐ No _____
16. Are you familiar with the Coordinated Intake & Referral (CI&R) process through the Healthy Start Coalition? ☐ Yes ☐ No
17. Coordinated Intake & Referral refers pregnant women & infants to the following Home Visiting agencies; which ones are you familiar with? ☐ Healthy Start ☐ Healthy Families ☐ Nurse Family Partnership ☐ Parents as Teachers ☐ Early Head Start
18. Is the CI&R patient referral follow up letter your office receives helpful? ☐ Yes ☐ No _____
19. How can the Healthy Start Coalition help you better serve your patients? _____

_____

20. Would you be interested in receiving the latest Florida Maternal/Child Birth Data for your county? ☐ Yes ☐ No

Part C

Delivery Facility/Provider/Clinic Name: _____

Hours of Operation: _____

Name/Title of Person completing survey: _____

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APPENDIX C
SOURCE REFERENCES

American Congress of Obstetricians and Gynecologists
https://www.acog.org/topics/long-acting-reversible-contraception

March of Dimes, Quick Reference Fact Sheets, Stillbirth, retrieved from:
http://www.marchofdimes.com/professionals/14332_1198.asp#causes

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https://www.marchofdimes.org/pregnancy/alcohol-during-pregnancy.aspx

United States Department of Health and Human Services, Office on Women's Health. 2019. *Frequently Asked Questions: Prenatal Care*.
https://www.womenshealth.gov/a-z-topics/prenatal-care

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U.S. Department of Health and Human Services. *The 2018 HHS Poverty Guidelines.*

Healthy Start Coalition of Hardee, Highlands and Polk Counties, Inc. *Fetal and Infant Mortality Review Summaries, 2016-2018.*

U.S. Census Bureau, American Fact Finder and Quick Facts. *United States Census 2018 and State and County Quick Facts.* October 2018.