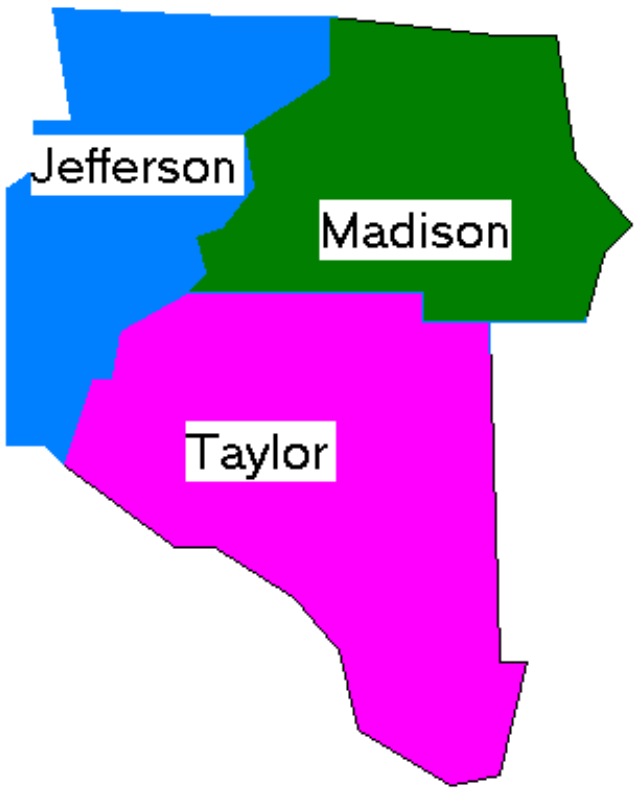
HEALTHY START

Healthy Start Coalition of Jefferson, Madison & Taylor Counties, Inc.



2021 – 2026
Service Delivery Plan Update for Maternal and Infant Health

Healthy Start Coalition of Jefferson, Madison & Taylor Counties, Inc.

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June 30, 2021

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Introduction

During the 1991 Florida Legislature Session, the Florida Healthy Start legislation was passed (Section 383.216 Florida Statutes). This legislation called for the establishment of prenatal and infant health care coalitions. The coalitions were to form public and private partnerships in developing and maintaining systems of care that ensure adequate and appropriate prenatal and infant care to all women and infants throughout Florida. In 1997, the Florida Legislature expanded the legislative mandate for Healthy Start from prenatal through age 1; to prenatal through age 3.

In 1992, local volunteers from the public and private sector began meeting on a regular basis to discuss ways to improve the overall health and social conditions of children and pregnant women in Jefferson, Madison and Taylor Counties. The three-county area had long been wrestling with the growing number of teen-age pregnancies, pervasive poverty and an infant mortality rate that had at times been two and three times the state infant mortality rate. With this foundation the Healthy Start Coalition of Jefferson, Madison and Taylor Counties was formed.

The Coalition is a non-profit 501 (c) (3) organization and is one of thirty-two prenatal and infant health care coalitions in the State of Florida. Primary planning staff consist of an Executive Director, Program Director, and a Certified Community Health Worker. There is a nine-member board consisting of three representatives from each county. Board of Directors meetings are held quarterly.

Primary funding for the Healthy Start Coalition of Jefferson, Madison and Taylor Counties, Inc. is provided through the Florida Department of Health, Infant, Maternal, and Reproductive Health Program. Funding is provided through state general revenue and federal funds from the Maternal and Child Health Block Grant. In 2001, the Agency for Health Care Administration, in collaboration with the Department of Health and the Association of Healthy Start Coalitions, developed a 1915(b) Medicaid waiver to provide additional funds for Healthy Start services in order to provide higher intensity of services. This waiver also included a component for the provision of case management services to SOBRA (Sixth Omnibus Budget Reconciliation Act) women eligible for Medicaid due to their pregnancy. In 2013, that Waiver was re-authorized with different parameters, including the deletion of SOBRA services, and for the first time the Agency of Health Care Administration (AHCA) began to contract directly with a representative of the Coalitions. The Healthy Start MomCare Network, the Administrative Services Organization representing all Healthy Start Coalitions in Florida is the negotiator and contractor for all Healthy Start Medicaid Waiver in Florida.

The Coalition has also been successful, with the support of the advocacy of Coalition membership, to solicit funding and become the lead entity for Healthy Families services in a five-county area including the Coalition catchment area of Jefferson, Madison, and Taylor, but extending to serve families in Lafayette

and Hamilton Counties. The Coalition was a natural fit when new funding from the legislature in 2015 expanded Healthy Families to cover areas in Florida without these services. Since the last Service Plan, the Healthy Families Program has received credentialling nationally from Healthy Families America for meeting its rigorous standards of quality.

Coalition Role

The role of the Coalition is centered on defining and improving systems of care for the maternal and child health population. The primary focus of the Coalition is to ensure that every pregnant woman has access to prenatal care and that every child has access to services that promote normal growth and development. The Coalition has the opportunity to affect positive change in these systems through continuous quality improvement activities in the home visiting services for which it has oversight, and also through developing collaborative relationships with other agencies that serve the 0-3 population. The Coalition promulgates the context of the Social Determinants of Health in each facet of its operations, in terms of developing community-wide strategies, as well as Continuous Quality Improvement functions for programming. The Coalition's membership collectively understand that the health and well-being of a community are not determined solely by the availability of health care, but also on the availability of jobs, education opportunities, positive activities for the community's youth, and a sense of hope for the future.

The Coalition works in partnership with the Florida Department of Health and other private and public providers to ensure the needs of our communities are met. This partnership affords the citizens a much-needed voice in the decisions being made concerning our communities.

Responsibilities of the Coalition are to:

- Promote the health and well-being of all pregnant women and their children through public awareness and outreach
- Identify and address local health care needs for pregnant women and their families through designing systems of care
- Establish and provide oversight of the Healthy Start system of care
- Ensure quality assurance of Healthy Start services
- Ensure comprehensive prenatal and infant health care services are available and accessible
- Allocate public and private funds received by the Coalition for Healthy Start services
- Plan for new and expanded services that avoid duplication and promote partnerships and collaboration among existing service providers
- Develop partnerships to form a coordinated system of care for pregnant women and infants

In executing the tasks of identification of needs and gaps in services, the Coalition must be successful in partnering and collaboration. This design is the highest efficiency model of care that avoids duplication and encourages resource development. This also defines the strength of the Coalition, in

terms of the capacity of its membership and whether or not their participation advances the mission of the Coalition. The Coalition membership is defined in Florida Statute Section 383.216(5) and in Florida Administrative Code, Chapter 64-F2. The membership of the Healthy Start Coalition of Jefferson, Madison, and Taylor Counties Inc. is identified as of May 2021 as follows:

Category	Member
Consumers of family planning, primary care or prenatal care services, at least two of whom are low-income or Medicaid eligible	Individual Consumers
County Health Department	• Jefferson County Health Department • Madison County Health Department • Taylor County Health Department
Migrant and community health centers, if their service area contains any part of the Coalition's service are represented by the Coalition	• Madison Medical Center (FQHC) • Taylor Medical Center (FQHC) • Taylor Dental Center (FQHC)
Hospitals, birthing centers and other providers of maternity and/or infant services to the population included in the Coalition's service area	• A Woman's Pregnancy Center • Doctor's Memorial Hospital • Madison County Memorial Hospital • Little Pine Pediatrics LLC • Apalachee Mental Health • A New Dawn, a New Beginning • Taylor County Recovery Center • Capital Regional Medical Center • Tallahassee Memorial Hospital
Local medical societies	• Big Bend Area Health Education Center • American Heart Association – Big Bend Chapter
Local health planning organizations	• Big Bend Rural Health Network • United Way of Big Bend • Big Bend Cares • FSU MPH Program • Madison Taylor Opioid Response Coalition
Local maternal and infant health advocacy interest groups and community organizations	• Kiwanis • March of Dimes • Healthy Families /Ounce of Prevention Fund of FL • Healthy Start • Florida CHAIN • 2-1-1 Help Me Grow
County and municipal governments	• City of Madison • City of Perry • Jefferson Board of County Commissioners • Jefferson County Extension Office • Madison County Extension Office

	• Madison County Board of County Commissioners • Madison County Sheriff • Madison County Recreation Association • Monticello Police Department • Madison County Supervisor of Elections • Taylor County Extension Agent • Taylor County Board of County Commissioners • Town of Greenville • Town of Lee
Social services organizations	• 4-H (Jefferson, Madison and Taylor Counties) • Ability First • American Red Cross • Big Bend AHEC • Big Bend Hospice • Boys and Girls Club (Taylor) • Capital City Youth Services • Children's Home Society • Department of Children and Families (ESS, Protective Services, Child Support Enforcement) • Department of Juvenile Justice • Elder Care Services • FDLRS/Miccosukee • Kids, Inc (Early Head Start Jefferson and Madison) • Madison Senior Center • Senior Center of Jefferson County • Suwannee River Economic Council • Taylor County Senior Citizens Center • Taylor County Early Head Start
Local education communities	• FSU School of Nursing • NFC Allied Health • Early Learning Coalition of the Big Bend • Jefferson County Head Start • Jefferson County School System • Madison County School System • North Florida College • North Florida Child Development (Head Start, Madison) • Taylor County Head Start • Taylor County Pre-K • Vocational Rehab
Community organizations who represent or serve the target population	• Big Bend Community Based Care • Brehon Institute • Capital Area Community Action Agency • Early Learning Coalition of the Big Bend • Catholic Charities • DISC Village • Guardian Ad litem • Legal Services of North West Florida • Lighthouse of the Big Bend • Three Rivers Legal Services • Workforce

	• Partnership for Strong Families • Madison Youth Ranch (a branch of FL Methodist Children's Home) • POPIN/FND
Representatives from minority organizations	• Big Bend Cares • HIV/AIDS Bureau • Ministerial Association
Local housing /shelter organizations	• Refuge House of Jefferson County • Refuge House of Madison County • Refuge House of Taylor County
Local homeless coalitions	• Big Bend Homeless Coalition
Corporations/private industry	• Big Bend Transit • Jefferson/Monticello Chamber of Commerce • Madison Chamber of Commerce • Taylor/Perry Chamber of Commerc • Madison County Community Bank
Insurance/managed care organizations	• Humana • Lighthouse • WellCare/Staywell
Churches /religious organizations	• Antioch Missionary Baptist Church, Perry • Christ Episcopal Church, Monticello • First Presbyterian Church, Perry • New Mt.Zion Missionary Baptist Church, Perry • Shiloh Missionary Baptist Church, Madison • Renewed Life Outreach Ministries • St. James Episcopal Church, Perry • Stewart Memorial AME, Perry • Architillery Missionary Baptist Church • Shiloh Missionary Baptist Church • Mount Zion AME • Harvest Center Ministries • Fellowship Missionary Baptist Church • Casa Bianca Missionary Baptist Church • New Brooklyn Missionary Baptist Church • Middle Florida Baptist Association
Community volunteers/Infant and Child advocates	• Greene Publishing • Monticello News • Perry Newspapers

Recap of Previous Service Delivery Plans

2016-2021

The most recent plan that closes June 30, 2021 is very unique in the history of the Healthy Start Coalition of Jefferson, Madison and Taylor for a specific reason. It could succinctly be named the "plan that rebuilt the system". Coalition leadership guided the development of this plan using those elements that were already underway in terms of Healthy Start programmatic changes, and also those that were inevitable at the time the plan was authored. The plan started with the visioning in December of 2015 where Board members conceived "By 2020, every pregnant woman residing in Jefferson, Madison and Taylor Counties will have access to evidence-based home visiting services, ensuring the best start in life for her baby". The key here is evidence-based. At this juncture, the elements of the Healthy Start Redesign were quickly developing, and the Coalition had already become a pilot for the Coordinated Intake and Referral project under MIECHV. The Coalition had already just signed on to be the lead agency for the Healthy Families Seven Rivers program as well. Therefore, the convergence of all these programmatic changes and implementations resulted in a plan that focused almost solely on programming.

The results of those programmatic infrastructure activities resulted in developing a local Home Visiting Advisory Board from the CI&R activities and developing materials and other business agreements and charter documents that were modeled in the rest of the state from the pilot work. In addition, the Coalition was heavily involved in the rollout of the Healthy Start 2.0 program in early 2019, including serving as chair of the education and training team that developed the quality training pieces. The Coalition was also a pilot for the new program and was instrumental in developing the tweaks to the system in 2018 that were unique to implementing these large-scale changes in rural communities. The Coalition also chaired the committee on Healthy Start Standards and Guidelines that proposed standards to support the new program model. In addition, the Healthy Families program became a selected site in Florida for accreditation from Healthy Families America. The services that are now available in these counties to the 0-3 population are better coordinated, are delivered by highly trained professionals, and are held to a higher standard of rigorous quality as a result of the work over the last five years.

In addition to the primary goal of programmatic development, the Coalition also devoted its community work during these years to consumer education and preconception health messaging. The previous plans prior to 2016 were foundational in terms of developing women's health messaging and activities that could be replicated with success including neighborhood canvassing and education workshops. The Certified Community Health Educator single handedly maintained the efforts of health education to consumers of maternal and child health while the fledgling programs were being built during these formative years. The experiences gained from consumer education and programmatic achievements are the springboards for building the 2021-2026 Service Plan.

2008-2015

This plan was the longest in service for the Coalition, as the Florida Department of Health extended its due date two years in anticipation of the impact of the Healthy Start programming redesign. This planning phase of the Coalition focused on the Social Determinants of Health, in terms of allocating resources to the neediest families and creating greater resiliency for families in each of the counties. The Coalition invested in the Whole Child project, through its stakeholder planning activities as well as the Whole Child Connection, a web-based tool to link families to resources. Greater emphasis was made for consumer education, and the role of the Coalition Community Health Educator focused more on consumers than key stakeholders, combining a message of preconception health, and access to care. The Coalition's Community Health Worker became one of the first Certified Community Health Workers in Florida, a testament to the Coalition's focus on consumer education. The Affordable Care Act also molded this period for the Coalition; participating in local insurance navigation efforts as well as serving on the statewide KidCare Advisory Council became activities the Coalition associated with increasing its capacity for consumer education. The Coalition also focused on the black-white gap in birth outcomes, creating a pilot project through funding from the Closing the Gap project at Office of Minority Health. The evaluation from this preconception case-management model is used in the next planning phase of the Coalition (2016-2021) to create preconception workshops and further the mission of focusing on preconception health status.

2004-2007

This plan encompassed the most dynamic community input, evident from the action steps that included Coalition involvement in nearly every facet of the community. The plan was broad in scope, working towards permeating all areas of social service provision through creating new networks with different groups, being more visible in the community, and working with Healthy Start providers in a more technical and supportive way to increase "other" services. This plan was also the cornerstone leading the Coalition to focus on maternal care, opening up the foundation of preconception awareness. Through additional leveraged resources and a renewed focus on preconception health, the relationships forged as a result of this action plan allowed the Coalition to build a cadre of volunteers, focused on the message of women's health prior to pregnancy.

2000-2003

This Service Delivery Plan focused specifically on the systems of care for pregnant women and infants in the catchment area. During this time, the Coalition was challenged with implementing the Medicaid Waiver and addressing all systems of care in each county. Healthy Start Programs and Services were targeted as first priority and were restructured and expanded to meet the needs in each county. The successful implementation of this plan moved the Coalition to a higher standard of accountability. Each

Provider significantly increased their number of direct services by expanding their infrastructure. Together the Coalition and Providers have increased quality assurance/quality improvement activities. Fiscal accountability has also been reached through implementation of standardized procedures.

1995-2000

Five major health problems were identified in the 1995 Service Delivery Plan for Jefferson, Madison and Taylor Counties: Infant Mortality, Low Birth weight, Teen pregnancy, Trimester of entry into prenatal care, and Maternal Smoking. During the 1995 Service Delivery Plan the Coalition attempted to diminish barriers to increase access to care for pregnant women. Efforts included developing a child sitting program at each Health Unit. This program was successful in the early stage of the program but became difficult to maintain due to a lack of volunteers. Transportation barriers were also addressed. Flyer and business cards were developed with information on how to access public/private and Medicaid transportation. These were distributed to all social service agencies and providers of maternal and child health within each county. A special transportation fund was established in Madison County specifically for pregnant women. This was later defunded due to lack of utilization. During the 1995 Plan, efforts were also placed on teen pregnancy prevention in all three counties. Taylor County was the only county to establish a program specifically for teens that addressed all issues facing teenagers, including teen pregnancy prevention. This program was called “Insider Television”. This program was very successful for two years. It was later cut due to funding and a lack of teen participation.

Major Accomplishments of the Last Five Years

Over the last five years, the Coalition has made several changes in the maternal and child health system in the three –county area by both expanding services and increasing the quality of services provided. At the beginning of the period, there was a significant amount of work devoted to state-level activities for Healthy Start redesign, and piloting Coordinated Intake and Referral. Healthy Families services were added as an additional resource for families in need of intensive home visiting services and parent education.

One of the most significant accomplishments is the system of care built as a result of the collaborative process of the Home Visiting Advisory Board, a perpetual advisory council formed as a result of the Coordinated Intake and Referral project. The Board has developed agreements that succinctly describe their roles and dedication to avoid duplication of resources, as well as their ongoing commitment to ensuring evaluation of the system of care. This Board reviews data and marketing products that result in improvements to the system and increased identification of participants in Connect services. The Board participates in training to improve the quality of Connect services as well as responsiveness to referrals from providers in the coordinated system.

Another mammoth undertaking of the Coalition included adding Healthy Families services to the menu of available resources to families in these communities. The Healthy Families Seven Rivers project was funded in August 2015 and was selected for accreditation in January of 2019. At the conclusion of this planning cycle the project is fully staffed, including bi-lingual services, is fully accredited by Healthy Families America, and has a capacity to serve 65 families.

Towards the end of this planning cycle is the unprecedented COVID-19 pandemic and its impact on maternal and child health. The Coalition diversified its contracting unit to include an independent contractor in order to reach pregnant women that were becoming more difficult to identify through telephonic methods. In addition, other areas of deficit in the Healthy Start program were identified and many strategies are converging at the end of this planning cycle to ensure quality in perpetuity in Healthy Start. These include continued diversification of subcontractors, the addition of a breastfeeding peer support group, and the recent hire in February of 2021 of a full-time Program Director devoted to CQI processes. The next Service Plan will build upon this expansion of Healthy Start and include mechanisms for increasing skilled service providers, including a requirement for a Registered Nurse and Mental Health Services available within the staffing patterns of subcontracted providers. The programs have been built and the quality is being measured; the next steps are to increase capacity in service provision.

Service Delivery Planning Process

Hybrid Methods for Service Delivery in a Pandemic

Mobilizing for Action through Planning and Partnerships: A Community Approach to Health Improvement (MAPP)

The Coalition implemented a hybrid of the MAPP process, beginning in March 2019 with Board members and key stakeholders developing a timeline for activities and gaining consensus on needs assessment contents. Throughout the remainder of 2019, breastfeeding survey instruments were developed, consumer focus groups were conducted and needs assessment activities commenced. In December 2019, Coalition Board and planning committee reviewed the draft findings of the needs assessment and developed the vision statement for the framework of the next Service Plan. “By 2025, the Coalition will expand leadership and community collaboration to promote home visiting and service planning around the Social Determinants of Health for Jefferson, Madison and Taylor Counties’ pregnant women and babies”.

Due to the pandemic, the Coalition has become creative in the design for action planning to include the key components, or phases of the MAPP process. In March of 2021 a local instrument to solicit information on the public health system in the tri-county communities, including a broad assessment of the understanding of the Social Determinants of Health was issued and concluded on May 31, 2021. Those results will dictate

the items in the Action Plan that address the need for education amongst key stakeholders in the community to affect positive change in Maternal and Child Health.

Process for Needs Assessment Activities

Goals

The Healthy Start Coalition of Jefferson, Madison and Taylor Counties, Inc. is statutorily mandated to evaluate the needs of the maternal and child health population within its catchment area. The undertaking for the Needs Assessment includes the vision to enhance partnerships and engage new partners to create shared, meaningful goals for this area's maternal and child health populations and programs. The primary goal is to assess priority issues identified through careful data analysis and as described by the community. The Coalition then addresses those issues considered most urgent through its strategic planning process.

Leadership

The Leadership Team for the MCH Needs Assessment included executive, management and research expertise in the Coalition, its Board of Directors, and its contracted service providers. The primary data collection and analysis is provided by the Executive Director, Donna Hagan, MBA. In March of 2020, the Coalition contracted with leadership from the Madison Health Department with expertise in the CHIP and CHA processes to review the needs assessment prepared by the Executive Director. This consultant provided guidance on key areas in demographics and facilitated a discussion of the key findings of the project in late March 2020 with the Coalition membership. The Leadership Team at the conclusion of the needs assessment folded in to the monthly Program Manager meetings of the service providers and continued with monthly updates throughout 2020 (virtually) to facilitate, guide, and make decisions about the progress and outcomes of the assessment and plans for the Service Plan. The Leadership Team was active in all aspects of the assessment, including survey development and input into the data analysis.

Methods

The method for the assessment includes a broad approach in order to assure input from as many stakeholders and experts as possible and analysis that balances the quantitative and qualitative research. The methods covered three different processes: data analysis, surveys, and program evaluation for Healthy Start services.

Data collection and analysis for the assessment began in the summer of 2019 and included collecting and analyzing many reports and assessments that had been completed prior to that date. Survey instruments were designed in March of 2019 to collect consumer input on breastfeeding barriers, and another instrument was designed in March of 2021 to collect feedback from Coalition members, service providers, consumers, and Board members on their understanding of the Social Determinants of Health. Coalition member input includes those who are employed in school districts, community-based services, local public health agencies, childcare, home visiting, early intervention services, reproductive health services, private medical care, mental health services, and services for children with special health needs.

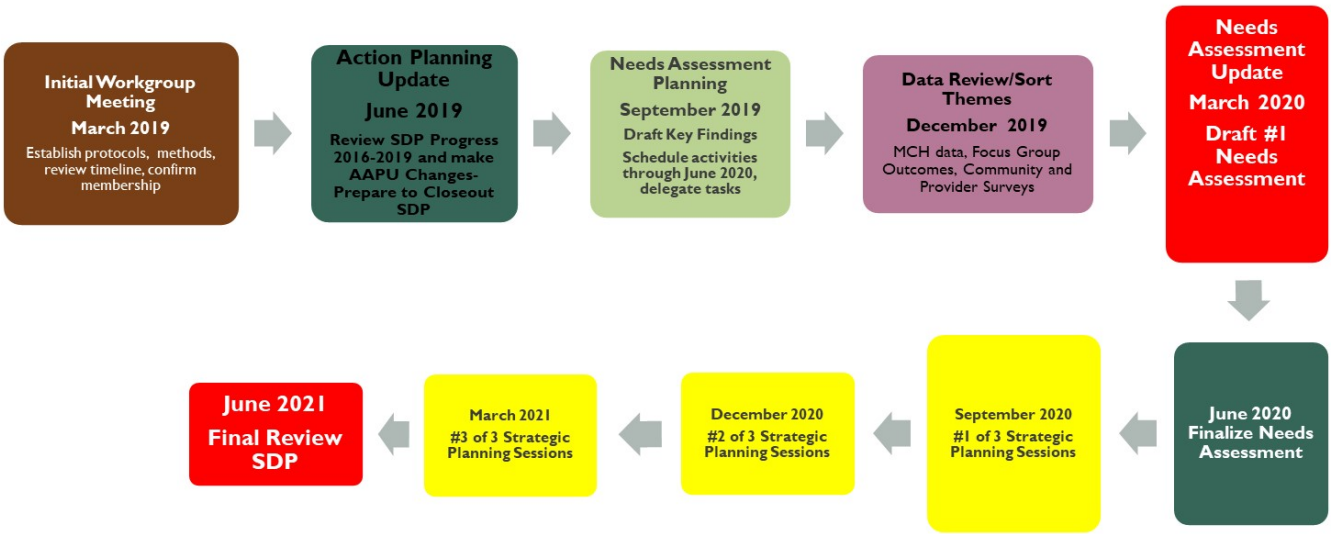
In June 2021 the results from the community survey were pulled electronically and compiled to drive the components of the Action Plan as it relates to community education on the Social Determinants of Health.

Timeline for Service Planning Activities

The Coalition designed and implemented a plan for scheduling time and inclusion of community partners, beginning with March 2019, and concluding June 2021. During this process, the monitoring of the timeline and schedule and assurance of tasks was maintained by the Executive Director. The consultant for the needs assessment provided an opportunity in late March of 2020 to review the findings of the Needs Assessment with members of the planning committee and the Board of Directors.

The Coalition Executive Director subsequently conducted trainings in both September and November 2020 with Coalition members. Current Healthy Start Coalition members are a group consisting of social workers, administrators, program administrators, Board members, school personnel, faith-based representatives, health educators, health care professionals, local government officials, and concerned citizens who provided valuable insight into how to break down the barriers to effective prenatal and infant health care in the tri-county area. These trainings were in lieu of the face-to-face strategic planning sessions conducted in prior years, pre-pandemic. The purpose was to educate on the key findings and to prepare for the survey instrument in the Spring in order to gather input into the Service Delivery Plan.

The overall organization process of both needs assessment collection and community input can be summarized:



Visioning/Community Input/Formulating Goals and Strategies-*although these are described within the MAPP process as separate functions within the process, these steps were co-occurring across all facets of our process between March 2019 and June 2021 and cannot be described as separate processes for our communities.*

An overview of the proposed final plan contents was provided to the Board of Directors on June 7, 2021 to include four priorities for 2021-2026: 1) Quality and Expansion of Programming, 2) Preconception Education and Awareness, 3) Coalition-building around the SocDH and, 4) Screening and Referral Infrastructure. These priorities are the framework of the Service Delivery Plan. The next steps are finalizing the plan, submitting for approval to the Florida Department of Health, and revealing the final plan to Coalition members during the fall 2021.

Other Sources of Information

During the planning and assessment process, other sources of information and areas of community health were analyzed. Senior management of the Madison and Jefferson Health Departments conducted QI projects around verifying and matching date for breastfeeding initiation and entry into care between Vital Statistics, Healthy Start and WIC. The findings are substantial, and the Coalition used this information in its needs assessment and as building blocks for the infrastructure-related section of the Action Plan. In addition, Coalition staff attended various other community meetings (virtually) to solicit input and find solutions to our community's problems. These meetings consisted of the Madison-Taylor Opioid Response Coalition, Department of Juvenile Justice Councils, Domestic Violence Task Forces, and Community Health Improvement Planning activities of the local hospital and health departments. Additionally, information was gathered from program staff through QI activities that results in additional administrative activities to be included in the Service Plan for 2021-2026.

Fetal and Infant Mortality Review (FIMR) data was not used during the Needs Assessment process. JMT is no longer part of a regional committee that only reviews a sample of Infant and Fetal Deaths for a five-county area, limited by resources. The Coalition's MCH Needs Assessment does, however take a deep dive into the causes of infant death and there are plans in the 2021-2026 Service Plan to determine the feasibility of an annual infant death review for JMT.

Resource Inventory and Gaps in Services

The three-county coalition area covers approximately 2,584 square miles and has limited health care resources available to its residents. Madison County Memorial Hospital and Doctor's Memorial Hospital (Taylor) are the two local hospitals serving county residents yet neither have Labor and Delivery facilities. As of June 2021, there are no obstetric providers other than the county health departments and no birthing facilities within thirty minutes of the local health department, the only providers of prenatal care within

Jefferson, Madison and Taylor Counties. Madison and Taylor County has increased the availability of various specialty services by partnering with hospitals and private providers in Leon County in an effort to bring specialists to the community on a part-time basis, including internal medicine, orthopedists, orthodontia, and optometry. The availability of these services is limited and is closely held with receiving care through hospital-contracted physicians. Most residents must seek specialty services in surrounding counties. Jefferson County residents continue to utilize neighboring counties for many of their service needs.

However, there has been additional momentum in the availability of Mental Health and Substance Abuse services in the counties. Disc Village has expanded their focus on substance use and mental health and forged the project called the Madison-Taylor Opioid Response Coalition, a planning grant that provides resources and procures services related to growing substance abuse service needs. This newly formed group is pursuing residential housing in Madison County for substance-using women. Moving Beyond Depression, a perinatal depression counseling service, is now available for JMT through a Leon-county based provider. Capital Regional Behavioral Health also continues to identify strategies to outpost services.

Parenting resources have increased dramatically since the last Service Plan with the addition of Healthy Families Seven Rivers, serving Jefferson, Madison, Taylor, Hamilton, and Lafayette Counties. Parenting services are further strengthened with the use of FSU's Partner for a Healthy Baby© curriculum. Circle of Parents™ training for both Healthy Start and Healthy Families staff was conducted in July of 2018 and these parenting groups have re-started post pandemic as an additional means of parent support services.

Transportation remains an issue for the coalition area. With the implementation of Medicaid Managed Care, the local Disadvantaged Transportation Boards' role has significantly changed focus. Prior to 2015, the local Board had oversight over the designated Coordinated Transportation Provider, Big Bend Transit, as the sole Medicaid transportation provider for the area. Under MMA laws, Medicaid services can be "bid" to private providers based on the consumer-driven focus. The quality and dependability of that transportation is now outside the purview of the local Board, with the oversight being driven by the Agency for Health Care Administration. The effects locally are lack of communication, control, and optimization of resources as it relates to transportation in sparsely-populated rural communities.

Over the past seven years, Jefferson, Madison and Taylor Counties have experienced additional changes in the provision of prenatal and pediatric services that are detailed below:

- Connect services, the front-line triage into all home visiting services was launched in these communities in July 2018, providing education and referral services to all referred pregnant women and infants
- Little Pine Pediatrics LLC has expanded its practice beyond Taylor and Madison offices, to include a Jefferson office in 2019

- A Federally Qualified Rural Health Center, namely Tri County Medical Center in Greenville (western Madison County) closed its doors in late 2013 and re-opened under a different name in Madison proper, reducing the ability for the poorest in the westernmost part of Madison County to access services
- Early Head Start services, while shrinking in Madison County, have been expanded in Taylor County with services becoming available in February of 2020
- Medicaid Managed Care plans are more visible in the communities and the relationship between Healthy Start and the MCO's continues to be one of a constant focus on the avoidance of duplication of resources

Resource Inventory

The following resources are available and applicable for all counties in the Jefferson, Madison, and Taylor County catchment area. All three counties generally share providers within and across county lines, as well as benefit from services from Leon County.

Jefferson County Health Department
1225 W. Washington Street
Monticello, FL 32344
Offers Environmental Health Services, WIC Services, Family Planning, Primary Care, Healthy Start Services, Improved Pregnancy Outcome, School Health, Dental, STD and HIV testing, and Immunizations.

Prenatal Services

The Jefferson County Health Department has the following:

- 1 Physician (contracted with Tallahassee Memorial Hospital) - 1/2 day, once/month
- 1 Nurse Mid-Wife – 1/2day/week (Tuesday pm)
- 1 Registered Nurses for Triage – 5 days/week

WIC

Women, Infant, & Children provide nutritional education and breastfeeding education and support services are available one day a week. The WIC Program in this county is under the Leon County Health Department umbrella.

Connect Services

Using the prenatal and infant universal screening infrastructure, Connect services are a single point of entry for intake and referral for community services and supports that best support families' individual needs. Pregnant women and families with young children are guided by a

Connect worker to services such as education and support for childbirth, newborn care, parenting skills, child development, food and nutrition, mental health, and financial self-sufficiency.

Healthy Start

Healthy Start services include targeted support services that address identified risks. The range of Healthy Start services available to pregnant women, infants and children up to age three include: Information and referral, Comprehensive assessment of service needs, Ongoing Care Coordination, Smoking Cessation Counseling, Childbirth Education, Breastfeeding and Parenting Support and Education, Well Woman Care Education, and Home visiting. The Healthy Start Program also provides, PEPW Medicaid eligibility determinations, incentives and Group Prenatal Care and Circle of Parents

Family Planning

Family Planning is offered each Wednesday and every other Friday by a Certified Nurse Midwife.

Comprehensive School Health Program

This program includes nurses and clinic aides at all public schools in Jefferson County. The services provided by the school health program includes, but is not limited to: vision screening, hearing screening, medication monitoring, and nutrition information. Referrals are also made to outside resources if necessary.

Madison County Health Department

218 SW Third Avenue
Madison, FL 32340
Offers Environmental Health Services, WIC Services, Family Planning, Primary Care, Healthy Start Services, Improved Pregnancy Outcome, School Health, Dental, STD and HIV testing, and Immunizations.

Prenatal Care Services

The Madison County Health Department which has the following staff available to them:

- 1 Physician (contracted w/Tallahassee Memorial Hospital) - 1/2 day once/month
- 1 Nurse Mid-Wife/ARNP (for immediate perinatal care) – ½ day/week (Tues am)
- 1 Registered Nurses for Triage – 5 days/week

WIC

Women, Infant, Children nutritional education and support services are available at the Jefferson County Health Department two days a week. The WIC Program in this county is now under the Leon County Health Department umbrella.

Connect Services

Using the prenatal and infant universal screening infrastructure, Connect services are a single point of entry for intake and referral for community services and supports that best support families' individual needs. Pregnant women and families with young children are guided by a Connect worker to services such as education and support for childbirth, newborn care, parenting skills, child development, food and nutrition, mental health, and financial self-sufficiency.

Healthy Start

Healthy Start services include targeted support services that address identified risks. The range of Healthy Start services available to pregnant women, infants and children up to age three include: Information and referral, Comprehensive assessment of service needs, Ongoing Care Coordination, Smoking Cessation Counseling, Childbirth Education, Breastfeeding and Parenting Support and Education, Well Woman Care Education, and Home visiting. The Healthy Start Program also provides PEPW Medicaid eligibility determinations, incentives and Group Prenatal Care and Circle of Parents.

Family Planning

Family Planning is offered two days a week by a Certified Nurse Midwife, who is also an ARNP, at the Madison County Health Department.

Comprehensive School Health Program

This program includes nurses and clinic aides at all public schools in the county. The services provided by the school health program includes, but is not limited to: vision screening, hearing screening, medication monitoring, and nutrition information. Referrals are also made to outside resources if necessary.

Taylor County Health Department

1215 N. Peacock Avenue
Perry, Florida 32347
Offers Environmental Health Services, WIC Services, Family Planning, Primary Care, Healthy Start Services, Improved Pregnancy Outcome, School Health, Dental, STD and HIV testing, and Immunizations.

Prenatal Care Services:

The Taylor County Health Department which has the following staff available to them:

- 1 Physician (associated with Tallahassee Memorial Hospital) - 1/2 day once/month
- 1 ARNP – 1/2 day every other except last week
- 1 Registered Nurse for Triage– 5 days/week

WIC

Women, Infant, & Children provide nutritional education and breastfeeding education and support services are available one day a week. The WIC Program in this county is now under the Leon County Health Department umbrella.

Connect Services

Using the prenatal and infant universal screening infrastructure, Connect services are a single point of entry for intake and referral for community services and supports that best support families' individual needs. Pregnant women and families with young children are guided by a Connect worker to services such as education and support for childbirth, newborn care, parenting skills, child development, food and nutrition, mental health, and financial self-sufficiency.

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Healthy Start Coalition of JMT

Healthy Families Seven Rivers

Comprehensive home visiting by paraprofessionals to prenatal or postpartum mothers to provide intensive parenting services as a child abuse prevention model. The target child can be served up to age 5.

Domestic Violence

- **Refuge House**

  1255 Washington Street, Monticello, FL 32344 | S. Range St. Madison, FL 32340 | P.O. Box 672 Perry, FL 32348

  Provides services to survivors of domestic violence, sexual assault and partner abuse and their families. Refuge House also offers support and "safe" places for women and children.

Mental Health

- **Apalachee Center for Human Services**

  South Highway 19, Monticello, FL | 225 SW Sumatra Madison, FL | 301 Industrial Dr, Perry, FL 32348

  Offers diagnosed psychiatric and social behavioral services for children and adults; no longer the catchment area's Medicaid provider for children's mental health services.

- **Florida Therapy, Inc.**

  1834 Jacliff Ct, Ste. A
  Tallahassee, FL 32308
  Medicaid provider for children's therapeutic, behavioral, and psychiatric services.
  Therapeutic Behavioral On-Site Services for Children and Adolescents
  Assists children and their families who have complex needs in an effort to prevent a more intensive and restrictive behavioral health placement. Main office in Leon County; locations co-located with other agencies in Jefferson, Madison, and Taylor Counties; provides home visiting.

Substance Abuse

- **DISC Village Inc.** Madison-Taylor Opioid Response Coalition– 1012 S Jefferson St, Perry, FL Family Intervention Specialists & Case Management. Primary addiction services for at-risk prenatals are offered to referrals from Department of Children and Families, Healthy Start and Healthy Families.

- **Taylor County Recovery Center –** 215 N Washington St, Perry, FL. Outpatient Substance Abuse/Drug Treatment Programs, Certified Addiction Counselor.

Transportation

- **Big Bend Transit, Inc.**
  290 W. Dogwood Street
  Monticello, FL 32344
  Provides transportation for Medicaid and non-Medicaid clients to and from medical services.

- **Private Medicaid Transportation provided under Managed Care Organizations**

Pediatric Services

- **Tallahassee Memorial Family Medicine (Monticello Family Medicine)**
  1549 S. Jefferson
  Monticello, FL 32344
  Satellite of TMH, Tallahassee: 2 physicians and 1 PA on staff.
  Full-service family practice – medical care for all ages, female care, EKG and X-Rays.

- **Madison Medical Center (Federally Qualified Health Center under North Florida Medical Centers)**
  235 SW Dade, Madison, FL
  General Primary Medical Care, Diagnostic Laboratory, Diagnostic X-Ray, Diagnostic Tests/Screens

- **Premier Medical Clinic**
  Ray Bobila, MD
  315 E Ash St
  Perry, FL 32347
  Full-service family practice including on-site services in Cardiology, Women's Health, Occupational, Internal, Diagnostic, Pediatric and Preventative Medicine.

- **Little Pine Pediatrics LLC**
  1702 S Jefferson St
  Perry, FL 32348, and
  194 NE Hancock Ave
  Madison, FL 32340

205 N Mulberry St
Monticello, FL 32344

Services for Children with Special Needs

- **Kids Incorporated – Jefferson County Early Head Start Center**
  395 E. Washington St.
  Monticello, FL 32344

- **Kids Incorporated – Bright Days-Madison County Early Head Start Center**
  250 NW Haynes St.
  Madison, FL 32340
  The program provides comprehensive services to low-income pregnant women and children - birth through three years of age - and their families. Participants must meet income eligibility requirements and a minimum of 10% of the children served have special needs. Provides education and therapy (physical, occupational and speech). Education services and therapy are provided for children and their families who exhibit developmental delays.

- **Florida Diagnostic and Learning Resources System (FDLRS)/Miccosukee**
  3955 W. Pensacola St.
  Tallahassee, FL 32304
  Serves Jefferson and Taylor Counties. The various programs include Child-find, human resource development, parent services and technical assistance. This program also involves exceptional student education in counties served. Program headquarters is located in Tallahassee.

- **Children's Medical Services/Florida Department of Health**
  2390 Phillips Road
  Tallahassee, Fl 32308
  These services mostly located in Tallahassee are available to children in all three counties. CMS provides services to children with special health needs (serious or chronic physical or developmental conditions that require extensive preventive and maintenance care) from birth to age 21 who meet medical and financial criteria. The program provides a continuum of services from prevention and early intervention programs to primary care with direct linkages to specialty and long-term care needs; www.cms-kids.com.

- **Children's Home Society – Early Steps (EIP)**
  1801 Miccosukee Commons Drive
  Tallahassee, FL 32308

Serving children birth to age three who have, or are at risk for, developmental delay. A service plan is developed based on assessment, and services are coordinated and monitored through age 3.

- **Parents of the Panhandle Information Network (Family Network on Disabilities)** – 2196 Main St, Dunedin, FL; Funded by the U.S. Department of Education, Office of Special Education Programs (OSEP) provides parent training and information (PTI) services to the Panhandle of Florida. Services help to ensure that parents of children with the full range of disabilities have the training and information they need to prepare their children for not only school, but to be able to lead productive, independent lives to the fullest extent possible. http://fndusa.org/contact-us/programs/popin/

Childbirth Education (other than Healthy Start)

- **Brehon Institute for Family Services-Madison/Taylor County**
  S.A.F.E. (Safe and Family Education)
  P. O. Box 1382 P.O. Box 721
  Perry, FL 32348 Madison, FL 32341
  Home visiting program for young pregnant women and babies who are at risk. Childbirth education and parenting skills provided.

Parenting Education (other than Healthy Start)

- **Healthy Families Seven Rivers**
  1476 SW Main St
  Greenville, FL 32331
  Takes referrals for at-risk families of child abuse and neglect for intensive parenting services through home visiting venue.

- **Brehon Institute for Family Services-Madison/Taylor County**
  S.A.F.E. (Safe and Family Education)
  P. O. Box 1382 P.O. Box 721
  Perry, FL 32348 Madison, FL 32341
  Home visiting program for young pregnant women and babies who are at risk. Childbirth education and parenting skills provided.

Dental Care for Pregnant Women

- **Taylor Dental Center**

  409 East Ash Street
  Perry, FL 32347

Services Provided:
General Primary Dental Care (Preventive; Limited Emergency)

- **Taylor County Health Department**
  1215 N Peacock Ave
  Perry, FL 32347
  Services include a referral for every pregnant woman for primary evaluation, regardless of payer source.

- **Jefferson and Madison County Health Departments**
  Services include those limited to pregnant women who have regular Medicaid, generally under age 21. Services available on a sliding scale for non-Medicaid clients.

Other Pregnancy Services

A Women's Pregnancy Center—345 NW Marion St, Madison, FL-for Taylor and Madison County clients. 919 W. Pensacola St, Tallahassee, FL for Jefferson clients; Offering free pregnancy/ultrasound tests, counseling, abortion alternatives and post-abortion counseling, medical referrals, and supplies/clothing for mother and child; www.awpc.cc.

Local and Surrounding Hospitals

Jefferson County does not have a local hospital. All services requiring hospitalization must be received out of town. Depending on the illness, situation, or circumstance, persons in Jefferson County usually receive services at Tallahassee Memorial Healthcare, Tallahassee Community Hospital, or Archbold Memorial Hospital (in Thomasville, Ga.). Each of these three facilities is at least 20 to 35 miles away. As with the other two surrounding counties, there are no obstetrical services available. Women must travel out of town for delivery.

Tallahassee Memorial HealthCare
1300 Miccosukee Road
Tallahassee, FL 32308
TMH offers a wide range of healthcare services. These services include Neonatal Intensive Care Unit and the women's specialty services at **A Woman's Place @ TMH**—include childbirth classes, infant-child CPR, the ABC's of babies, classes for siblings and babysitting. Breast feeding support group and breastfeeding apparel, electric breast pumps (sales and rentals), accessories also available at Mommy Market. Counseling is available for post-partum depression. The Perinatal Bereavement Program at TMH offers counseling provided for anyone who has experienced a miscarriage, stillbirth, or death of a child during the first year of life. The majority of persons having any difficulty in pregnancy or childbirth will use the services offered at Tallahassee Memorial Healthcare.

Capital Regional Medical Center

2626 Capital Medical Blvd.
Tallahassee, FL 32308
CRMC offers delivery services as well as a variety of healthcare services. Newly rejuvenated and rebuilt building, new building additions and new equipment, the focus on improved patient care is considered their specialty.

Shands Hospital
University of Florida ,Gainesville, Florida
Shands Hospital specializes in children's healthcare. There are numerous services and specialties offered by Shands. These include a Neonatal Intensive Care Unit, with Level I, II and III services offered, a burn unit with services offered and tailored to fit the patient/child's need and condition, a pediatric oncology unit specializing in children's cancer, a cancer center offering a wide range of services, including housing for patient's family, a bone marrow transplant unit, specializing in bone marrow transplants. There are also a number of other services offered which are especially for children.

Madison County Memorial Hospital
224 NW Crane Ave
Madison, Florida 32340
Madison County Memorial is a small rural hospital serving Madison and nearby counties. Emergency services are offered as well as inpatient and outpatient services. Home Health services are offered as well as physical, occupational, and speech therapy. Extremely critical patients would most likely be transferred to Tallahassee, or Valdosta, Georgia.

Doctor's Memorial Hospital
333 N. Byron Butler Parkway
Perry, Florida
DMH offers both inpatient and outpatient care to residents of Taylor and surrounding counties. Emergency room services are also available. X-rays, Lab services and various other healthcare options are available.ICU and Pediatric units are available. Home Health services are offered which includes pediatric nursing, physical, occupational and speech therapy. Extremely critical patients if necessary would most likely be transferred to Tallahassee Memorial or Shands Gainesville.

Other hospitals which provide services to these counties are South Georgia Medical Center Valdosta, Georgia, and Archbold Memorial Hospital Thomasville, Georgia and North Florida Regional Medical Center Gainesville, Florida. These hospitals range from 35 to 100 miles away.

Additional service providers, based on proximity

Although there are no substantial changes in the resource inventory for our communities in the last seven years, the area has benefitted from advancements in the maternal and child health sector of neighboring Leon County. The add-on resources that each county has availability to access are:

2-1-1 Big Bend, Family Health Line/Help Me Grow—PO Box 10950; Statewide hotline provides supportive counseling, information, and referrals on a variety of family planning, pregnancy, and young child issues. Help Me Grow provides developmental screening and appropriate referrals for developmental delays for children 0-8; www.211bigbend.org; (800) 451-2229

Big Bend La Leche League—2626 Care Dr. Ste. 109, Tallahassee, FL; League helps mothers breast feed by peer support, education, information, and encourages healthy development of babies; La Leche League International (www.llli.org); Florida (www.lllflorida.com)

Brehon House — Serves women 18 years and older who are homeless and pregnant; www.brehoninstitute.com.

Compassionate Friends Early Loss Program —Dealing with miscarriage, still birth, and infant death; tcfot@yahoo.com; www.tcftallahassee.com.

Children's Home Society Pregnancy Counseling—1801 Miccosukee Commons Dr; Counseling for birth parents with an unplanned pregnancy who are considering adoption for their child; or referring individuals in a crisis pregnancy to appropriate community resources; www.chsfl.org.

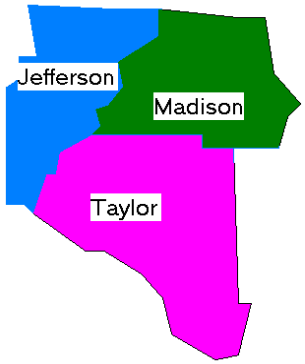
Early Learning Coalition of the Big Bend Region—1940 N Monroe St, Ste 70, Tallahassee, FL-Child-care resource and referral; www.elcbigbend.org.

The International Cesarean Awareness Network, Inc. (ICAN) a nonprofit organization whose mission is to improve maternal-child health by preventing unnecessary cesareans through education, providing support for cesarean recovery, and promoting Vaginal Birth After Cesarean (VBAC); www.ican-online.org.

March of Dimes (Big Bend Division)—1990 Village Green Way, Ste 3, Tallahassee, FL 32308; Resources to help insure a healthy birth for every baby; www.marchofdimes.com.

Demographic Snapshot

County Health Profiles, Florida Health Charts

	Jefferson	Madison	Taylor
			
Population *2019 data, the Florida Legislature, Office of Economic and Demographic Research*	Jefferson County is one of the smallest counties in the state of Florida. The low density of the county characterizes it as a "rural" area. The estimated population in 2019 was 14,842 which accounts for only 0.07% percent of Florida's total population. The county's percentage of black population is 34.3%, over twice the percentage for FL at 16.9%.	Madison County is also designated a "rural" area with an estimated population in 2019 of 19,533. The county's percentage of black population is more than Jefferson and more than twice the percentage of the state at 37.8%. The average number of births in 2017-2019 for Madison County is 193,	Taylor County has one of the longest coast lines in Florida at 46 miles and is geographically twice the size of its contiguous neighbors, yet its population is only slightly higher than Madison County. The estimated population is 22,652 for 2019 with 76.5% white, 19.6% black, and 3.9% other. These demographics are very different than

	The average number of births in Jefferson County for 2017-2019 was 123, of which 43% were black.	down 14% from averages in 2013-2015. Recently there is an upward trend in the number of Hispanic births, from 3% to 5%.	Jefferson and Madison who have a higher black population. The average number of births in Taylor for 2017-2019 is 228, with 76% of those white.
Socioeconomic Indicators *US Bureau of the Census, 2015-2029 indicators per American Community Survey*	Unemployment rate of 6.2% compared to Florida's rate of 5.6%. Median Income $47,240 compared to FL $55,660 Children under 18 in poverty – 25.3%, compared to state rate of 20.1% Individuals, age 25 and older with no high school diploma 18% compared to 11.8% for FL	Unemployment rate of 4.7% compared to Florida's rate of 5.6%. Median Income $37,037 compared to FL $55,660 Children under 18 in poverty – 44.4%, compared to state rate of 20.1% Individuals, age 25 and older with no high school diploma 19% compared to 11.8% for FL	Unemployment rate of 5.9% compared to Florida's rate of 5.6%. Median Income $40,306 compared to FL $55,660 Children under 18 in poverty – 33.8%, compared to state rate of 20.1% Individuals, age 25 and older with no high school diploma 21.2% compared to 11.8% for FL

Maternal and Child Health Needs Assessment
Executive Summary

Jefferson, Madison and Taylor County residents have an average of 578 births per year, small numbers for the purposes of statistical significance for Florida, but substantial in terms of the disparity in birth outcomes. These are impoverished, rural communities considered to be economically disadvantaged with a poor prognosis for economic growth. It is important to note that while maternal and child health has improved significantly in Florida since the inception of the Healthy Start system of care in 1992, poor maternal and child health outcomes persist in these smaller communities.

One obvious trend that permeates this needs assessment is the presence of the black-white gap. While it is most prominent in Madison County, outcomes for all three counties signify true health disparities in birth outcomes. The Social Determinants of Health are key factors in the health outcomes in the rural communities of Jefferson, Madison and Taylor Counties, Florida. Perpetual poverty plays a key role in health outcomes, and these counties are some of the poorest in the state of Florida.

The causes of infant death in Madison County were primarily linked to short gestation, neonatal complications and overall health status. Preconception care and counseling are primary interventions needed for the African American maternal population in Madison County. In Taylor County, infant mortality has a discernable trend downwards for all races. For all counties combined, the primary cause of infant deaths were SIDS, unintentional injuries (suffocation) and birth defects for white babies. In Jefferson County, causes of death for black babies were related to maternal complications and prematurity.

Although premature birth is the leading cause of infant death, there are many contributing factors, most of which are associated with the preconception health status of the mother and her characteristics during pregnancy, which include nutritional status, pregnancy history, present pregnancy characteristics, psychological characteristics and adverse behaviors. 7.4% of babies born to residents of Madison County are born prematurely with low birth weight. In Jefferson County that percentage is 7% and 6.4% for Taylor County. The numbers are almost double for black babies, as 12.1% of all black babies in Madison County are born premature with low birth weight, compared to just 3.2% for white babies. In Jefferson County 9.7% of all black babies are premature with low birth weight, compared to 5.2% for whites. In Taylor County, the disparity narrows, with 7% of black babies born premature with low birth weight, compared to 6.2% for whites.

Smoking is associated with serious health concerns throughout all age groups, but smoking is especially detrimental to birth outcomes. Tobacco usage in all forms is linked to poor birth outcomes including preterm delivery, LBW and VLBW, IGUR and neonatal death. In JMT, the smoking rate is consistently

above the state average and alarmingly, in Taylor County the rate is twice the state average. There is a substantial white-black gap with white women smoking 2.5 times more than their black counterparts.

Obesity during pregnancy can result in complications for both the mother and the fetus, but specifically women with a higher than normal body mass index (BMI) are linked to preterm labor, low birth weights and stillborn deliveries; these women are more likely to receive a planned or emergent caesarian section due to health concerns. For Jefferson, Madison, and Taylor Counties, the average for women who are obese at conception are 35% for the three counties, up substantially from 13% in 2015. There are reasons to believe that this factor is a significant component to the overall health of the mother, and supports the notion that preconception health counseling is essential and should be included in planning service delivery.

The shorter the interval between the delivery of one baby and the conception of another has a strong correlation to LBW and VLBW outcomes. The accepted hypothesis is that nutritional depletion and stress on the mother's body from the labor and delivery process results in a higher-risk pregnancy and poor birth outcome for the subsequent infant due to lack of restoration. The lack of at least an 18-month interval is a significant concern for Jefferson County where over 41% of the births have a shorter interval, specifically for white mothers.

Although there are no private obstetric practices or birthing facilities in these counties, the local health departments do offer prenatal care services to low and moderate-risk women. The availability of these services has not been able to minimize the black disparity when it comes to birth outcomes, yet the absence would most likely create a greater gap based on access to care. In Madison County, over 60% of the pregnant women seek care at the local health department. Healthy Start services are also co-located in the health departments to expand the impact of prenatal care through education and home visiting. Rates of late entry into prenatal care have risen dramatically to nearly 11% in Madison County. Additional research conducted by the local health department suggests this data is inaccurate, as it is gathered during the process of the electronic birth record and many obstetric records from which the data is abstracted by birth clerks may be lacking completeness.

The recurring theme of racial disparity is present when discussing births to unwed mothers. In JMT births to unwed black mothers happen at a rate of three times that of their white counterparts and the percentages in these counties among black women are well above the state average. Research points to the presence of the father being more vital to positive birth outcomes than just financial security. When education and socio-economic status is accounted for among unwed mothers, the black-white birth outcome disparity persists. Determining the root cause for the disproportionate marital status among black women is a task beyond the scope of this needs assessment but is one that affects outcomes for black women in JMT, and service delivery planning should focus on engaging fathers.

Education status has continued to be a reliable tool in assessing the overall health of a population. Women in JMT are below the state average for high school completion among birthing mothers. Considered to be the most powerful determinant of health, mothers over the age of 19 without a high school diploma have improved dramatically from 2016 and are 2.7% for Jefferson, 2.2% for Madison, and 3.6% for Taylor County. However, the black-white gap persists, with black mothers twice as likely as their white counterparts of not having a high school diploma.

Births to teens is linked to perpetual poverty among teen mothers as well as very pre-term delivery, LBW, VLBW and neonatal mortality. Within the JMT communities, this characteristic was previously a major issue among teens in Taylor County where the rate dropped from 26.1 per 1,000 live births in 2016 to 14.6. However, the trend in Jefferson County is increasing with a rate twice the state average (13.6 per 1,000 births, compared to 7.4 for Florida). Teen pregnancy is conducive to poor conditions that span several disciplines from public health and social welfare to economic growth in the community. It is a perpetual problem that increases the vulnerable population and decreases the working population. Evaluation of existing service interventions is needed to pinpoint the limitations and create strategies to address the needs.

The lower breastfeeding initiation rates among black women in JMT are significant, especially in Taylor County, where only 48% of black women initiate breastfeeding, compared to 75% for their white counterparts. Breastfeeding is less common in women who receive WIC benefits and it is well documented that most low-income mothers know the health benefits of breastfeeding, but lack the peer and family support, face barriers at school and work, and receive information not conducive to breastfeeding. Strategies to improve the breastfeeding rate among black women in JMT should address the barriers that keep black women from engaging in healthy postnatal behavior for them and their babies. Some of these barriers have been identified in the breastfeeding survey conducted 2019/2020.

The characteristics of the birth mother provide a limited understanding of the maternal and child population of JMT. Similar to the analysis of infant mortality and birth outcomes, these characteristics reveal that there are significant differences between the three counties. There are factors outside the health of the birth mother that have significant implications on her unborn child. Some of these factors have different levels of influence and others are outside of the control of the birth mother. The Social Determinants of Health observed within these communities are a direct result of high rates of poverty, especially for the black population.

The characteristics of the three communities have an influence on the health of the women in the communities on both the personal, interpersonal and community level. This influence has no

identifiable origin and this makes the task of addressing the need complicated, but not impossible. It is believed that interventions outside of the healthcare system are likely to have the greatest effect on health disparities as those contributing factors are present well before the issues are brought to the attention of medical providers. Healthy Start (HS) provides a health-social system of care within the JMT community that provides this intervention. The Healthy Start system provides targeted strategies at the community level and promotes the engagement of the healthcare system and social services as a support to the overall health of women before, during and after pregnancy as a method to tackle birth disparities in JMT. The most significant solutions observed in this needs assessment is the focus on preconception health among black women in all three counties. Preconception health is linked to poor birth outcomes and the characteristics of the birth mother that is linked to those outcomes. Science supports that a woman's health prior to her pregnancy holds immense control over the success of her pregnancy, and the life-course projection of her infant.

COVID-19

During the preparation of this needs assessment the health pandemic known as Coronavirus has greatly impacted the communities of Jefferson, Madison and Taylor Counties, in terms of access to health systems. While the current positivity rates are low comparable to the rest of Florida, pregnant women and infants are being impacted in ways that will not be measured for some time. It is clear that women are more reluctant to seek obstetric care due to the threat of contracting the virus in the medical community, and some immunizations for their infants may be delayed for the same reason. It is also evident that more families are falling into poverty due to the economic impact of business closures and unemployment. Additionally, service providers report an increase in overall stress, lack of coping mechanisms for additional stress created as a result of the pandemic, including a rise in domestic violence. All of these factors, while not immediately measurable and included in this assessment, must be considered in the immediate planning needs for maternal and child health in these communities.

Summary of key findings

Key Maternal and Infant Health Status Indicators

- The Social Determinants of Health are key factors in the health outcomes in the rural communities of Jefferson, Madison and Taylor Counties, Florida:
    - Poverty for female householder families with children under 5 is 87% in Madison County, compared to 47.1% for Jefferson and 60.4% for Taylor.
    - Percent of Individuals that lived in a different house 1 year earlier is 11% for Taylor.
    - *Madison* County remains the poorest of the three counties, with the lowest median income of $35,509 in Florida
- The infant mortality rate for Jefferson is 9.0 infant deaths per 1,000 live births in 2018, compared to 6.0 for Florida. Madison and Taylor were 10.9 and 8.3, respectively.
- There were 16 infant deaths in Taylor County for the ten year period 2009-2018. The leading cause of infant death for whites were SIDS and congenital anomalies. For black infant deaths, the causes were primarily related to short gestation and low birth weight, and maternal complications.
- There were 13 infant deaths in Jefferson County for the ten year period 2009-2018. The leading cause of infant death for whites were equally contributed to congenital anomalies, SIDS, and complications of intrauterine anatomy. For black infant deaths, the causes were primarily related to short gestation and low birth weight, and maternal complications.
- There were 20 infant deaths in Madison County for the ten year period 2009-2018 with the leading cause of infant death for whites were short gestation and low birth weight, followed by maternal complications and SIDS. For black infant deaths, the causes were primarily related to neonatal complications.
- Fetal Deaths are increasing for Jefferson County from 9.9 in 2012-2014 to a rate of 15.8 for 2016-2018 (N=6)
- There have been 5 fetal deaths in Madison County in the last three years, four of them were black.
- Fetal Deaths in Taylor County are the lowest, at 5.7, compared to the state rate of 6.8.
- Jefferson County currently has the highest rate of low birth weight babies at 11.5% and the 6th highest rate for white LBW babies at 9%. In Madison County, 16.3% of black babies are LBW, compared to 6.1% for whites. In Taylor the gap is smaller at 8.4% for whites and 11.8% for blacks. The statewide average for LBW is 8.7%
- Madison County currently has the highest rate of Very Low Birth Weight Babies (Below 1500g) at 3.8%. 15 of the 21 babies born in the last three years in this category were black.

- White mothers tend to smoke during pregnancy compared to their black counterparts; in Taylor County, white women smoke at a rate 2.5 times greater than blacks during pregnancy (19.7%, compared to 8.3%)
- Madison has the fifth highest rate of preterm birth *with low birth weight* in the state at 7.4%. Of the 41 babies in the last three years born too soon, 29 of them were black.
- Rates of obesity at the time the pregnancy occurred has increased to 37.2% in Taylor, 36.6% in Jefferson, and 33.8% for Madison, up from 13% collectively in 2014.
- The rates for black unwed mothers are 87.9%, 82.4%, and 84.7% for Jefferson, Madison and Taylor respectively; nearly one in nine black babies are born to an unwed mother.
- Jefferson and Taylor Counties are significantly higher than the state average for mothers >19 with no high school education at 16.6% and 16.4%, compared to the state at 11.9%.
- The teen pregnancy rate (ages 15-17) for Taylor County has decreased from 26.1 per 1,000 live births, the second highest in Florida (2012-2014) to 14.6 for 2016-2018. The rate for Jefferson, however has increased to twice the state average at 13.6 (7.4 for FL).
- Jefferson has one of the highest rates for Inter-Pregnancy Intervals <18 months at 41.2% overall and the highest in the state for whites at 45.1%.
- Madison County had the 6th highest rate of 3rd trimester entry or no prenatal care in the state at 10.6%. Of the 47 women in three years, 19 were white, 28 were black and 2 Hispanic. Taylor and Jefferson's rates were 9.8% and 8.7%, compared to the state at 6.7%.***
- Breastfeeding initiation rates are lower than the state averages as a whole. However, for blacks compared to their white counterparts, there are significant gaps. This is most pronounced in Taylor County with 75% of whites initiating breastfeeding, compared to just 48% for blacks. In Madison County the black rate has improved from 37% (2012-2014) for blacks to 57% (2016-2018).
- Prenatal screening rates have fallen below 60%.
- Prenatal screens that are positive have increased to 45%, up from 36% over the last five years.
- Infant screens that are positive have decreased to 23% from 32%.
- The number of referrals from the birthing facility is down from 36% to 23%.
- Referrals to Connect, the one-door entry into home visiting for fiscal year 18/19, compared to overall referrals to Healthy Start for the previous fiscal year are down 48%.
- Overall, for the Coalition members surveyed, 80-90% felt that the Coalition was collaborative in the approach to improving maternal and child health, including avoiding duplication of services.
- Overall, contracted providers of the Coalition were satisfied with the contracting process, allocation of resources and communication.
- Overall, the consumers who attended preconception health workshops felt the community health worker was very knowledgeable and engaging, yet they could use more information on stress reduction, folic acid, and domestic violence.

- Of the respondents in the Family Planning focus groups, those aged 25 and younger demonstrated greater awareness of options and utilization than more mature women.
- Of the Family Planning focus group participants, 60% did not have a medical home.
- Of the breastfeeding survey respondents (survey concluded May 2020), an equal number of them (35%) reported the number one reason that they chose not to breastfeed prenatally is either due to inconvenience or discomfort or uneasiness with the sensation of a nursing infant

Member Survey

The Coalition membership survey was prepared as part of the Internal Quality Initiative and focuses on the role of the Coalition in terms of mobilizing the community toward issues that improve maternal and child health. The survey was designed to reach, as survey respondents, a broad audience of health care and social services providers and community leaders. This audience of potential participants included state and local public health providers, state and local providers of other governmental social services, school-based health centers, childcare providers, and representatives of organizations such as health professional organizations, non- profit organizations, community development/activist organizations, faith-based organizations, businesses, and volunteer organizations. The feedback from the community survey will be used to determine education strategies for mobilizing the community toward the Social Determinants of Health.

Consumer Input

Consumer input for this needs assessment was procured in three ways in a manner to elicit specific feedback from various types of maternal and child health consumers. A survey instrument was developed in March 2019 to reach Healthy Start and county health department clients who stated they would not be breastfeeding. The collection of reasons why and the trends are analyzed in the consumer survey section as well as discussed during the breastfeeding data analysis. The second set of consumer input data is derived from the evaluation of the women's health workshops conducted twice per year in each county. This feedback is critical in measuring the understanding of preconception health messaging and its role in improving birth outcomes. The third set of consumer input data is derived from the Healthy Start satisfaction surveys issued in December 2019.

INFANT and FETAL MORTALITY

Infant Mortality is simply defined as the death of children under the age of one year. However, its meaning for a community and as an indicator of overall well-being of human society is complex at best. The *infant mortality rate* is an estimate of the number of infant deaths for every 1,000 live births. This rate is often used as an indicator to measure the health and well-being of a county, state, or nation, because factors affecting the health of entire populations can also impact the mortality rate of infants. There are obvious differences in infant mortality by age, race, and ethnicity, which deepen the meaning for health planners who seek out root causes to reduce and eliminate infant mortality.

First identified as a social problem by William Farr in 1865, infant mortality has long been the instrument for which nations have been measured in terms of overall health. The primary role of the Healthy Start Coalition under Florida Statute 383.216 is to reduce and eliminate infant mortality in a geographical area of Florida assigned to the Coalition. The data used for evaluating infant mortality is provided by the Florida Department of Health through the FLHealthCharts web application.

The Florida Department of Health devotes considerable resources to collecting and reporting data on infant mortality. The FDOH publishes its annual Actual Versus Expected Infant Deaths by Coalition area. For the most recent 2017 updated analysis, there were no significant variances. Of the 521 births in 2017, the State Bureau of Family Health Services predicted 3 infant deaths. The area experienced 2 infant deaths for the 2017 single year for a rate of 3.84 infant deaths per 1,000 live births. This report is crucial in determining new emerging barriers to optimal maternal and child health care as well as local strengths that prevent poor birth outcomes.

ANALYSIS

The rural counties of Jefferson, Madison and Taylor Counties in North Florida experience an average birth count collectively each year of 578 births. Jefferson is the fourth smallest county in Florida in terms of population and has had a significant decline in its number of births beginning in 2009 with an overall decrease of 18% in the average number of births between the last two multi-year periods. Table 1.0 illustrates the birth counts for these counties over the last multi-years.

When birth *counts* are relatively small, the infant death indicator can be volatile when displayed as *rate for a single year*. Table 1.1 depicts the infant death counts for these counties and the State of Florida and Table 1.2 reflects these counts by race. While the infant death counts in Florida represent a marked trend downwards, the counts in the small counties reflect an infant death rate that should be reviewed with caution, in terms of discerning trends. The most remarkable example of this volatility occurs for Jefferson County when looking at the single year infant death rate for 2013 at 29.6, nearly five times the state average. The optimal methodology for reviewing infant death rates for smaller counties is the use of the three-year rolling average over a multi-year period. Figures 1.0, 1.1, and 1.2 reflect the infant death rates (rolling 3-year average) for the span of multi-years. There are no identifiable trends from this information, other than a positive trend in Taylor County with fewer infant deaths than the state.

Table 1.0 Births by Year of Birth and Mother's County of Residence

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	Total
Jefferson	155	127	126	139	135	127	124	121	142	111	1,307
Madison	229	211	214	212	221	191	210	197	175	184	2,044
Taylor	285	271	242	221	247	217	249	248	204	242	2,426
Total	669	609	582	572	603	535	583	566	521	537	5,777

For the multi-year period the average number of births is 578, the average for the last five years is lower at 548 for the three-county area, which mirrors the overall slight decline in births for the state.

Table 1.1 Infant Deaths, Counts and Rates Per 1,000 Live Births

Year	Jefferson		Madison		Taylor		Florida	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate
2009	3	19.4	1	4.4	2	7.0	1,525	6.9
2010	1	7.9	4	19	5	18.5	1,400	6.5
2011	1	7.9	3	14	3	12.4	1,372	6.4
2012	1	7.2	2	9.4	1	4.5	1,285	6.0
2013	4	29.6	0	0.0	0	0.0	1,318	6.1
2014	1	7.9	4	20.9	0	0.0	1,327	6.0
2015	0	0.0	0	0.0	3	12.0	1,400	6.2
2016	0	0.0	3	15.2	0	0.0	1,380	6.1
2017	1	7.0	1	5.7	0	0.0	1,355	6.1
2018	1	9.0	2	10.9	2	8.3	1,334	6.0

For the multi-year period, Jefferson County had 13 infant deaths; Madison had 20 and Taylor, as the largest county by population, had 16 infant deaths.

Table 1.2, Resident Infant Death County by Year by Race/Ethnicity by Residence County

Year	Jefferson			Madison			Taylor			Totals
	White	Black	Hispanic	White	Black	Hispanic	White	Black	Hispanic	
2009	2	1	0	0	0	1	1	1	0	6
2010	1	0	0	0	4	0	3	2	0	10
2011	1	0	0	0	3	0	2	1	0	7
2012	0	1	0	0	1	1	1	0	0	4
2013	0	4	0	0	0	0	0	0	0	4
2014	0	1	0	2	2	0	0	0	0	5
2015	0	0	0	0	0	0	2	1	0	3
2016	0	0	0	0	3	0	0	0	0	3
2017	0	1	0	0	1	0	0	0	0	2
2018	0	1	0	1	1	0	1	1	0	5
Totals	4	9	0	3	15	2	10	6	0	49

Figure 1.0 Infant Deaths Per 1,000 Live Births, 3-Year Rolling Rates, Jefferson County and Florida

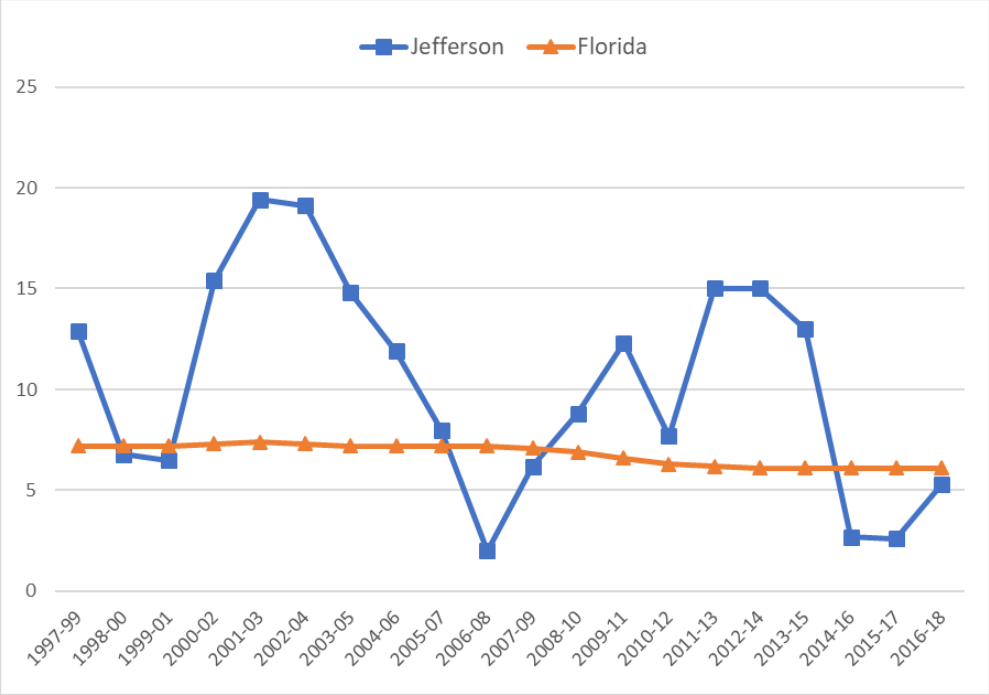


Figure 1.1 Infant Deaths Per 1,000 Live Births, 3-Year Rolling Rates, Madison County and Florida

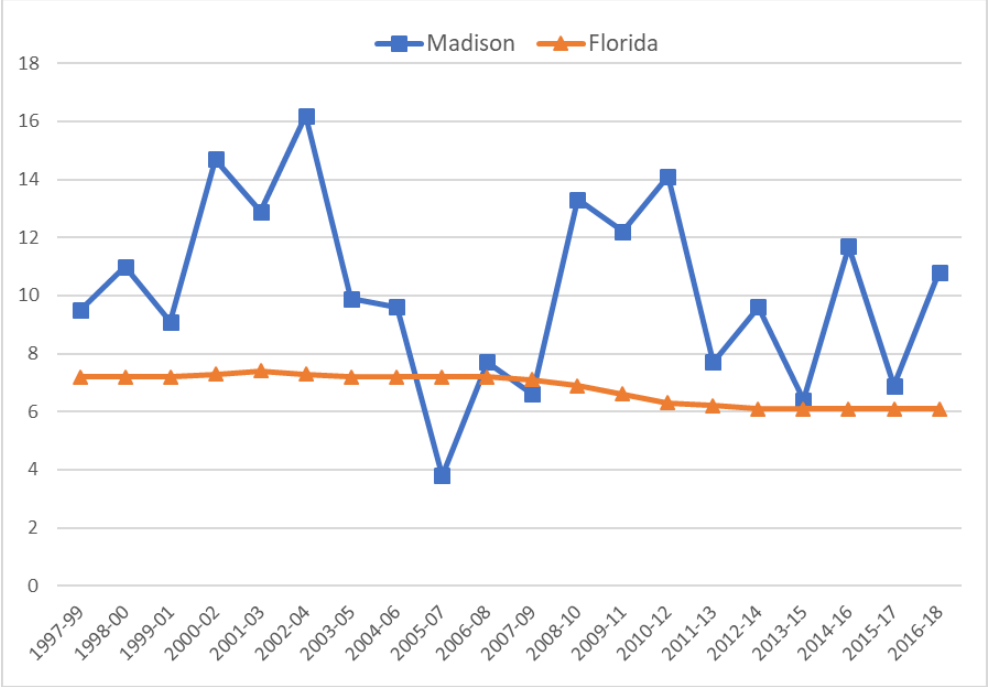
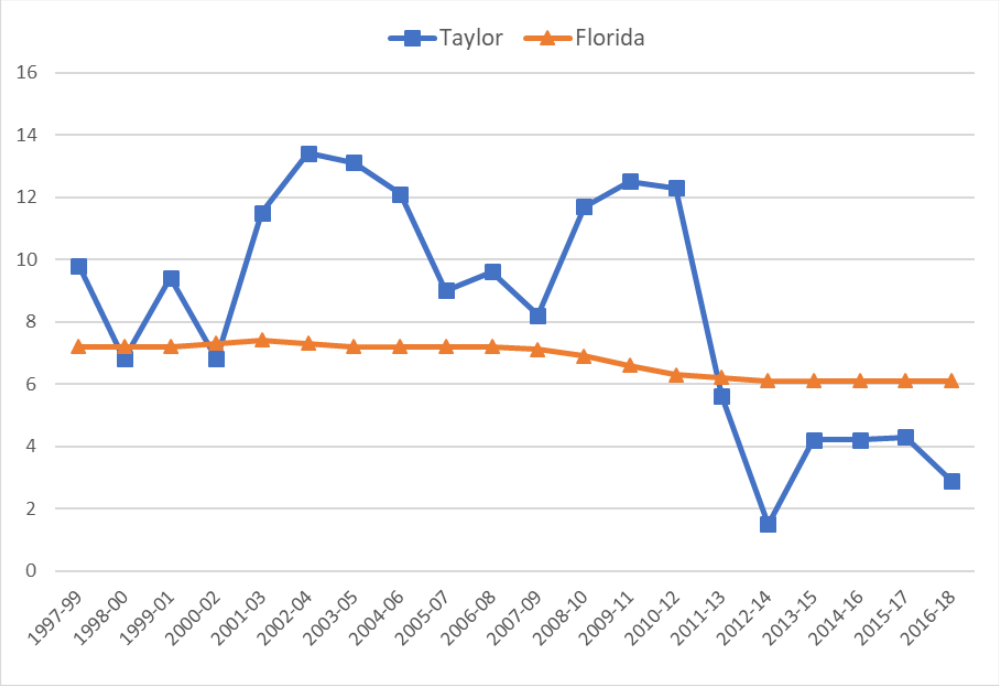


Figure 1.2 Infant Deaths Per 1,000 Live Births, 3-Year Rolling Rates, Taylor County and Florida



Black-White Gap in Infant Mortality

Although infant mortality rates have dropped for Florida as a whole, rural communities experience infant death as volatile rates when compared to the state. However, what is comparable is the racial gap between black and white infant death rates. The difference between white and black infant death rates is significant and is persistent across Florida, across small counties, and across the United States. For Jefferson County, Figure 1.3 reflects the disparity in infant mortality between blacks and whites; for 2016-2018 the black-white gap is significant. The rate for black infant deaths is 12.7, compared to zero for whites, or *13 to 1*.

For Madison County, Figure 1.4 depicts the infant mortality rate over the last multi-years by *race*. The most recent three-year average is 8.4 for black infant deaths, compared to just 3.2 for whites for 2016-2018. This is a ratio of nearly 3:1. The trend of the black-white gap is significant in Madison County, in that it is *consistent* across the years. The only years where the gap narrows are 2012-2015 where the Hispanic deaths occur. Since most Hispanics also often identify as white, this raises the white rate to almost that of the black rate for those years. The small Hispanic population and the significant impact on the infant mortality rate for the Hispanic ethnicity is an example of volatility when comparing rates in small population sets. The Hispanic population is less than 1% of the Madison County population; one infant death in 2012 results in a three- year rolling rate of 58.8. (Hispanic population is now close to 6%) Table 1.2 shows the actual number of Hispanic infant deaths (3) over the multi-year period.

Taylor County has a slightly different outcome for infant mortality by race. The infant mortality rate overall has sharply declined in Taylor since 2013 yet the black white gap is nearly 2:1 for all multi-years. The 2016-2018 rates, however, are very low for both races, at zero for blacks and 1.9 for whites.

It is difficult to disentangle the direct links between the recent trends in infant mortality and their causes without additional research, but the persistence of this black-white gap challenges efforts to reduce health disparities. It is important to investigate factors behind this worrisome trend. It is possible that more black women have high-risk pregnancies than others.

Social factors like increases in unemployment and poverty rates or reduced access to health care are important social factors to consider when approaching the black-white gap.[2]

Figure 1.3

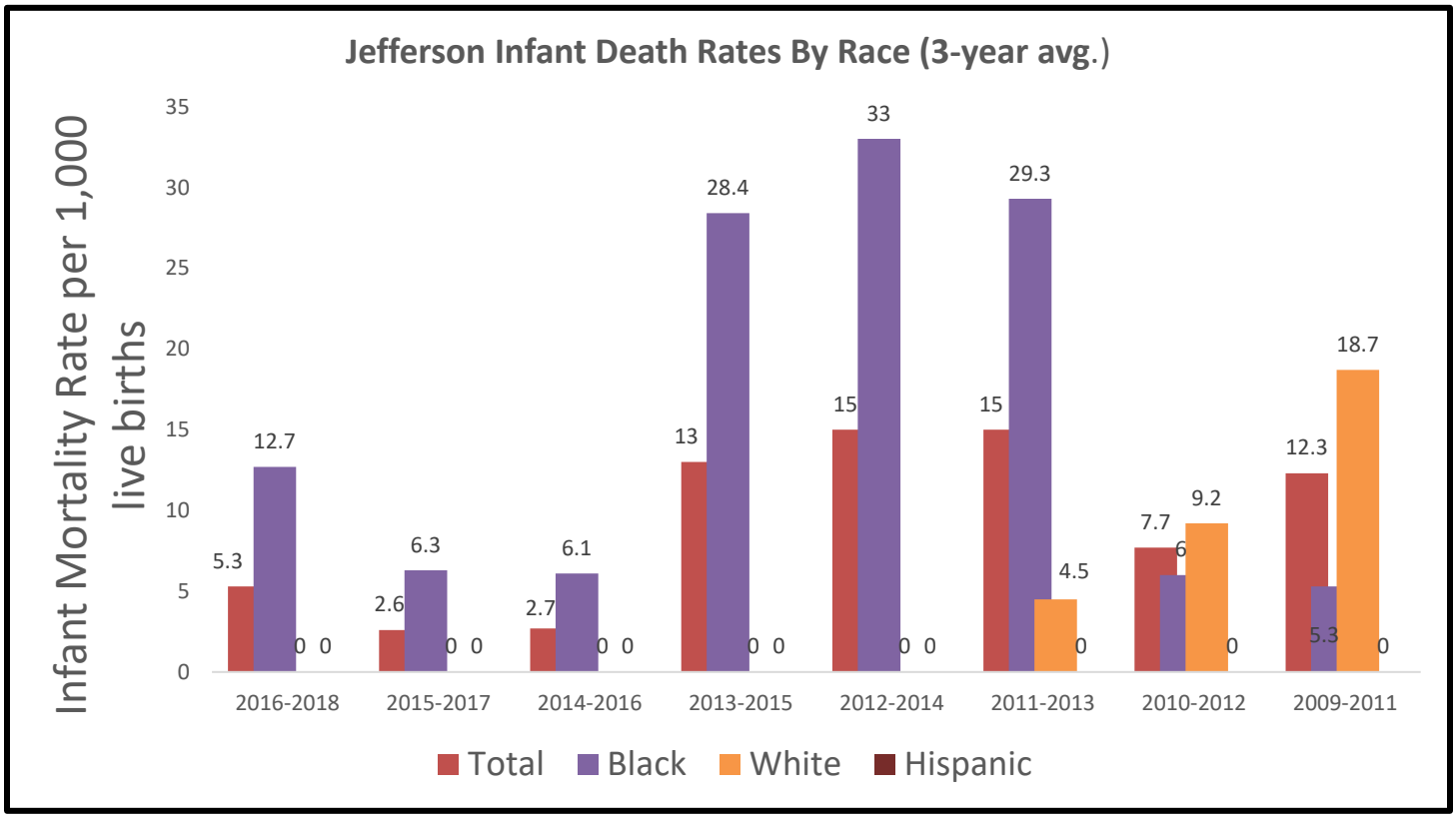
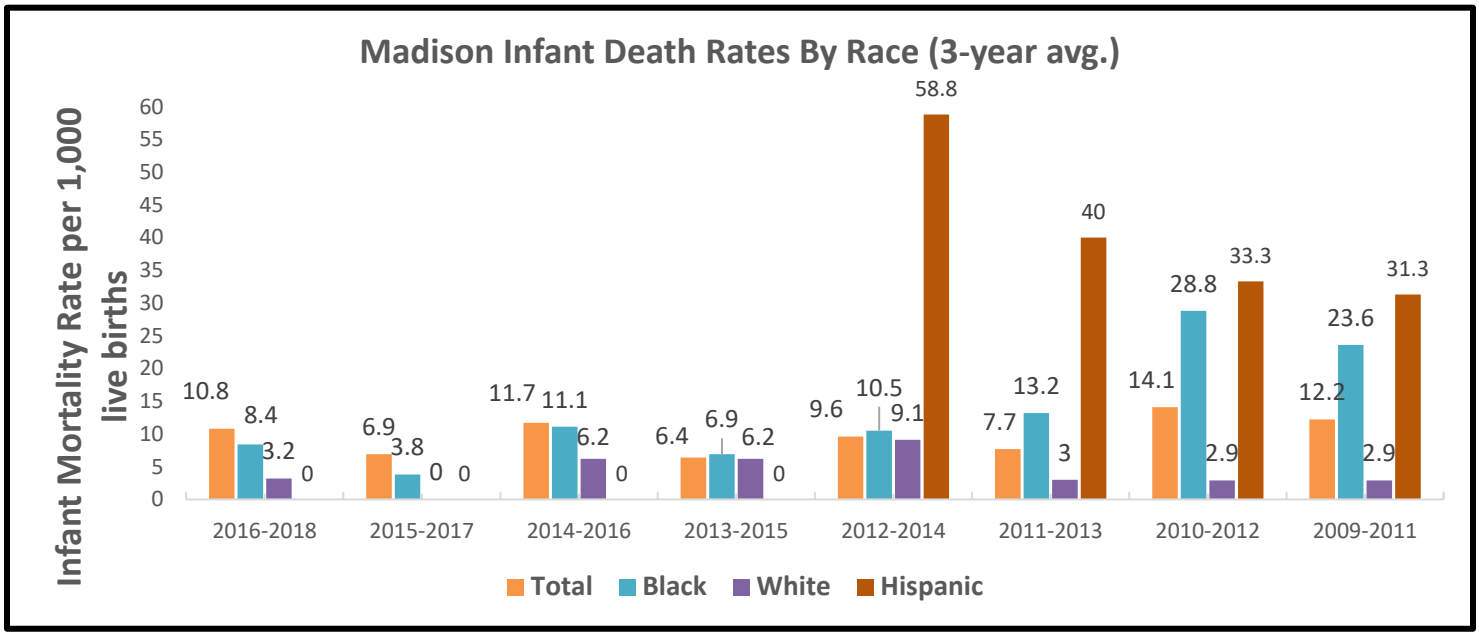


Figure 1.4



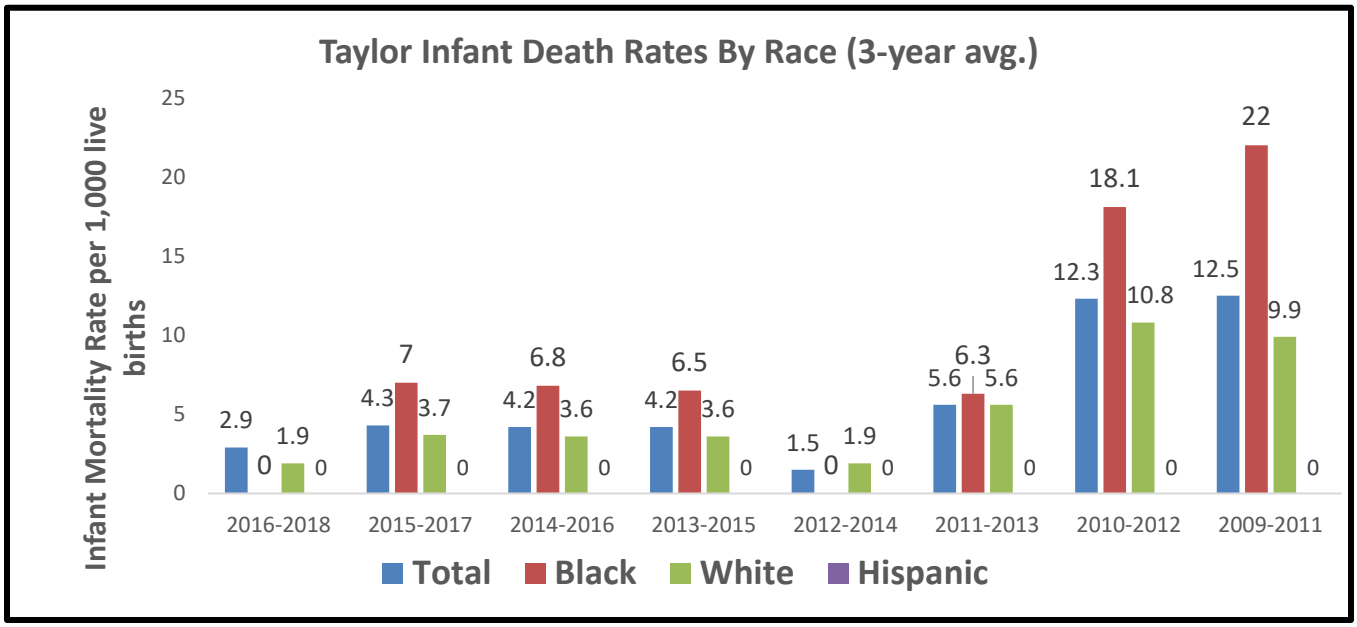
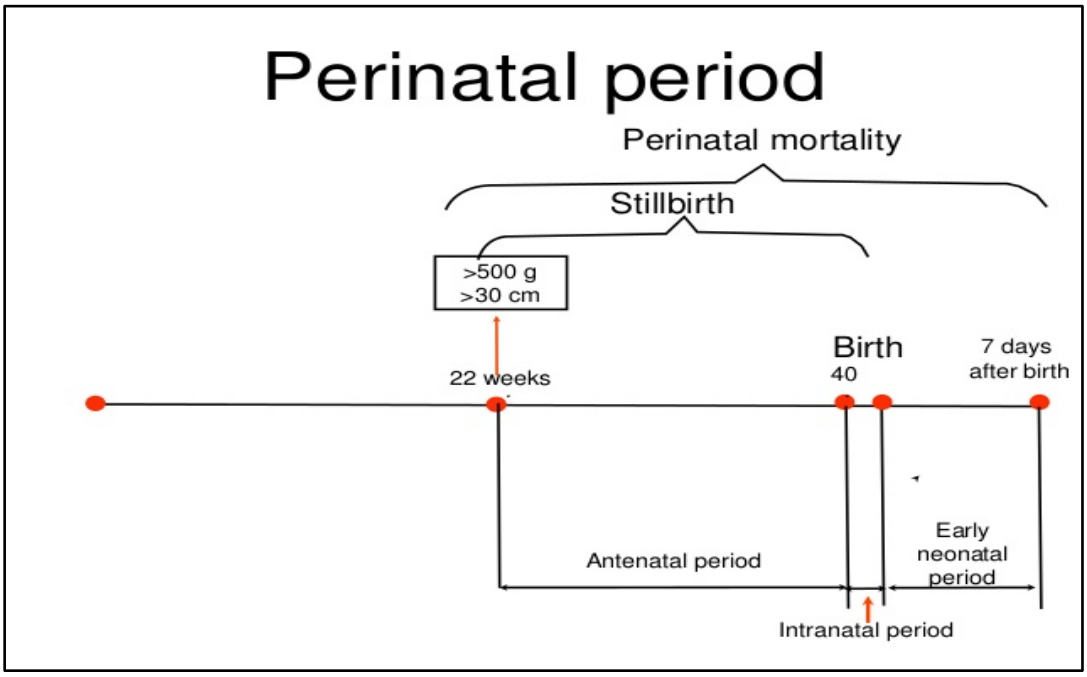


Figure 1.5

PERINATAL MORTALITY

The perinatal period commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth. Perinatal mortality and maternal health are closely linked. Perinatal mortality refers to the number of stillbirths (fetal deaths) and the number of infant deaths in the first week of life (early neonatal mortality).

The denominators for all perinatal rate computations are per 1,000 live births plus fetal deaths for their respective time period. The distinction is useful for monitoring perinatal mortality throughout the gestational age spectrum because the majority of fetal deaths occur before 28 weeks of gestation.[2]



Fetal mortality

Fetal death refers to the intrauterine death of a fetus prior to delivery. Fetal mortality is generally divided into three periods: early (less than 20 completed weeks of gestation), intermediate (20–27 weeks of gestation), and late (28 weeks of gestation or more). Although the vast majority of fetal deaths occur early in pregnancy, Florida, like most states in the United States only report fetal deaths at 20 weeks of gestation or more, and these intermediate and late fetal deaths are the subject of this analysis. Statistics on fetal death exclude data for induced terminations of pregnancy. Fetal mortality rates in this report are computed as the number of fetal deaths at 20 weeks of gestation or more per 1,000 deliveries. Table 1.3 below reflects the fetal death rate for all races for the last multi-years. These numbers are less volatile than infant mortality and indicate significant perinatal health issues addressed later in the text. Although the state of Florida has experienced a steady decline in fetal deaths over the last multi-years, the counties of Jefferson, Madison and Taylor have seen an increase in fetal deaths, especially in Jefferson County, which is currently twice the state average.

Table 1.3

Fetal Deaths Per 1,000 Deliveries, 3-Year Rolling Rates				
Year	Jefferson	Madison	Taylor	Florida
2016-18	15.8	8.9	5.7	6.8
2015-17	12.8	10.2	8.5	6.9
2014-16	5.3	6.6	9.7	6.9
2013-15	7.7	8.0	9.7	7.0
2012-14	9.9	6.4	5.8	7.1
2011-13	12.3	7.7	9.8	7.2
2010-12	7.6	10.9	9.4	7.2
2009-11	4.9	12.1	11.2	7.2
2008-10	0.0	13.2	9.3	7.2
2007-09	0.0	6.6	12.7	7.3
2006-08	0.0	5.1	13.0	7.4
2005-07	2.0	2.5	8.9	7.4
2004-06	4.0	8.2	4.0	7.4
2003-05	4.2	8.4	2.9	7.5
2002-04	4.2	11.7	4.4	7.6
2001-03	6.4	8.6	4.3	7.7
2000-02	8.7	14.5	6.8	8.0
1999-01	17.1	13.5	8.0	8.0
1998-00	15.7	17.0	8.1	7.9
1997-99	14.9	12.5	9.7	7.8

Neonatal mortality

A neonatal death is defined as a death during the first 28 days of life (0-27 days). The rate is calculated by the number of neonatal deaths x 1000 divided by the total number of live births for the same time period. 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 health care available. Neonatal mortality information is generally associated with risk factors and

issues related to pregnancy and birth. Table 1.4 shows the neonatal infant death rate for the last multi-years for all three counties. When overlaid with total infant death rates, the data is identical for most years, indicating that nearly all infant deaths were in the neonatal period. The statistical differences occur during 2014-2016 in Madison County where the infant deaths occurred primarily beyond the neonatal period and in Taylor County for four out of the last five years, where the infant deaths were classified as SIDS deaths beyond the neonatal period. For the purposes of developing general themes, however, the neonatal infant death rate and the overall infant death rate are the same or very close in all years in all counties, reflecting that the target infant risk period is the first 28 days of life.

Table 1.4

Neonatal Infant Deaths Per 1,000 Live Births, 3-Year Rolling Rates				
	Jefferson	Madison	Taylor	Florida
Years	Rate	Rate	Rate	Rate
2016-18	2.7	10.8	2.9	4.1
2015-17	2.6	6.9	0.0	4.2
2014-16	2.7	6.7	0.0	4.2
2013-15	7.8	1.6	0.0	4.1
2012-14	10.0	4.8	0.0	4.0
2011-13	7.5	7.7	1.4	4.1
2010-12	5.1	11.0	8.2	4.2
2009-11	9.8	9.2	10.0	4.4
2008-10	8.8	7.4	9.4	4.5
2007-09	6.2	4.0	5.8	4.5
2006-08	2.0	3.9	6.0	4.6
2005-07	8.0	2.5	6.4	4.6
2004-06	9.9	5.5	6.7	4.6
2003-05	12.7	5.6	7.3	4.6
2002-04	14.9	8.8	7.4	4.8
2001-03	15.1	7.2	5.8	4.9
2000-02	11.0	8.8	2.7	4.8
1999-01	4.3	6.1	6.7	4.7
1998-00	6.8	7.9	6.8	4.7
1997-99	12.9	6.3	7.0	4.8

Postneonatal Deaths

Postneonatal Mortality Rate is the number of resident newborns dying between 28 and 364 days of age divided by the number of resident live births for the same geographic area (for a specified time period, usually a calendar year) and multiplied by 1,000. Compared to fetal deaths and neonatal deaths these numbers are relatively small for all years, further indication that the most vulnerable periods of risk are the perinatal and neonatal periods for determining interventions. The majority of the Taylor postnatal deaths for the most recent multi-years were SIDS deaths.

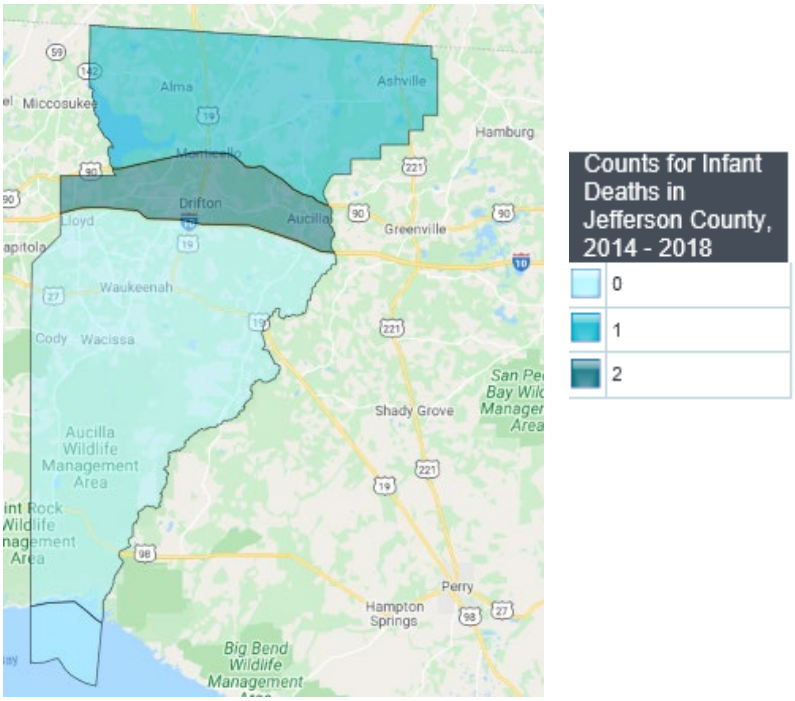
Table 1.5

Postneonatal Infant Deaths Per 1,000 Live Births, 3-Year Rolling Rates				
	Jefferson	Madison	Taylor	Florida
Years	Rate	Rate	Rate	Rate
2016-18	2.7	0.0	0.0	2.0
2015-17	0.0	0.0	4.3	2.0
2014-16	0.0	5.0	4.2	1.9
2013-15	5.2	4.8	4.2	2.0
2012-14	5.0	4.8	1.5	2.1
2011-13	7.5	0.0	4.2	2.1
2010-12	2.6	3.1	4.1	2.2
2009-11	2.5	3.1	2.5	2.2
2008-10	0.0	5.9	2.3	2.4
2007-09	0.0	2.7	2.3	2.5
2006-08	0.0	3.9	3.6	2.6
2005-07	0.0	1.3	2.6	2.6
2004-06	2.0	4.1	5.4	2.6
2003-05	2.1	4.2	5.8	2.6
2002-04	4.3	7.4	6.0	2.6
2001-03	4.3	5.8	5.8	2.5
2000-02	4.4	5.9	4.1	2.5
1999-01	2.2	3.0	2.7	2.5
1998-00	0.0	3.1	0.0	2.4
1997-99	0.0	3.2	2.8	2.4

Census Tract Maps for Infant Mortality

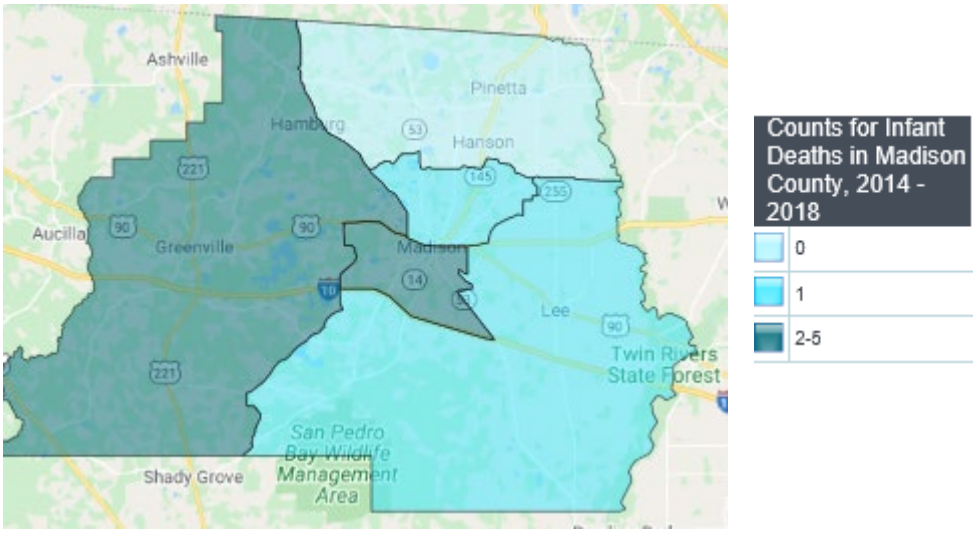
Each of the three county census tracts are below and indicate a repeated theme. Most of the infant deaths occur within the major city limits in each county, which is the primary location of the African American demographic who experience infant loss *at least* twice as much and up to *four times as often* as their white counterparts. The white population in these rural communities is more likely to live on farms outside the city limits in each community. The exception to that is Taylor County which also includes substantial coastal properties, which are exclusively white. Census tracts are the preferred unit of analysis compared to zip codes. They are designed to have a homogenous population with an average of 4,000 people. The tracts are established as consistent blocks of geography that remain stable over a 10-year period. Every decennial, the U.S. Census Bureau updates census tract boundaries to coincide with the updated population figures. Data in the FLHealthCHARTS Community Map uses 2010 census tract boundaries.[1]

Figure 1.6 Jefferson County Census Map for Infant Mortality



The infant deaths in Jefferson County, according to the Census Map have not occurred south of the Interstate, a sparsely populated area with coastal access. Also, there was only 1 infant death north of the city limits for the five years included in the map. The concentration of infant deaths for Jefferson County have occurred within the city limits of Monticello, the county seat for Jefferson County.

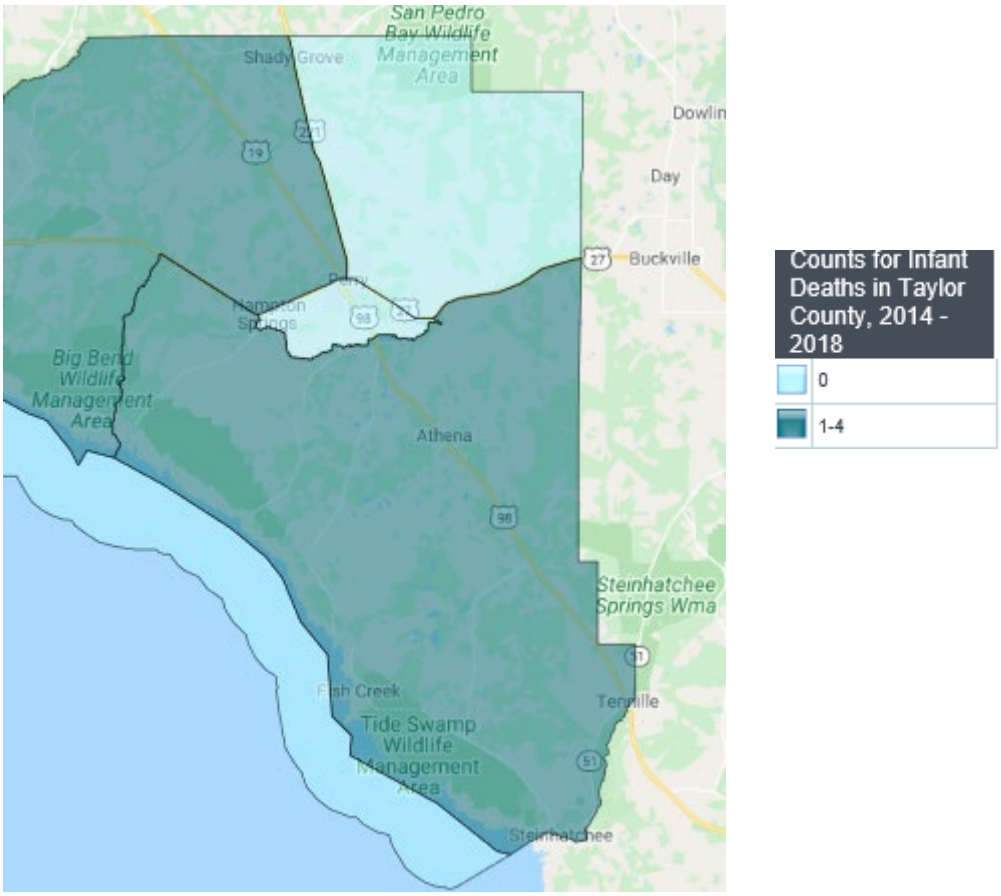
Figure 1.7 Madison County Census Map for Infant Mortality



Infant deaths in Madison County, according to the Census Map, occur primarily within the city limits of Madison as well as areas west of Madison, known as Greenville. The Greenville area is inclusive of all areas west of the city of Madison all the way to the Jefferson and Taylor County boundaries. Zero deaths have occurred in the last five years in northern Madison

County, which is primarily farms and a lakeside community that borders South Georgia. There was one infant death in the easternmost part of the county.

Figure 1.8 Taylor County Census Map for Infant Mortality



Taylor County is a huge land mass that is sparsely populated in the western coastal areas, which are primarily marsh. The southern end of the county is a community that is detached from the city of Perry and has few resources for families, including an hour drive to the closest prenatal care provider. All infant deaths occurred either in the city limits of Perry, the sparse southwest, or in the Steinhatchee community at the southernmost point in Taylor.

CAUSES OF DEATH

There are 130 causes of infant death listed for the infant and fetal death certificate in Florida. However, they are five major groupings that allow ease of analysis and are widely accepted[3]:

1. Birth Defects
2. Pre-Term Birth
3. Maternal Complications of Pregnancy
4. Sudden Infant Death Syndrome
5. Injuries

For the 13 infant deaths in Jefferson County over the last multi-years, 6 were related to maternal causes or pregnancy conditions; 5 of the 6 were black babies. These maternal causes are important as they validate the need for preconception care and counseling services, which is the core message for infant mortality prevention both at the national and state levels.

Leading causes of death for Jefferson County were Maternal Complications of Pregnancy (23%) which include a variety of maternal issues such as obesity, hypertension, diabetes, mental health conditions, UTI's and anemia. Birth Defects (23%) and SIDS (23%) were the other two major categories of infant deaths for Jefferson County.

Leading causes of death in Madison County are nearly all associated with prematurity. Of the 20 babies that died in the last multi-years, 12 have a cause of death related to short gestation or prematurity; 8 of these were black babies. In Taylor County, the causes are more along racial lines between blacks and their white counterparts. Of the 16 babies that died in Taylor County between 2009 and 2018, 11 were white, while 5 were black. However, for white babies the causes were predominantly birth defects and SIDS. Cause of death for black babies centered more on maternal complications and prematurity.

Table 1.6 Jefferson County - Resident Leading Causes of Infant Death by Race and Ethnicity, 2009-2018

	White	Black & Other	Hispanic	Total
Newborn Affected by Maternal Complications of Pregnancy (P01)	0	3	0	3
Newborn Affected by Complications of Placenta, Cord, and Membranes (P02)	1	0	0	1
Disorders Related to Short Gestation and Low Birth Weight, Not Elsewhere Classified (P07)	0	1	0	1
Interstital Emphysema & Related Conditions Originating in the Perinatal Period (P25)	1	0	0	1
Congenital Malformations, Deformations, & Chromosomal Abnormalities (Q00-Q99)	1	2	0	3
Sudden Infant Death Syndrome (R95)	1	2	0	3
Unintentional Injuries (V01-X59)	0	1	0	1
Total	4	9	0	13

Table 1.7 Madison County - Resident Leading Causes of Infant Death by Race and Ethnicity, 2009-2018

	White	Black & Other	Hispanic	Total
Other Non-rankable Cause of Death	0	4	0	4
Renal Failure & Other Kidney Disorders (N17-N19, N25, N27)	0	1	0	1
Newborn Affected by Maternal Complications of Pregnancy (P01)	0	3	0	3
Newborn Affected by Complications of Placenta, Cord, and Membranes (P02)	0	1	0	1
Disorders Related to Short Gestation and Low Birth Weight, Not Elsewhere Classified (P07)	1	2	1	4
Neonatal Hemorrhage (P50-P52, P54)	0	3	0	3
Congenital Malformations, Deformations, & Chromosomal Abnormalities (Q00-Q99)	0	0	1	1
Sudden Infant Death Syndrome (R95)	2	0	0	2
Unintentional Injuries (V01-X59)	0	1	0	1
Total	3	15	2	20

Table 1.8 Taylor County - Resident Leading Causes of Infant Death by Race and Ethnicity, 2009-2018

	White	Black & Other	Hispanic	Total
Other Non-rankable Cause of Death	1	0	0	1
Septicemia (A40-A41)	0	1	0	1
Bronchitis, Not Elsewhere Specified (J40-J42)	1	0	0	1
Newborn Affected by Complications of Placenta, Cord, and Membranes (P02)	0	1	0	1
Slow Fetal Growth & Fetal Malnutrition (P05)	1	0	0	1
Disorders Related to Short Gestation and Low Birth Weight, Not Elsewhere Classified (P07)	1	1	0	2
Bacterial Sepsis (P36)	0	6	0	1
Congenital Malformations, Deformations, & Chromosomal Abnormalities (Q00-Q99)	2	1	0	3
Sudden Infant Death Syndrome (R95)	3	1	0	4
Unintentional Injuries (V01-X59)	1	0	0	1
Total	10	6	0	16

References

[1]Florida Department of Health (2018). Florida CHARTS - Community Health Assessment Resource Tool Set, accessed February 2020 http://www.flhealthcharts.com/charts/default.aspx

[2]World Health Organization Maternal, Newborn, Child and Adolescent Health, https://www.who.int/maternal_child_adolescent/topics/maternal/maternal_perinatal/en/

[3]Centers for Disease Control and Prevention (http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/InfantMortality.htm)

CONCLUSION

While infant mortality is a complex subject that has far-reaching implications for discerning overall population health, it is important to note that while infant deaths for Florida have decreased as a whole, indicators for these smaller communities are much more difficult to discern trends, patterns, and causes due to the volatility of small numbers. These numbers, though volatile due to their small nature, do allude to trends throughout the makeup of these communities. One obvious trend is the overall consistency of the presence of the black- white gap. While it is most prominent in Madison County, its consistent presence in all three counties allude to true health disparities that have a direct impact on birth outcomes. In the literature, the reduction of the overall population's infant and fetal mortality rates while certain groups, specifically those of African American heritage, have no recent or sustained reduction shows a failure to alter health inequities (Hogan *et. al*). The data represents conditions that have perpetuated a difference of the reproductive life course among black and white women in these communities, but the root causes of these differences require some exploration. While alike at first glance, there are distinct characteristics of each county that provide a better understanding of the women and babies served in these communities.

Jefferson County, in summary, is a small county that serves as a bedroom community to the location of jobs in both Leon County, Florida, and Thomas County, Georgia. The only large employers are the school system, the county prison, and an assisted living facility. The residents that live there either commute to work, live on established farms and plantations, or are semi-retired eclectic entrepreneurs. The most at-risk population are the unemployed and underemployed black families, most of which reside within the city limits of Monticello. These families are the target population for maternal and child health interventions and strategies for Jefferson County. Observation of the presented data on Jefferson County allows for conclusions on the relationship between maternal health and infant mortality to help formulate prevention and intervention strategies. Between the years 2009 and 2018, 33% of the black infant deaths in Jefferson County resulted from maternal complications of pregnancy (Table 1.6). Exploration of the characteristics of the birth mother might explain the community trend among the black, female population of Jefferson County, who experience higher infant death rates. This is covered later in the text.

Madison County, whose population is 40% black, 55% white and 6% Hispanic has the most pronounced disparities. Black mothers experience infant loss on average 4:1 than their white counterparts in Madison County. Like Jefferson, most of the infant deaths occurred to mothers who live in the city limits of Madison, with close access to prenatal care at the local county health department. The causes of infant death in Madison County were primarily linked to maternal complications and overall health status. Nearly all of the infant deaths in the last five years in Madison County were neonatal deaths. The association between maternal body mass index (BMI), specifically within the obesity range, and mortality risk is most evident in the neonatal period (Aune *et. al* and Sailhu *et. al*). The literature points to the high neonatal deaths in Madison County as possibly being a result of obesity. Preconception care and counseling are primary interventions needed for the African American maternal population in Madison County.

In Taylor County, infant mortality has a discernable trend downwards for all races. Fetal deaths have also sharply declined. The majority of infant deaths were white, SIDS deaths, unintentional injuries (suffocation) and birth defects for white babies. Causes of death for black babies were related to maternal complications and prematurity. Among all three counties, Taylor County is unique in that its main culprit is a postnatal behavior that is completely preventable. While overall infant mortality rates have been steadily declining in Taylor County, the data identifies unsafe sleep practices as the primary risk among white infants in Taylor County.

Consistent amongst all counties is the pervasive racial disparity in infant mortality. The best long-term solution involves eliminating the chronic stress of all black women by confronting racism and inequality – but this will be difficult and lengthy work. In the short term, we can better educate African-American women and their health care providers to raise awareness of these issues, we can individualize their care by collaborating with providers to provide personalized monitoring and

treatment, and we can continue research into this tragic gap in order to improve the health of African-American women and their babies.

Additional resources

Aune D, Saugstad OD, Henriksen T, Tonstad S. (2014) Maternal body mass index and the risk of fetal death, stillbirth, and infant death: a systematic review and meta-analysis. *JAMA, 311*, 1536-46.

American Sociological Association (2018). Race and ethnicity. Retrieved from http://www.asanet.org/topics/race-and-ethnicity

Collins, James & David, Richard (2007). Disparities in Infant Mortality. American Journal of Public Health. https://ajph.aphapublications.org/doi/10.2105/AJPH.2005.068387

The RACE Project: American Anthropology Association (2016). Health connections: Do genes determine our health? Retrieved from http://www.understandingrace.org/humvar/sickle_01.html

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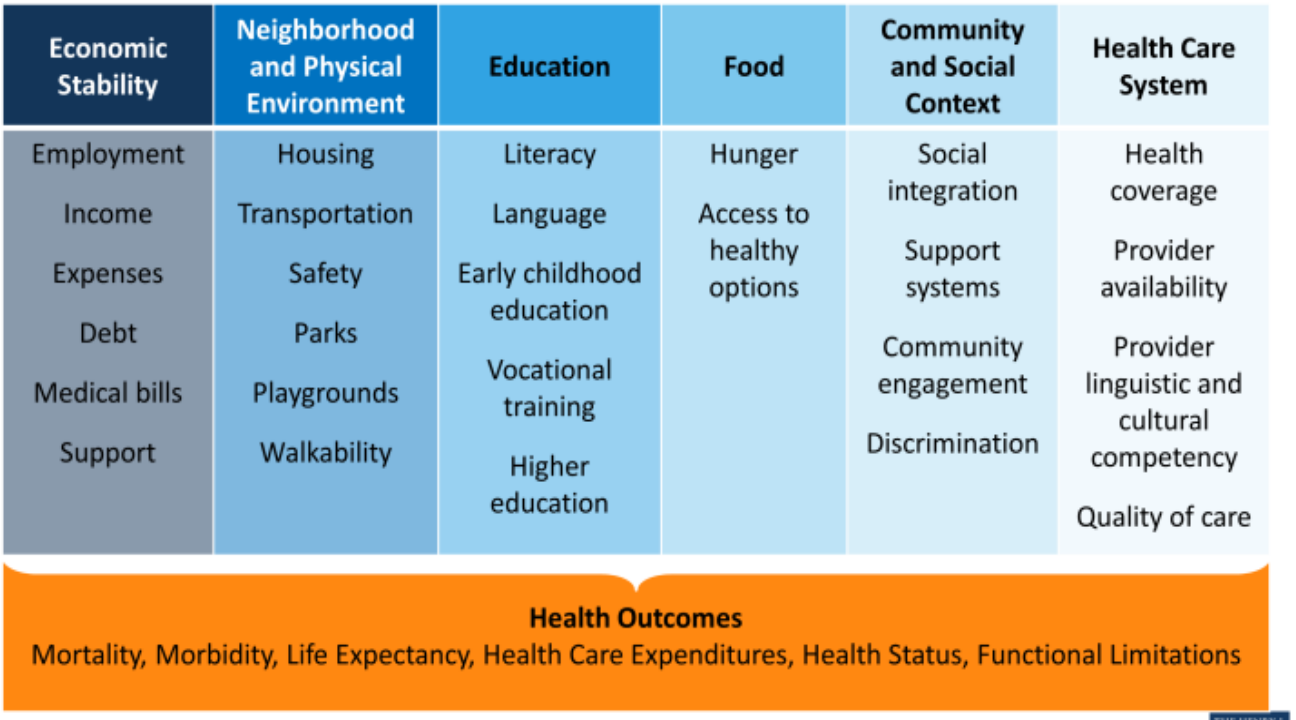
SOCIAL DETERMINANTS OF HEALTH

It is difficult to understand the impact of infant mortality in the context of health equity without exploring the social determinants of health that are the root causes of health inequities. The significant black-white gap in infant mortality for these communities averages 3:1 consistently over the last multi-years. All other health outcomes, including cancer and diabetes rates, as well as overall morbidity, echoes the repeat theme of racial inequity. Health disparities, or the difference in the incidence and prevalence of health conditions and health status between groups is most commonly used to describe this health issue. These persistent outcome disparities prompted the World Health Organization (WHO) to convene the first Commission on Social Determinants of Health in 2005. Their mission is to "marshal the evidence on what can be done to promote health equity, and to foster a global movement".



The primary work of that milestone has been to permeate every health system with a foundational understanding of what causes health inequity, the result of the systematic and unjust distribution of the social determinants of health. The inaugural Commission defined the Social Determinants of Health as those life-enhancing resources whose distribution across populations effectively determines length and quality of life. To affect these resources, the Commission made three overarching recommendations: 1) Improve daily living conditions, 2) Tackle the inequitable distribution of power, money, and resources, and 3) Measure and understand the problem and assess the impact of the action.[1]

In fulfilling the Commission's recommendation to measure and understand the problem, national organizations including the Centers for Disease Control (CDC), and the Health Resources & Services Administration (HRSA) have responded by assessing plans for including activities designed to address the Social Determinants of Health (SDOH) with its funded agencies and across provider disciplines. CDC funds eight specific SDOH-related projects across sectors including housing, education, and transportation. This includes the Partnerships to Improve Community Health (PICH).

The National Association of County and City Health Officials (NACCHO) took on a large project in 2014 to study the contents of county health department's community health assessments (CHA) and community health improvement plans (CHIP) as it relates to comprehensive inclusion of addressing the SDOH.[2]

NACCHO developed the Community Health Improvement Matrix, which measured the CHIPs and CHAs as presented to the Public Health Accreditation Board. This matrix is a bivariate map that includes the level of *prevention* on the vertical axis and the level of *intervention* on the horizontal axis. The prevention levels are those traditional public health categories of primary, secondary, and tertiary with an added category by NAACHO for primordial (preventing the emergence of SDOH).[2]

The intervention levels are those built on the Social Ecological Model and include individual, interpersonal, organizational, community and public policy. This portion of this needs assessment included herein expounds on these levels as designed by the matrix, in the context of maternal and child health.

The Social Ecological Model (SEM) is a theory-based framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviors, and for identifying behavioral and organizational leverage points and intermediaries for health promotion within organizations. While varying programs and agencies use different versions of the model, the basic concept of interventions remain the same. These are measured at the individual, interpersonal, organizational, community, and policy levels.[4]

Individual Level

The core of most SEM models represents the individual who might be affected by the health issue. In the context of this needs assessment, this would be the reproductive-age population and their infants up to age 3. The intervention at this level seeks to increase the individual's knowledge and influence his or her attitudes toward, and beliefs regarding maternal and child health issues.[4] Examples include:

- The benefits of preconception health monitoring
- The intention to plan a family
- The risks and benefits of early and adequate prenatal care
- Access to affordable and convenient services, including clinical and supportive home visiting

Interpersonal Level

The next section of the SEM theory represents prevention activities implemented at the interpersonal level. These activities are intended to facilitate individual behavior change by affecting social and cultural norms and overcoming individual-level barriers. Friends, family, health care providers, and community health workers represent potential sources of interpersonal messages and support.[4]

Organizational Level

This represents prevention activities implemented at the organization level. These activities are intended to facilitate individual behavior change by influencing organizational systems and policies. Health care systems, employers or worksites, health care plans, local health departments, tribal urban health clinics, and professional organizations represent potential sources of organizational messages and support.

Community Level

This represents activities implemented at the community level. These activities are intended to facilitate individual behavior change by leveraging resources and participation of community-level institutions such as the Healthy Start Coalitions.

Policy Level

This level represents activities at the policy level. These activities involve interpreting and implementing existing policy. Federal, state, local, and tribal government agencies may support policies that promote healthy behavior.

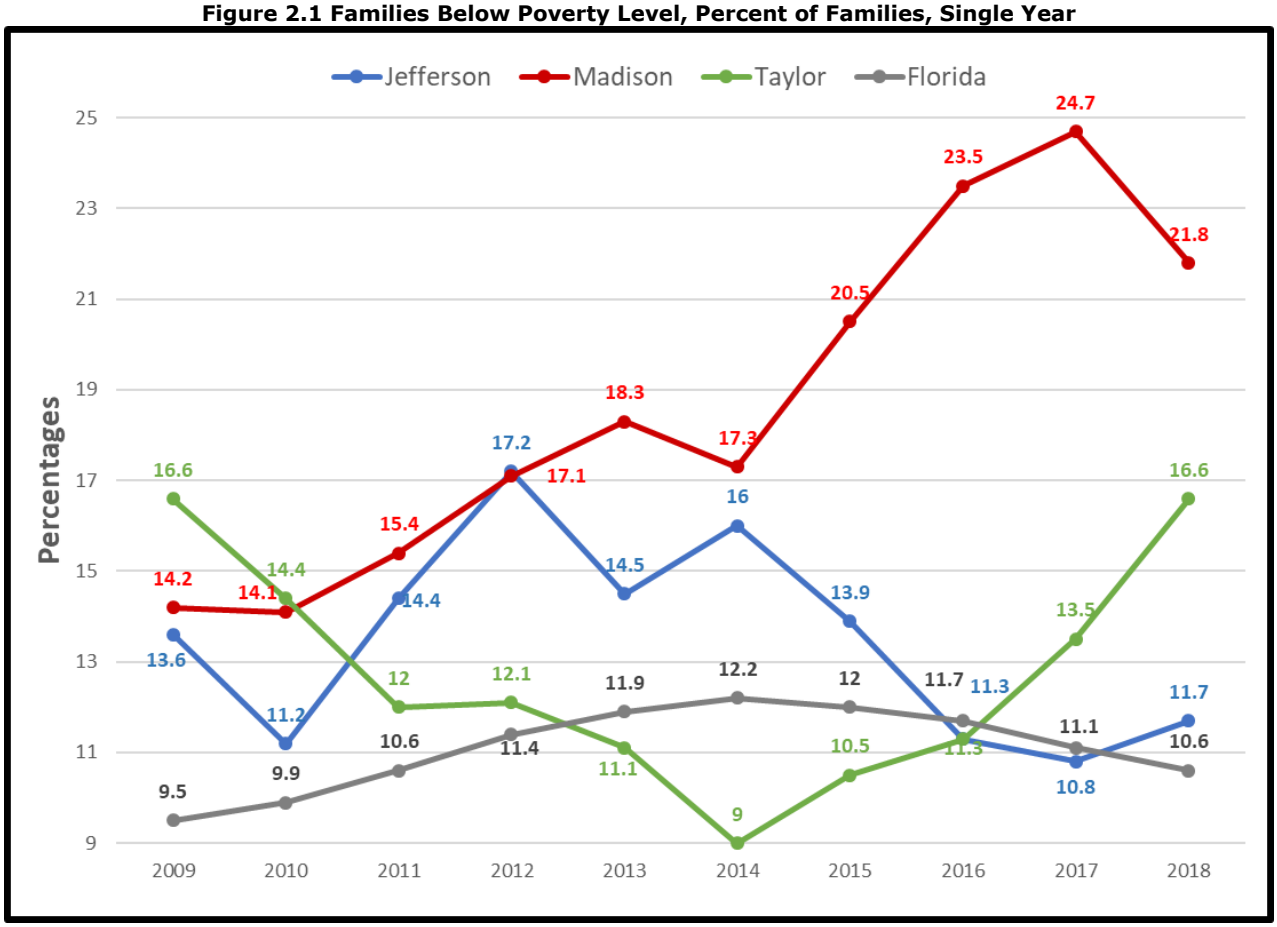
In addition to analyzing the data for community and interpersonal level interventions it is also important to understand the issue by assessing the consumer most affected by the issue, or the service provider included in the resource framework. The consumer and coalition member feedback for maternal and child health systems is included in the consumer feedback section of this needs assessment.

Community Level

Income/Poverty

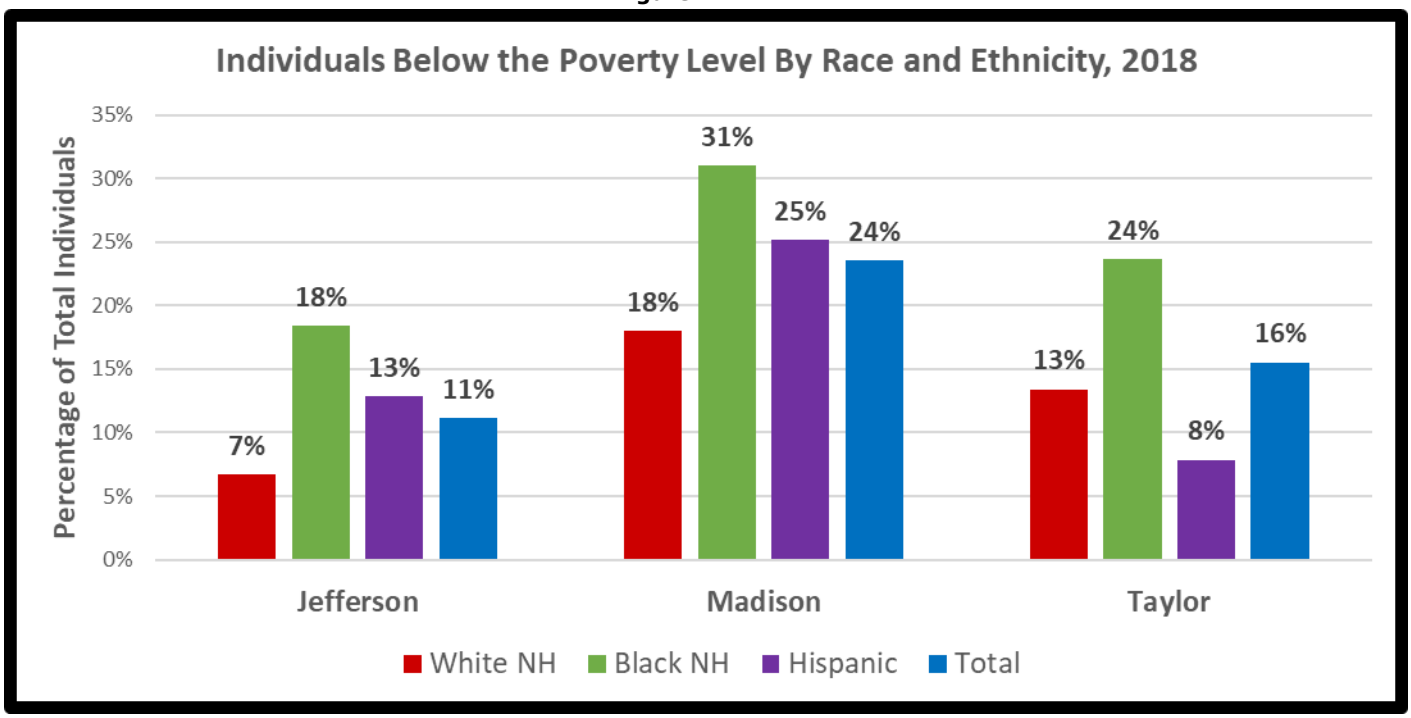
Jefferson, Madison and Taylor Counties are among the poorest in the state of Florida. In Jefferson County, nearly 11.7% of families live in poverty, in Madison County the percentage is nearly twice that at 21.8%, and 16.6% of families in Taylor County fall in this category. These are significantly different than the last review of this data and the trends are increasing in poverty for Madison and Taylor while decreasing significantly for Jefferson. Jefferson's rate of poverty is just slightly higher than the state average of 14.8%[5]

Figure 2.1 Families Below Poverty Level, Percent of Families, Single Year



The individual poverty rate for racial and ethnic minorities varies by county. In Jefferson County, 11% of individuals lived below the poverty level in 2018. This included 7% of the total White, non-Hispanic residents, 18% of the total Black, non-Hispanic residents and 13% of the total Hispanic residents. During 2018, 16% of individuals residing in Taylor County lived below the poverty level. This included 13% of the total White, non-Hispanic residents, 24% of the total Black, non-Hispanic residents and 8% of the total Hispanic residents. Of the three counties, Madison County had the highest percentage of individuals living below the poverty level in 2018 at 24%. This included 18% of the total White, non-Hispanic residents, 31% of the total Black, non-Hispanic residents and 25% of the total Hispanic residents.

Figure 2.2



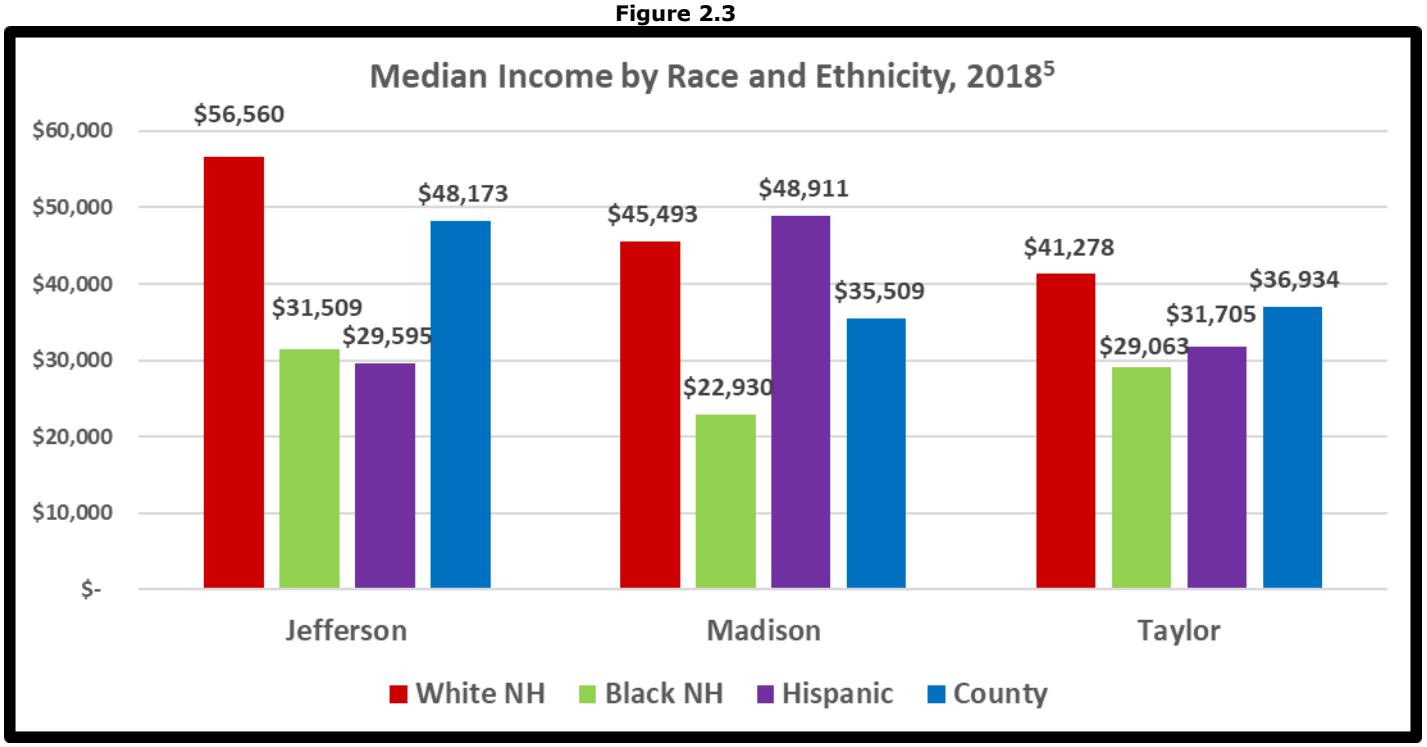
To further explore the income and poverty issues a data set is shown below that reflects the primary indicators other than those listed above. While measuring overall poverty rates over time to assess the change in the community is used for signifying a population shift (Figure 2.1), reviewing data by race is also important when evaluating health inequities (Figure 2.2)

2018 Data[5]	% Families Rec. Food Stamps	% Families Under 100% Poverty w/Female Householder	Median Household Income	Median Value Owner-Occupied Units	% Civilian Labor Force Unemployed	% Individuals Over Age 25 with High School Diploma	% of Population Over 25 with Bachelor Degree[7]
Jefferson	15.8	31	$48,173	$117,900	4.9	33.3	22
Madison	19.9	49.1	$35,509	$87,400	5.7	38.1	13.8
Taylor	21.6	40.8	$36,934	$82,900	6.2	43.3	7.4

In Madison, nearly half of families headed by a female live in poverty. This is an important measurement for social determinants because single parent families below the poverty level cannot afford adequate housing, food, clothing, transportation, day care, and other essential basic needs. A higher percentage of single parent families below the poverty level indicates a greater need for government services and programs. The median household income for Florida for the single year 2018 was $53,267.[5] The average median income for the communities of Jefferson, Madison, and Taylor Counties are significantly below this threshold, especially the poorest of the three counties in Madison

where the median income is $35,509. Figure 2.3 depicts the racial disparity in incomes; the median income for black families was almost half of their white counterparts in each county. It is also worth noting that Hispanic median income in Madison was higher than the White counterparts and higher than the county as a whole.

Figure 2.3



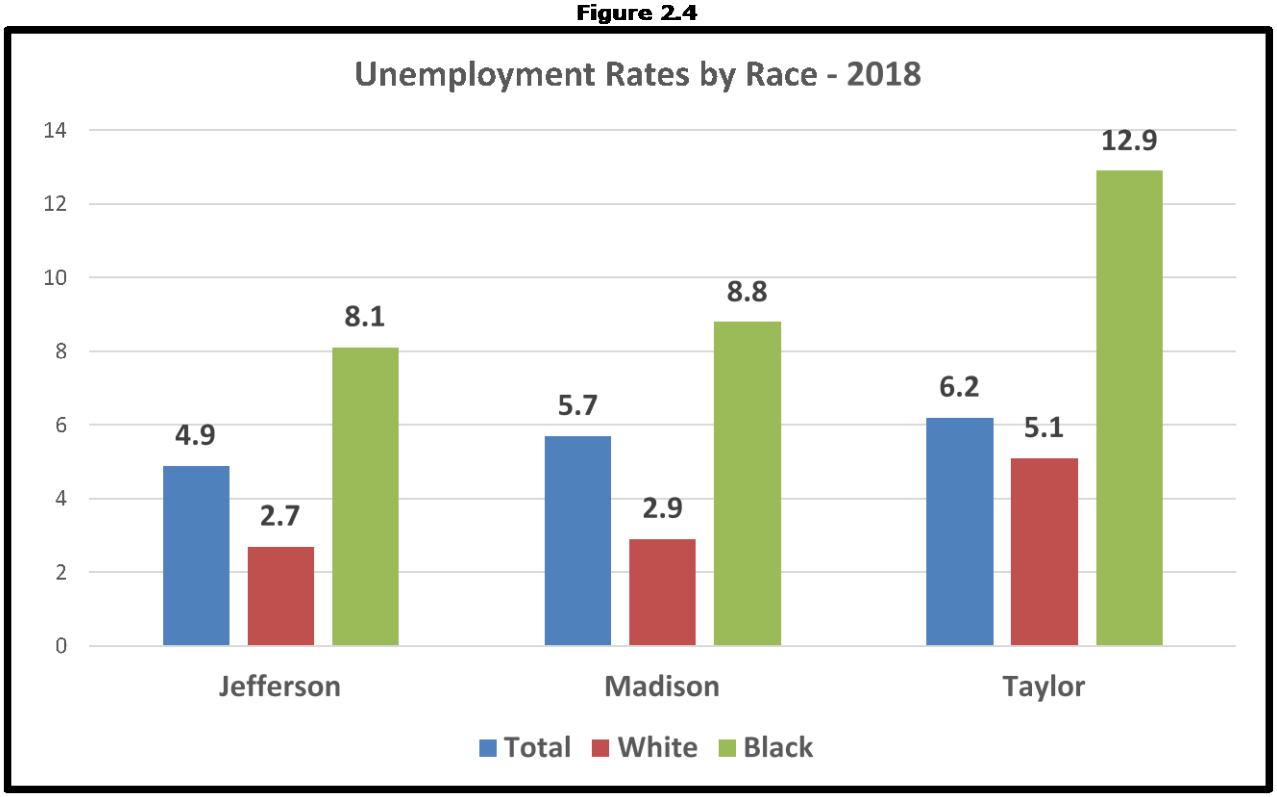
Housing

Home ownership, an important indicator of the distribution of resources, follows the trend for inequity amongst black families in a more dramatic fashion. In Jefferson and Madison Counties, the home ownership ratio is nearly equal across races with ratio of owner-occupied housing being nearly 1 to 1. However, in Taylor County that ratio is 6:1 for whites owning property compared to blacks.[5] The value of housing is not available by race for the Health Equity Profiles by County, but discernable trends based on local knowledge is available, including samples of property values from the local property appraisers. Large-acreage farms with estimated values of $250,000-$1,000,000 [are] compared with frame, single family dwellings built in the city limits near railroad tracks of $14,000-$20,000, with blacks owning the majority of the latter category. Madison County especially was a feeder community to the larger cotton industry in South Coastal Georgia in the early 1900's. As a result, many shanty-type homes were constructed for employees of the railroad system to support the demand. These homes, with only basic improvements, as well as tiny lots with newer construction exist in small rural towns and house primarily the poorest black populations. This would account for the *number* of homes being close to equal, yet the value gap is more than significant. This is evident in Madison and Jefferson Counties, primary locations for the East-West Rail system across Florida.

Unemployment

Reducing or eliminating unemployment is critical to eliminating poverty, establishing home ownership, increasing access to health care, and improving health equity. The unemployment rates below in Figure 2.4 indicate that black families are nearly *three* times more likely to be unemployed than their white counterparts.[5]

Figure 2.4



Education

Children born to parents who have not completed high school are more likely to live in an environment that poses barriers to health. Education and education policy are linked to poor health, in terms of cultural values that include education, support its attainment, and reduces stress to impoverished families.[6]

In Florida, 28.8% of individuals over the age of 25 have a high school diploma. For Jefferson County, that number is slightly higher at 33.3%; Madison's rate for *2018* is 28.1%, and Taylor fares better at 43.3%.[7] However, for the same year (2018), for those same group of individuals (>25), those that have a bachelor's degree or higher are 29.2% for Florida as a whole. For the counties of Jefferson, Madison and Taylor Counties, the rates are much lower at 22%, 13.8%, and 7.4% respectively.[7]. For purposes of the social determinants of health, this indicates that community policies do not support a value system where higher education is valued, and a high school diploma does not equate to high paying jobs.

Additionally, there may also exist a lack of access to higher education, especially in Taylor County. A 2-year college, namely North Florida College also hosts a four-year university on its campus in Madison County. Taylor County residents may have transportation barriers to access these education opportunities.

Most interesting, however, are high school graduation rates, by race. There are no *significant* racial differences for graduation rates. Blacks graduate from high school in these communities at a greater rate than their white counterparts.[5]

Health Care

Efforts to improve health have traditionally looked to the health care system as the key driver of health and health outcomes. The Affordable Care Act (ACA) increased opportunities to improve health by expanding access to health coverage and supporting reforms to the health care delivery system. These include expansion of health care to the working poor through Medicaid expansion, increased resources for home visiting services for pregnant women through the Maternal, Infant, Early Childhood Home Visiting Initiative (MIECHV), and standardization of minimum coverage through an accessible insurance marketplace. However, these important federal initiatives have had little impact on access to health care in the rural communities of Jefferson, Madison and Taylor Counties because Florida has chosen not to expand Medicaid, and because these families do not benefit from MIECHV programs in these counties, which are funded based on substantiated volume of cases.

The Women, Infants, and Children (WIC) program is available in the communities of Jefferson, Madison and Taylor Counties, and is substantially under-utilized. WIC is a nutrition program for women who are pregnant or breastfeeding or who have recently been pregnant, infants and children under age 5. WIC provides no cost access to healthy foods, nutrition education and counseling, breastfeeding support, referrals to health care, immunizations, and community services.

WIC is an income-based program where participants meet the criteria if they are currently receiving Medicaid, Temporary Cash Assistance (TCA), or Food Assistance, or not receiving public assistance and meeting the same income guidelines.

The percent of WIC eligibles *served* is compared to the total number of WIC Eligibles as a county/WIC local agency performance indicator. This includes pregnant and postpartum women and children ages 0-4. In Jefferson County, only 63.7% of the population eligible for WIC are receiving the service; in Madison County 53.7% receive services, and in Taylor County 102% receive WIC.[7] While the Taylor eligibles served data for 2018 is likely an error or a duplication of women choosing an alternate pickup location for WIC services other than their county of residence, the numbers are traditionally higher in Taylor County for WIC utilization.

Health care providers for these counties are in high demand and great shortage; there are no birthing facilities nor practicing OB-GYN services in these counties. The local health departments contract for low to moderate risk prenatal care so that women have access to these services locally. This is well utilized in Madison and Taylor Counties. The availability of providers is presented below. This data represents 2018 data in Florida Charts, however, the procurement system for this information may be flawed; there is a well-established pediatric practice in both Taylor and Madison County and family practitioners that are most likely included in the physician category.

Provider Rates (per 100,000 population)[7]			
	Jefferson	Madison	Taylor
Family Practitioners	13.5 (N=2)	5.1 (N=1)	4.4 (N=1)
Pediatricians	6.7 (N=1)	0	0
Physicians	53.9 (N=8)	15.4 (N=3)	35.3 (N=8)
Dentists	13.5 (N=2)	20.5 (N=4)	17.7 (N=4)

Neighborhood

Just as conditions within our homes have important implications for our health, conditions in the neighborhoods surrounding our homes also can have major health effects. Social and economic features of neighborhoods have been linked with poor health outcomes and risk factors for chronic disease, mental health, injuries, violence and other important health indicators. More obvious examples include pollution, garbage, and structural damage, but where someone lives also contributes to their motivation for exercise, propensity for seclusion based on crime, and participation in risky behaviors such as alcohol and drug use. The opposite is also true; neighborhoods with walking areas, playgrounds and close proximity to healthy foods encourages healthy behaviors.[8]

According to the Environmental Public Health Tracking Program, the percentage of individuals in 2019 within a half-mile access to public recreation spaces and parks is 45.19% in Florida, compared to 4.16% for Jefferson County, 8.72% for Madison County, and 17.82% for Taylor. Although this is due largely in part to the sparseness and low population density, Jefferson County fares significantly worse in this category. Access to healthy food, also measured as the percent of the population within ½ mile of source is 1.51% for Jefferson, 3.43% for Madison and 2.63% for Taylor County.[6]

Crime rates calculated by the Florida Department of Law Enforcement and reported in the Florida CHARTS system[7] are measured per 100,000 population. The crime index, also population-based using the Federal Bureau of Investigation's Uniform Crime Reporting System, measures the major violent and property crimes. Since the last review of this data in 2014 the trend in crime rate has decreased significantly in Madison County, by 41%, while increasing in Taylor County by 48%.

	Total Crime Index Counts 2014	Total Crime Index Counts 2018	% Index Change	Total Crime Rate per 100,000 2014	Total Crime Rate per 100,000 2018	% Rate Change

Jefferson	321	355	10.6%	2,199.1	2,410.9	9.6%
Madison	556	330	-40.6%	2,880.4	1,699.3	-41%
Taylor	503	722	43.5%	2,193.4	3,243.8	47.9%

Interpersonal Level

Obesity and Smoking Rates

While obesity during pregnancy is discussed in detail later in the text, obesity in the general population is indicative of lifestyle choices perpetuated by poverty. Poor nutrition is often a direct result of both the lack of availability of healthier choices, but also an economic decision where less healthy foods are cheaper and more readily available. Examples of this include the existence of "dollar" stores whose top sellers are potato chips for fifty cents, and limited frozen, prepared foods. The absence of fresh produce and meats in the sparsely populated rural communities force continued support for these low-cost merchants where families often maximize their resources under the misguided idea of thrift over nutrition.

In Florida, 63.2% of adults are overweight or obese. Jefferson County is slightly higher than the state average at 68.1% while Madison County is 65.7%. In Taylor County, however, 70.9% are overweight or obese. (BRFSS, 2016)[9]

In Florida, 15.5% of adults are current smokers, compared with 11.5% for Jefferson, 16.2% for Madison, and 21.6% for Taylor County. (BRFSS 2016)[9]

Conclusion

Like most rural communities across the nation, these counties have severe health disparities amongst the black population. The factors of social determinants of health (SDOH) have a large influence. Based on our understanding of SDOH and comparing them to the facts observed within these communities there is no surprise concerning the subpar black maternal outcomes. There are high rates of poverty across all three counties among the black population with blacks making $10,000 less annually on average than their white counterparts. Some of these disparities are not exclusively related to race, but rather a mixture of contributing factors that include poor access to healthcare that is familiar to rural communities all across the United States. JMT is significantly vulnerable because there are no birthing facilities, no maternal- fetal medicine specialists or newborn intensive care units within these counties. In regard to SDOH there are also no inpatient substance abuse services, limited outpatient substance abuse providers, limited mental health services, limited access to fresh food sources and a novice economic infrastructure.

The characteristics of the three communities have an influence on the health of the women in the communities on both the personal, interpersonal and community level. It is believed that interventions outside of the healthcare system are likely to have the greatest effect on health disparities as those contributing factors are present well before the issues are brought to the attention of medical providers[3].

Healthy Start (HS) provides a health-social system of care within the JMT community that provides the intervention the literature supports. HS provides interventions conducted at the community level and promotes the engagement of the healthcare system and social services as a support to the overall health of women before, during and after pregnancy as a method to tackle birth disparities in JMT. The most significant solutions observed in this needs assessment is the focus on preconception health among black women in all three counties. Preconception health is linked to poor birth outcomes and the characteristics of the birth mother that is linked to those outcomes. Science supports that a women's health prior to her pregnancy holds immense control over the success of her pregnancy, and the life-course projection of the fetus.

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[8]Robert Wood Johnson Foundation, Commission to Build a Healthier America. (September 2008). Where We Live Matters for Our Health: Neighborhoods and Health ISSUE BRIEF 3.
[9]Behavioral Risk Factor Surveillance System (BRFSS), Florida Charts accessed February 2020.

Birth Outcomes

Improving the well-being of mothers, infants, and children is an important public health goal for Florida and our nation - their well-being determines the health of the next generation.[1] Poor birth outcomes have large-scale societal impact - emotionally, socially and economically. In the United States - the annual societal economic cost including medical, educational, and lost productivity associated with preterm birth alone is estimated at $26.2 billion.[2]

Hospital charges for babies with a primary diagnosis of prematurity/low birth weight delivery average $75,000 per child as compared to the cost for babies without complications at $1,300 per child.[3] The costs to the family, child and society are exponential throughout a child's lifetime and cannot be measured only in dollars.

Premature birth

For the counties of Jefferson, Madison and Taylor, birth outcomes are significantly and consistently poorer than most areas in Florida; prematurity rates are indicative of these negative trends. A *premature birth* is a *birth* that takes place more than three weeks before the baby is due. In other words, a *premature birth* is one that occurs before the start of the 37th week of pregnancy. Normally, a pregnancy usually lasts about 40 weeks. Although advances in medicine have dramatically increased survival rates for preemies, every baby born premature has a higher risk of long-term and chronic lung problems, arterial hypertension and type 2 diabetes, all of which are predictors for accelerated aging, cardiovascular disease, and early death.[5&6]

For the three-year rolling average of preterm birth 2016-2018[4], roughly 10% of all babies born to Florida mothers are born before the 37th week of gestation, or prematurely. In Jefferson, the statistics mirror the state at 10.2%, in
Madison the rate is slightly higher at 12.4% and 10.8% in Taylor County. However, babies can be born at a healthy weight even if they are slightly premature, so Florida has developed the data set for premature with low birth weight, which is more telling of trends in birth outcomes.

For the rolling three-year average 2016-2018, 7.4% of babies born to residents of Madison County are born prematurely with low birth weight, in Jefferson County that percentage is 7% and 6.4% for Taylor County. The numbers are almost double for black babies, at 12.1% of all black babies in Madison County are born premature with low birth weight, compared to just 3.2% for white babies. In Jefferson County 9.7% of all black babies are premature with low birth weight, compared to 5.2% for whites. In Taylor County, the disparity narrows, with 7% of black babies born premature with low birth weight, compared to 6.2% for whites.[4]

Low Birth Weight, Very Low Birth Weight

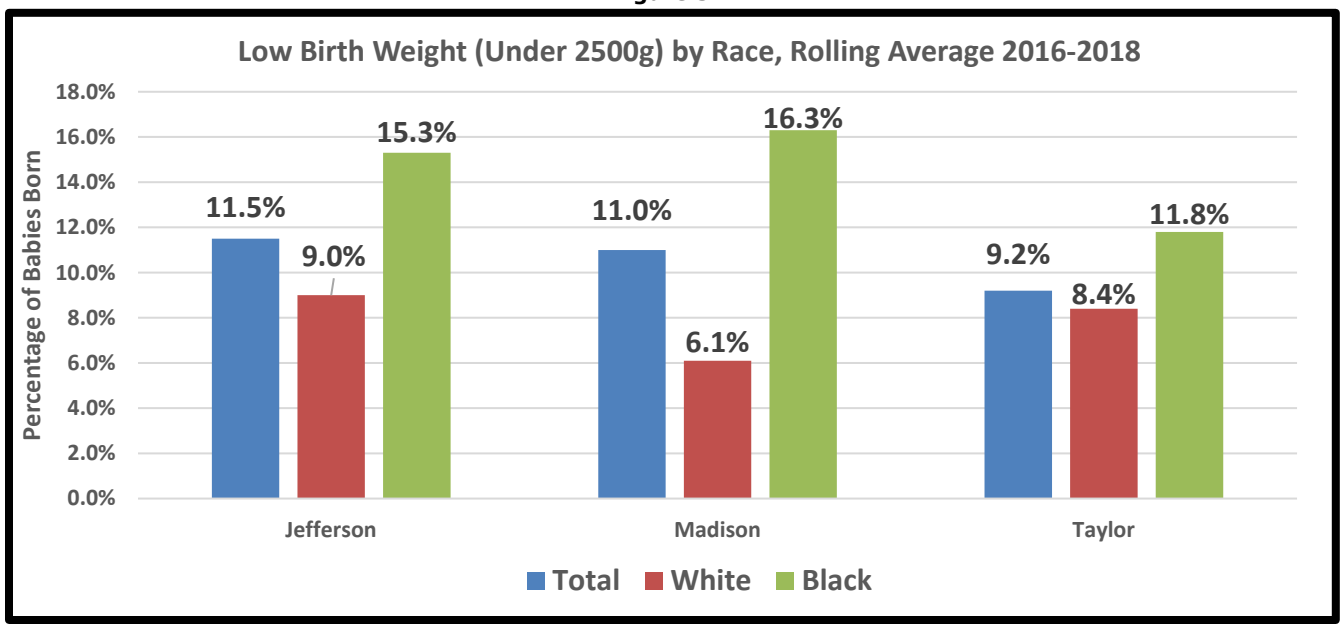
Although there is a strong correlation between low birth weight and premature birth, the two outcomes can also be exclusive of each other. An infant born late preterm can have significant

nourishment and be at a healthy weight and a low-birth weight infant can be born at full gestational age. Low birth weight most often, however, is caused by prematurity but can also be caused from inadequate growth of the fetus, issues around the mother's health status including smoking and periodontal disease, birth defects, and environmental toxins.[2] Low birth weight is defined as less than 5 ½ lbs. (2,500g) and very low birth weight is 3 lbs. 5 oz. (1,500g).

The smallest babies in Florida *per capita* are born in these counties. In Jefferson County, 11.5% of babies are born weighing below 2,500 grams and 11% of Madison County babies are underweight. Taylor County fares better with only 9.2% of babies identified as low birth weight, closer to the state average of 8.7%. Following the trend for prematurity, black rates are much higher. In Madison County, 16.3% of black babies are born below a healthy weight while the rates in Jefferson County are 15.3%. Taylor County's black low birthweight rate is just slightly lower at 11.8%.[4]

Figure 3.1 below depicts the significance of the black white gap in low birth weight. In Madison County, nearly three times more black babies than white are born below a healthy weight. Note there were no Hispanic low birth-weight babies noted for these counties during 2016-2018.

Figure 3.1



Low birth weight is a persistent issue in these counties. The multi-year trends (Figures 3.2, 3.3 and 3.4) for Jefferson, Madison and Taylor Counties depict low birth weight as a chronic problem, one that is trending in the least favorable direction for Jefferson County and one that is consistently much more pronounced than the rest of the state in Madison County.

Figure 3.2 Live Births Under 2,500 Grams (Low Birth Weight), 3-Year Rolling Rates, Jefferson County and Florida

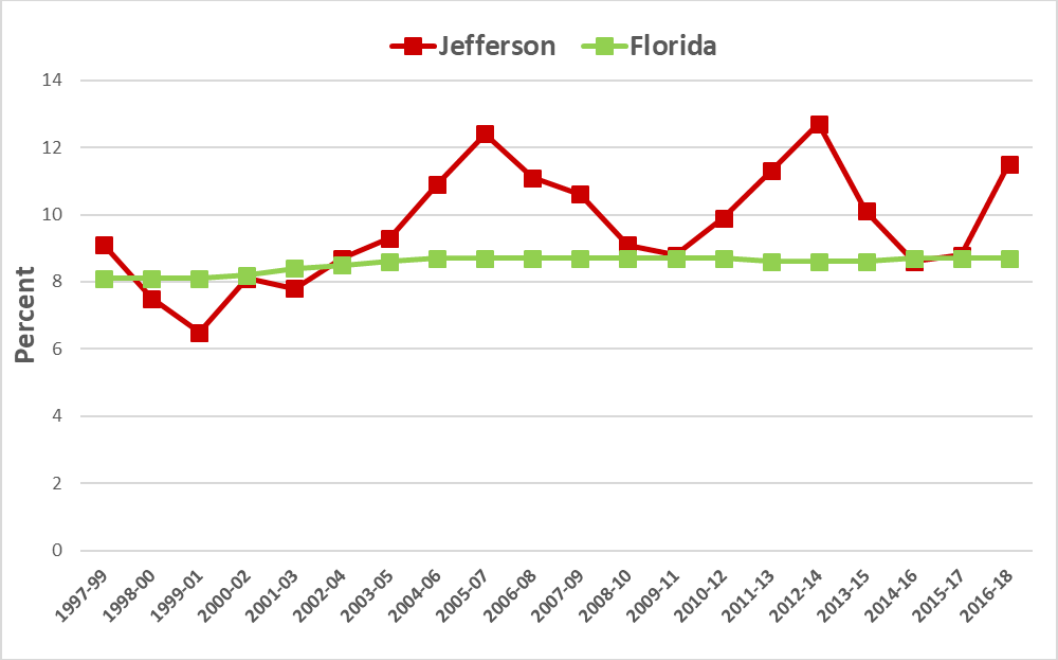


Figure 3.3 Live Births Under 2,500 Grams (Low Birth Weight), 3-Year Rolling Rates, Madison County and Florida

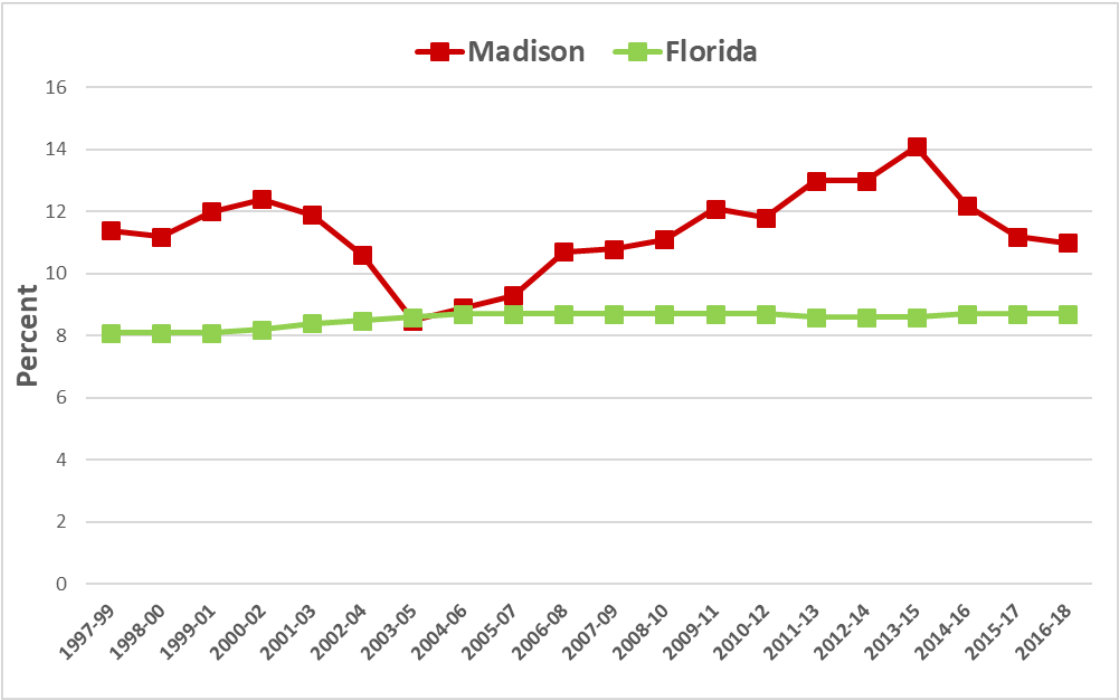
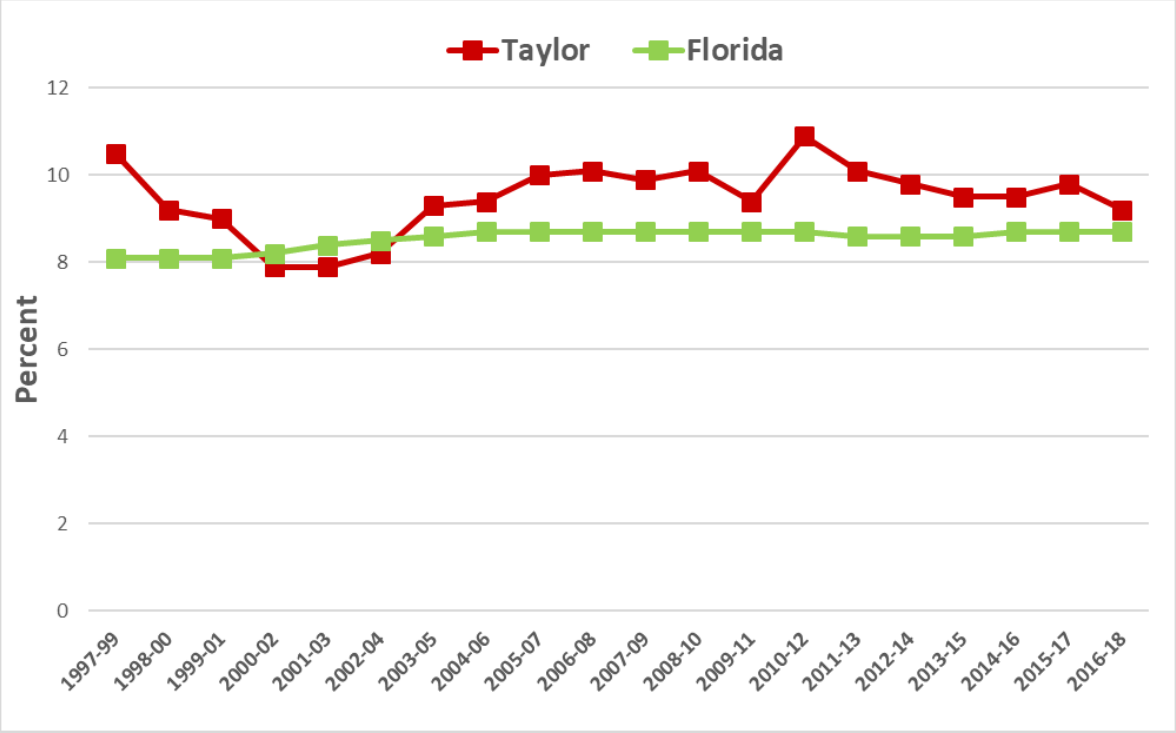


Figure 3.4 Live Births Under 2,500 Grams (Low Birth Weight), 3-Year Rolling Rates, Taylor County and Florida



Very low birth weight, or infants born below 1,500 grams is also a significant indicator of poor outcomes in these counties. Madison County fares worst in the state for the three-year rolling average 2016-2018 at **3.8**% of all babies born in Madison County are very low birth weight. Jefferson and Taylor are 1.9% and 1.7%, closer to the state average of 1.6%.[4] Of the 21 babies born in this category in Madison County for these years, 15 were black for a black very low birth weight percentage of 6.3%, the fifth highest in the state.[4] Note there were no Hispanic very low birth-weight babies noted for these counties during 2016-2018.

Preconception/Interconceptional Health Status

Preconception care is defined as a set of interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management. Certain steps should be taken before conception or early in pregnancy to have a maximal effect on health outcomes. Preconception care is more than a single visit to a health-care provider and less than all well-woman care, as defined by including the full scope of preventive and primary care services for women before a first pregnancy or between pregnancies (i.e., commonly known as interconception care).

Preconception care is recognized as a critical component of health care for women of reproductive age. The main goal of preconception care is to provide health promotion, screening, and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies.

Improving preconception health and pregnancy outcomes will require more than effective clinical care for women. Changes in the knowledge and attitudes and behaviors related to reproductive health are required to improve preconception health. Health promotion campaigns aimed at reducing smoking, misuse of alcohol, intimate partner violence, obesity, human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), reduction of vaccine-preventable diseases, and exposure to occupational hazards are among those intentional population health efforts to change these behaviors. However, the majority of U.S. adults are not aware of how these and other health and lifestyle factors influence reproductive health and childbearing. Therefore, the preconception status of a woman prior to pregnancy is a reliable predictor of birth outcomes.

SMOKING DURING PREGNANCY

The dangers of tobacco use are widely known including contributing to lung disease and cancer, and heart disease. Smoking *during pregnancy* causes additional health problems, including premature birth (being born too early), certain birth defects, and even infant death.

Women who smoke during pregnancy are more likely than other women to have a miscarriage. Smoking can cause problems with the placenta—the source of the baby's food and oxygen during pregnancy. For example, the placenta can separate from the womb too early, causing bleeding, which is dangerous to the mother and baby.

Smoking during pregnancy can cause a baby to be born too early or to have low birth weight—making it more likely the baby will be sick and have to stay in the hospital longer. A few babies may even die. Smoking during and after pregnancy is a risk factor of Sudden Infant Death Syndrome (SIDS). SIDS is an infant death for which a cause of the death cannot be determined. Babies born to women who smoke are more likely to have certain birth defects, like a cleft lip or cleft palate.[8]

Smoking rates during pregnancy have declined overall for Florida, but remain consistently higher in these counties, especially Taylor County. For the three-year rolling average for 2016-2018, all counties in this assessment had smoking rates during pregnancy higher than the state average of 4.8%. Jefferson had the lowest smoking rate of the three areas at 7.8%. However, Taylor's three-year rate for smoking during pregnancy was 17.1%, one of the highest in Florida. In Madison County, 11.9% of pregnant women smoked for 2016-2018 [4]. Figures 3.5, 3.6 and 3.7 reflect the trends over time, each with recent improvements in smoking rates.

Figure 3.5 Resident Live Births to Mothers Who Smoked During Pregnancy, 3-Year Rolling Rates, Jefferson County & Florida

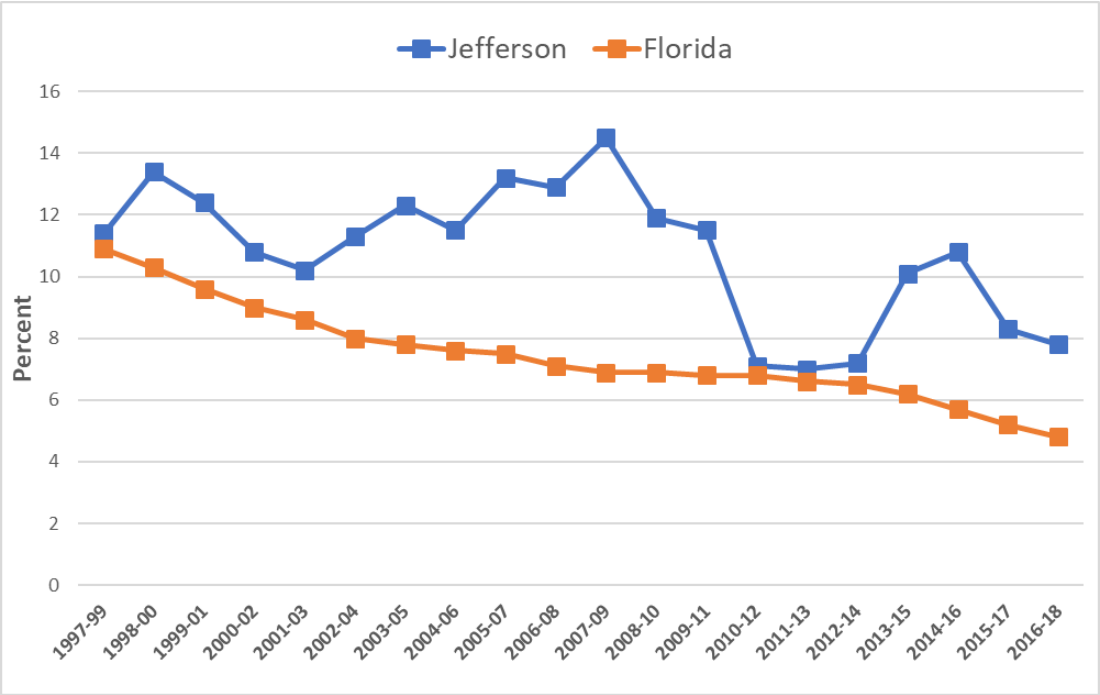


Figure 3.6 Resident Live Births to Mothers Who Smoked During Pregnancy, 3-Year Rolling Rates, Madison County & Florida

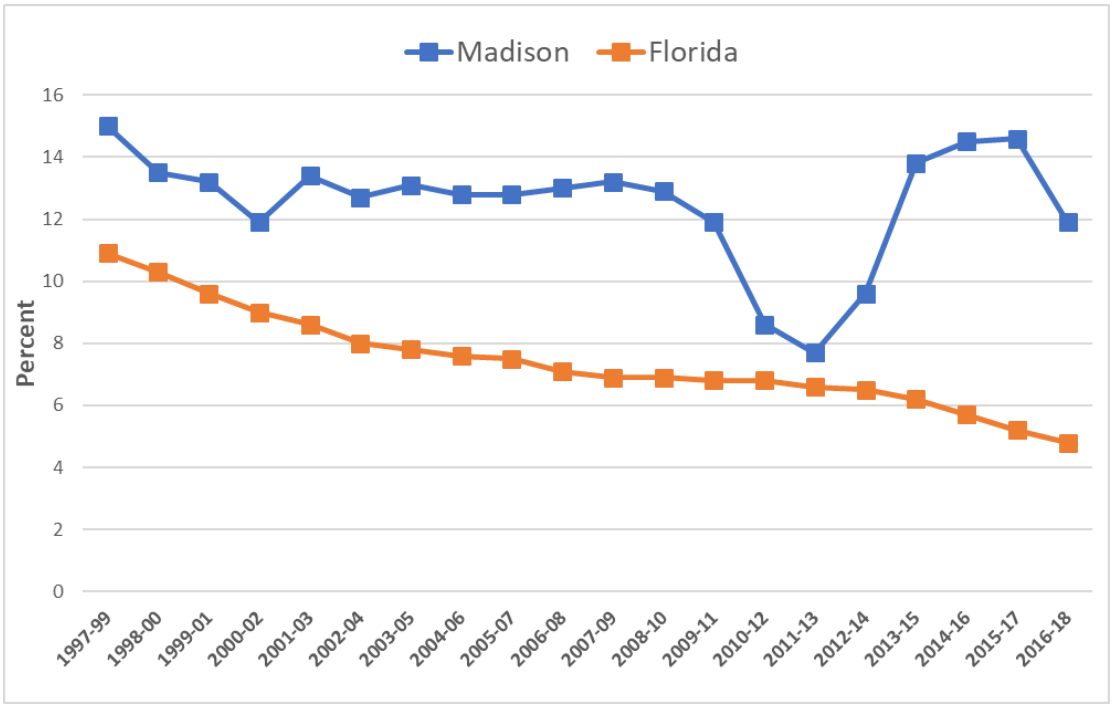
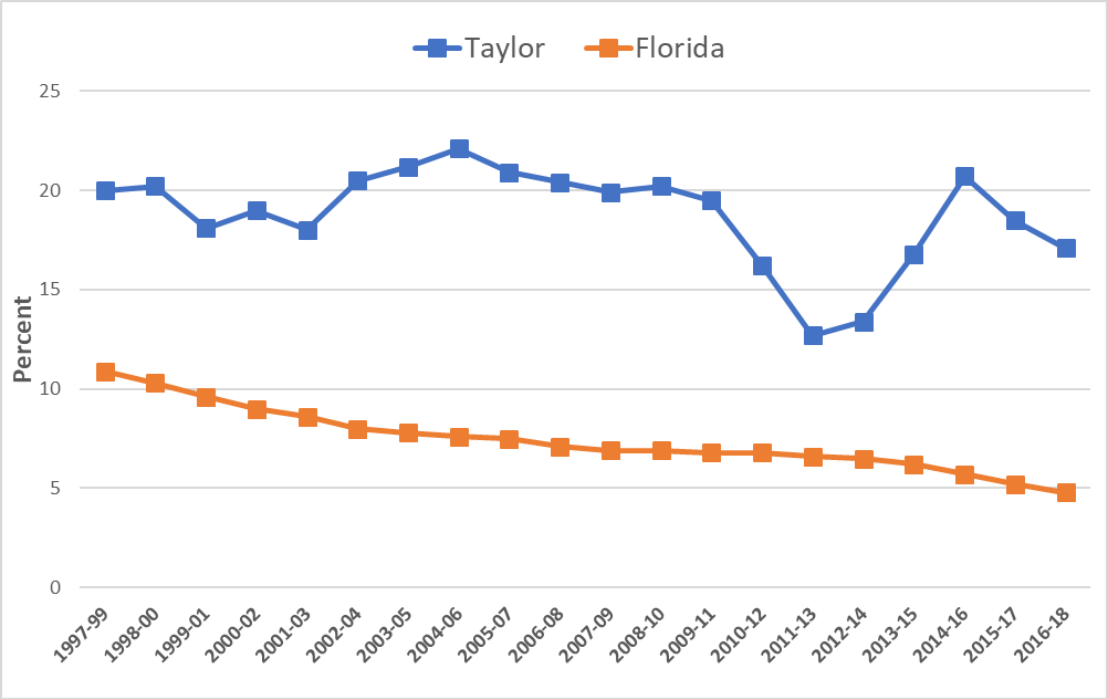
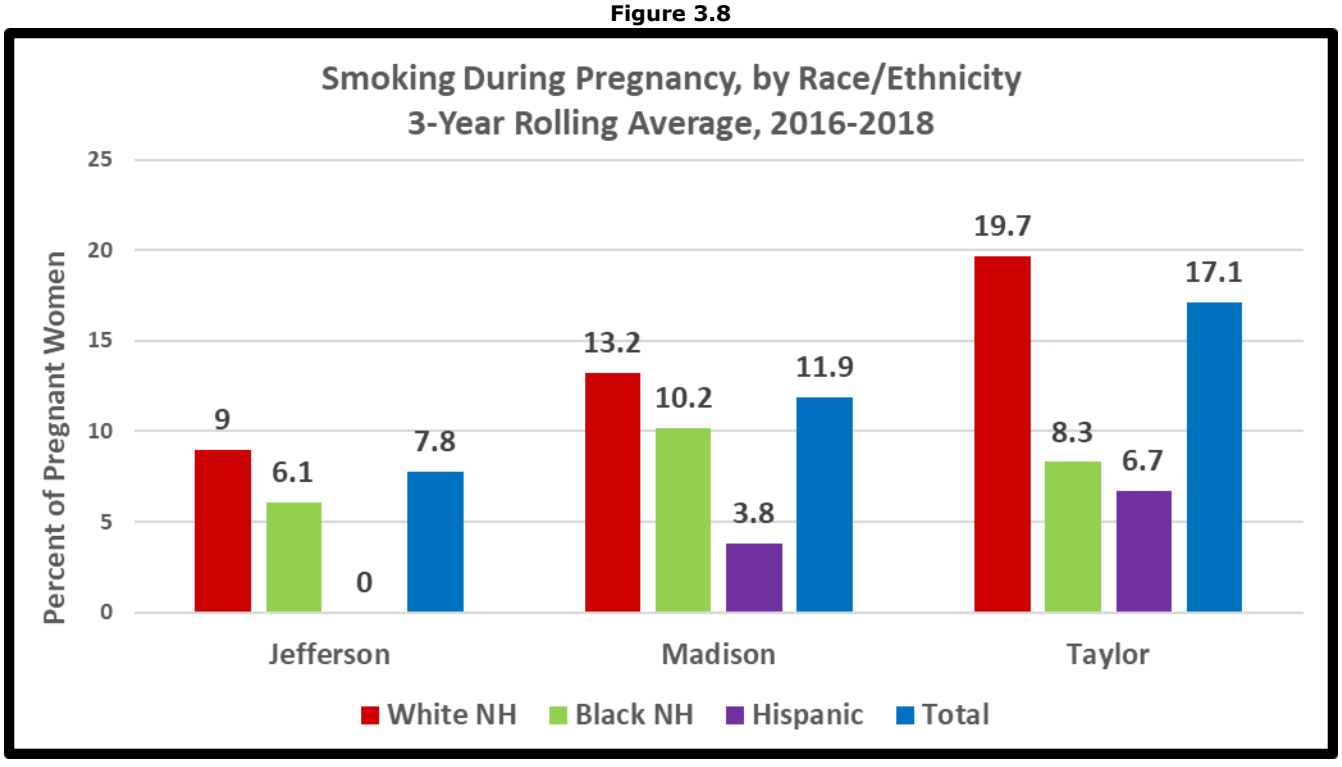


Figure 3.7 Resident Live Births to Mothers Who Smoked During Pregnancy, 3-Year Rolling Rates, Taylor County & Florida



Smoking during pregnancy, however, is *less* prevalent among black and Hispanic pregnant women than in whites, as shown in Figure 3.8.

Figure 3.8



OBESITY AND OVERWEIGHT DURING PREGNANCY

The amount of weight gained during pregnancy can affect the immediate and future health of a woman and her infant. The population demographics of women who become pregnant have changed dramatically over the past decade; more women are overweight or obese at conception. The Institute of Medicine (IOM) defines overweight women as those with BMI of 25–29.9. Body Mass Index (BMI) is calculated as weight in kilograms divided by height in meters squared. The IOM defines obesity as a BMI of 30 or greater.[9]

Being overweight or obese during pregnancy increases the risk of various pregnancy complications. Obese women are more likely to have diabetes that develops during pregnancy (gestational diabetes) than are women who have a normal weight. Women who are overweight or obese are at increased risk of developing pregnancy complications characterized by high blood pressure and signs of damage to another organ system, often the kidneys (preeclampsia).

Obesity can also create labor problems, increase the likelihood of elective and emergent C-sections, and increases the risk of infections. Prenatal care is often expanded for this overweight and obese population, including careful weight gain monitoring, additional and delayed ultrasound, additional testing for gestational diabetes and more frequent prenatal care visits. Those pregnant women at the highest rates of obesity are considered to have an adverse pregnancy, which increase costs significantly.

Taylor County has some of the highest rates of obesity at the time pregnancy occurred, at 37.2%, compared to 25.1% for Florida for the 2016-2018 three-year rolling average. Jefferson's county rate is 36.6% and Madison is 33.8%.[4] While the rates have increased for Florida and the nation as a whole, rates of obesity at the time pregnancy occurred has continued to climb, especially in Taylor County. Figures 3.10, 3.11 and 3.12 depict the alarming trends in each county over time.

Figure 3.9 shows that the issue of obesity during pregnancy is elevated for the black population and in the Hispanic population, with the exception of Madison County. The numbers of Hispanic pregnant women overall are small in these three counties; however, the percentage of those who were obese at the time of pregnancy was high. In Taylor County nearly twice as many black women were obese at conception compared to their white counterparts.[4]

Figure 3.9

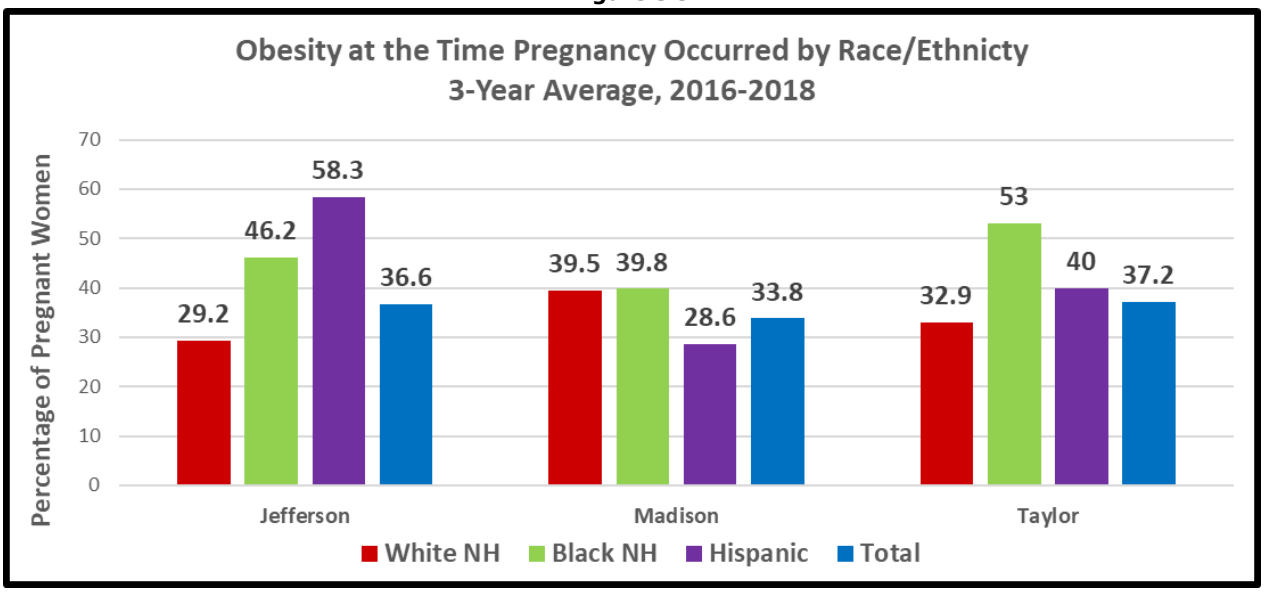


Figure 3.10 Births to Obese Mothers at time Pregnancy Occurred, 3-Year Rolling Rates, Jefferson County and Florida

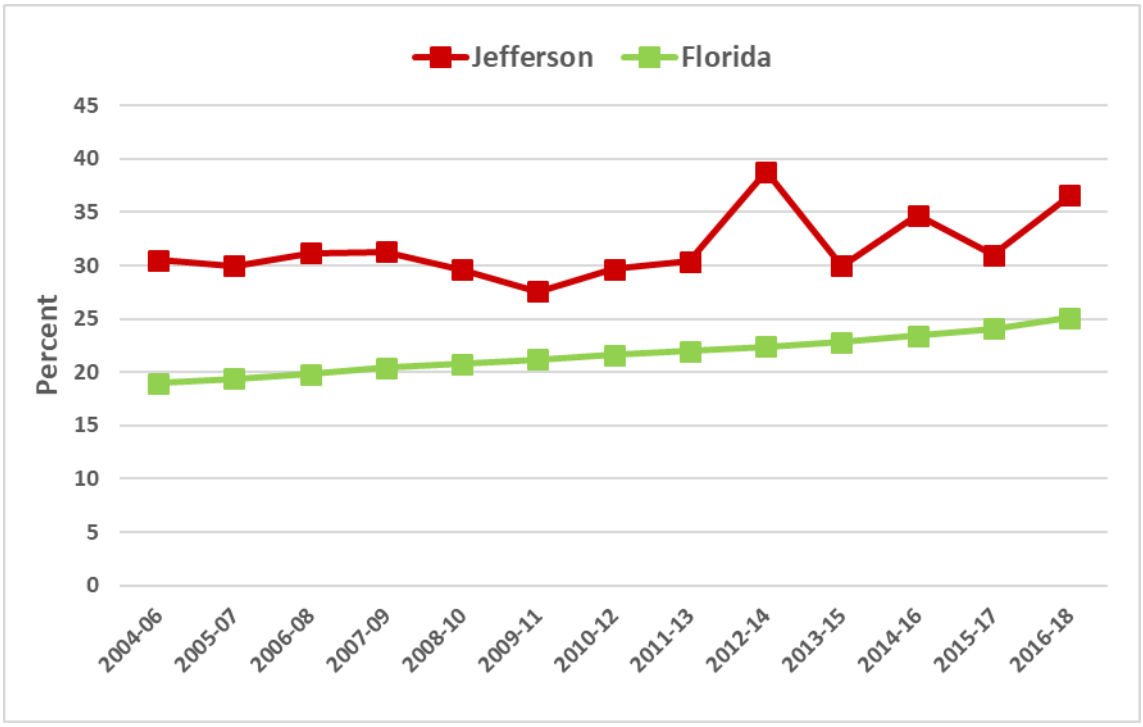


Figure 3.11 Births to Obese Mothers at time Pregnancy Occurred, 3-Year Rolling Rates, Madison County and Florida

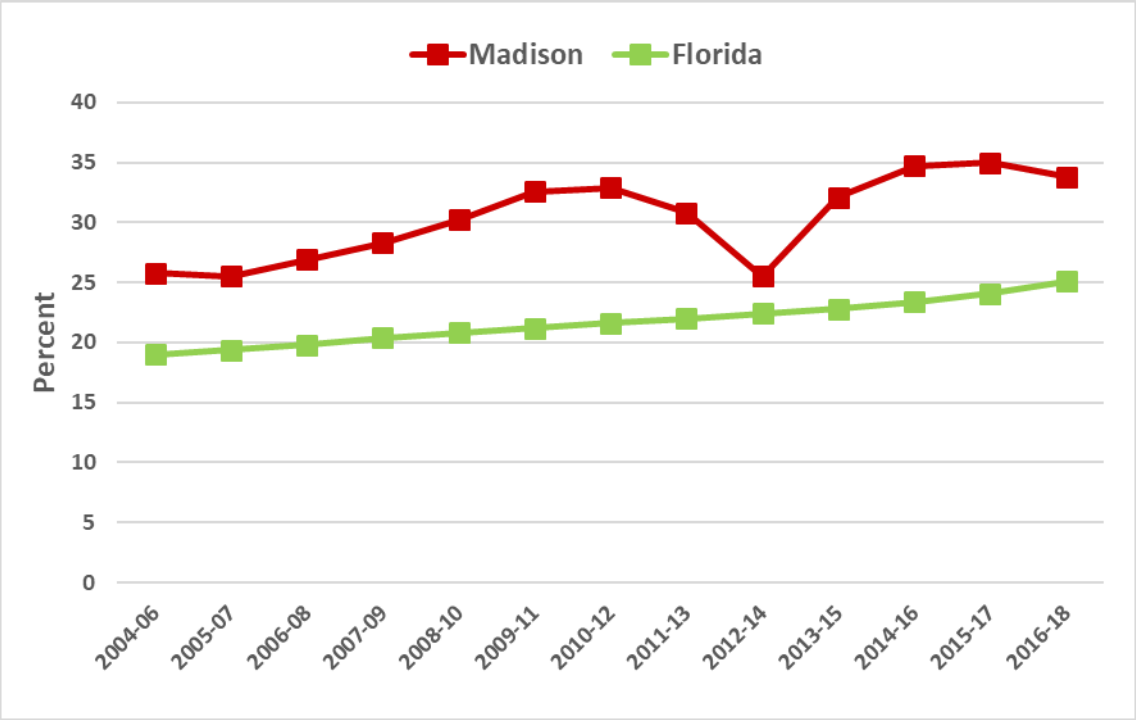
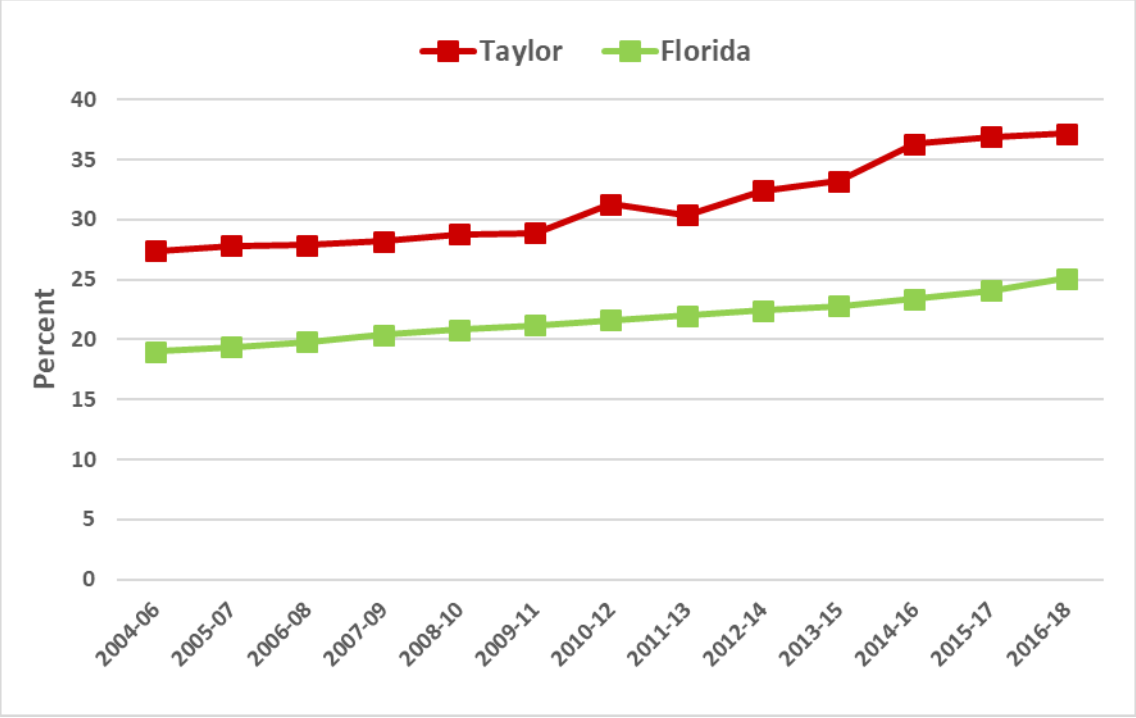


Figure 3.12 Births to Obese Mothers at time Pregnancy Occurred, 3-Year Rolling Rates, Taylor County and Florida



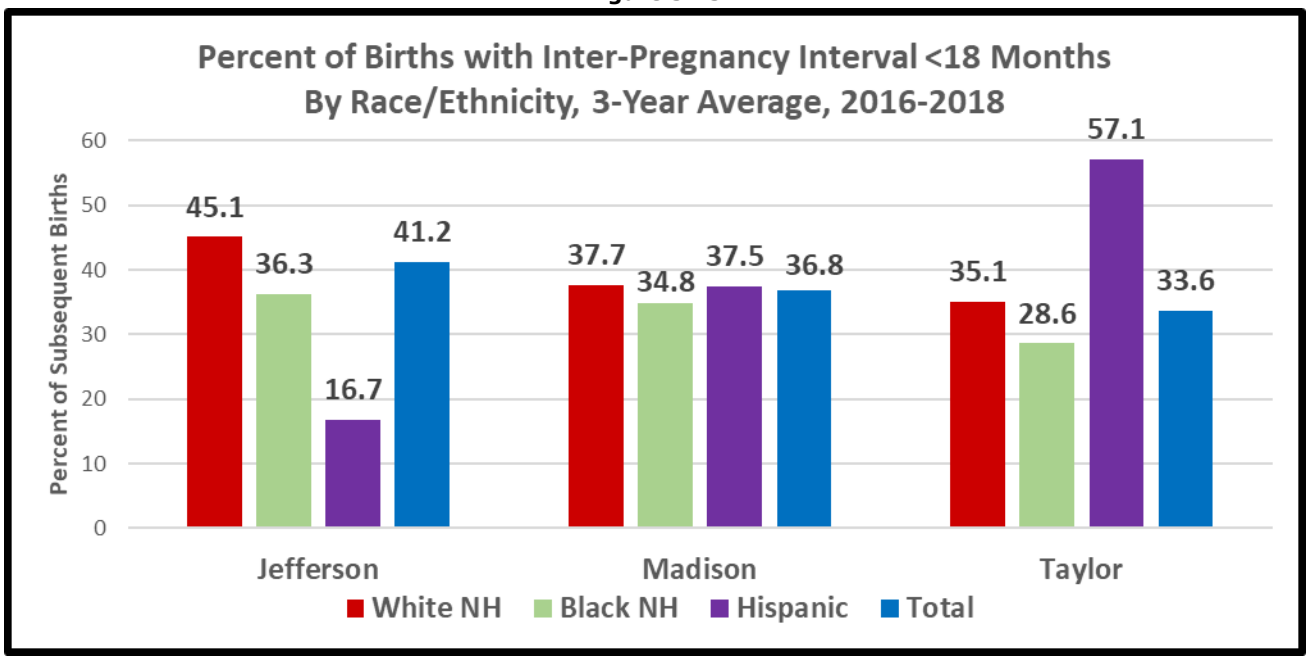
PREGNANCY INTERVALS <18 MONTHS

Family planning is essential to the health and general well-being of both mother and child (and father). An integral part of family planning is pregnancy spacing, or the amount of time between each pregnancy. The Centers for Disease Control and Prevention (CDC) has conducted extensive research on optimal baby spacing. The ideal interval is 18 months between birth of the first child and conception of the second (or subsequent).[10]

Compared with mothers that conceived during the ideal interval, those who became pregnant again within six months had a 30 to 40 percent greater chance of producing premature or undersize babies. Babies conceived too soon have problems because the mother is recovering from vitamin depletion, blood loss and reproductive system damage from the prior birth, and elevated stress from caring for a newborn.

This is a significant issue for Jefferson County, which has a high percentage of births with shorter intervals at 41.2%. Madison and Taylor County have only a slightly better interval rate at 36.5% and 33.6%, respectively (3-yr rolling average 2016-2018).[4] When reviewing the data by race, however, it is important to note that the increase in shortened intervals is more predominant for whites, similar to the smoking trends. Also note that 4 of the 7 births to Hispanic women in Taylor County had a pregnancy interval less than 18 months, or 57.1%. (Figure 3.13)

Figure 3.13



The long-term trends for births with intervals less than 18 months for Madison and Taylor Counties follow the trend for Florida, which has remained static for multi-years, with a slight decline over the

last five years. Jefferson, however, is increasing in shorter birth intervals while the state is improving. (Figures 3.14, 3.15, and 3.16)

Figure 3.14 Births with Inter-Pregnancy Interval < 18 Months, 3-Year Rolling Rates, Jefferson County and Florida

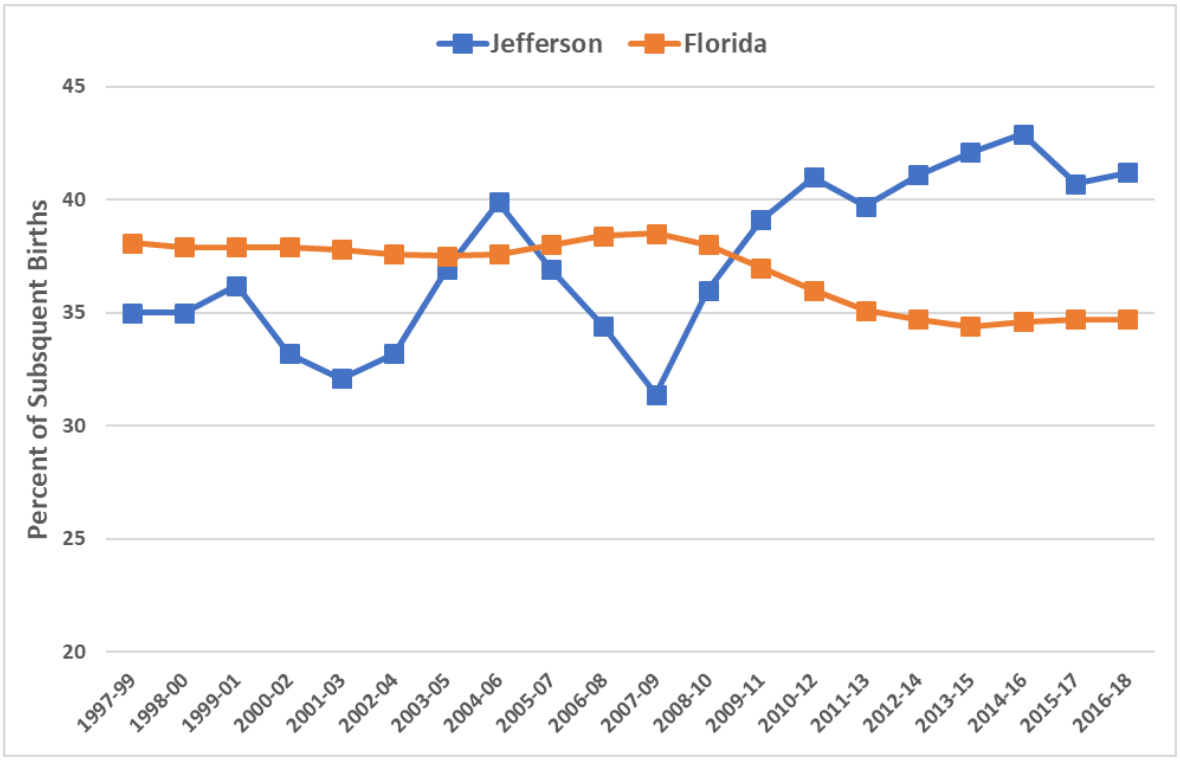


Figure 3.15 Births with Inter-Pregnancy Interval < 18 Months, 3-Year Rolling Rates, Madison County and

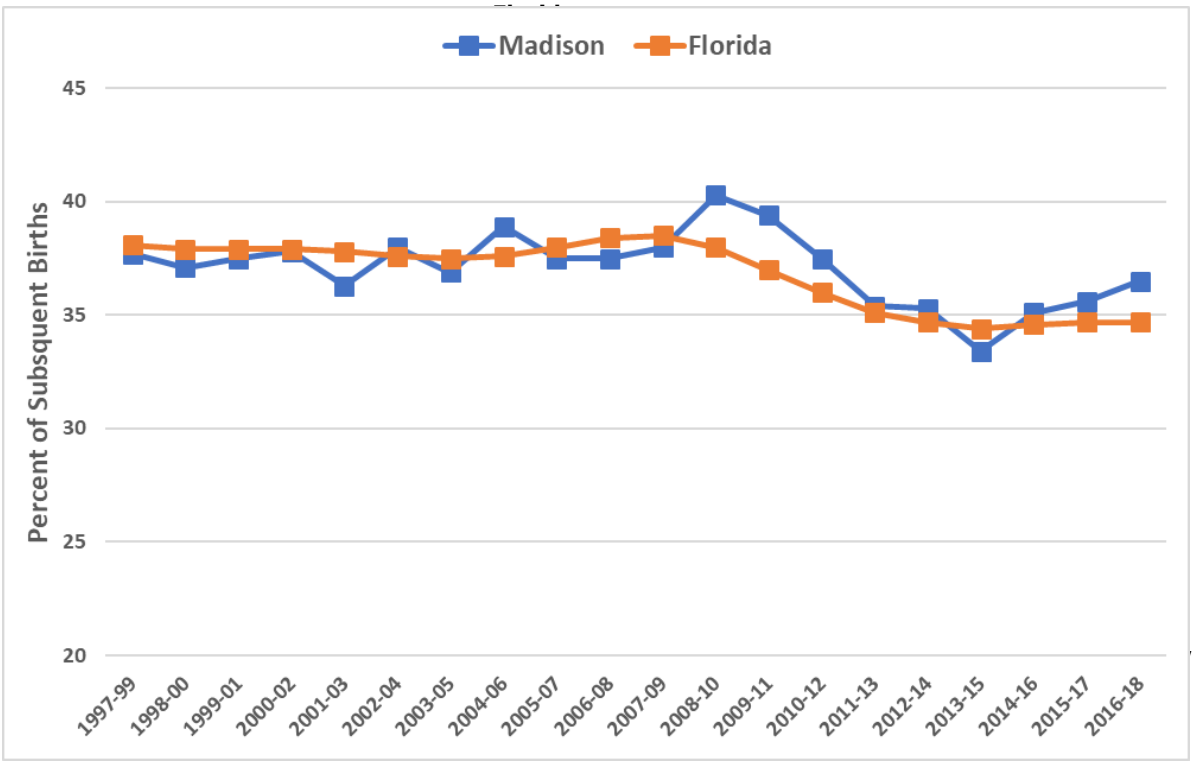
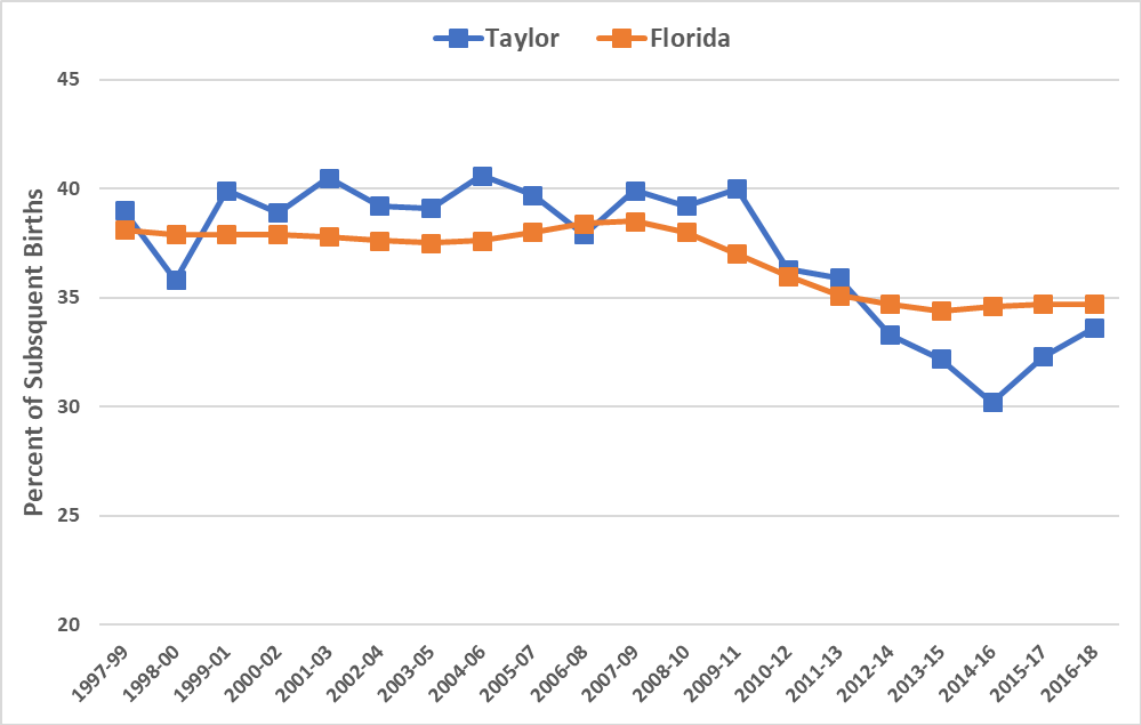


Figure 3.16 Births with Inter-Pregnancy Interval < 18 Months, 3-Year Rolling Rates, Taylor County and Florida



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Conclusion

Although premature birth is the leading cause of infant death, there are many contributing factors that prevent a full gestational period of 40 weeks. These factors range from medical diagnoses such as infections and incompetent cervix, premature rupture of membranes, hypertensive disorders, substance abuse, and even unknown causes of preterm labor. Early elective cesareans are also included in the category of late preterm births. While common, preterm labor does not have a known cause, but there are prevalent trends that point to risk factors. Many of these risk factors are directly associated with the preconception health status of the mother and characteristics during pregnancy, which includes nutritional status, pregnancy history, present pregnancy characteristics, psychological characteristics and adverse behaviors. In the literature, there is a consistent racial disparity among women in regard to preterm birth. In developed counties, like the US and UK, women who identify as black, African-American and Afro-Caribbean are more likely than their white counterparts to deliver premature babies— specifically because of preterm premature rupture of the membrane, also known as PPROM (Goldenberg et. al). From the data on premature birth rates for JMT, especially the black prematurity rates, it is substantially a greater problem for the black community. Of the counties in Florida with the highest rates of blacks, Jefferson and Madison County have the highest rate of premature babies born to black mothers. In these two counties, the premature birth outcomes amongst black babies are a reflection of the literature. This disparity remains unexplained due to numerous confounding variables and inconsistencies once a hypothesis is established. Also significant is the overall decline in premature birth for all mothers in Taylor County. This alludes to an ideal characteristic or protective factor that is consistently changing this birthing outcome for the better in Taylor County. There are maternal risk factors that have a higher association with preterm births and linking these characteristics to the black women in Madison and Jefferson County is the best means of action to identify risk-specific intervention.

The health outcomes of the youngest and smallest members of society are a good indication of the health of a population. The data reflects that the tri-county area of Jefferson, Madison and Taylor counties has some of the worst low weight birth outcomes in the entire state of Florida. As aforementioned, prematurity primarily causes Low Birth Weight (LBW) and Very Low Birth Weight (VLBW) in infants, so it is no surprise that Jefferson and Madison Counties have non-ideal outcomes in this category based on the data presented. While preterm birth is the leading cause, LBW and VLBW is also a result of intrauterine growth restriction (IUGR), which is a diagnosis given to growth-restricted fetuses and defined by the American College of Obstetrics and Gynecology (ACOG) as estimated fetal weight of less than 10th percentile for gestational age. IUGR is the second leading cause of perinatal death and IUGR babies have higher risks of disorders like respiratory distress syndrome and hemorrhaging (Suhag

and Berghella). Maternal factors that cause IUGR include short inter-pregnancy interval, race and low socioeconomic status (Suhag and Berghella). This supports the notion that family planning as well as other preconception components play a role in the LBW and VLBW outcomes.

Smoking is associated with a plethora of health concerns throughout all age groups, but smoking is especially detrimental to birth outcomes. Tobacco usage in all forms is linked to poor birth outcomes to include preterm delivery, LBW and VLBW, IGUR and neonatal death (Cnattingus et al and Vardavas et. al). Tobacco usage has been on a decline across the nation and the state of Florida due to effective prevention and intervention strategies from national and local public health agencies. Despite efforts, there are still areas where tobacco usage among pregnant women remain prevalent. In JMT, the smoking rate is consistently above the state average and, alarmingly, in Taylor County the rate is twice the state average. Incidence of white women who smoke during pregnancy is more prevalent than their black counterparts, especially in Taylor County. There is an apparent gap in services to women of birthing age in all three counties. Evidence suggests that almost half of women who smoked prior to pregnancy continue to smoke during their pregnancy and may not believe that there is merit in smoking cessation during the pregnancy (Knopik 2009). This may be the case in Taylor County as 26% of all women identified as "smoker" based on Florida Charts 2018 data. Service delivery has to focus on cessation efforts among pregnant women throughout JMT. Research supports that early tobacco cessation during pregnancy significantly modifies adverse pregnancy outcomes and even results in birth outcomes comparable to women who never smoked during their pregnancies (Knopik 2009 and Vardavas et. al). This is the message that needs to make it to the target population to make efforts for intervention more successful.

The consequences of obesity on population health is well known and linked to conditions like heart disease, diabetes and hypertension. These same concerns remain true for maternal obesity. Obesity during pregnancy can result in a plethora of medical complications for both the mother and the fetus, but specifically women with a higher than normal body mass index (BMI) are linked to preterm labor, low birth weights and stillborn deliveries (Athukorala et. al and Dohetry et. al). These women were also more likely to receive a planned or emergency caesarian section due to health concerns like preeclampsia or complications during the delivery process, respectively (Athukorala et. al). In women labelled as overweight and obese prior to pregnancy there is an increase in chronic medical conditions before, complications during the pregnancy and at birth (Dohetry et al.). The preconception health of the mothers was linked to black infant deaths in all three of the JMT counties (Figures 1.3, 1.4, 1.5). The data shows that the rates of overweight and obese women in these counties is an alarming trend when compared to the state averages, specifically in Taylor County. There are reasons to believe that this factor is a significant component to the overall health of the mother. This supports the notion that target-specific services on preconception health counseling is essential amongst this population and should be included in further planning on service delivery.

There is a greater understanding on the consequences associated with the pregnancy intervals also known as baby spacing. The shorter the interval between the delivery of one baby and the conception of another has a strong correlation to LBW and VLBW babies (Eijsden et. al). The accepted hypothesis is

that nutritional depletion and stress on the mothers' body from the labor and delivery process results in high-risk pregnancy and poor birth outcomes for the subsequent infant due to lack of restoration (Zhu 2005 and Eijsden et. al). The data reflects that this is a concern among all of the women in the tri-county area, but specifically a large concern for Jefferson County. The data concerning baby spacing among all three counties alludes to a need in family planning in service delivery.

Understanding of the birth outcomes provides a snapshot analysis of the overall health of the maternal and infant population. In theory, it would provide for retrospective view on the needs of women of birthing age. This is not easily identified in the tri-county area. The birth outcomes amongst Jefferson, Madison and Taylor Counties reinforces the idea that these communities hold exceptionally different populations. There is no consistency among all three counties to identify a common poor birth outcome and then plan accordingly. However, there are trends that can be observed in the data that suggest that the characteristics of the birth mother prior to conception has a major impact on the birth outcomes. All of the discussed birth outcomes are identified in the literature to stem from behavior patterns of the mother before the pregnancy including BMI, smoking habits, and utilization of family planning services. One common theme amongst the literature consulted on birth outcomes is that the best means of action for addressing birth outcomes is services geared towards preconception health counseling.

Additional resources

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PRENATAL CARE

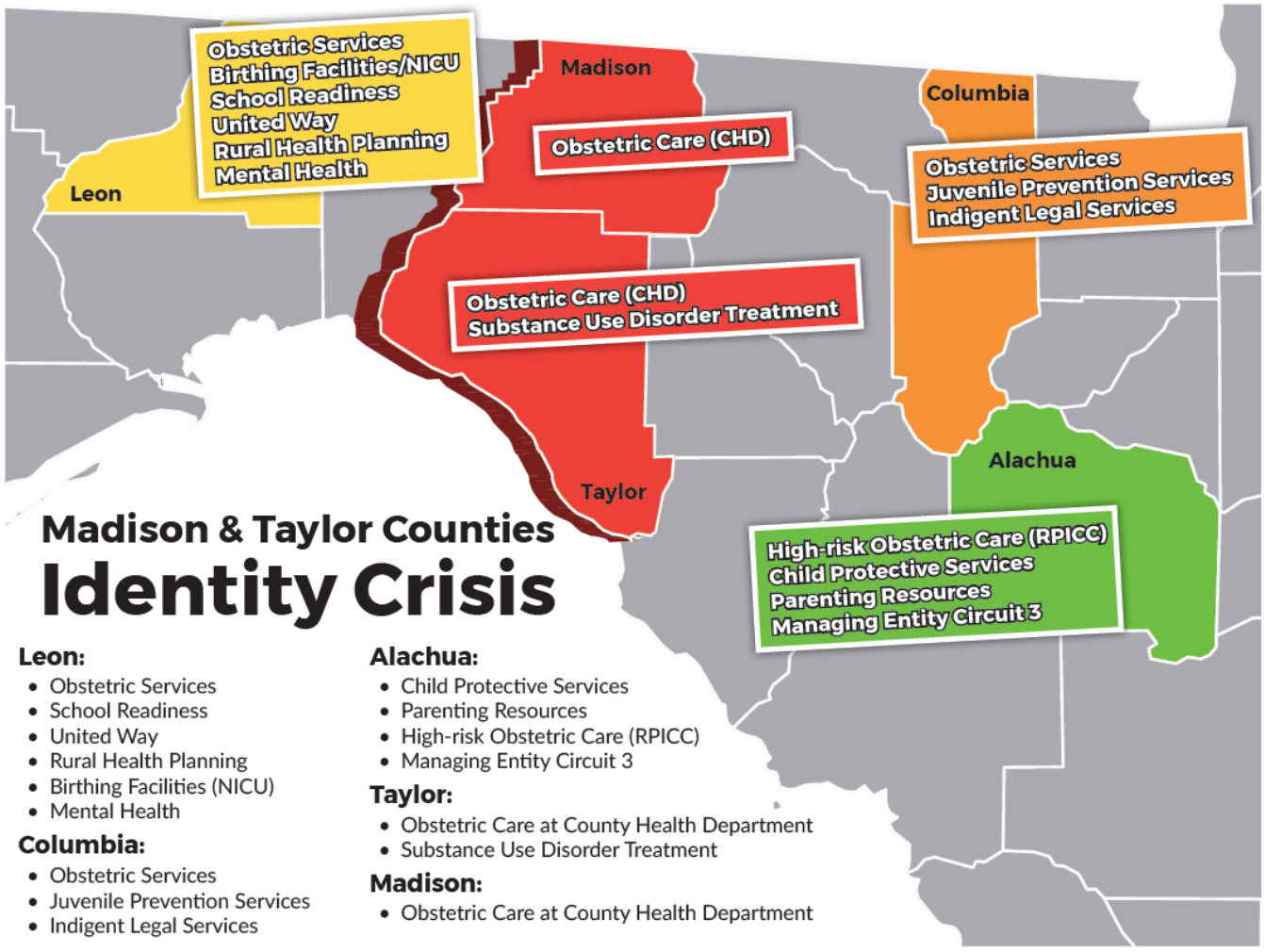
Prenatal care, for the most general understanding, is the medical interventions intended to reduce the incidence of low birth weight and other adverse birth outcomes. The notion of medical interventions throughout pregnancy only became widely accepted in this century as a value to both mother and child.[1] However, a significant amount of research from diverse disciplines on the topic of prenatal care expands the research scope to include those interventions that are nutritional and educational in nature to define a more holistic approach to prenatal care and its efficacy. Much of the controversy of the effectiveness of prenatal care in preventing poor birth outcomes is rooted in the notion of defining dosage. Life course theorists suggest that women who seek early prenatal care for planned pregnancies are those with higher incomes, have a higher value on education and personal health, and pass these values within their own culture to their offspring, perpetuating health for the infant and across his life course as well. Therefore, dosage is not the only scientific measure of prenatal care efficacy.[3]

The most widely known and practiced prenatal interventions to optimize birth outcomes among practicing obstetricians are 1) psychosocial (aimed at smoking and other health behaviors); 2) nutritional (aimed at adequate weight gain and chronic disease management); and 3) medical (aimed at general morbidity).[2] System level approaches like the Florida Healthy Start system impact the accessibility and appropriateness of services for the entire target population. These ancillary activities include interventions based on risk factors, health promotion, social services, and case management and provide varying approaches and benefits. The data on the collective impact of systems of care and the correlation to the success of prenatal care in reducing poor birth outcomes hinges on the idea that prenatal care is a more unified concept than currently acknowledged.[2]

Prenatal care has not been demonstrated to improve birth outcomes conclusively. However, policymakers deciding on funding for prenatal care must consider these findings in the context of prenatal care's *overall* benefits across the life course of the individual and potential cost-effectiveness. Cost-effective reductions in low birth weight deliveries are proven to correlate with adequate prenatal care, but have proven difficult to establish as single contributors of good health.[4]

In the rural communities of Jefferson, Madison and Taylor Counties, there are no private obstetric providers practicing within the counties and no birthing facilities. These communities primarily depend on Leon County (Tallahassee), with a few births delivered in Columbia (Lake City) and Alachua (Gainesville) for deliveries, high risk obstetric care, and in-patient perinatal specialty care. However, the county health departments in each county provide low to moderate risk obstetric care services. This is highly utilized in Madison County, as the furthest point from any birthing facility in Florida at 110 miles round trip. Due to the unique geographical location of the two eastern counties, their residents are not clearly identified in one or another medical community, often further fragmenting the supportive services associated with prenatal care. The graphic below demonstrates that limited services are available at long distances in each direction for both Madison and Taylor Counties.

Figure 4.1



For the purposes of measuring prenatal care in this needs assessment, the Kotelchuck index for adequate measurement of care is used. According to the Florida Department of Health, prenatal care (PNC) refers to the medical care that women receive during pregnancy. These health care visits provide benefits to both the mother and baby and are used to monitor the progress of a pregnancy. To achieve the greatest benefit for both the mother and baby, it is recommended that women begin PNC visits in the first trimester of pregnancy or as soon as pregnancy is suspected or confirmed. Early PNC allows health care providers to identify potential problems as early as possible so they can be prevented or treated before they become serious. During the first PNC visit, the health care provider conducts a physical exam, a pelvic exam, takes a complete health history, and orders blood tests. Follow-up visits are less detailed, and focus on monitoring the baby's growth, the mother's weight gain, and her blood pressure as well as

addressing any questions or concerns the mother may have. Ensuring that all women receive early and adequate PNC is a top maternal and child health priority. Public health programs emphasizing access to and utilization of early PNC services exist that focus on those women least likely to receive early PNC including teens, women with less than a high school education, and Black and Hispanic women.[5]

One of the strengths of the communities of JMT is the utilization of the local health departments for services. This results in higher rates of early entry into care. For the three-year rolling average 2016-2018, Florida's rate for early (1st trimester) prenatal care was 77.4%. Jefferson was slightly lower than the state average at 75.9% while Madison and Taylor rates are 75.3% and 77.9% respectively.[5] Even though Jefferson County has closer proximity to Leon County service providers, the county has also experienced a slight increase in the Hispanic population which may account for less than expected early care rates. The slight shift in demographics is more evident when reviewing rates over time. Figures 4.3, 4.4, and 4.5 reflect the trends over time, with rates falling below 80% in the last five years for all three counties. Figure 4.2 shows the early access rates by race. There are no significant differences between races that access early prenatal care, other than the significant difference in Hispanics in Jefferson County.

Even though there are limited resources within these communities for prenatal care, the infrastructure of *obstetric services located at the county health departments* is the safety net for ensuring early access in these communities. Otherwise, the trend lines in Figures 4.3-4.5 would likely be inverted.

Figure 4.2

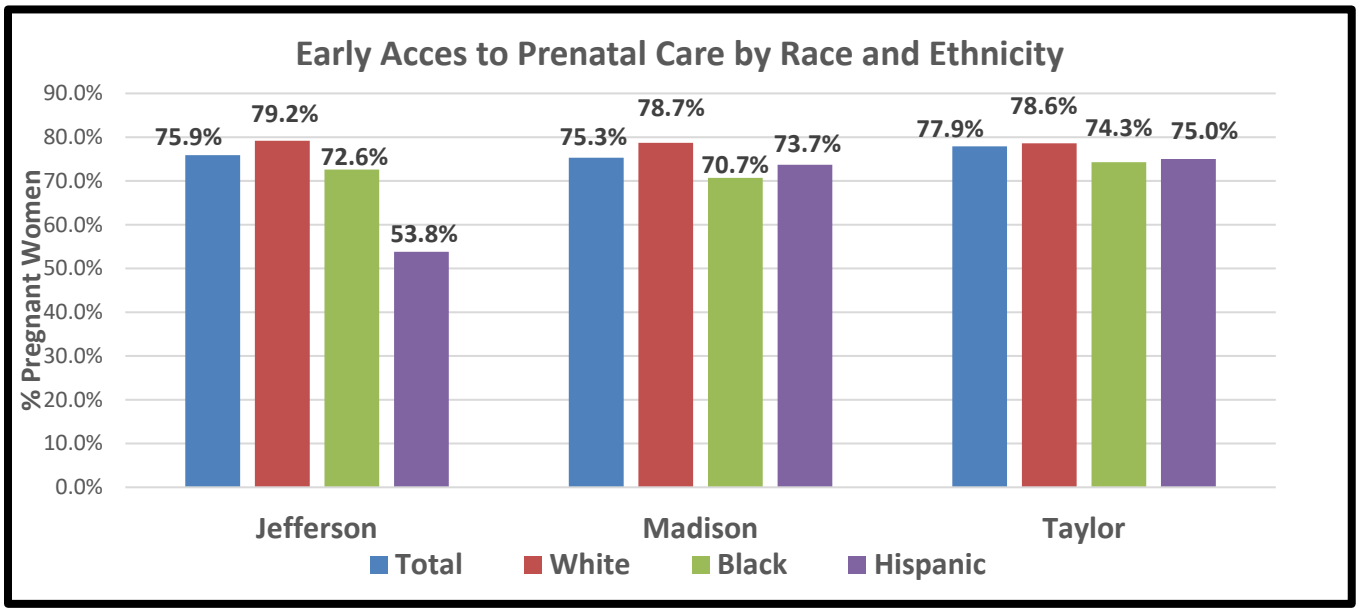


Figure 4.3 Births to Mothers with 1st Trimester Prenatal Care, 3-Year Rolling Rates, Jefferson County and Florida

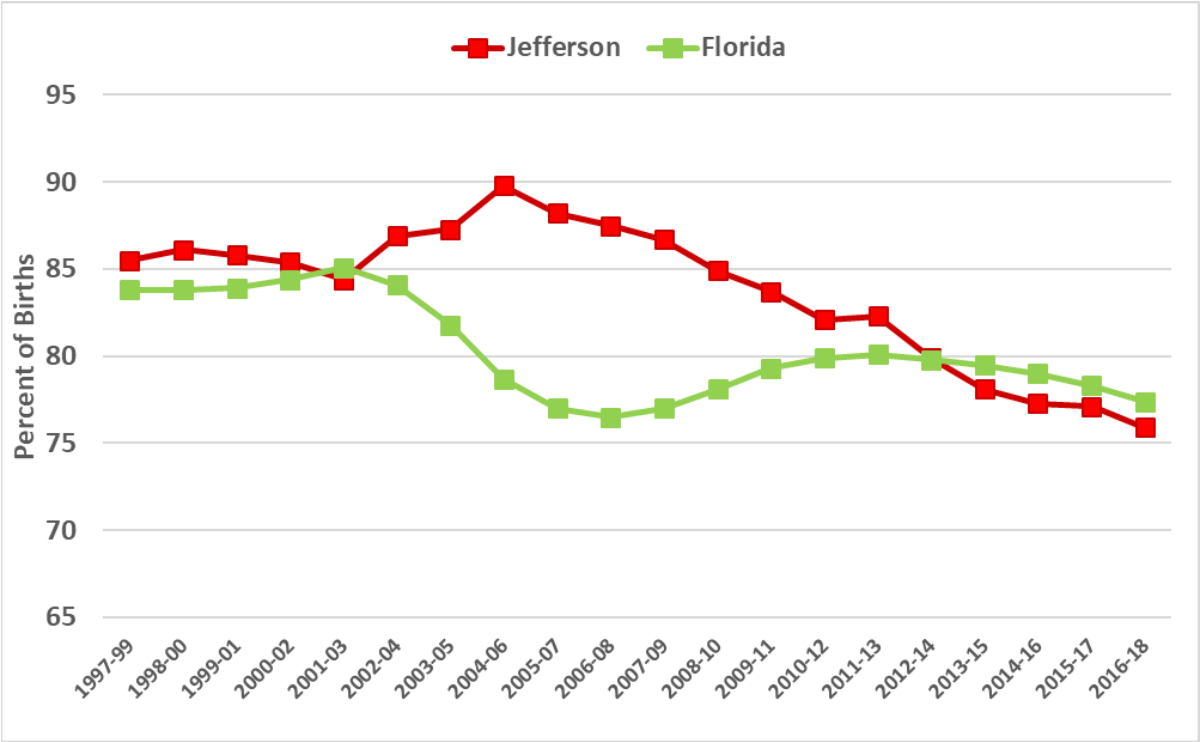


Figure 4.4 Births to Mothers with 1st Trimester Prenatal Care, 3-Year Rolling Rates, Madison County and Florida

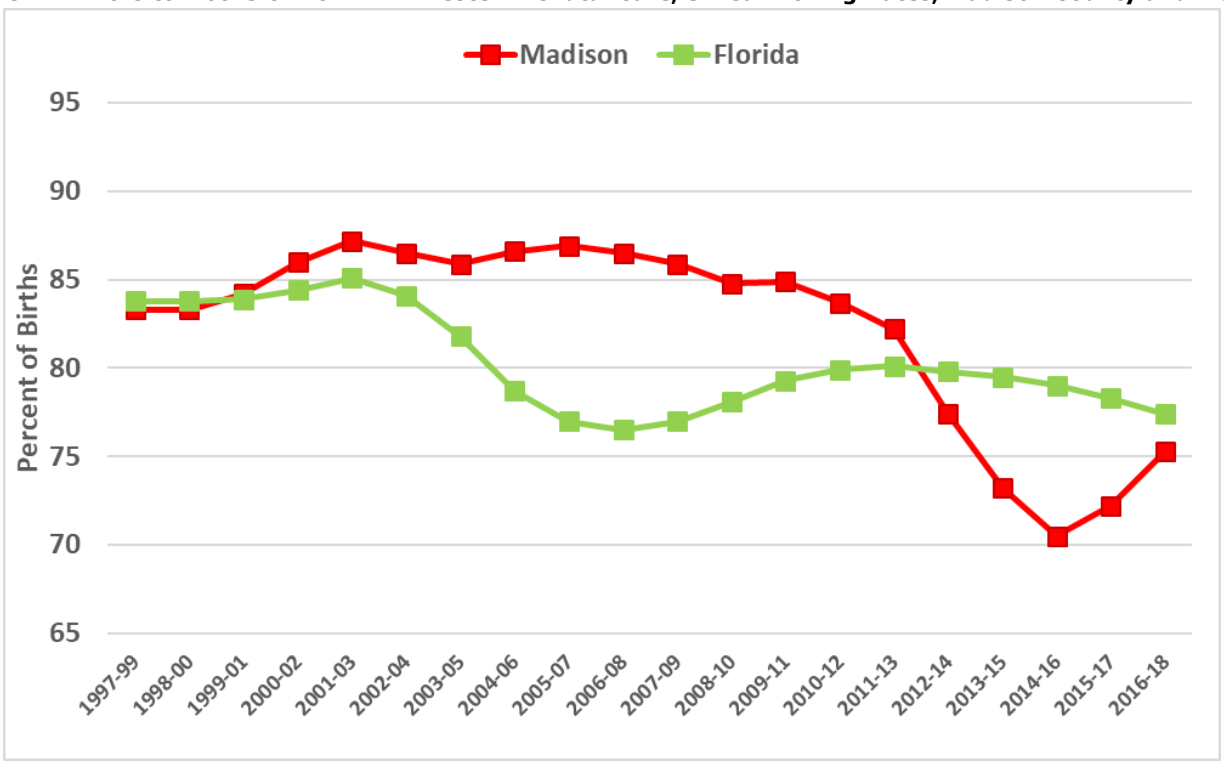
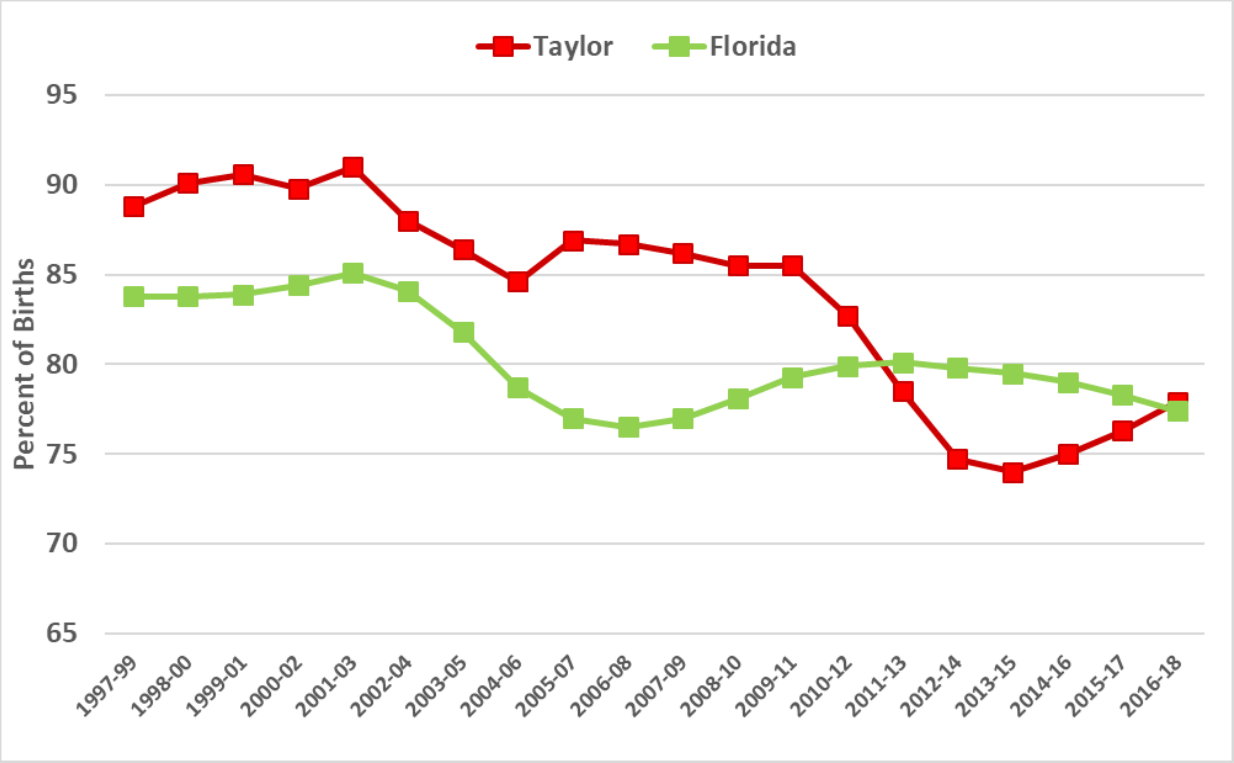


Figure 4.5 Births to Mothers with 1st Trimester Prenatal Care, 3-Year Rolling Rates, Taylor County and Florida

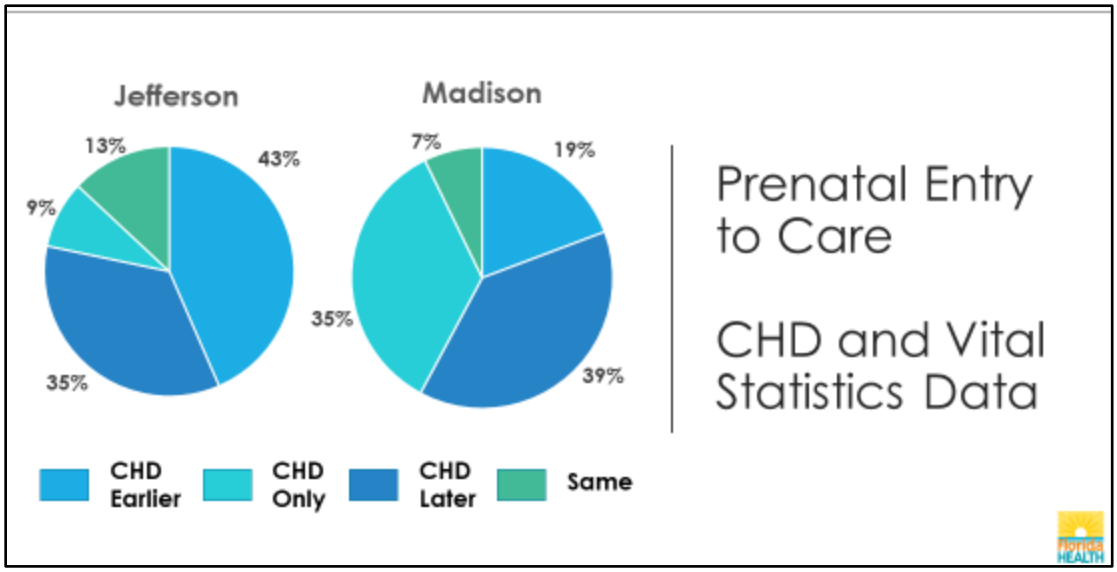


For the same reason that early entry into prenatal care is a predictor of better birth outcomes and the opportunity for intervention, late entry into prenatal care is a cause for alarm. There are many reasons why women enter into care late or have no prenatal care at all. These range from denial about the pregnancy or hiding a pregnancy from others, to a personal belief that that there are no benefits to early care. Some women who are substance-dependent may not seek care until delivery to avoid issues associated with their dependency. Undocumented citizens may only present at delivery as well, since Medicaid does not cover the majority of the cost of their prenatal care.

In Florida, 6.7% (2018) of pregnant women are late to care, or have no prenatal care at all. For the counties of Jefferson, Madison, and Taylor these averages are higher than the state, at 8.7%, 10.6%, and 9.8%, respectively.[5] Since these numbers have doubled since the last needs assessment in 2016, the Healthy Start Leadership Team partnered with the Jefferson County Health Department during its Community Health Assessment process in 2018 and 2019 to research how this data is collected. Informal data was gathered from Healthy Start care coordination teams that gave cause for a deeper dive into the data, including conflicting data gathered by birth clerks in hospitals and self-report by Healthy Start participants. The process was reviewed and the Jefferson and Madison Health Departments took on an extensive Quality Improvement project to compare the data on entry into prenatal care between clients of the county health department, compared to the data gathered by vital statistics. In only 13% of

Jefferson records and 7% of Madison records did the health department and Vital Statistics have the same prenatal entry to care date.[6]

Figure 4.6



The Coalition will continue to partner with the local health departments to advocate for policy changes in collecting and monitoring data as well as partnering with neighboring Healthy Start Coalitions to train birth clerks in Leon facilities.

[1]Alexander, Greg R., and Carol C. Korenbrot. "The role of prenatal care in preventing low birth weight." *The future of children* (1995): 103-120.

[2]Fiscella, Kevin. "Does prenatal care improve birth outcomes? A critical review." *Obstetrics & Gynecology* 85.3 (1995): 468-479.

[3]Kotelchuck, Milton. "An evaluation of the Kessner Adequacy of Prenatal Care Index and a proposed Adequacy of Prenatal Care Utilization Index. *"American journal of public health* 84.9 (1994): 1414-1420.

[4]Lu, Michael C., and Neal Halfon. "Racial and ethnic disparities in birth outcomes: a life-course perspective." *Maternal and child health journal* 7.1 (2003): 13-30.

[5]Florida Department of Health, Florida CHARTS - Community Health Assessment Resource Tool Set, accessed February 2016 http://www.flhealthcharts.com/charts/default.aspx

[6] Beck, Pam (2020) DOH-Jefferson/Madison MCH Analysis, Comparison Study of Prenatal and Postnatal Indicators.

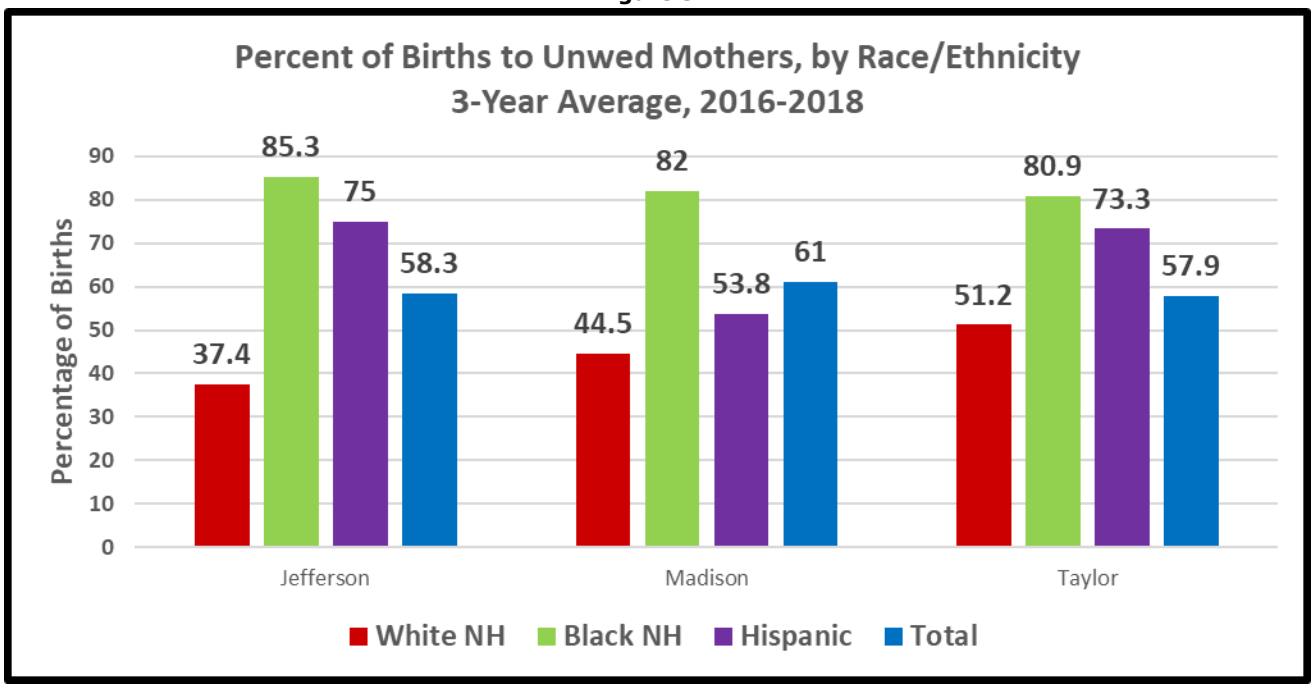
CHARACTERISTICS OF THE BIRTH MOTHER

BIRTHS TO UNWED MOTHERS

The percentage of births to unmarried women has been increasing steadily since the 1940s and has increased even more markedly in recent years. Trends in births outside of marriage reflect changing norms regarding sexual behavior and family formation. Policy makers consider births to unwed mothers important because it is linked to measures of child well-being. Births outside of marriage are often associated with disadvantage for both children and their parents. Single parents who have children outside of marriage are younger on average, have less education, and have lower incomes than married parents. Children who are born to unmarried parents are more likely to live in poverty and to have poor developmental outcomes.[2]

Births to unwed mothers are a common demographic across the Florida panhandle. The counties of Jefferson, Madison, and Taylor have some of the highest rates in Florida for this indicator. In Jefferson County, 58.3% of births are to unwed mothers; the numbers are even higher in Madison at 61% and Taylor's rate is 57.9%, compared to the state average of 46.7% for the three-year rolling average 2016-2018.[1] Figure 5.1 shows the dramatic difference between white and black babies born to unwed mothers, revealing a cultural norm in the black community. Nearly nine in ten black babies are born to an unwed mother in these counties. The number of Hispanic births in all three counties are small; however, the percentage of births to unwed Hispanic mothers is high.

Figure 5.1



These counties, compared with Florida as a whole, have always had much higher concentrations of infants born to unwed mothers. While this is a national, state and local trend that has shifted toward the norm of nonmarital fertility, the issue is more pronounced in these rural communities. Figures 5.2, 5.3 and 5.4 depict these consistent trends for each county over the last multi-years, compared with the state of Florida.

Figure 5.2 Births to Unwed Mothers, 3-Year Rolling Rates, Jefferson County and Florida

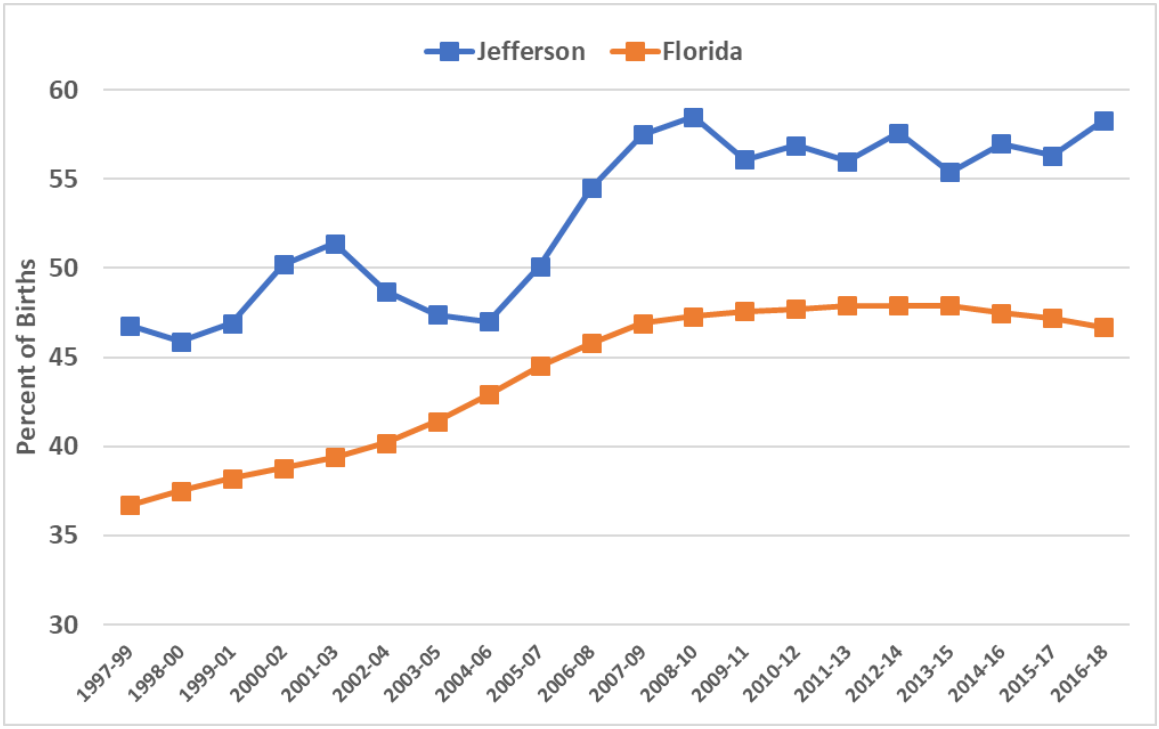


Figure 5.3 Births to Unwed Mothers, 3-Year Rolling Rates, Madison County and Florida

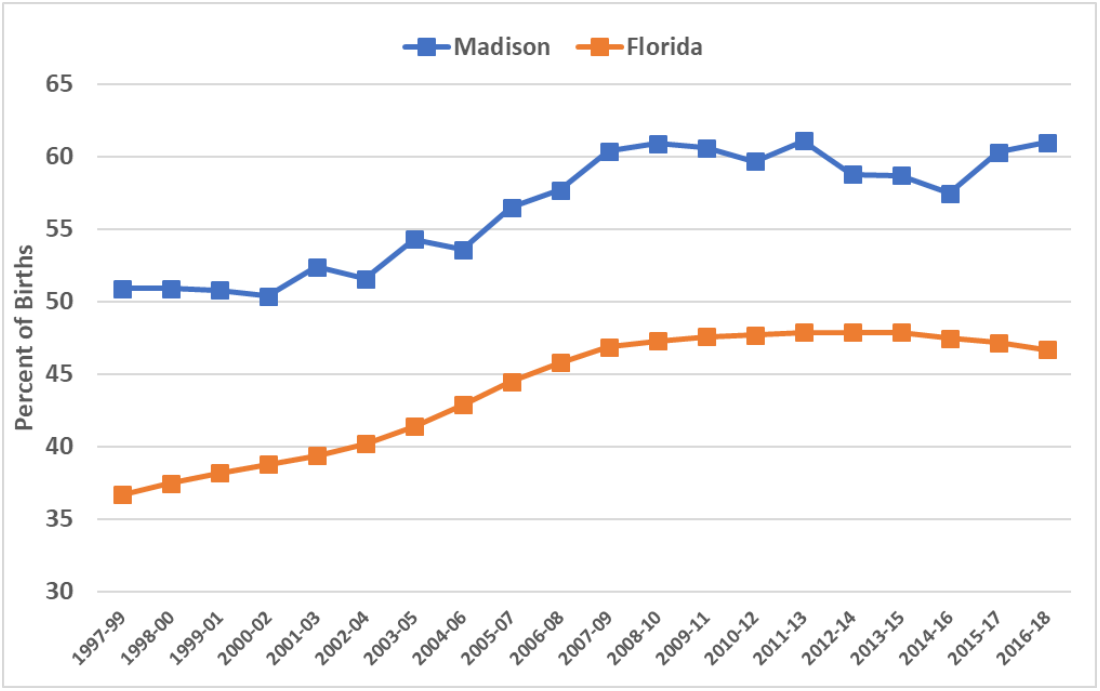
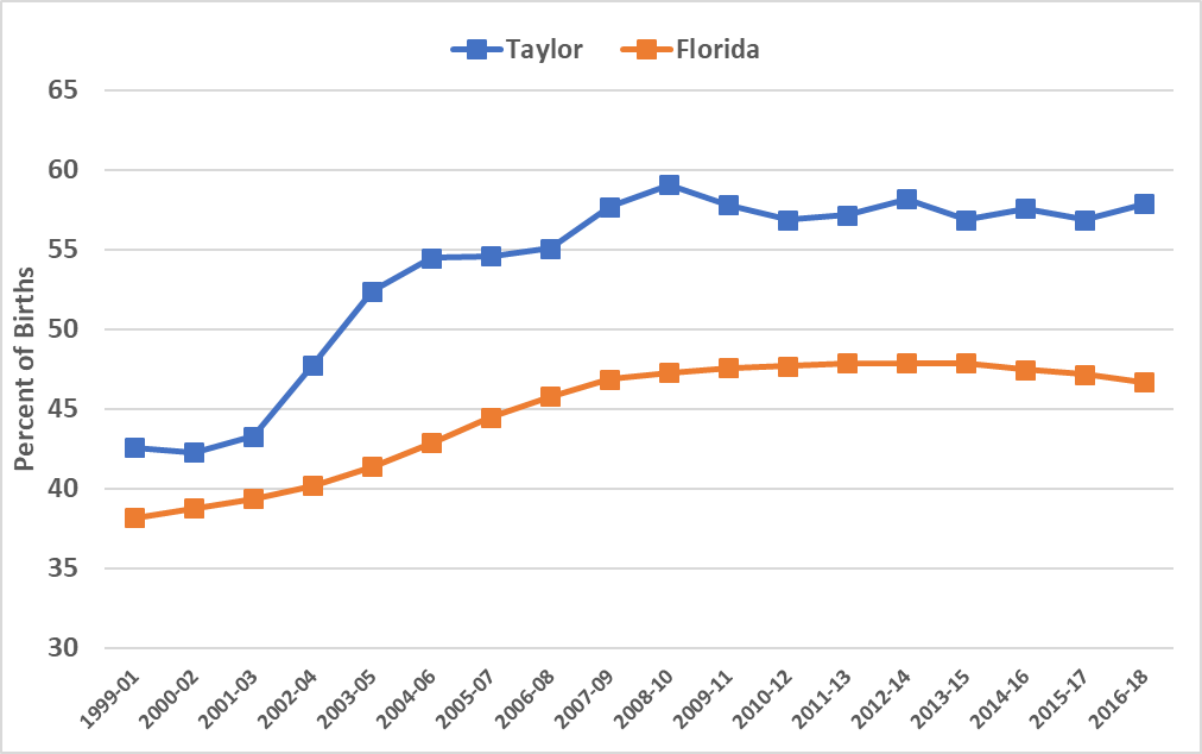


Figure 5.4 Births to Unwed Mothers, 3-Year Rolling Rates, Taylor County and Florida



EDUCATION STATUS

Lack of education is a primary indicator of perpetual poverty. Therefore, lack of a high school education is also a primary risk factor for poor birth outcomes, based on the direct correlation between poverty and the life course perspective that dictates poor health outcomes overall for the poor.[2] During pregnancy, poor mothers are likely to face multiple stressful life events, including feeling isolated, teenage pregnancies, unemployment, more crowded or polluted physical environments, and far fewer resources to deal with these exposures. The early child health consequences of poverty and pregnancy are multiple, and often set a newborn child on a life-long course of disparities in health outcomes. Included are greatly increased risks for preterm birth, intrauterine growth restriction, and neonatal or infant death. Poverty has consistently been found to be a powerful determinant of delayed cognitive development and poor school performance. Behavior problems among young children and adolescents are strongly associated with maternal poverty, whose root cause is often lack of education.[2]

For Florida, 11.92% (2016-2018) of mothers ages 19 and over do not have a high school education. In the counties of Jefferson, Madison and Taylor, the concentration of this indicator is higher at 16.6%, 14%, and 16.4% respectively.[1]

The 20-year trend for Florida is moving in a positive direction towards increasing high school completion prior to pregnancy, and greater value is held on the high school diploma in Florida collectively, through many state and local initiatives that emphasize the importance of education. With

the exception of Jefferson County, the maternal population in the counties of Jefferson, Madison and Taylor are following this positive trend. (Figures 6.2, 6.3 and 6.4) Of significant interest, however, is that the racial disparity for these counties is widening compared to the last needs assessment in 2016. Figure 6.1 below shows a more significant racial disparity with blacks in Madison County having a higher prevalence of no high school education before pregnancy. Hispanic numbers are small for each county; however, the percentages are high for births born to Hispanic mothers over the age of 19 with no high school education.

Figure 6.1

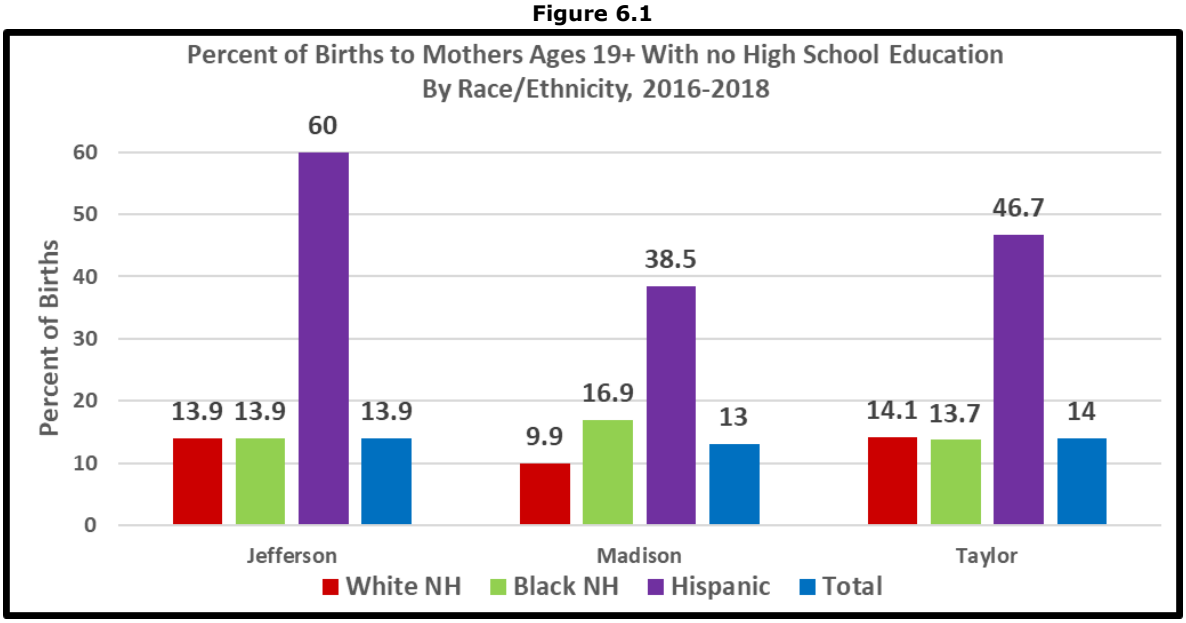


Figure 6.2 Births to Mothers Ages 19+ Without High School Education, 3-Year Rolling Rates, Jefferson County and Florida

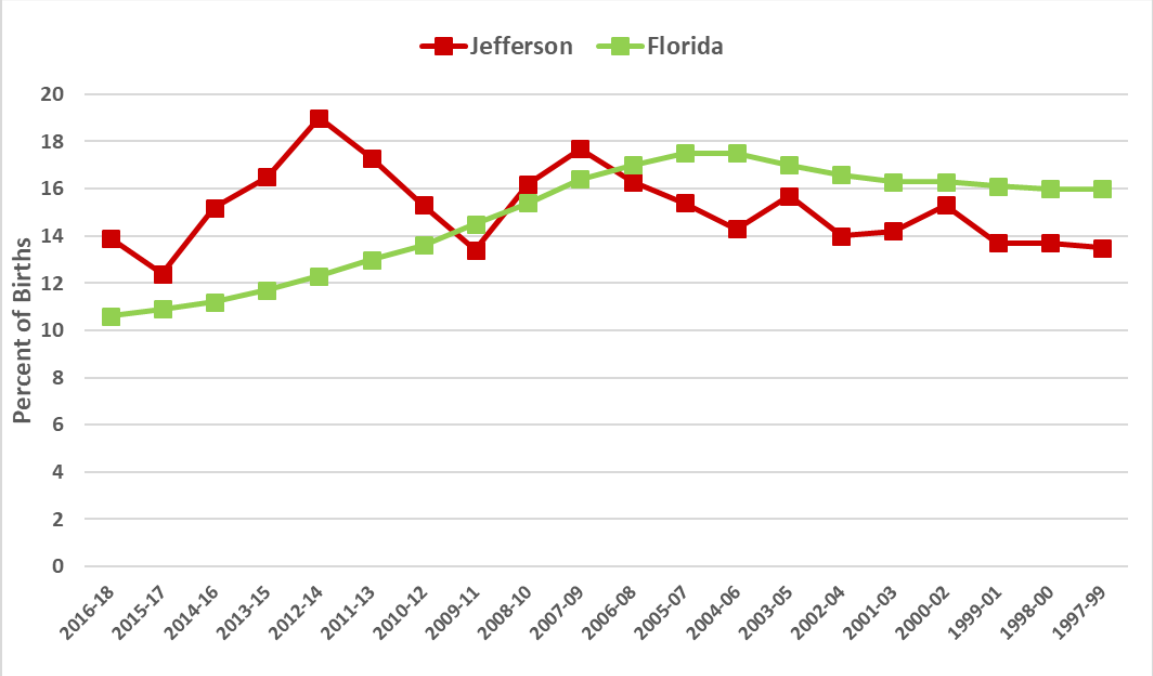


Figure 6.3 Births to Mothers Ages 19+ Without High School Education, 3-Year Rolling Rates, Madison County and Florida

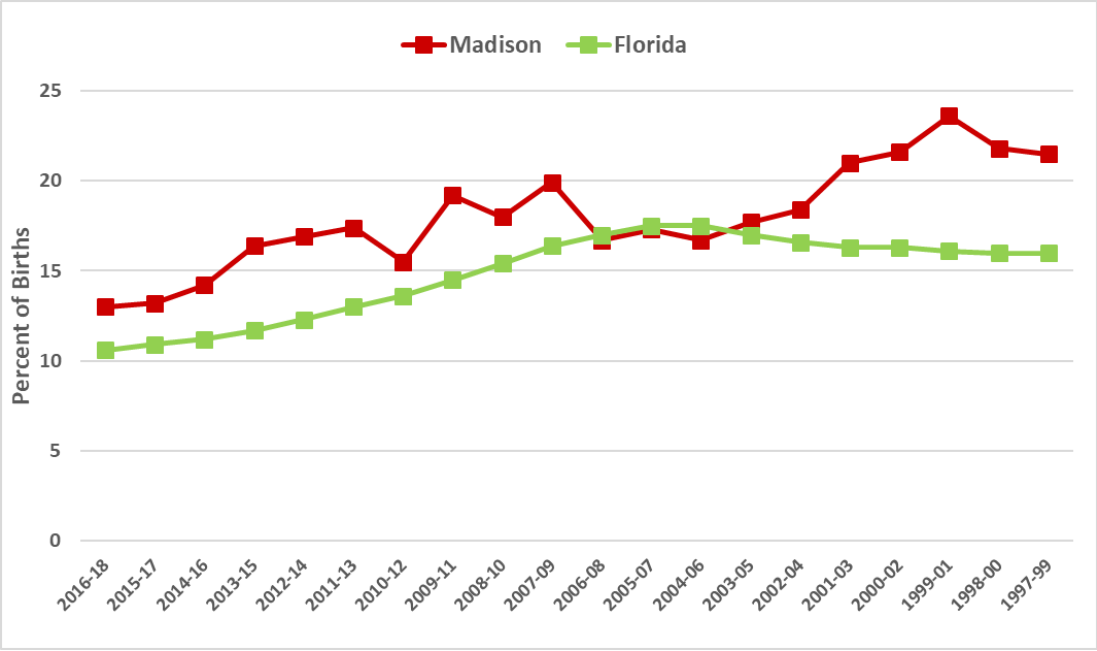
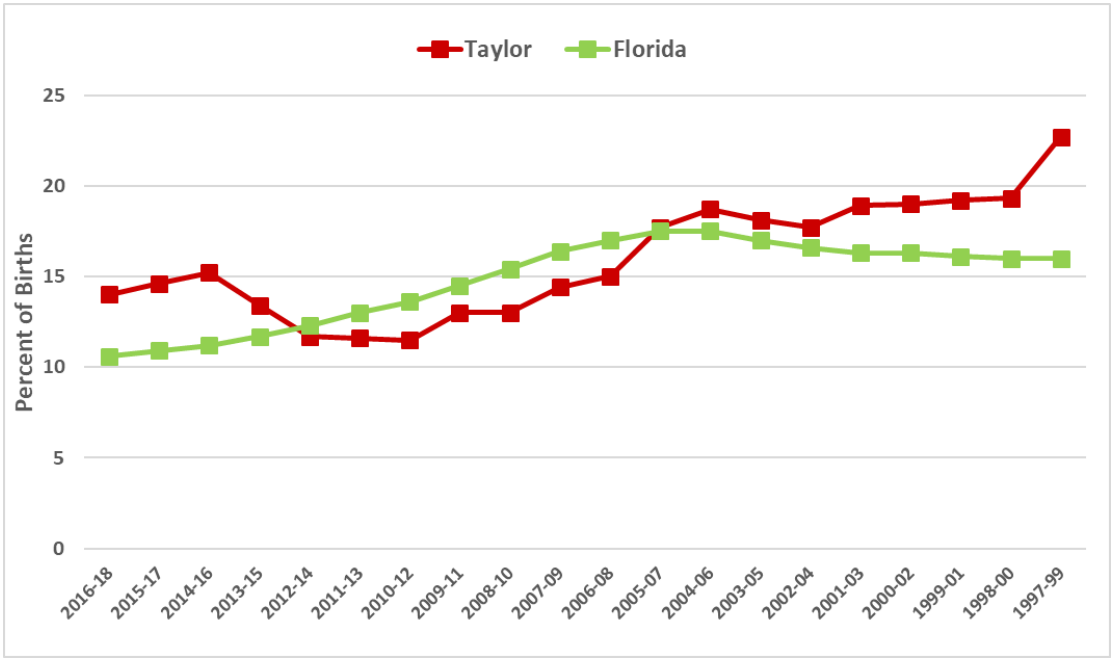


Figure 6.4 Births to Mothers Ages 19+ Without High School Education, 3-Year Rolling Rates, Taylor County and Florida

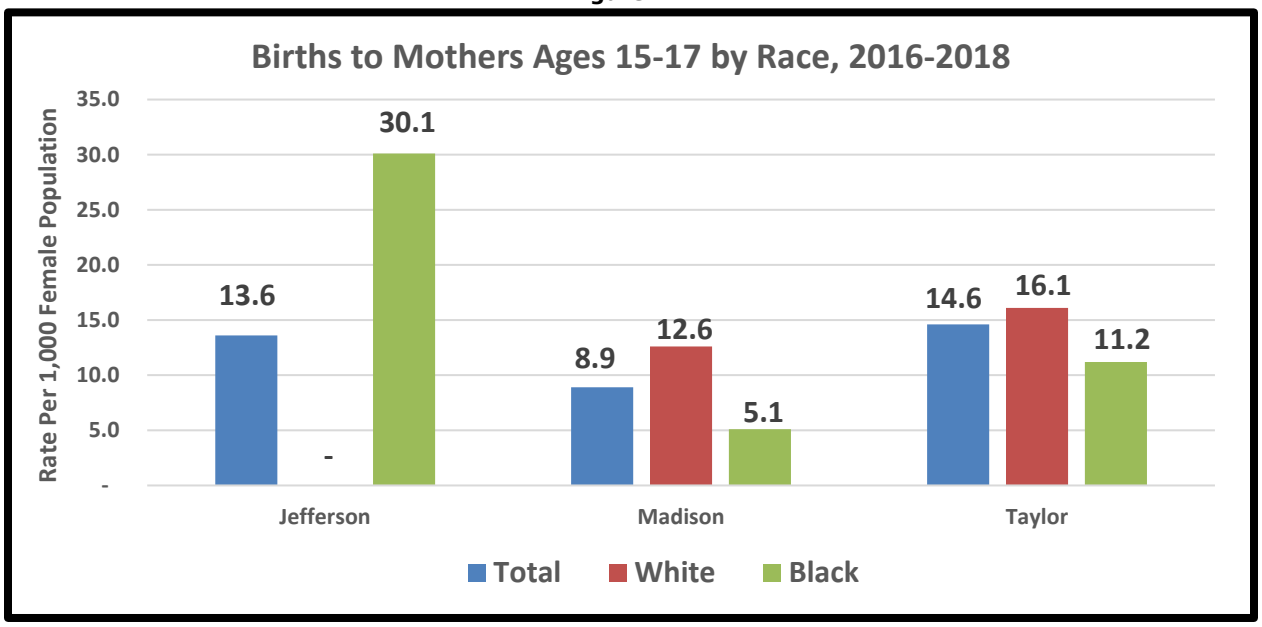


TEEN BIRTHS

Similar to unwed mothers and mothers with no high school education, births to teens specifically are a maternal characteristic that foretells of a general life course perspective of poverty, poor health and developmental outcomes, and perpetual teen pregnancy.[3] Births to teens are most often a subset of the unwed and uneducated category but analyzed separately for the purposes of targeted intervention for preventable outcomes. For the purpose of this needs assessment, teen pregnancy is quantified as births to mothers ages 15-17. This age group is targeted in terms of school-based strategies for prevention and intervention. According to the Florida Department of Health, teen pregnancy is a critical public health issue that affects the health, educational, social and economic future of the mother and child. Teen pregnancy is closely linked to a host of other critical social issues as well: welfare dependency, out-of--wedlock births, responsible fatherhood, and workforce development in particular. Adolescents are less likely to seek out prenatal care because they are afraid or embarrassed. This phenomenon and the immature physical nature of adolescents result in higher rates of low birth weight babies than in other age groups. As the offspring of adolescent mothers grow, they are more apt than children born to older women to have health and cognitive problems, and to be the victims of neglect or abuse.[1]

Unlike other maternal characteristics which are expressed as a percentage of the births, teen pregnancy is a rate calculated by the number of births per 1,000 of the female population within the age group selected. The teen pregnancy rate for the rolling three year average 2016-2018 for Florida for the age category of 15-17 is 7.4. Jefferson County's rate has increased to 13.6, just under Taylor's rate of 14.6. Madison County's teen pregnancy rate is 8.9.[1] The racial makeup of the teen birth issue is presented below in Figure 7.1; there are no significant racial disparities other than *all* teen births (N=8) in Jefferson County were to black mothers. There were no Hispanic births listed for any of the three counties during 2016-2018.

Figure 7.1



In reviewing the multi-year trend for teen births, it is important to note that the downward trend of teen births for Jefferson County is reversing slightly over the last five years. However, birth rates are low in Jefferson, which creates the volatility in numbers (Figure 7.2). In Madison County (Figure 7.3) mirrors the overall decline in teen births for Florida, at nearly the same intensity. However, for Taylor County, teen pregnancy remains a perpetual problem embedded in the culture (Figure 7.4).

Figure 7.2 Births to Mothers Ages 15-17, Rates Per 1,000 Population, 3-Year Rolling Rates, Jefferson Co & FL

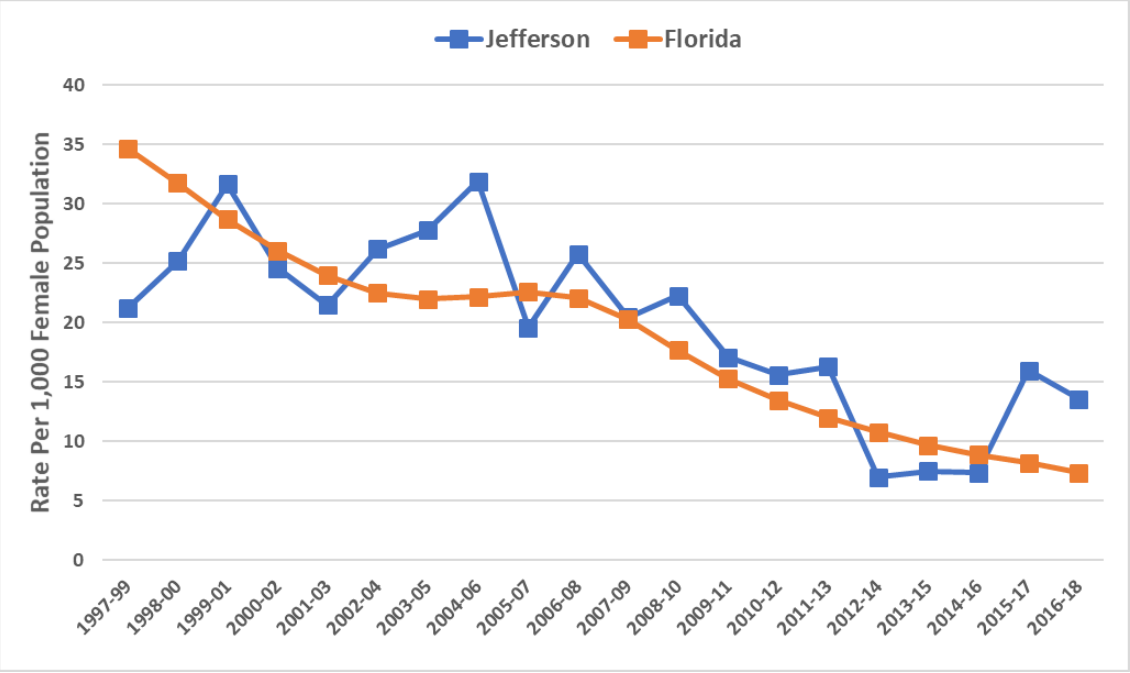


Figure 7.3 Births to Mothers Ages 15-17, Rates Per 1,000 Population, 3-Year Rolling Rates, Madison Co & FL

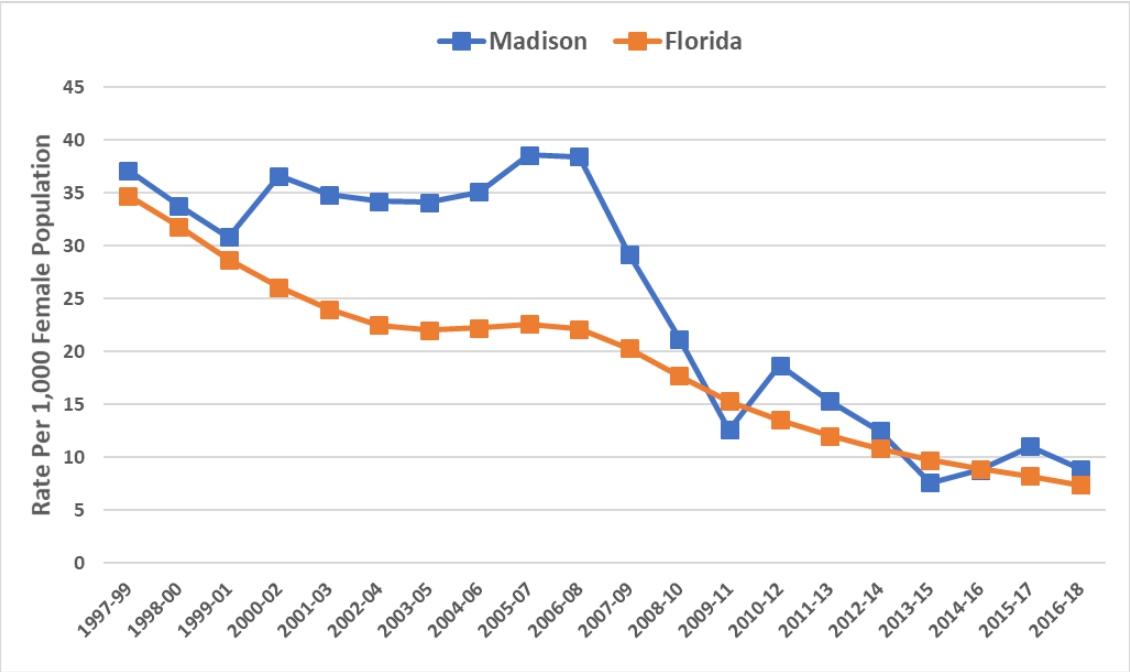
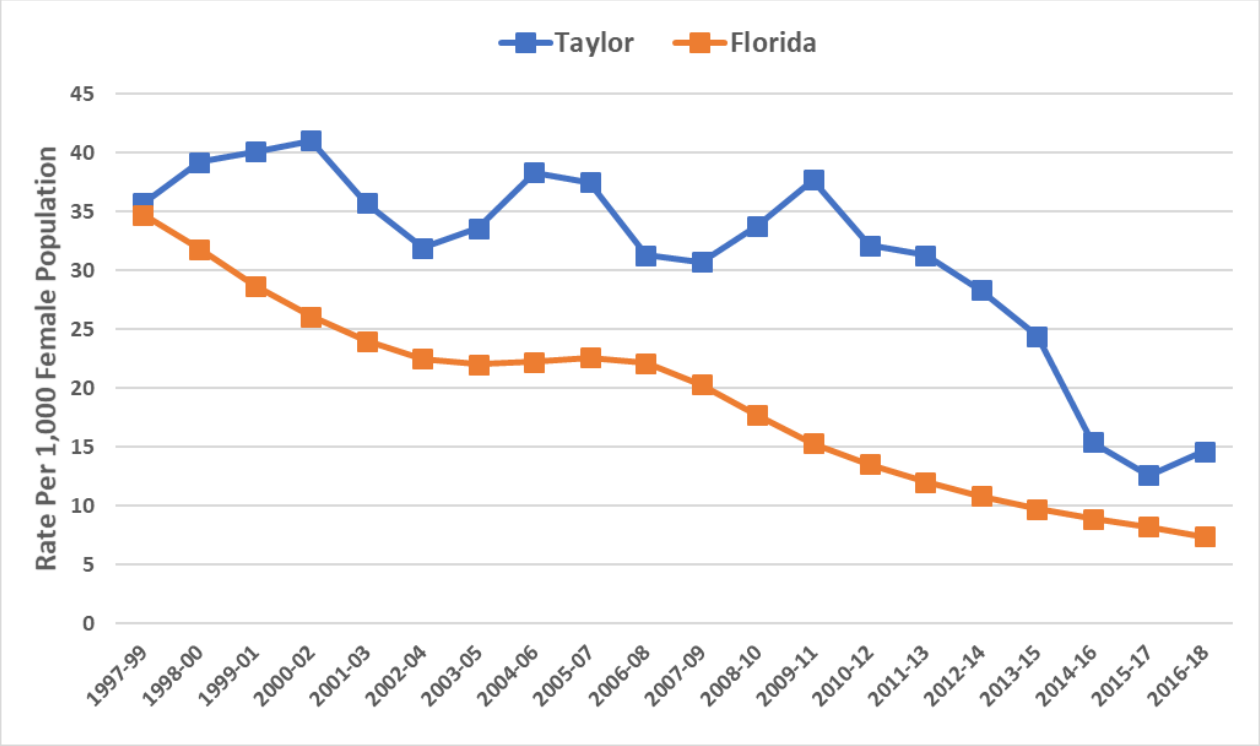


Figure 7.4 Births to Mothers Ages 15-17, Rates Per 1,000 Population, 3-Year Rolling Rates, Taylor County & Florida



TEEN PREGNANCY RECIDIVISM

Because teen pregnancy is a preventable, community issue, recidivism is a measurement of the interventions for this outcome. For Jefferson, Madison, and Taylor Counties, it is a measure of the outreach to and implementation of home visiting services within the Healthy Start teen population served. Home visiting is offered to first time and teen moms within the Healthy Start participant pool in each of the three counties. Repeat births to teens measures the number of births to 15-19 year olds where the mother had at least one previous birth and is expressed as a percentage of all births to mothers 15-19.[1]

In Florida, 15.4% (2016-2018) of births to teens ages 15-19 are *repeat* births to a teen. In Jefferson County, 21.7% are repeat births (N=5). In Madison and Taylor Counties, those rates are much lower at 5.1% and 8.1%, respectively.[1] This data indicates interventions are appropriate in Madison and Taylor Counties to prevent teen pregnancy recidivism and the number of births in Jefferson County, while very low, indicate that more targeted outreach is needed. All 5 of the repeat births to teens were black mothers.

For the multi-year trend, Florida has decreased the repeat births to teen rate by nearly 8 percentage points, a slow but steady decline. However, for Jefferson County, the rate is making an alarming climb

upwards. It is important to note, however, that both Madison and Taylor Counties (Figures 8.2 and 8.3) have had consistently lower rates for repeat teen births than the Florida average.

Figure 8.1 Repeat Births to Mothers Ages 15-19, 3-Year Rolling Rates, Jefferson County and Florida

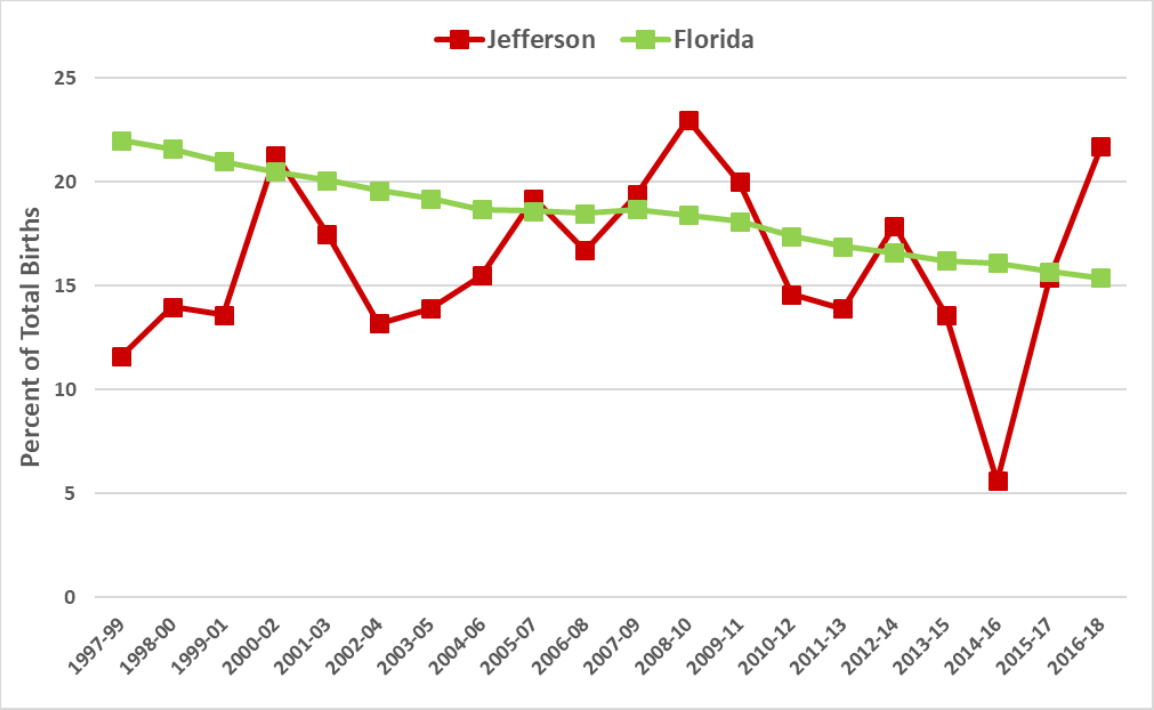


Figure 8.2 Repeat Births to Mothers Ages 15-19, 3-Year Rolling Rates, Madison County and Florida

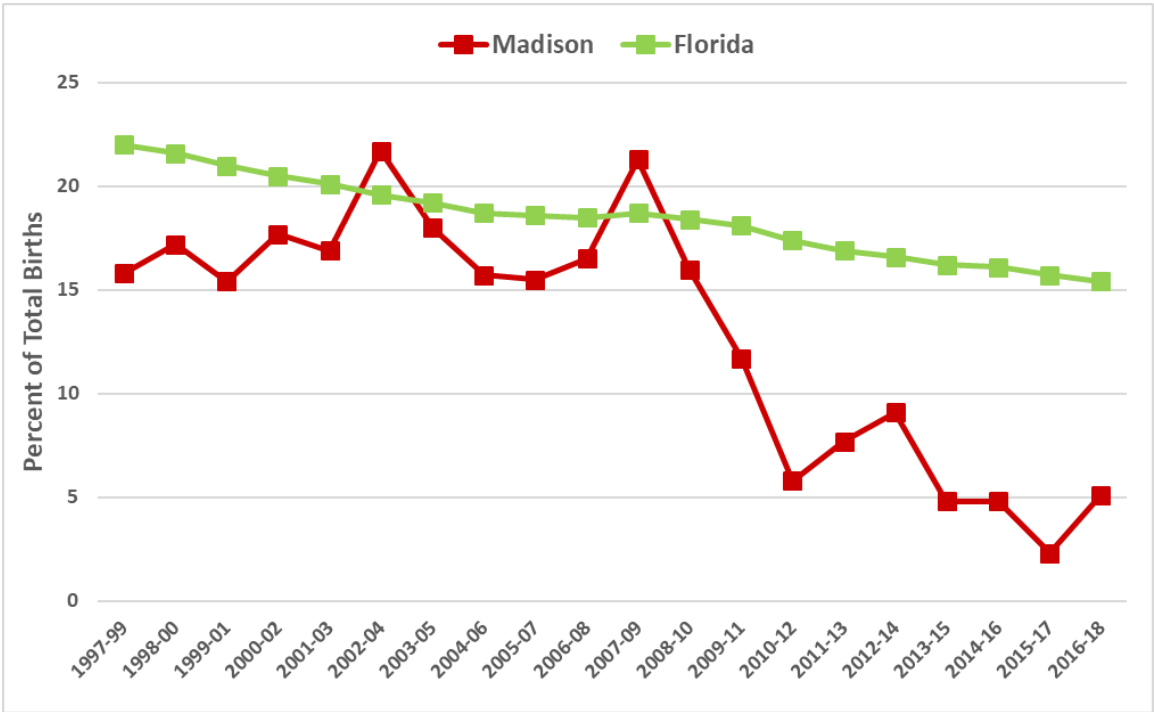
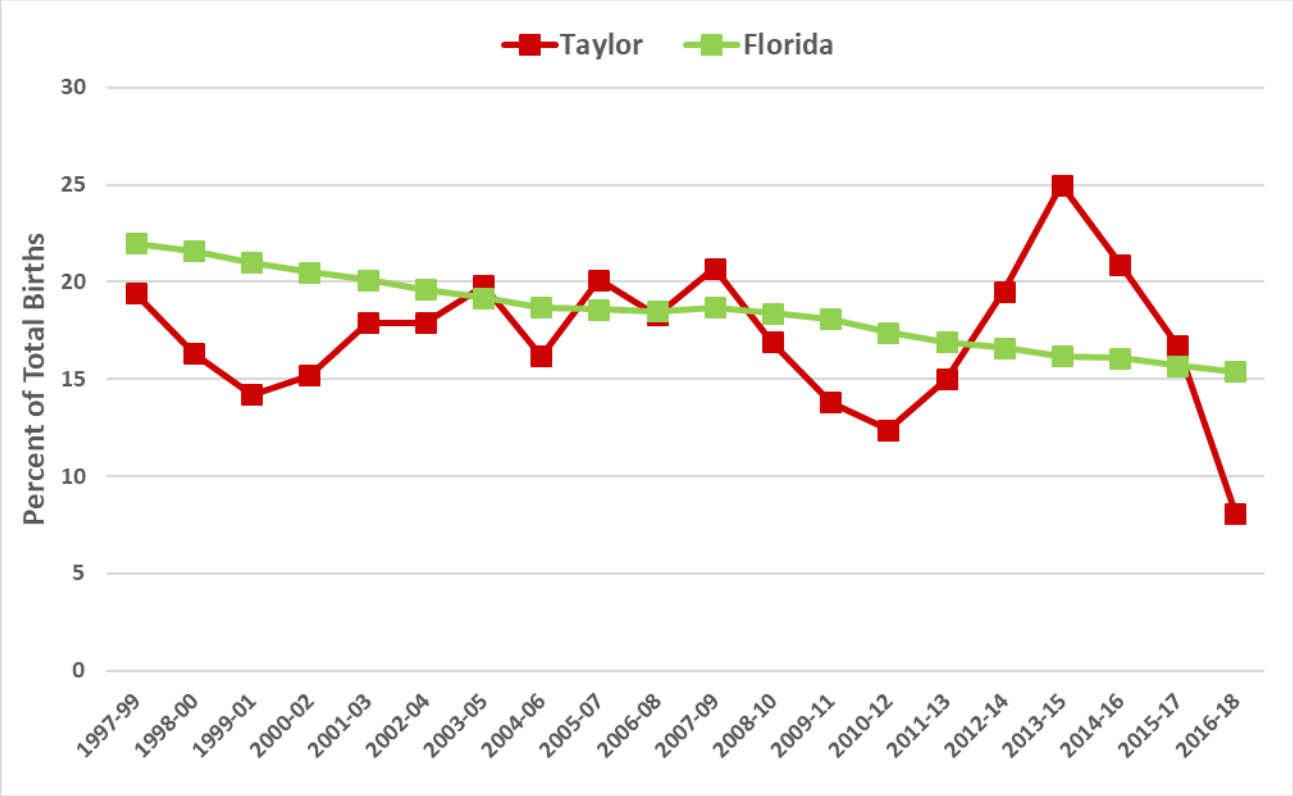


Figure 8.3 Repeat Births to Mothers Ages 15-19, 3-Year Rolling Rates, Taylor County and Florida



BREASTFEEDING INITIATION

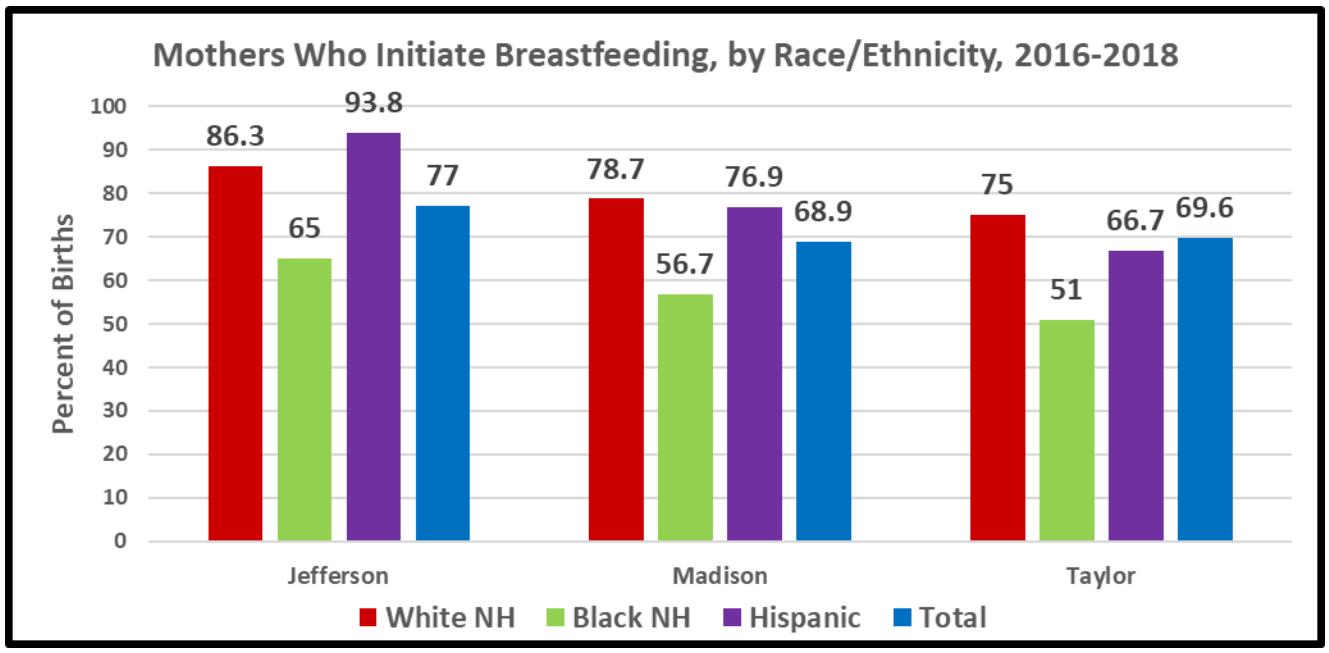
Breastfeeding has many health benefits for both the mother and infant. Breast milk contains all the nutrients an infant needs in the first six months of life. Breastfeeding protects against diarrhea and common childhood illnesses such as pneumonia, and may also have longer-term health benefits for the mother and child, such as reducing the risk of obesity in childhood and adolescence. Breastfeeding has also been associated with a higher intelligence quotient (IQ) in children. (World Health Organization, 2018)

Provision of mother's breast milk to infants within one hour of birth is referred to as "early initiation of breastfeeding" and ensures that the infant receives the colostrum, or "first milk", which is rich in protective factors.[4]

Current evidence indicates that skin-to-skin contact between mother and infant shortly after birth helps to initiate early breastfeeding and increases the likelihood of exclusive breastfeeding for one to four months of life as well as the overall duration of breastfeeding. Infants placed in early skin-to-skin contact with their mother also appear to interact more with their mothers and cry less.[4]

In Florida, 86.1% (2016-2018) of women initiate breastfeeding in the important first moments after birth. This data is a relatively new collection, in that data prior to 2005 is not consistent or available to establish long term trends. Even though early initiation is important to Florida families as a whole, the percentage of women who initiate breastfeeding in Jefferson County is only 77%; in Madison County, only 68.9% of women initiate breastfeeding, and in Taylor County the rate is 69.6%.[1] However, whites in these counties have a breastfeeding initiation rate that is more than 20 percentage points higher than the rates of blacks; the Hispanic rates are higher than those of blacks as well (Figure 9.1). The black-white gap has narrowed slightly since the last needs assessment, but remains a significant indicator of intervention for the Healthy Start Coalition and the local county health departments through their Community Health Improvement Plan (CHIP) process. Since this set of data is also collected by the same processes during the electronic birth registration process that affects the prenatal care rates (Section 4), the same review was conducted for the subset of health department clients to match data sets. (Figure 9.2)

Figure 9.1



Jefferson and Madison Quality Improvement Project

To compare breastfeeding data across the health department clinic, Healthy Start, WIC and Vital Statistics, prenatal patient data for 2017 and 2018 from Florida's Health Management System (HMS) was matched to Healthy Start, Vital Statistics and WIC data to identify data inconsistencies. Common data fields were compared to identify discrepancies. There were 50 records initially for Jefferson and 99 for Madison. The total was later revised to 46 and 83 because some records were not found by Vital Statistics. (Some had not given birth at the time of the match. Other reasons could include pregnancy did not come to term, adoption, and delivery out-of-state).

- Of the 46 records in the Jefferson sample, Vital Statistics documented breastfeeding initiation in 32 of them, or 70%.
  - 16 were Black, non-Hispanic
  - 8 were White, non-Hispanic
  - 7 were Hispanic
- Of the 83 records in the Madison sample, Vital Statistics documented breastfeeding initiation in 29 of them, or 35%.
  - 15 were Black, non-Hispanic
  - 6 were White, non-Hispanic
  - 8 were Hispanic

In conclusion, there is a significant difference in the data sets, presented below in Figures 9.2 and 9.3. WIC data overwhelmingly states that there are significantly more women initiating breastfeeding than is reported by Vital Statistics and collected at birth. The Coalition is partnering with the local health departments to provide support to change policy on how this indicator is collected and reported. To address the black-white gap, the Coalition has also administered a survey to those women, who, during pregnancy indicate they choose not to breastfeed. In order to identify strategies to increase the overall breastfeeding rates, this information is useful in identifying educational needs.

Figure 9.2 Documentation of Breastfeeding Across Healthy Start, WIC and Vital Statistics, 2017-2018, Jefferson

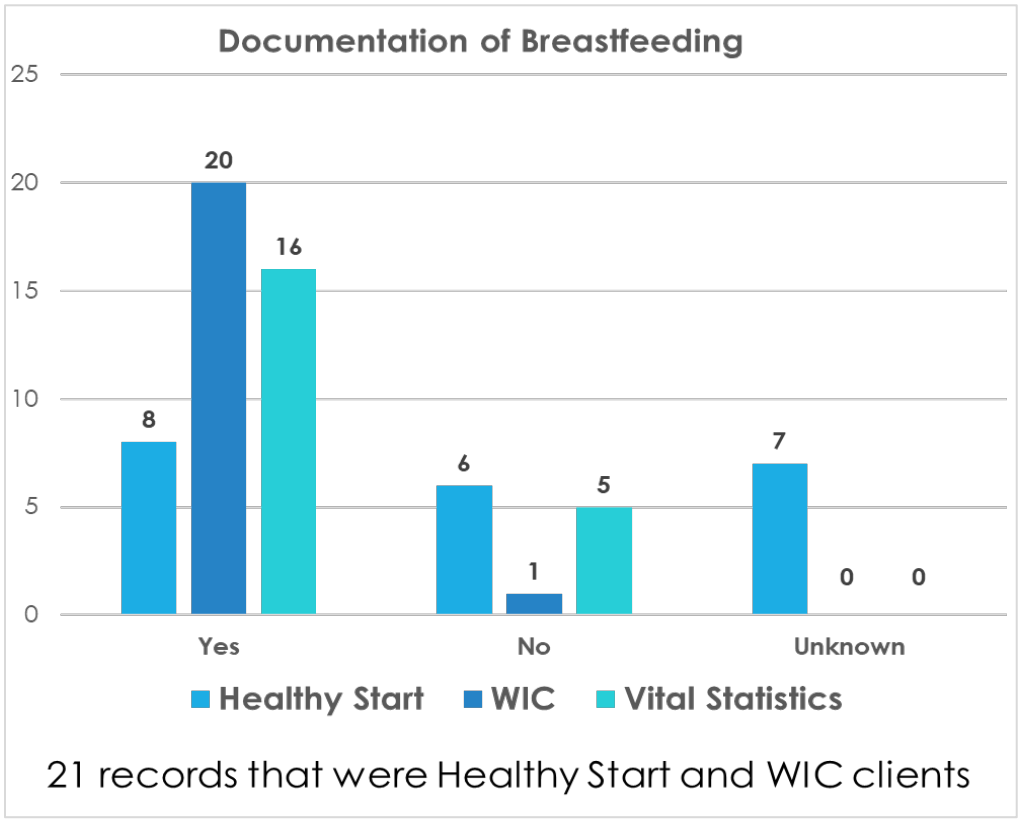
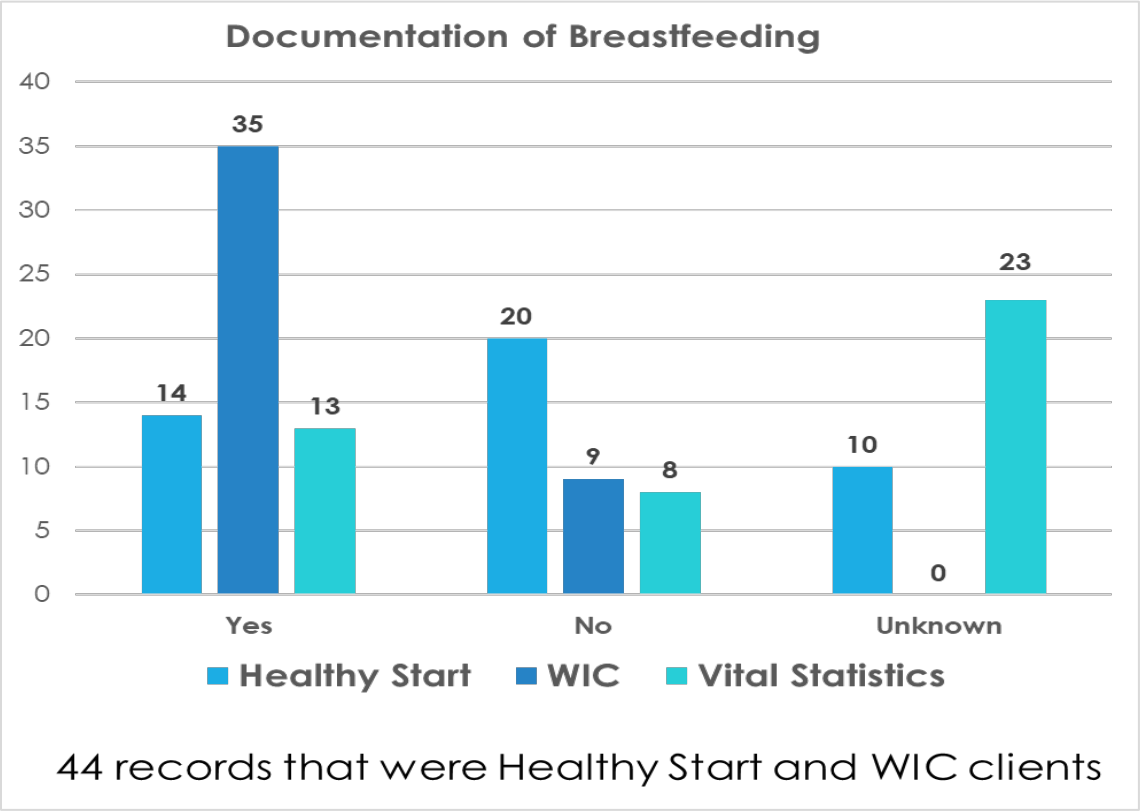


Figure 9.3 Documentation of Breastfeeding Across Healthy Start, WIC and Vital Statistics, 2017-2018, Madison County



Breastfeeding Surveys

Since the breastfeeding initiation rates by race has been a consistent issue in these counties, the Coalition has implemented strategies over the last five years to increase resources for women, including strategies for Healthy Start providers to become licensed as Certified Lactation Counselors. To further address the disparity in breastfeeding outcomes, the Coalition conducted a survey during April 2019 – June 2020 with pregnant women who presented at the local health departments for prenatal care or Healthy Start services who indicated that they would not be breastfeeding postnatally. This survey was designed to elicit information on potential areas where more education could be provided to alter that decision when possible. The full results of the survey is included in the consumer input section and summarized below:

- Respondents were primarily from Taylor County (51%) and represented the 25-34 age group, and were 50% white and 50% black
- Respondents reported equally their number one reason for not breastfeeding was 30% inconvenience, 35% unpleasant sensation, and 35% medical reasons
- Other reasons for not breastfeeding included primarily that friends did not breastfeed, and grandparents and parents did not breastfeed

BIRTHS TO WOMEN>35

Advanced maternal age (AMA) refers to women who give birth after the age of 35, where health risks are more prevalent. Women in this age group are considered at a higher risk for a poor birth outcome, because their age is a predictor of other health problems, like diabetes, high blood pressure, and birth defects such as Down's Syndrome.[5] While there is a growing trend in delaying childbearing post-career, women in this age group have had long term exposure to environmental hazards and stress, which reduces the resiliency of the reproductive system.[6]

Births to Women by any age category is expressed as a rate per 1,000 of the female population for the age group selected (same as teen birth calculations). For Florida, the rolling three-year average for 2016-2018 was 31.9, and is steadily climbing, as more women across the state are putting off motherhood after career establishment and other life goals. Locally, Jefferson County's rate is the highest of the three counties at 24.1. Madison and Taylor rates for AMA are 17.0 and 15.5, some of the lowest in Florida. This equates to around 15-20 births each year that fall into this AMA category.[1]

MULTIPLE GESTATION

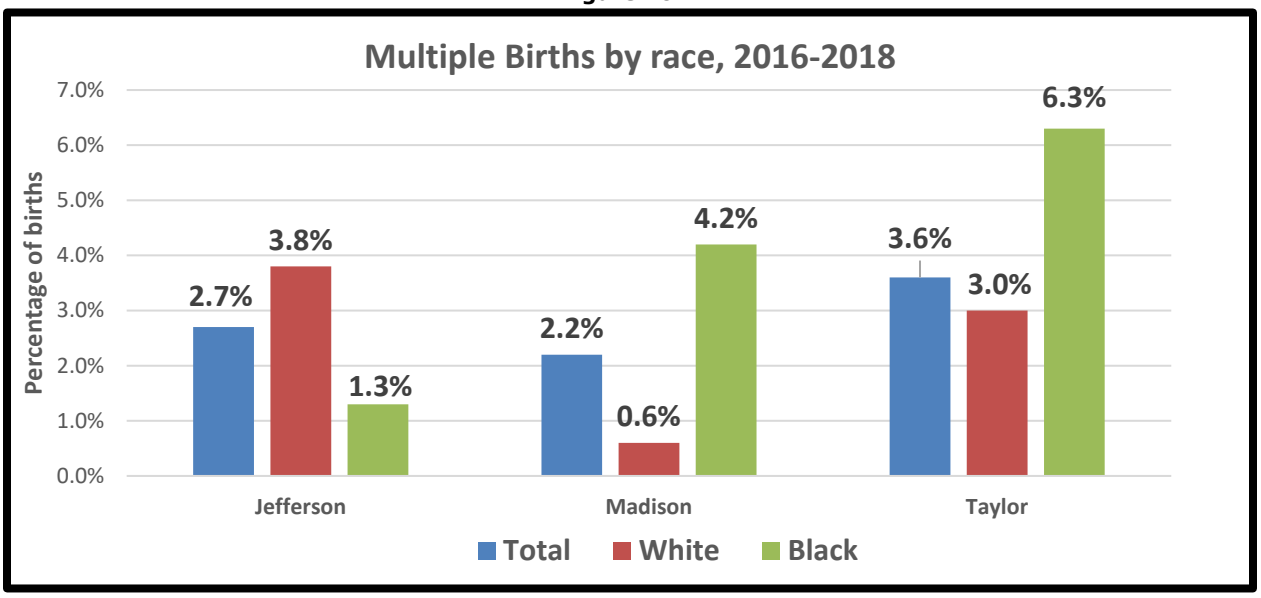
Being pregnant with multiples means being pregnant with twins, triplets or more. More than 3 in 100 women (3 percent) are pregnant with multiples each year. Most women with multiples are pregnant with twins, but some women get pregnant with three (triplets), four (quadruplets) or more babies. These are called higher-order multiples.[7]

Premature birth (birth before 37 weeks of pregnancy) is the most common complication of being pregnant with multiples. Women who are pregnant with multiples are 6 times more likely to have babies early than those who are pregnant with one baby. Also, multiple gestation infants are more likely to have health complications than singletons. Women need expanded prenatal care with multiple gestations and close monitoring to reduce the impact of impending prematurity.[7]

Extreme preterm multiples are more likely to have lower birth weight; higher maternal age; and higher rates of assisted conception, antenatal steroid use, and cesarean delivery compared with singletons.[8] The mortality rate is significantly higher in multiples compared with singletons; the odds for mortality in extremely preterm NICU infants of multiple gestation is significantly higher compared with singletons.[8]

In Florida, 3.3% of all births were multiples (2016-2018). Taylor County has seen a significant number of multiple births in the last several years and the numbers of multiples is increasing over time. Taylor's current rate is higher than the state at 3.6% (N=25), compared to Jefferson and Madison at 2.7% (N=10) and 2.2% (N=12), respectively. In reviewing the data by race, it is apparent that the higher rates of multiples contribute to the black-white gap in low birth weight, since the majority of multiples are black babies. There were no multiple births to Hispanic women during the time frame (Figure 10.1).

Figure 10.1



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[3]Lu, Michael C., and Neal Halfon. "Racial and ethnic disparities in birth outcomes: a life-course perspective." *Maternal and child health journal* 7.1 (2003): 13-30.

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[6]Hunt, Patricia A., and Terry J. Hassold. "Human female meiosis: what makes a good egg go bad?" *Trends in Genetics* 24.2 (2008): 86-93.

[7]March of Dimes, *Being Pregnant with Twins, Triplets, and other multiples*. June 2015. Retrieved February 2020 2016 from http://www.marchofdimes.org/pregnancy/multiples-twins-triplets-and-beyond.aspx.

[8]Yeo, Kee Thai, et al. "Trends in Morbidity and Mortality of Extremely Preterm Multiple Gestation Newborns". *American Academy of Pediatrics* August 2015, Volume 136/Issue 2.

Conclusion

While greater access to prenatal care has improved birth outcomes in all groups, it still has not been able to minimize the black disparity when it comes to birth outcomes. There is no known explanation for the black- white gap that exists, and there is contention amongst researchers on how to evaluate and provide solutions for this gap. Lu and Haflon (2010) conceptualized birth outcomes as the end product of the entire life course of the mother and created a 12-point plan to address improving birth outcomes. This plan is comprehensive and for the purpose of this needs assessment includes only a few points. Within the study, there is emphasis on improving healthcare for African American women by providing inter-conception care for women with previous adverse pregnancy outcomes and increasing access to preconception care for African American women. The increase of preconception health counseling has been a reoccurring theme within this needs assessment as a viable solution based on the birth outcomes presented by the data. Inter-conception health is also a viable strategy as mothers with poor birth outcomes are more likely to have a subsequent poor birth outcome. Collectively, the data for the majority of birth outcomes in these counties are related to characteristics that the birth mother has control over, therefore, inter-conception care could positively impact subsequent birth outcomes. Another point made by the study is strengthening African American families and communities through the coordination and integration of family support services and creating reproductive social capital in the African American communities. The concept of reproductive social capital is emerging and focuses on increasing the connection between black pregnant women and their local community (Lu & Haflon 2010). Like other communities, there is a strong faith-based presence in the black community in these counties with a potential for furthering reproductive social capital.

The recurring theme of racial disparity is present when discussing births by unwed mothers. The known societal shift in norms around the definition of the family unit is reflected in the steady increase in births to unwed mothers, yet there is a disproportionate shift amongst black women. In these counties, births to unwed black mothers occur at a rate of three times that of their white counterparts and the percentages in these counties among black women are well above the state average. It would seem that the link between unmarried mothers and poor birth outcomes is the lack of consistent financial support from the father, which equates to low socioeconomic status (SES) for the mother and it is well documented that a low maternal SES is a risk factor for preterm births, LBW and VLBW outcomes. The anomaly is that research points to the presence of the father being more vital to positive birth outcomes than just financial security as when education and SES is accounted for among unwed mothers, the black- white birth outcome disparity still exist (Reichman *et. al*). Determining the root cause for the disproportionate marital status among black women is a task beyond the scope of this needs assessment. It is clear that this is a risk factor that is affecting the birth outcomes for black women in JMT and service delivery needs to focus on engaging fathers.

Education status has continued to be a reliable tool in assessing the overall health of a population. The fact is that those with a higher education level are more equipped to navigate complex healthcare systems and mobilize resources better than those with little to no education. This can be said without

taking into consideration that a lower education level increases the likelihood of having an SES below the poverty line. Although the trend line is improving over time, the data illustrates all three counties are below the state average for high school completion among birthing mothers. Maternal education has serious implications on the health of a fetus. Considered to be the most powerful determinant of health, it was found that mothers with low levels of education, who lived in rural areas were vulnerable to neonatal deaths, and particularly to death related to immaturity- related conditions (Luo *et al*). The low maternal education rates in JMT adds to the complexity of the social atmosphere in these communities that make its health concerns less ambiguous. While high school completion rates are subpar amongst JMT, it is of little value knowing this fact by itself as these communities are also deprived of employment opportunity and access to healthcare. The low education rates do not make pinpointing a characteristic as a culprit amongst these communities, but it does clarify the overall picture.

Very closely related to low maternal education is the issue of teen pregnancy and teen pregnancy recidivism. It is well known that the likelihood of a child to be raised in abject poverty increases if that child is born to a teen mother. Birth outcomes among this population also has poor prospects with teen pregnancy being linked to very pre-term delivery, pre-term delivery, LBW, VLBW and neonatal mortality (Chen, *et al*). Within the JMT communities, this characteristic is a major issue among teens in Taylor County. However, the trend line for Taylor is moving in the right direction, and births to teens are decreasing. Jefferson County has seen a recent increase in both teen births and teen pregnancy recidivism. This problem is conducive to poor conditions that span several disciplines from public health and social welfare to economic growth in the community. It is a perpetual problem that increase the vulnerable population and decreases the working population. Evaluation of the existing service intervention is needed to pinpoint the limitations and create strategies to address the needs.

The lower breastfeeding rate among black women in the JMT area is reflective of the literature with black infants being breastfed less than their white counter parts when considering ever being breastfed and exclusively being breastfed (Li *et. al*). While breastfeeding has more implications in child outcomes than it has in birth outcomes, the lack of breastfeeding does provide the opportunity to make generalizations about other characteristics of the mother. One third of working mothers return to work within 3 months after the birth of their baby and babies that are placed into daycare are less likely to breastfeed (Li et al). Breastfeeding is less common in women who receive WIC benefits and it is well documented that most low-income mothers know the health benefits of breastfeeding, but lack the peer and family support, face barriers at school and work and receive information not conducive to breastfeeding (Li et al). The black pregnant women in JMT are dually identified as the working poor and face the same barriers in these communities that are cited in the literature. Strategies to improve the breastfeeding rate among black women in JMT can be drawn on the outcome of the surveys for why women choose not to breastfeed.

In the recent decade there has been an influx of women entering the workforce and more women now than ever are the primary source of income in their households. This trend has trickled over into the

realm of maternal and infant health as more women have opted to have children at a later age, if at all. While there have been numerous advancements in medicine to make women more comfortable in making this decision, there are still maternal and fetal health implications that arise when having a child at an advance maternal age (AMA). These risks include genetic disorders and maternal complications, which have implications on birth outcomes. It is a trend across Florida as a whole that more women are having babies within the AMA age group and it is steadily increasing with time and acceptance. This is not true within the communities of JMT. All three counties are well below the Florida average for women giving birth over the age of 35. This information is significant as it provides a clear picture of the women in these communities, socially. It is a trend amongst women to delay child bearing to pursue educational and career goals, which usually lead to higher socioeconomic status. It is apparent based on the data presented on AMA births that educational pursuits and career advancement is not a priority for the women in JMT overall. The educational status of the communities and teen pregnancy rates demonstrate that the poor birth outcomes in these communities are in relation to poverty—as a result of poor education and the high burden of cost associated with children— rather than complications due to having a baby at an advanced maternal age.

It is well documented in medical research that multiple gestation is linked to poor outcomes, especially spontaneous pre-term birth and LBW/VLBW (Royer, 2007). Within the JMT communities multiple births is increasing, especially in Taylor County. Multiples are associated with low birth weight and prematurity and these statistics are congruent with an increase in the number of multiple gestation births.

The characteristics of the birth mother provides a limited understanding of the birthing population of JMT. Like the analysis of infant mortality and birth outcomes it reveals that there are significant differences between the three counties. What can be determined from the analysis thus far is that there are factors outside of the health of the birth mother that has significant implications on her unborn child. Some of these factors have different levels of influence and others are outside of the control of the birth mother.

Additional resources

Lu, M.C. & Halfon, N. (2003)"Racial and ethnic disparities in birth outcomes: a life-course perspective." *Maternal and child health journal* 7.1 (2003): 13-30.

Reichman, N.E., Hamilton, E.R., Hummer, R.A. & Padilla, Y.C. (2008). Racial and Ethnic Disparities in Low Birthweight among Urban Unmarried Mothers. *Maternal Child Healthy Journal* 12, 204-215

Li, R., Darlins, N., Maurice, E., Barker, L., Grummer-Strawn, L.M. (2005). Breastfeeding rates in the United States by Characteristics of the child, mother or family: The 2002 National Immunization Survey. *Pediatrics*, 115 (1) 31-37.

Lou, Z., Wilkins, R., Kramer, M.S. (2006). Effect of Neighborhood income and maternal education on birth outcomes: a population- based study. *Canadian Medical Association Journal*, 174 (10) 1415-1421.

Chen, X.K., Wen, S.W., Fleming, N., Demissie, K., Rhoads, G.G., Walker, M. (2007). Teenage pregnancy and adverse birth outcomes: a large population based retrospective cohort study. *International Journal of Epidemiology*. Accessed February 2020 https://www.ncbi.nlm.nih.gov/pubmed/17213208.

Royer, H. (2009). Separated at birth: US twin estimates of the effects of birth weight. *American Economic Journal: Applied Economics*, *1*(1), 49-85.

HEALTHY START SYSTEM OF CARE

At the core of maternal and child health interventions in Florida is the Healthy Start system of care. Developed under statutory authority in 1992, this system includes a community-based approach to improving maternal and child health. This is accomplished through the 32 Healthy Start Coalitions statewide which are the local evaluators, policy advocates, and planners of community and programmatic strategies to improve birth and developmental outcomes. The role of the Coalitions also includes programmatic oversight of the home visiting services through the care coordination system, referred to as Healthy Start services.

The current Healthy Start program in Florida was updated March 2019 to incorporate the most promising evidence-based practices since its inception. Over the last 27 years, emerging evidence and interventions have developed in the areas of Perinatal Depression, Intimate Partner Violence, Developmental Screening and Referral, and Substance Abuse Screening and Interventions. These concepts are now included in the Healthy Start program delivery system, whose guidelines were finalized and rolled out for implementation in March 2019.

Measuring proper dosing and intensity for current Healthy Start services is of great importance to the Healthy Start Coalition, both from the perspective of managing contractual obligations for the subcontracted providers of service, but also as an assurance of optimal birth outcomes related to intervention. Healthy Start includes targeted support services that address identified risks. The range of Healthy Start services available to pregnant women, infants and children up to age three include:

- A triage system of reaching every pregnant woman and infant and funneling participants into service models that best meet the needs of the family, including other home visiting services, namely Connect services
- Outreach, information, referral and community referrals and support to assure access to needed services
- Screening and intervention pathways for high-risk prenatals, including Family Goal Planning, and education using the Partners for a Healthy Baby™ curriculum
- Screening and intervention pathways for perinatal depression
- Screening and intervention pathways for tobacco use
- Screening and intervention pathways for Intimate Partner Violence and Substance Abuse
- Inter-conception education and counseling
- Psychosocial and nutritional counseling
- Childbirth, breastfeeding and parenting support and education
- Home visiting

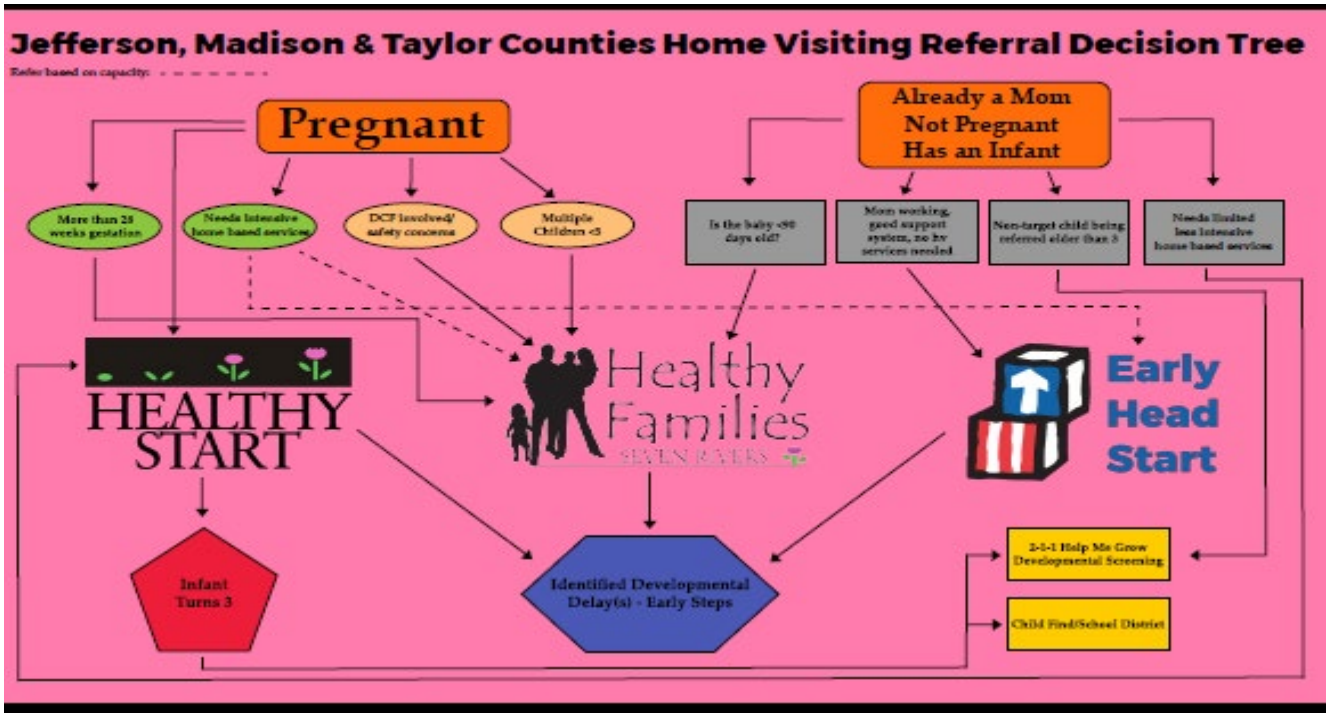
While each of the interventions is designed to address risks, the primary intake instrument for Healthy Start is a universal prenatal risk screen, a questionnaire developed to assess a woman's overall risk for a

poor birth outcome, administered at her first obstetric visit. The Healthy Start Coalitions assure this risk screening is in place as a universal assessment of the risk of the population, and to identify participants that are eligible for Healthy Start services with a score of 6 or higher for pregnant women and 4 or higher for infants. The Healthy Start system model is one of identification and funneling into care those pregnant women in need of services to support optimal birth outcomes. This needs assessment will address the efficacy of the triage system, the intensity of services, and the screening infrastructure.

Healthy Start Screening/Connect

Effective July 1, 2018 the State of Florida adopted the Coordinated Intake and Referral (CI&R) System of identifying and triaging families statewide. This is a two-part system that involves collaboration at the community provider level as well as a service component (Connect). In February 2016 the Coalition launched its community project, to create collective impact for services to the 0-3 population by partnering to ensure there is no "wrong door" for entry into care for this population. The end result has been an effective multi-agency agreement that holds agencies accountable for the seamless system of care and optimal utilization of minimal resources. The product of the community-level work has been to create a system for which pregnant women and infants are identified and funneled into care through the coordinated system. Figure 11.1 below is the local Decision Tree for JMT, which depicts the service flow when participants are identified and in need of services.

Figure 11.1



Connect Services

Once a prenatal or infant screen, or community referral has been received, the Connect worker will use the Decision Tree to help guide a participant to the services that can best meet the family's needs. All programs for which the participant qualifies are explained and offered, and the participant is the decision-maker. At a minimum, all participants are referred to 211. The effectiveness of this triage system called *Connect* statewide is limited by the prenatal and infant screening infrastructure. All prenatal and infant screens in Florida are documented in Florida's Health Management System (HMS). If the screen is referred by the provider and the participant has consented to share information, then the screen is shared through a bridge between the HMS and Well Family System, the web-based case management system used by Connect.

Prenatal Risk Screening

The screening infrastructure for Healthy Start is an indicator of the volume of births, validation of the risk population and the established goal for providing resources to pregnant women in need. The tables below capture the basic elements of the prenatal screening infrastructure in Jefferson, Madison and Taylor Counties, Florida.[1]

There are major concerns with the trends in the screening infrastructure, evidenced by the data in Table 11.1:

1. The percentage of women screened has fallen below 60% for the most recent fiscal year, down from the five-year average of 75%.
2. The percentage of positive screens (those at greatest risk and need for intervention) has increased from 36% to 45% over the last five years.
3. The total number of prenatal screens that actually are shared with the Connect system through the Well Family user interface is only 54% (number agreeing to share information divided by number consenting to screen). Therefore, if the prenatal screen was the total source of referrals for pregnant women, then Connect could only contact 54% of all pregnant women in these counties.

Table 11.1[1]

PRENATAL SCREENING RESULTSSCREENS FROM JULY 2018 THROUGH JUNE 2019 AS OF 08/12/2019

COALITION/COUNTY	EST # OF PREGNANT WOMEN	TOTAL FORMS PROCESSED	TOTAL CONSENTING TO SCREEN	PERCENTAGE OF WOMEN SCREENED	PERCENTAGE OF WOMEN CONSENTED	NUMBER OF POSITIVE SCREENS	PERCENTAGE OF POSITIVE SCREENS	NUMBER BASED ON OTHER FACTORS	NUMBER CONSENTING TO PARTICIPATE	NUMBER AGREEING TO SHARE INFORMATION
HSC of Jefferson/Madison/Taylor Counties										
Jefferson	117	60	52	44.44%	86.67%	19	36.54%	9	28	27
Madison	197	137	126	63.96%	91.97%	63	50.00%	21	83	75
Taylor	226	160	140	61.95%	87.50%	60	42.86%	22	80	71
COALITION TOTAL:	**540**	**357**	**318**	**58.89%**	**89.08%**	**142**	**44.65%**	**52**	**191**	**173**
GRAND TOTAL:	**540**	**357**	**318**	**58.89%**	**89.08%**	**142**	**44.65%**	**52**	**191**	**173**

PRENATAL SCREENING RESULTSSCREENS FROM JULY 2017 THROUGH JUNE 2018 AS OF 08/11/2018

COALITION/COUNTY	EST # OF PREGNANT WOMEN	TOTAL FORMS PROCESSED	TOTAL CONSENTING TO SCREEN	PERCENTAGE OF WOMEN SCREENED	PERCENTAGE OF WOMEN CONSENTED	NUMBER OF POSITIVE SCREENS	PERCENTAGE OF POSITIVE SCREENS	NUMBER BASED ON OTHER FACTORS	NUMBER CONSENTING TO PARTICIPATE	NUMBER AGREEING TO SHARE INFORMATION
HSC of Jefferson/Madison/Taylor Counties										
Jefferson	130	78	65	50.00%	83.33%	39	60.00%	6	44	40
Madison	176	147	132	75.00%	89.80%	71	53.79%	18	89	81
Taylor	229	231	200	87.34%	86.58%	62	31.00%	25	85	79
COALITION TOTAL:	**535**	**456**	**397**	**74.21%**	**87.06%**	**172**	**43.32%**	**49**	**218**	**200**
GRAND TOTAL:	**535**	**456**	**397**	**74.21%**	**87.06%**	**172**	**43.32%**	**49**	**218**	**200**

PRENATAL SCREENING RESULTSSCREENS FROM JULY 2016 THROUGH JUNE 2017 AS OF 08/05/2017

COALITION/COUNTY	EST # OF PREGNANT WOMEN	TOTAL FORMS PROCESSED	TOTAL CONSENTING TO SCREEN	PERCENTAGE OF WOMEN SCREENED	PERCENTAGE OF WOMEN CONSENTED	NUMBER OF POSITIVE SCREENS	PERCENTAGE OF POSITIVE SCREENS	NUMBER BASED ON OTHER FACTORS	NUMBER CONSENTING TO PARTICIPATE	NUMBER AGREEING TO SHARE INFORMATION
HSC of Jefferson/Madison/Taylor Counties										
Jefferson	129	93	78	60.47%	83.87%	33	42.31%	9	42	38
Madison	186	154	139	74.73%	90.26%	68	48.92%	28	93	88
Taylor	232	174	146	62.93%	83.91%	56	38.36%	18	69	63
COALITION TOTAL:	**547**	**421**	**363**	**66.36%**	**86.22%**	**157**	**43.25%**	**55**	**204**	**189**
GRAND TOTAL:	**547**	**421**	**363**	**66.36%**	**86.22%**	**157**	**43.25%**	**55**	**204**	**189**

PRENATAL SCREENING RESULTSSCREENS FROM JULY 2015 THROUGH JUNE 2016 AS OF 08/13/2016

COALITION/COUNTY	EST # OF PREGNANT WOMEN	TOTAL FORMS PROCESSED	TOTAL CONSENTING TO SCREEN	PERCENTAGE OF WOMEN SCREENED	PERCENTAGE OF WOMEN CONSENTED	NUMBER OF POSITIVE SCREENS	PERCENTAGE OF POSITIVE SCREENS	NUMBER BASED ON OTHER FACTORS	NUMBER CONSENTING TO PARTICIPATE	NUMBER AGREEING TO SHARE INFORMATION
HSC of Jefferson/Madison/Taylor Counties										
Jefferson	118	88	76	64.41%	86.36%	28	36.84%	7	35	29
Madison	211	162	151	71.56%	93.21%	73	48.34%	24	95	81
Taylor	244	248	208	85.25%	83.87%	56	26.92%	21	76	76
COALITION TOTAL:	**573**	**498**	**435**	**75.92%**	**87.35%**	**157**	**36.09%**	**52**	**206**	**186**
GRAND TOTAL:	**573**	**498**	**435**	**75.92%**	**87.35%**	**157**	**36.09%**	**52**	**206**	**186**

Postnatal Screening

While prenatal risk screening is statutorily required in Florida to assess pregnant women and to allocate resources for intervention, so is postnatal screening. This occurs in conjunction with preparation of the birth certificate, usually by birth records clerks in delivery facilities across Florida. For the counties of Jefferson, Madison and Taylor, there are no delivery hospitals and Tallahassee Memorial and Capital Regional Medical Center located in Leon County are the two primary delivery facilities where this screening occurs. Infants who score a "4" or more on this instrument are considered at risk of poor developmental outcomes and death in the first year of life.

One of the caveats for how this score can be easily achieved for these counties is a simple reflection of the demographics. As stated earlier, these counties have high rates of minorities, unmarried pregnant women, and low economic status. Therefore, an infant that scores a "4" based on 1) race black, 2) mother unmarried, 3) Medicaid as payer source, and 4) father's name not on birth certificate, is a common occurrence. Data for postnatal screens is presented below in Table 11.2 and interpreted:

1. The screening rate is a measurement of how many screens were done in conjunction with the birth certificate, for nearly 100% completion rate.
2. The number of positive screens is decreasing from 32% to 23% of all infant screens scoring 4 or more for JMT.
3. The number of actual participants is down from 36% to **23%** which means that the local birthing facilities are not referring 100% of positive screens. If 100% of all positive screens and those Referred for Other Factors (BOOFS) were referred to Healthy Start/Connect, then the participation rate would be closer to 41%.
4. Intervention is needed to increase the referral rate for positive screens at local birthing facilities that serve Jefferson, Madison & Taylor Counties.
5. Intervention is needed to increase the number of referred for other factors.

Table 11.2[1]

INFANT SCREENING RESULTSBIRTHS FROM JULY 2018 THROUGH JUNE 2019 AS OF 08/12/2019

COALTION/COUNTY	TOTAL # OF INFANTS	TOTAL SCREENED	PERCENTAGE OF INFANTS SCREENED	NUMBER OF POSITIVE SCREENS	POSITIVES AS PERCENT OF TOTAL SCREENED	REFERRED BASED ON OTHER FACTORS	NUMBER OF PARTICIPANTS
HSC of Jefferson/Madison/Taylor Counties							
JEFFERSON	117	117	100.00%	29	24.79%	20	31
MADISON	197	196	99.49%	53	27.04%	30	50
TAYLOR	226	225	99.56%	40	17.78%	46	47
COALITION TOTAL:	**540**	**538**	**99.63%**	**122**	**22.68%**	**96**	**128**
GRAND TOTAL:	**540**	**538**	**99.63%**	**122**	**22.68%**	**96**	**128**

INFANT SCREENING RESULTSBIRTHS FROM JULY 2017 THROUGH JUNE 2018 AS OF 08/17/2018

COALTION/COUNTY	TOTAL # OF INFANTS	TOTAL SCREENED	PERCENTAGE OF INFANTS SCREENED	NUMBER OF POSITIVE SCREENS	POSITIVES AS PERCENT OF TOTAL SCREENED	REFERRED BASED ON OTHER FACTORS	NUMBER OF PARTICIPANTS
HSC of Jefferson/Madison/Taylor Counties							
JEFFERSON	130	108	83.08%	24	22.22%	24	25
MADISON	176	159	90.34%	38	23.90%	33	47
TAYLOR	229	189	82.53%	45	23.81%	46	52
COALITION TOTAL:	**535**	**456**	**85.23%**	**107**	**23.46%**	**103**	**124**
GRAND TOTAL:	**535**	**456**	**85.23%**	**107**	**23.46%**	**103**	**124**

INFANT SCREENING RESULTSBIRTHS FROM JULY 2016 THROUGH JUNE 2017 AS OF 08/07/2017

COALTION/COUNTY	TOTAL # OF INFANTS	TOTAL SCREENED	PERCENTAGE OF INFANTS SCREENED	NUMBER OF POSITIVE SCREENS	POSITIVES AS PERCENT OF TOTAL SCREENED	REFERRED BASED ON OTHER FACTORS	NUMBER OF PARTICIPANTS
HSC of Jefferson/Madison/Taylor Counties							
JEFFERSON	129	89	68.99%	28	31.46%	10	24
MADISON	186	139	74.73%	45	32.37%	17	46
TAYLOR	232	189	81.47%	53	28.04%	13	49
COALITION TOTAL:	**547**	**417**	**76.23%**	**126**	**30.22%**	**40**	**119**
GRAND TOTAL:	**547**	**417**	**76.23%**	**126**	**30.22%**	**40**	**119**

INFANT SCREENING RESULTSBIRTHS FROM JULY 2015 THROUGH JUNE 2016 AS OF 08/14/2016

COALTION/COUNTY	TOTAL # OF INFANTS	TOTAL SCREENED	PERCENTAGE OF INFANTS SCREENED	NUMBER OF POSITIVE SCREENS	POSITIVES AS PERCENT OF TOTAL SCREENED	REFERRED BASED ON OTHER FACTORS	NUMBER OF PARTICIPANTS
HSC of Jefferson/Madison/Taylor Counties							
JEFFERSON	118	114	96.61%	43	37.72%	7	39
MADISON	211	211	100.00%	61	28.91%	28	83
TAYLOR	244	240	98.36%	72	30.00%	21	84
COALITION TOTAL:	**573**	**565**	**98.60%**	**176**	**31.15%**	**56**	**206**
GRAND TOTAL:	**573**	**565**	**98.60%**	**176**	**31.15%**	**56**	**206**

Since the total number of screens entering the system has decreased in the last few years and the Connect system came online in July 2018, the Coalition evaluated the total number of all referrals coming into the system to determine the impact to the Healthy Start System of care. Figure 11.2 depicts a system concern; total referrals to the entire system of care are down 48%, and overall impact to Healthy Start is a reduction in referrals of **42%.**

Figure 11.2[2]

CI&R Referrals
Performance Analysis
July 1, 2018 - May 31, 2019

Provider: Madison County Health Dept					**Provider: Madison County Health Dept**					**Provider: Taylor County Health Dept**			
County: Jefferson					**County: Madison**					**County: Taylor**			
Total WFS Referrals (Screens)	Healthy Start	Healthy Families			Total WFS Referrals (Screens)	Healthy Start	Healthy Families			Total WFS Referrals (Screens)	Healthy Start	Healthy Families	
1	1	0	Jul-18		5	5	0	Jul-18		5	5	0	Jul-18
2	2	0	Aug-18		5	5	0	Aug-18		10	9	1	Aug-18
3	3	0	Sep-18		6	6	0	Sep-18		3	3	0	Sep-18
1	1	0	Oct-18		8	3	5	Oct-18		5	2	3	Oct-18
4	3	1	Nov-18		5	5	0	Nov-18		5	5	0	Nov-18
5	4	1	Dec-18		3	3	0	Dec-18		4	4	0	Dec-18
7	5	2	Jan-19		5	4	1	Jan-19		12	10	2	Jan-19
1	1	0	Feb-19		9	9	0	Feb-19		8	8	0	Feb-19
1	1	0	Mar-19		4	4	0	Mar-19		6	4	2	Mar-19
1	1	0	Apr-19		4	4	0	Apr-19		5	5	0	Apr-19
2	2	0	May-19		6	5	1	May-19		9	9	0	May-19
			Jun-19					Jun-19					Jun-19
28	24	4			60	53	7			72	64	8	
	86%	14%				88%	12%				89%	11%	

Statewide Averages

45448	32408	7213			Statewide:					Statewide:			
	71%	16%				71%	16%				71%	16%	

Total Number of Referrals In Well Family System					Total Number of Referrals In Well Family System					Total Number of Referrals In Well Family System			
July 1 2017 - May 31 2018	69				July 1 2017 - May 31 2018	139				July 1 2017 - May 31 2018	124		
July 1 2018 - May 31 2019	28				July 1 2018 - May 31 2019	60				July 1 2018 - May 31 2019	72		
	-41%					-43%					-58%		
					Overall	332							
						160							
						-48%							

Due to the changes in the system and the overall decrease in screens entering the system, the Coalition engaged the Florida State University in 2018 to evaluate the impact to families when infants are not properly identified and funneled into services. That study provided support for the birthing facilities to increase referrals to the system and was shared with local birthing facilities. The full report and the latest version of both the prenatal and postnatal screens are included in the Appendix.

Healthy Start Services

Until July 1, 2015 Healthy Start services were entered, collected, and analyzed using Florida's Health Management System (HMS). After that point, services were collected in the Well Family System (WFS) case management system. A service is measured as a unit of time (in one-quarter hour increments) devoted to encounters with Healthy Start participants. The basic concept of intensity of services is the duration of time and frequency of encounters should be consistent with risk appropriate care and optimization of resources allocated for services.

The total services for the last four fiscal years is below in Table 11.3. From this data, there are identifiable trends.

1. Even though total clients served have decreased 53%, the assumption is that the same number of services would be provided to fewer clients, as the overall model shift has been to increase intensity and duration for the highest risk clients. That is not reflective in the data, since services are also down 45%.
2. The reduction in the total number of clients is correlated to the reduction in total referrals (screens).

Table 11.3

	2018-2019	2017-2018	2016-2017	2015-2016
Coalition				
Total Clients	290	479	495	543
Total Services	4495	7532	9089	9937
Jefferson/Madison CHD				
Total Clients	165	291	306	307
Total Services	2569	4554	5798	5920
Taylor CHD				
Total Clients	128	189	189	238
Total Services	1926	2978	3291	4017

Substance Use among HS Participants

For Healthy Start participants, those involved with substance use are identified through coding appropriately for referrals. This identifier is significant in that it labels participant data in order to properly assess the need for substance abuse intervention services. Healthy Start Redesign components regarding Substance Abuse Screening instruments and Intervention Pathways address identification of substance use on a much broader scale for Healthy Start. As these interventions were approved in March 2019, the data is beyond the scope of this needs assessment.

Although we know that locally, substance use during pregnancy is a significant problem, many private providers in Leon County do not routinely test for substance use. Therefore, there is no means to determining substance abuse use for the entire pregnant population, as only those using the local health department for prenatal care are universally screened for substance use. Healthy Start participants may disclose during Healthy Start service provision, which would also generate an identifier used in documentation. Effective with March 2019 services, this information can be extracted from the tools administered to establish baseline data. This is not available for this assessment. However, there is limited 2016 BRFSS data on adults binge drinking and marijuana use that can be used to compare behaviors with other adults in Florida to establish a general understanding of risk for females of reproductive age. Tables 11.4 and 11.5 provide a picture of these counties as having a lower tendency for alcohol and substance abuse than the state of Florida.[3]

Table 11.4

Adults who engage in heavy or binge drinking, Overall				
Year	Jefferson	Madison	Taylor	Florida
2002	17.7% (11.5 - 23.9)	10.9% (7.1 - 14.6)	12.2% (8.8 - 15.6)	16.4% (15.5 - 17.4)
2007	17.1% (11.8 - 24.0)	10.0% (7.0 - 14.1)	18.6% (14.1 - 24.2)	16.2% (15.3 - 17.2)
2010	13.2% (9.0 - 17.4)	15.0% (9.8 - 20.2)	14.4% (9.1 - 19.7)	15.0% (14.0 - 16.0)
2013	12.9% (7.9 - 17.9)	13.9% (8.1 - 19.7)	9.9% (5.7 - 14.1)	17.6% (16.6 - 18.6)
2016	8.5% (5.3 - 11.8)	11.6% (8.1 - 15.2)	12.9% (8.7 - 17.0)	17.5% (16.7 - 18.4)

Table 11.5

Adults who used marijuana or hashish during the past 30 days, Overall				
Year	Jefferson	Madison	Taylor	Florida
2016	3.5% (1.2 - 5.7)	3.4% (1.4 - 5.4)	4.7% (2.1 - 7.4)	7.4% (6.7 - 8.0)

[1]Healthy Start Reports, Division of Public Health Statistics and Performance Management accessed February 2020 http://www.flpublichealth.com/HS/rdPage.aspx

[2]Connect service data, via the Well Family System accessed November 2019 https://gbcmc.com/wfsd/main/wfs.asp

[3] Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion

Health Problem Analysis Process

The Coalition Executive Director, Healthy Start Program Managers (2), and nine Board members formed the Health Problem Analysis Workgroup in December 2012. In 2021 this group reviewed the analysis chart and provided updates that correspond to emerging trends in care, including the Medicaid Managed Care program as well as the impact of the COVID-19 pandemic.

In this process, current data was made available, and guidance was given to distinguish Risk Factors, Direct Contributing Factors, and Indirect Contributing Factors. The workgroup used this chart and data trends to prioritize the Action Planning.

The health problem analysis chart below is used to assist with analysis of health problems. The following definitions are used in health problem analysis:

- ✓ Health Problem: a situation or condition of people that is considered undesirable, is likely to exist in the future, and is measured as death, disease or disability.
- ✓ Risk Factor: scientifically established factors that relate directly to the level of a health problem.
- ✓ Direct Contributing Factor: scientifically established factors that directly affect the level of a risk factor.
- ✓ Indirect Contributing Factor: community specific factors that directly affect the level of a direct contributing factor.

Health Problem Analysis Chart

Health Problem	Risk Factors	Direct Contributing Factors	Indirect Contributing Factors	Priority Given by HPA Workgroup, based on data trends
Infant and Fetal Mortality	**Prematurity and Low Birth Weight**	Overall Preconception Health Status, Access and utilization of Services	Lack of collaboration among service delivery providers of services 0-3, Social Determinants of Health and cultural values	→The Coalition, through the guidance of the HPA workgroup has given this issue priority in terms of addressing the racial disparity in all birth outcomes. The Coalition will work to develop a stronger screening and triage infrastructure for identification of participants and collaboration among agencies that provide home visiting to

Health Problem	Risk Factors	Direct Contributing Factors	Indirect Contributing Factors	Priority Given by HPA Workgroup, based on data trends
				pregnant women and serve 0-3.
		Maternal Health-Vaginal Infections	Better screening rates may have lead to the increased number of STD's; however, adequately, not diagnosed and treated aggressively, follow-up tests not often enough	→The Coalition will address STD's by offering preconception workshops that include this topic, but also participating in the established planning activities of the county health department's CHIP plans, which address STD's.
		Inadequate Entry into Prenatal Care	Perceived barriers to care, lack of knowledge on how to access Medicaid and care, perception that early and continuous care is not necessary, navigation of health plans, and fear of service access due to pandemic.	↑The Coalition has identified the screening infrastructure for both pregnant women and infants as a top priority issue, which will be addressed through stronger marketing campaigns for screening and positive post-pandemic messaging.
		Smoking	Addictions, lack of Knowledge about risk, lack of recognition of problem, lack of knowledge and support to stop or cut back on tobacco use, lack of follow-up.	→The Coalition will address smoking prevalence through preconception education, community education and awareness, as well as providing more intensive Healthy Start tobacco cessation services as part of improved programming

Health Problem	Risk Factors	Direct Contributing Factors	Indirect Contributing Factors	Priority Given by HPA Workgroup, based on data trends
		Toxic Stress	Not aware of psychosocial counseling value, not aware of impact of stress on pregnancy, unable to recognize stress other than routine lifestyle (SocDH), lack of services targeting root causes of toxic stress	→Coalition to coordinate with subject matter experts to present to consumers during preconception education workshops, as well as key community stakeholders to increase awareness and advocate for services. The Coalition also plans to contract for Moving Beyond Depression services.
		Hypertension and Other Chronic Diseases	Knowledge deficit on impact of chronic diseases on pregnancy and the special care to be taken while pregnant	
		Alcohol and Substance Use	Addictions, lack of knowledge, lack of recognition of problem, lack of diagnosis, lack of follow-up.	→Identification of the issue prenatally will be supported by new protocol for Plans of Safe Care.
		Teen Pregnancy	Lack of effective education, lack of birth control, lack of resources, peer pressure, lack of self esteem	→The Coalition can impact teen birth recidivism through strengthening its reach with Healthy Families, to increase IC services to teens.
		Preterm Labor	Knowledge deficit regarding signs and	→Education during Healthy Start service

Health Problem	Risk Factors	Direct Contributing Factors	Indirect Contributing Factors	Priority Given by HPA Workgroup, based on data trends
			symptoms of preterm labor and factors which contribute to preterm labor	delivery for participants.
		Inadequate Nutrition and Obesity	Possible barriers to accessing WIC services, knowledge deficit related to importance of good nutrition during pregnancy including prenatal vitamins and folate	→Obesity rates during pregnancy are declining. Preconception education workshops are planned to address this topic, as well as community education on the impact of preconception health status and the role of the Social Determinants of Health in context of poverty and obesity.
		Health and Safety	Mothers who initiate breastfeeding early and breastfeed longer	→The Coalition hopes to increase breastfeeding rates among African Americans as well as with all women in the catchment area through continuation of credentialing for Healthy Start staff, peer support, and social media.
	Child Abuse/Neglect	Suffocation Sudden Infant Death Syndrome	Knowledge deficit regarding back to sleep and co-sleeping, familial beliefs,	→ Healthy Families is under the umbrella of the HSC. For infant health interventions, the Coalition hopes to increase education related to SIDS amongst

Health Problem	Risk Factors	Direct Contributing Factors	Indirect Contributing Factors	Priority Given by HPA Workgroup, based on data trends
	Child Abuse/Neglect			high-risk parents, and through partnering for an improved curriculum, offer more intensive parenting education services.
		Fatherless Homes	Fathers lack of knowledge in how to be full partners in parenting, lack of understanding of children's developmental needs, lack of knowledge about safe environments and appropriate interactions	
		Mother with lack of coping skills	Lack of adequate support, lack of coping skills, lack of understanding of children's developmental needs, lack of knowledge about safe environments and appropriate interactions	→The Coalition has developed action planning strategies to address child abuse prevention through better utilization of Healthy Families services in the three-county area.

Target Population

Significant disparities exist between white and nonwhites in fetal and infant deaths, low birth weight, and very low birth weight, and the black-white gap is 3:1 for low birth weight and infant mortality. The demographics are varied among the counties, yet the black-white gap persists. Pervasive poverty and the Social Determinants of Health play a huge role in the persistent poor birth outcomes in these communities. The outcomes are the same for each county, with Taylor County having a higher teen pregnancy rate and a significant amount of white women who smoke. All of the impending strategies of the Coalition over the next five years will be applied with the same intensity across all counties.

Data for **Jefferson** County supports choosing the following target populations:

- ✓ Low Birth Weight and Very Low Birth Weight

  Non-white women of child bearing age
- ✓ Pregnant women and families of infants who smoke
- ✓ White women who have shorter pregnancy intervals
- ✓ Pregnant Teens

Data for **Madison** County supports choosing the following target populations:

- ✓ Low Birth Weight and Very Low Birth Weight

  Non-white women of child bearing age
- ✓ Pregnant women and families of infants who smoke
- ✓ White women who have shorter pregnancy intervals
- ✓ Pregnant Teens

Data for **Taylor** County supports choosing the following target populations:

- ✓ Low Birth Weight and Very Low Birth Weight

  Non-white women of child bearing age
- ✓ Pregnant women and families of infants who smoke
- ✓ White women who have shorter pregnancy intervals
- ✓ Pregnant Teens
- ✓ Substance using women

External Healthy Start Program Monitoring

I. Overview of Program

Purpose

The purpose of the Quality Assurance Program at the Healthy Start Coalition of Jefferson, Madison and Taylor Counties, Inc. (the Coalition) is to assess and improve the quality and appropriateness of care being provided to pregnant women and infants by contracted providers and to ensure services are effective for the families receiving assistance from the Coordinated Intake and Referral team, or enrolled in Healthy Start. The program ensures that any deficiencies identified through the monitoring and evaluation process that are not in compliance with established standards are targeted for corrective action.

Goals

The goals of the Quality Assurance Program are as follows:

A. To ensure that the established levels of quality care are maintained and continuously improved by all providers through
    1) The monitoring and evaluation of the care, services and processes provided to participants in order to identify areas for improvements and deficit trends;
    2) Identification of training needs based on the monitoring system;
    3) The implementation of corrective actions when deficit trends and opportunities for improvement are identified; and
    4) Monitoring and evaluating the resolution of the problem or opportunity for improvement to ensure the corrective action has been effective.

B. To ensure appropriate utilization of services, timeliness of service provision, and accessibility to services through
    1) Ongoing review of state and local reports to examine status of process indicators, performance measures and outcomes;
    2) Establish performance improvement projects when expected target goals are not being met; and
    3) Re-evaluate processes implemented for continuous quality assurance.

C. To ensure Coalition operations are in compliance with state statutes, contract requirements, and internal quality standards through
    1) Quarterly review and evaluation of the agency work plan by staff;
    2) Self-monitoring of compliance on an annual basis; Accomplishment of goals and objectives in the Service Delivery Plan; and
    3) Annual community survey of Coalition’s responsiveness to the community's needs within the confines of statutes and our mission,
    4) Annual provider survey of Coalition's responsiveness to the providers needs within the confines of statutes and our mission.

D. To ensure the effectiveness of the Quality Assurance Program through
    1) The integration of information from all quality assurance activities;
    2) The annual assessment of the monitoring and evaluation process to determine its effectiveness; and
    3) Appropriate revisions to the program and/or service delivery plan as identified through the annual evaluation.

II. Organization

The Quality Assurance Program is designed to encourage participation by Healthy Start Coalition staff, Coalition members and subcontracted service providers to provide usable data to assess service performance in relation to the Healthy Start Standards and Guidelines, Intervention Pathways, and the Coalition's adherence to contract requirements and state statutes. Other indicators of quality and appropriateness may be assessed based on the specific needs of Jefferson, Madison, and Taylor Counties for future planning or special projects.

A. Quality Assurance Committee

Responsibilities

The quality Assurance Committee shall be responsible for ensuring the monitoring and evaluation of contracted services based on the most current Healthy Start Standards and Guidelines. The committee will also review quality assurance activities of the Coalition relative to internal standards and utilization of services for input into revision of the Quality Assurance Plan annually.

Membership

The membership of the Quality Assurance Committee will include the Healthy Start Coalition Executive Director and Program staff, board members and County Health Department staff. The Board of Directors represents a diverse group of professionals who have experience or background in nursing, social services, counseling, program management, contract management, or quality Assurance.

Meetings

The Quality Assurance Committee will meet ~~semi-~~annually. The meetings will address a review of monitoring tools and procedures for each contract year and a review of the Quality Assurance Plan with recommendations for revisions. The updated QI Plan will be sent to committee members within 15 days after the date of the meeting.

III. Quality Assurance Functions

A. Service Monitoring of Subcontracted Providers and Program Outcomes

Purpose

The purpose of service monitoring is to ensure important aspects of care are being provided as outlined in the most current edition of the Healthy Start Standards and Guidelines. Procedures and

protocols are reviewed to ensure compliance with the contract, including adequate staffing, reporting, coding, quality assurance activities, and data entry. Documentation of service provision is reviewed to ensure risk appropriate services are being offered at the intensity indicated per the leveling system. The effectiveness of programs and services in relation to established performance and outcome measures is evaluated as established in the provider's contract.

Activities

- Annual Technical Assistance (TA)
- Annual Administrative Review of Services Provided as required by the Deliverables section of the Healthy Start Contract
- Annual Shadowing of Home Visits and Initial Intakes
- Quarterly Record Review of Healthy Start Services
- Quarterly Record Review of Coordinated Intake and Referral Services
- Quarterly Evaluation of Performance and Outcome Measure goal attainment per provider
- Annual Satisfaction Survey results
- Semi-Annual Fiscal Monitoring of Expenditures by Random Sample
- Annual Reconciliation of Budget vs Expenditures for Healthy Start funding

Process

1. Each provider will be monitored by the Coalition at least twice during the contract year. This will include a Technical Assistance (TA) visit in the first quarter of the fiscal year, followed with the Annual Administrative Monitoring in the fourth quarter of the fiscal year. The Service Provider will conduct peer reviews as part of their internal plan. These reviews may be conducted jointly on site between the Coalition and the Service Provider. The Appendix includes a narrative summary of the function of all the monitoring forms, provider data reporting forms, and performance measure reports for each provider, and a current sample of the Quality Improvement Plan (QIP). Monitoring tools and data report forms are identified in each subcontract.
2. Prior to each Annual monitoring visit, the provider will receive electronic notice confirming the date, time, and location of the monitoring. The annual monitoring will include an administrative review of contract requirements, record reviews, observation/shadowing of direct services, and an evaluation of the provider's goal attainment of performance and outcome measures.
3. Annual monitoring visits will include an entrance and exit conference. The Coalition will jointly lead these reviews. The purpose of the entrance review is to go over the purpose of the monitoring, schedule for the review, and answer any questions. The exit review will provide a brief synopsis of the findings. The provider will then receive a written report from the Coalition within 15 days of the monitoring summarizing the findings and identifying any corrective action requirements, if necessary. The monitoring report is to be completed by the Coalition.
4. During the 2nd and 3rd Quarter, HS Provider Staff will conduct their internal peer reviews, participate in trainings offered by the Coalition on the core program components,

documentation and skill building. The Coalition will conduct a TA visit during the 1st Quarter in addition to the annual site visit and provide a brief record review and review of supervision documentation. The Coalition may also participate in monthly staff meetings of the provider for emerging system issues and programmatic review using the management reports of the Well Family System.

B. Monitoring of the Coordinated Intake and Referral System (CI&R)

Purpose

CI&R program is operated by Coalition sub-contracted service providers. The purpose of client care monitoring is to ensure that the program is meeting contract requirements in service provision, documentation standards, performance measure goal attainment, and participant satisfaction with the program.

Activities

- Participation in the quarterly meeting of the Local Home Visiting Advisory Council
- Quarterly Well Family Data Reports for adherence to decision trees, capacity concerns
- Quarterly monitoring of the contract requirements for Initial Intake completion
- Quarterly Record Reviews
- Annual Implementation Evaluation

Process

1. Record Reviews will be conducted on a random sample of Initial Intakes that were 1) referred to Healthy Start for an Initial Assessment, or 2) referred to another home visiting program, or 3) received education only. The criterion for record reviews is 10% of the current Initial Intakes that were completed or a minimum of 6 records randomly selected from the Well Family CIR System. Records will be reviewed for compliance with local decision trees and Chapter 4 of the HSSG. A Quality Improvement Plan (QIP) will be developed by the Executive Director with follow-up on implementation and results of the next review.
2. The Coalition will perform record reviews for the 1st and 4th Quarters and the Provider will perform record reviews for the 2nd and 4th Quarters.
3. The Coalition will conduct an annual administrative and services monitoring of the program for maintenance of contract compliance using the Well Family System data reports and through direct observation of the Initial Intake. If corrective action is necessary, the Coalition will develop the plan and designated HSC Staff will monitor the implementation and results.

C. Resource Utilization Review/Utilization Management

Purpose

The purpose of utilization management is to ensure that the Healthy Start Screening Infrastructure is working efficiently to maximize screening rates so pregnant women can access services and to ensure that there is effective utilization of services to impact birth outcomes. Services should be provided as designed which takes into account risk factors, leveling, and care coordination needs.

Activities

- Quarterly Review of prenatal and postnatal screening rates from the Department of Health
- Review of Minutes from Regional Coalition Meetings
- Review of Screening Outreach Quarterly reports

Process

1. Quarterly, HS Coalition staff will review prenatal and postnatal screening rates and compare the state and local data. Deficiency in providers or birthing facilities falling below expected screening rates will be discussed with neighboring Coalitions when the provider is located outside the Coalition catchment area.
2. Deficiency in provider screening rates at the local County Health Department will be addressed directly with the CHD Administrator.
3. The CI&R reports from Well Family System will be monitored monthly to ensure the appropriate screens are being transferred from the Health Management System. Any discrepancies in sharing all screens that consent will be directed to the Healthy Start MomCare Network.

D. Quality Management of Coalition Operations

Purpose

The purpose of the quality management in the operations of the Coalition is to ensure maintenance of contract requirements and adherence to Coalition written policies and procedures. All tools and surveys are listed in the Appendix.

Activities

- Quarterly monitoring of Service Delivery Plan goals and accomplishments
- Annual self-monitoring of contract requirements and tasks required in statute
- Annual provider satisfaction survey to evaluate responsiveness to providers and identified needs in their interactions with Coalition staff.
- Bi-annual community survey of Coalition’s responsiveness to the community's needs.

Process

1. The Executive Director in conjunction with the Board of Directors and Coalition staff will develop action items for the Agency work plan and set dates for completion. This work plan will be reviewed with staff quarterly for updating staff on Coalition activities as well as monitoring completion of action items as targeted. The Executive Director will monitor timely completion at review. The Agency work plan is incorporated into the Coalition Service Delivery plan and reported to the State via the Coalition’s Quarterly Action Plan Report.
2. Coalition staff have established general qualities and internal standards related to professionalism, working environment, knowledge base and accuracy of communication, and timeliness in responding to the community and providers. Adherence to standards is measured through employee’s annual performance evaluation, during staff meetings and by the responses obtained from the community survey and provider satisfaction survey. Survey results are shared with the Coalition’s Service Delivery Planning Workgroup and deficiencies and strengths are incorporated into the Coalition’s Needs Assessment.

3. A provider satisfaction survey will be disseminated to all contract providers. The purpose of this survey is to elicit feedback on the Coalition's efficiency and effectiveness in helping providers maintain and improve services. The Executive Director will compile the results and present the report to the Service Delivery Plan Workgroup.
4. A community survey will be disseminated in each county every other year. The purpose of this survey is to elicit feedback on the Coalition's efficiency and effectiveness in working with the Community. The Executive Director will compile the results and present the report to Coalition staff.

IV. Program Evaluation

A. Assessment

1. Data collection is the foundation of quality assurance activities. The Coalition will collect data on processes and outcomes as well as utilization findings and participant satisfaction results to establish opportunities for improvement. Integration of information obtained will lead to an assessment of the quality assurance program.
2. Based on results, the Coalition may set priorities for quality assurance activities related to maternal and child health indicators that may be integrated into the service delivery plan and added to provider contracts.

B. Annual Review

The Quality Assurance Committee will review the QI plan annually for needed revisions, modifications, or enhancements.

Allocation of Funds to Sub-Contracted Providers

As a result of improved fiscal procedures linking funding to service deliverables beginning in 2012, the Coalition developed a mechanism of allocating funding that focused on service delivery. In 2014, the Coalition was able to maximize revenue for its providers through direct billing for Medicaid services through the Administrative Services Organization, namely the Healthy Start MomCare Network. The Coalition is a member of this ASO Network and bills directly for services that are eligible under the Healthy Start Waiver. This fee-for-service structure is passed down to subcontracts that will earn and receive their share of Medicaid earnings at a rate 10% lower than the Coalition's rate, for administrative purposes. Subcontractors receive their Medicaid funding, up to contract caps in addition to Base dollars allocated by the Florida Department of Revenue for Healthy Start services.

The Coalition disburses Base dollars by calculating the total number of births for the three-county area, and applying the percentage of those births by county. The result is a distribution of funding related to proportions of the total births for the area. The most recent calculation:

Resident Births by County of Residence (Mother) by Year of Birth

	Resident Births						Percentage of Births
	2015	**2016**	**2017**	**2018**	**2019**	**Total**	
Jefferson	124	121	142	111	117	**615**	22%
Madison	210	197	175	184	219	**985**	35%
Taylor	249	248	204	242	238	**1,181**	43%
Total	**583**	**566**	**521**	**537**	**574**	**2,781**	100%

Special Note:
Funds for an individual subcontractor were subtracted first from the allocation before distributing by birth rate. The individual contractor is a new strategy for the JMT Coalition, effective in March 2021 to diversify services and this contract covers all three counties in the catchment area.

COST ALLOCATION PLAN July 01, 2021 – June 30, 2022

Total Allocation: $ 403,169

A. Clinical Services:

Healthy Start positions that support prenatal clinic.

Provider: N/A **Allocation:** N/A

B. Coalition Planning Dollars

These funds are allocated for the service planning and execution of community-wide strategies to improve birth outcomes in Jefferson, Madison and Taylor Counties. **$119,857**

C. Connect Service

These services are intake and referral services provided by staff at the county health department who also have Healthy Start duties and Health Management System duties related to the logistics of the prenatal and infant universal screening instruments. **$ 16,446**

D. Healthy Start Services:

These services include: Healthy Start care coordination services, home visiting, smoking cessation, childbirth education, parenting support and education, breastfeeding support and education, interconceptional education and counseling, outreach to identify participants, outreach to community providers, CHD data entry, and lactation counseling services.

$226,549

Provider	CI&R Services (Connect)	Base Allocation	Allocation Methodology
Total Base for HS Services		$226,549	
Angelina Curtis, awarded individual contract March 1, 2021		$18,000	Calculated based on maintaining 7-10 clients, part-time contractor, comparative to full-time care coordinator
Residual for CHD Contracts (Base less individual contract)	**$16,446**	**$208,549**	

Madison County Health Department	$ 9,374	$118,873	35% of births in Madison County, 22% of births for Jefferson County-57% of CHD contract amounts
Taylor County Health Dept	$7,072	$89,676	43% of CHD Contract amounts

E. <u>Administration for All Healthy Start Funded Services:</u>

Services include: Quality Assurance/Quality Improvement, contract management/fiscal accountability, Healthy Start program training, programmatic technical assistance to contracted providers and reporting. **Allocation:** $40,317 (10%) of total Base Direct Services allocation) **<u>total: $ 40,317</u>**

<u>Contract Time Frames:</u>

Healthy Start and Connect Services:

1. Madison County Health Department – July 01, 2021- June 30, 2022
2. Taylor County Health Department – July 01, 2021 -June 30, 2022
3. Angelina Curtis – March 1, 2021 – December 31, 2022, and January 1, 2022 – June 30, 2022 (tentatively, based on successful execution of contract #1)

Action Plan Overview

Category A Activities, Strategies or Action Steps Changed, Revised or Deleted

1. The strategies in Category A have been revised to reflect the significant amount of work in programming during the last planning cycle. Strategies to implement Healthy Start redesigned services, hire a Program Director to oversee Continuous Quality Improvement, and related strategies to increase fiscal accountability have all been implemented successfully. Category A strategies in this cycle include Continuous Quality Improvement strategies for programmatic oversight, as well as expanding and diversifying Healthy Start services.

Category B Activities, Strategies or Action Steps Changed, Revised or Deleted

1. In Activity #1 from the previous Service Delivery Plan, the strategies included improvement for the Healthy Start screening infrastructure. This is a strategy that will be augmented in the next Service Plan to build upon the work of the previous cycle with infant screening barriers as well as address the impact of Managed Care and the pandemic.
2. Other strategies in Activity #1, to implement a coordinated intake and referral system, and to implement strategies to improve Parents as Teachers™ services have concluded. The CI&R activities in the previous plan have resulted in a sustainable Home Visiting Advisory Board that will have a perpetual role in improving services. The Parents as Teachers™ program has been replaced with Healthy Families Seven Rivers.
3. Activity #2 has become the cornerstone of the work of the Healthy Start Coalition of Jefferson, Madison and Taylor Counties and will continue into the 2021-2026 Service Delivery Plan with a few changes. The Coalition Executive Director will intensify efforts to educate the community on the Social Determinants of Health with strategies developed as a result of the community survey conducted during the spring 2021. Other preconception education efforts will be continued and expanded by the Certified Community Health Worker. These include women's health workshops, outreach events, neighborhood canvassing, and educating providers.
4. Activity #3 for breastfeeding and safe sleep will be expanded to include all infant safety and health, including building upon breastfeeding efforts of the previous planning cycle, increasing partnerships to provide safe sleep education, and adding an annual child safety fair.

Category A
2021-2026

1. CONTRACT REQUIREMENT OR IDENTIFIED HEALTHY START SYSTEM ISSUE:

a. What is the requirement or system/community-wide problem or need identified to be addressed by a strategy? **Continued Quality Improvement activities for programming**

b. What health status indicator/coalition administrative activity is being addressed by this strategy? **Evaluating the effectiveness of service delivery by providers.**

c. What information, if any, was used to identify the issue/problem (i.e. HPA, FIMR, screening, client satisfaction, interviews, QI/QA)? **2019/2020 QI Activities, Training logs, and technical assistance issues since inception of Healthy Start Redesign**

2. PLANNING PHASE QUESTIONS: (All Required)

a. What strategy has been selected to address this?
   - **i. Ensure continuous quality improvement in delivery of Healthy Start services**
   - **ii. Ensure accountability of direct service dollars for Healthy Start**
   - **iii. Diversify Healthy Start service providers to maximize resources and address population risk factors**
   - **iv. Determine the feasibility of a local Fetal and Infant Death Mortality Review project**

b. What information will you gather to demonstrate that you have implemented this strategy as intended (who, what, how many, how often, where, etc.)? **PDSA Cycle reports, Training Transcripts for staff in the FAHSC Learning Management System, Process Measures Reports, and Outcome Measures Reports.**

c. Where/how will you get the information? **Well Family System, CHD Fiscal Records, Coalition QI Reports, Internal Fiscal Reports**

d. What do you expect will be the observed impact of the strategy on the system or community-wide problem/need? **Quality of Healthy Start services continue to improve to address risk factors and improve birth outcomes.**

e. What information will you gather to demonstrate this change on the system? **Outcome data on Healthy Start participants compared to non-HS participants, participant satisfaction results, service records and QI reports.**

f. Where/how will you get the information? **Learning Management System, Well Family System, Florida Charts, and Coalition QI records.**

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3. ACTION STEPS:

i. Ensure continuous quality improvement in delivery of Healthy Start services

Action Step	Pers. Responsible	Start Date	End Date
Train the Coalition's new Program Director (hired 2/2021) on the Plan-Do-Study-Act CQI training concepts.	Executive Director	07/01/2021	06/30/2022
Train the Coalition's Program Director on all core Healthy Start trainings and opportunities for train the trainer in HS components.	Executive Director	07/01/2021	06/30/2026
Develop a training plan outline for all new Healthy Start hires.	Executive Director, HS PMs	07/01/2021	06/30/2022
Provide a monthly Healthy Start Program Manager technical assistance opportunity to communicate programmatic changes, gather input on proposed initiatives, and provide resources.	Executive Director	07/01/2021	06/30/2026
Annually, update the Coalition's QI Plan to include emerging system issues and changes in procedures and tools.	Executive Director	07/01/2021	06/30/2026
Conduct monthly record reviews for Healthy Start and Connect participants, and communicate findings to Healthy Start staff.	Executive Director	07/01/2021	06/30/2026
Conduct Semi-Annual Quality Assurance site visits to include service observations, resource inventory review, staff interviews, and supervision shadowing.	Executive Director	07/01/2021	06/30/2026
Implement Performance Improvement Plans as needed based on semi-annual QI activities as applicable.	Executive Director, Director of Programs	07/01/2021	06/30/2026
Impose Financial Consequences for inadequate deliverables on a monthly basis.	Executive Director	07/01/2021	06/20/2026
Conduct at least one QI project per year with subcontracted providers, targeting any deficit in service delivery or other systematic issues, and implement the PDSA cycle to improve practice.	Executive Director	07/01/2021	06/30/2026

ii. Ensure accountability of direct service dollars for Healthy Start

Action Step	Pers. Responsible	Start Date	End Date
Test the funding methodology in context of the model components, staffing	Executive Director	07/01/2021	06/30/2026

requirements and administrative duties, and issue annual contract caps for providers for Medicaid earnings.			
Include contract language in Healthy Start subcontracts that specifies reconciliation procedures for Base and Medicaid dollars.	Executive Director	07/01/2021	06/30/2026
Include a budget reporting format specification in the contract attachments for Healthy Start providers that requires expenditure reporting by funding source and identification of administrative funds.	Executive Director	07/01/2021	06/30/2026
Include the budget review as part of the semi-annual QI activities, requiring backup documentation of Healthy Start expenditures twice per year in contract.	Executive Director	07/01/2021	06/30/2026
Work with the Business Managers of each county health department to identify Cost Accumulators for Healthy Start and reconciliation procedures.	Executive Director, Subcontracted Providers	07/01/2021	06/30/2023
Provide reconciliation tools to subcontracted providers in the format of revenues at the beginning of the fourth quarter of each year.	Executive Director, Business Manager	04/01/2022	06/30/2026
Annually reconcile CHD budgets against revenues issued by the Coalition to determine any unexpended Base dollars and to prepare applicable spending plans for Medicaid funds	Executive Director, Subcontracted Providers, Coalition Bus. Mgr.	04/01/2022	06/30/2026
Annually review the incentive plans of subcontracted providers to ensure compliance with participation requirements.	Executive Director	07/01/2021	06/30/2026

iii. Diversify Healthy Start service providers to maximize resources and address population risk factors

Action Step	Pers. Responsible	Start Date	End Date
Address the top root causes of birth outcomes with subcontracted providers to map service delivery that best mitigates root causes (i.e. obesity and mental health)	Executive Director, Board of Directors, and Subcontracted Providers	07/01/2021	06/30/2023
Determine the feasibility of adding an Registered Nurse to the staffing model of Healthy Start within the CHD	Executive Director,	07/01/2021	01/31/2022

infrastructure, including funding sustainability.	Subcontractor Leadership		
Determine the feasibility of adding a mental health component to the staffing model of Healthy Start services	Executive Director, Moving Beyond Depression Contractor	07/01/2021	06/30/2026
Evaluate the efficacy if the independent Healthy Start contractor for purposes of renewing the contract	Executive Director, Program Director, Independent Contractor	07/01/2021	12/31/2021

iv. Determine the feasibility of a local Fetal and Infant Death Mortality Review project

Action Step	Pers. Responsible	Start Date	End Date
Contact contiguous Coalition for budget samples of infant death review projects.	Executive Director	07/01/2021	12/31/2021
Procure training for the Program Director for abstracting and conducting fetal and infant mortality review projects from larger Coalitions and statewide resources.	Executive Director, Program Director	07/01/2021	06/30/3022
Prepare a budget for a local FIMR project and solicit funding for an annual infant and fetal death review	Executive Director	07/01/2022	06/30/2023
If feasible, recruit an infant death review committee comprised of Board members, Coalition members, local health officials, and subcontracted providers.	Program Director	07/01/2023	06/30/2024
Annual facilitate an infant death review for as many fetal and infant deaths as feasible to explore root causes for the next planning cycle.	Program Director	07/01/2024	06/30/2026

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Quarterly Progress for _____
Quarterly Progress for _____

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4. REPORTING PHASE ANSWERS: (To be completed for the Annual Action Plan Update)

a. Demonstrate the changes in the system/community.

b. Will you drop/modify/expand/continue strategy next year and explain why?

Category B
2021-2026
Activity #1 – System of Care

1. **CONTRACT REQUIREMENT OR IDENTIFIED COMMUNITY-WIDE/SYSTEM ISSUE:**
   a. What is the requirement or system/community-wide problem or need identified to be addressed by a strategy? **Persistent low-birth weight and prematurity rates, and resulting *poor developmental outcomes* for infants associated with system of care issues.**

   b. What health status indicator/coalition administrative activity is being addressed by this strategy? **Identification and appropriate triage of pregnant women and infants into service delivery.**

   c. What information, if any, was used to identify the issue/problem (i.e. HPA, FIMR, screening, client satisfaction, interviews, QI/QA)? **Healthy Start screening rates, capacity data for programs serving 0-3, 2020 MCH Needs Assessment.**

2. **PLANNING PHASE QUESTIONS: (All Required)**
   a. What strategy has been selected to address this?
      i. **Improve the Healthy Start Referral Infrastructure for JMT pregnant women and infants**
      ii. **Utilize the Home Visiting Advisory Board to evaluate the system of care and strengthen referrals for the 0-3 population**

   b. What information will you gather to demonstrate that you have implemented this strategy as intended (who, what, how many, how often, where, etc.)? **Healthy Start screening data, Healthy Start screenings logs and referral documentation, Interagency agreement with the Home Visiting Advisory Council members, Capacity and Performance reports from all providers within the Coordinated System of Care.**

   c. Where/how will you get the information? **Vital Statistics (screening data), Well Family System.**

   d. What do you expect will be the observed impact of the strategy on the system or community-wide problem/need? **Improved identification of at-risk population, greater alignment with families' needs and resources, elimination of duplicative effort for home visiting and early childhood services, synergistic effect on service capacity and improved capacity to identify developmental delays for infants.**

   e. What information will you gather to demonstrate this change on the system? **Feedback loop for Centralized Intake and Referral (CI&R) and Screening Information.**

   f. Where/how will you get the information? **Vital Statistics, Well Family System.**

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3. **ACTION STEPS:**

i. **Improve the Healthy Start Screening Infrastructure for JMT pregnant women and infants**

Action Step	Pers. Responsible	Start Date	End Date
Provide a training on the screening infrastructure for Program Director and Home Visiting Advisory Board	Executive Director	07/01/2021	12/31/2021
Gather conclusions from screening training, including trends in declines in referrals to develop an outreach plan for prenatal providers in Leon County	Program Director	01/01/2022	06/30/2022
Collaborate with Leon prenatal outreach activities to target providers that serve JMT pregnant women, to increase referrals	Program Director	01/01/2022	06/30/2026
Develop Connect and other materials for dissemination in Leon County, specific targeting JMT women	Program Director	01/01/2022	12/31/2022
Collaborate with Leon Healthy Start Coalition for training and messaging to birthing facilities on the infant screening process	Executive Director	07/01/2021	06/30/2026
Develop an agreement with Leon and other contiguous Coalitions to annually evaluate the screening processes with Leon birthing facilities and develop regional strategies to address deficits in referrals and avoid duplication of effort	Executive Director	07/01/2021	06/30/2026
Quarterly analyze the prenatal and infant screening rates and communicate findings to Leon counterparts	Program Director	07/01/2021	06/30/2026
Develop instruments to disseminate locally on the impact of the pandemic and returning safely to prenatal and infant care	Program Director Subcontracted Providers CCHW	07/01/2021	06/30/2022
Distribute Connect marketing materials locally to providers	CCHW	07/01/2021	06/30/2026

i. **Utilize the Home Visiting Advisory Board to evaluate the system of care and strengthen referrals for the 0-3 population**

Action Step	Pers. Responsible	Start Date	End Date
Develop an instrument to solicit feedback on developing marketing materials to consumers on Connect services and seek	Program Director HVAB	07/01/2021	12/31/2021

approval from the Local Home Visiting Advisory Board			
Conduct focus groups with consumers of prenatal and infant care on their awareness of, understanding and experiences with Connect services in the community	CCHW	01/01/2022	06/30/2022
Develop a marketing campaign with measurable benchmarks on Connect services	Program Director	01/01/2022	12/31/2022
Conduct provider outreach to at least 2 providers monthly on Connect services, and distribute other relevant MCH information	CCHW	07/01/2021	06/30/2026
Convene the local advisory board consisting of Healthy Start, Healthy Families, Early Head Start, FDLRS, Head Start, Early Steps and 211 quarterly to review materials, review agreements, and review services	Executive Director HVAB	07/01/2021	06/30/2026
Provide data quarterly to the Home Visiting Advisory Board on referrals and services to solicit input on negative trends in referrals and services	Program Director	07/01/2021	06/30/2026
Quarterly evaluate the feedback loop to track and evaluate referral mechanisms between local agencies	Program Director	07/01/2021	06/30/2026
Annually review the community referral form and review data from Well Family System on referrals as to source (screen, community, etc)	Executive Director, Program Director HVAB	07/01/2021	06/30/2026
Annually review the Decision Tree and Interagency Agreement to update for service and process changes	Executive Director, Program Director, HVAB	07/01/2021	06/30/2026

Category B
2016-2021
Activity #2 – Preconception Health Status

1. **CONTRACT REQUIREMENT OR IDENTIFIED COMMUNITY-WIDE/SYSTEM ISSUE:**
   a. What is the requirement or system/community-wide problem or need identified to be addressed by a strategy? **Persistent low birth weight, high rates of prematurity and black infant deaths associated with the preconception health status of the mother.**

   b. What health status indicator/coalition administrative activity is being addressed by this strategy? **Low Birth Weight, Very Low Birth Weight, Premature Births, Fetal Deaths, and Infant Deaths.**

   c. What information, if any, was used to identify the issue/problem (i.e. HPA, FIMR, screening, client satisfaction, interviews, QI/QA)? **2020 MCH Needs Assessment, evaluation results from Women's Health Workshops.**

2. **PLANNING PHASE QUESTIONS: (All Required)**
   a. What strategy has been selected to address this?
      i. **Educate the community on the Social Determinants of Health and other contributing factors to the Black-White Gap in birth outcomes**
      ii. **Impact the Social Determinants of Health through targeted efforts in each sector of the community**
      iii. **Provide preconception education and outreach for non-pregnant females of reproductive age**

   b. What information will you gather to demonstrate that you have implemented this strategy as intended (who, what, how many, how often, where, etc.)? **Number of workshops, count and demographics of attendees, number and content of community presentations on SocDH, number and outcome of outreach activities, number of billboard ads and other media.**

   c. Where/how will you get the information? **Sign-in sheets for meetings, monthly outreach logs, and consumption information for outreach materials.**

   d. What do you expect will be the observed impact of the strategy on the system or community-wide problem/need? **Greater awareness at the stakeholder level on the issues that impact birth outcomes, greater awareness in the consumer population on the 16 topics of women's health, greater awareness in the general population on the issues that affect birth outcomes.**

   e. What information will you gather to demonstrate this change on the system? **Low birth weight rates, family planning utilization data, evaluation data from preconception workshops.**

f. Where/how will you get the information? **Preconception Evaluation forms generated by attendees, Florida Charts.**

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3. ACTION STEPS:

i. **Educate the community on the Social Determinants of Health and other contributing factors to the Black-White Gap in birth outcomes**

Action Step	Pers. Responsible	Start Date	End Date
Partner with the CHD "Healthy Baby Initiative" to analyze and present the SocDH to the community	Executive Director	07/01/2021	06/30/2026
Present MCH Data, the SocDH, and the Coalition role to all available civic clubs, community agencies, local government, and churches	Executive Director	07/01/2021	06/30/2026
Conduct the Annual "State of the Infant" presentation in each county to emphasize the black-white gap	Executive Director	07/01/2021	06/30/2026
Participate in local strategic planning activities of the hospitals and the county health departments to increase awareness on SOCDH and contributing factors	Executive Director	07/01/2021	06/30/2026
Utilize the Coalition's monthly Shared Services meeting in each county to pool resources and identify opportunities to increase resiliency in the community, record minutes, and conduct sharing of events and updates electronically	Executive Director, Business Manager, Program Director	07/01/2021	06/30/2026
Use Social Media and the Coalition's website to provide needs assessment data and contributing factors information to the general public	Program Director	07/01/2021	06/30/2026
Educate providers and key stakeholders in the community on the link between toxic stress and reduced physical health and academic success for children	Executive Director, SME	07/01/2021	06/30/2026

i. **Impact the Social Determinants of Health through targeted efforts in each sector of the community**

Action Step	Pers. Responsible	Start Date	End Date
Economic Stability-Advocate for job growth through participating in Economic Development Councils	Executive Director Local EDC Councils	07/01/2021	06/30/2026

Economic Stability -Develop partnerships with CareerSource to expand job opportunities for vulnerable families	Executive Director CareerSource Subcontracted Providers	07/01/2021	06/30/2026
Economic Stability - Include employment-related goals in home visiting services	Executive Director Program Director Subcontracted Providers	07/01/2021	06/30/2026
Economic Stability -Develop partnerships with agencies that provide economic assistance to develop budgeting and life-skills classes for recipients of assistance	Executive Director Local Financial Assistance Agencies and municipalities	07/01/2021	06/30/2026
Support appropriate neighborhood and physical environments: a. Housing – Developing partnerships with housing authorities and free legal services to address landlord barriers to safe housing b. Transportation – Serve on local transportation boards to advocate for women with children c. Safety/Parks/Playgrounds- Develop partnerships with local law enforcement to encourage foot patrol in areas with multiple families during peak times (after school, etc)	Executive Director Civil Legal Services Local Municipalities Local Law Enforcement	07/01/2021	06/30/2026
Support access to education and early literacy by sponsoring book drives for families with young children	Program Director CCHW ELC Coalition members	07/01/2021	06/30/2026
Support early childhood education by advocating for enrollment in early learning centers and the expansion of Early Head Start services	Executive Director CCHW	07/01/2021	06/30/2026

Vocational Training and Higher Education - develop partnerships with local institutions to survey the community on barriers to accessing education	Executive Director CCHW Local technical institutions and colleges	07/01/2021	06/30/2026
Promote proper nutrition for mothers and babies by reducing barriers: a. Hunger- promote food pantries with vulnerable families, advocate for delivery or coordinate transportation for food drives b. Access to healthy options- advocate for increased availability of fresh options in sparsely populated area with no fresh food access c. Community Education- Educate women of childbearing age on proper nutrition using community health educators	CCHW Program Director IFIS Churches and other food distribution sites Subcontracted Providers	07/01/2021	06/30/2026
Increase access to social support and healthcare through Social Inclusion- educate parents on leadership opportunities through Circle of Parents® support groups	Subcontracted Healthy Start providers Healthy Families	07/01/2026	06/30/2026
Support Systems- provide group education on the effects of Toxic Stress to pregnant women and infants	CCHW Subcontracted Providers	07/01/2021	06/30/2026
Community Engagement- advocate for health education and health fairs with Coalition membership and local providers	CCHW Coalition Membership	07/01/2021	06/30/2026
Health coverage – educate pregnant women and partners regarding Medicaid providers and benefit packages	Subcontracted Providers, Program Director (Social Media) CCHW	07/01/2021	06/30/2026
Provider availability – distribute regional provider lists and healthcare plans and transportation options	Program Director, Subcontracted Providers, CCHW	07/01/2021	06/30/2026

iii. **Conduct outreach to consumers of reproductive health services to educate on preconception health topics**

Action Step	Pers. Responsible	Start Date	End Date

Recruit the target population ages 14-44 females during available health fairs and outreach events for planned workshops	CCHW	07/01/2021	06/30/2026
Procure incentives for participation in women's health workshops	CCHW	07/01/2021	06/30/2026
Annually evaluate the women's health workshops to solicit data on education delivery, family planning method data, changes in attitudes on health and feedback on materials used	Executive Director, Program Director	07/01/2021	06/30/2026
Provide at least two workshops in each county on the 16 topics of women's health each year	CCHW	07/01/2021	06/30/2026
Solicit subject matter experts/guest speakers for additional topics requested by attendees (follow-up education)	CCHW SMEs	07/01/2021	06/30/2026
Conduct one annual workshop on toxic stress and the link to SOCDH and poor birth outcomes for consumers via Social Media	CCHW Program Director SMEs	07/01/2021	06/30/2026
Attend a minimum of 5 events monthly to disseminate information on family planning and women's heath	CCHW Coalition Membership	07/01/2021	06/30/2026
Design and conduct a social marketing campaign to develop messages for promoting preconception health knowledge and attitudes, and behaviors among men and women of childbearing age including: health as a value, family planning access, harmful effects of inadequate baby spacing, importance of early prenatal care, chronic disease management, transportation access, and the effects of toxic stress	Program Director CCHW	07/01/2021	06/30/2026
Provide an annual "Show Your Love" Preconception Health Fair	CCHW Madison Kiwanis	07/01/2021	06/30/2026
Conduct door to door canvassing to disseminate information on women's health and the importance of a medical home	CCHW	07/01/2021	06/30/2026

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Quarterly Progress for _____
Quarterly Progress for _____

Quarterly Progress for _____
Quarterly Progress for _____

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4. REPORTING PHASE ANSWERS: (To be completed for the Annual Action Plan Update)

a. Demonstrate the changes in the system/community.

b. Will you drop/modify/expand/continue strategy next year and explain why?

Category B
2021-2026
Activity #3 – Infant Safety and Development

1. **CONTRACT REQUIREMENT OR IDENTIFIED COMMUNITY-WIDE/SYSTEM ISSUE:**
   a. What is the requirement or system/community-wide problem or need identified to be addressed by a strategy? **Inadequate breastfeeding rates compared to the state, and lower breastfeeding rates for blacks compared to the state. Safe sleep practices associated with whites who breastfeed, and the relevance of both indicators to prevent infant death.**

   b. What health status indicator/coalition administrative activity is being addressed by this strategy? **Breastfeeding rates, SIDS deaths.**

   c. What information, if any, was used to identify the issue/problem (i.e. HPA, FIMR, screening, client satisfaction, interviews, QI/QA)? **MCH Health Needs Assessment, Consumer Feedback on Safe Sleep practices.**

2. **PLANNING PHASE QUESTIONS: (All Required)**
   a. What strategy has been selected to address this?
      i. **Increase breastfeeding rates for minorities**
      ii. **Increase education on safe sleep and infant safety**
      iii. **Increase education and intervention for substance-using women**

   b. What information will you gather to demonstrate that you have implemented this strategy as intended (who, what, how many, how often, where, etc.)? **Number of Healthy Start and Healthy Families clients initiating breastfeeding, attending safe sleep education, and receiving safe sleep incentives (Pack n Plays, Moses Baskets, etc), number of infant deaths from co-sleeping**

   c. Where/how will you get the information? **Well Family System, HFF Tracking System, Vital Statistics data.**

   d. What do you expect will be the observed impact of the strategy on the system or community-wide problem/need? **Increased breastfeeding rates for all populations, zero infant deaths from co-sleeping**

   e. What information will you gather to demonstrate this change on the system? **Healthy Start participant data for breastfeeding rates and safe sleep, and breastfeeding rates for the population.**

   f. Where/how will you get the information? **Well Family system, Florida Charts.**

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3. ACTION STEPS:

i. **Increase breastfeeding rates for minorities**

Action Step	Pers. Responsible	Start Date	End Date
Ensure Certified Lactation Counselor (CLC) credentialing amongst Healthy Start service providers by including language in contract	Executive Director	07/01/2021	06/30/2026
Provide breastfeeding education services to every African American woman enrolled prenatally in Healthy Start services	Program Director	07/01/2021	06/30/2026
Provide breastfeeding education services to every African American woman enrolled prenatally in Healthy Families services using the HFF standards or referring to group education for Healthy Start	HFSR Program Director	07/01/2021	06/30/2026
Annually, provide a mass canvassing to celebrate World Breastfeeding week and to educate the community on breastfeeding benefits in the catchment area	CCHW, CLC's Coalition Membership	08/01/2021	08/31/2025
Produce and distribute locally-created literature to encourage breastfeeding among targeted demographics in each county	Program Director Subcontracted Providers	07/01/2021	06/30/2026
Contract with a local peer counselor/CLC to provide virtual and social media support groups for prenatal and breastfeeding women to target after-hours and immediate breastfeeding barriers	Executive Director CLC Contractor	07/01/2021	06/30/2026
Provide incentives for breastfeeding mothers and procure supplies to encourage safe and sustained breastfeeding	Program Director CLC Contractor	07/01/2021	06/30/2026

ii. **Increase education on safe sleep and infant safety**

Action Step	Pers. Responsible	Start Date	End Date
Incorporate verification of discussion on where the infant sleeps in a revised infant record review form for Healthy Start	Program Director	07/01/2021	06/30/2026

Provide incentives for Safe Sleep education (pack and plays, Moses baskets) through local fundraising efforts	Executive Director	07/01/2021	06/30/2026
Conduct door to door canvassing to disseminate information on safe sleep practices	CCHW Subcontracted Providers Coalition Membership	07/01/2021	06/30/2026
Develop a billboard and bench advertisements to encourage safe sleep messages	Program Director Subcontracted Providers	07/01/2021	06/30/2026
Create a social marketing campaign to increase awareness on preventable causes of infant death, including co-sleeping	Program Director	07/01/2021	06/30/2026
Credential at least one staff member as a Certified Child Passenger Seat Technician in order to order and install car seats for participants and the community	Executive Director Coalition staff	07/01/2021	06/30/2022
Provide an annual Child Safety Fair to include Safe Sleep, Car Seat Safety and Water Safety	CCHW Subcontracted Providers Coalition Membership	07/01/2021	06/30/2026

i. **Increase education and intervention for substance-using women**

Action Step	Pers. Responsible	Start Date	End Date
Participate in leadership training for Plans of Safe Care with Circuits 2 and 3	Executive Director DCF Leadership	07/01/2021	06/30/2026
Provide local trainings to subcontracted providers on Plans of Safe Care	Executive Director	07/01/2021	06/30/2026
Include Plans of Safe Care in updates to Quality Assurance Plans and tools	Executive Director Program Director	07/01/2021	06/30/2026
Partner with the Madison-Taylor Opioid Response Coalition to bring awareness of the effects of substance use on newborn development	Executive Director Coalition members	07/01/2021	06/30/2026
Partner with the Madison-Taylor Opioid Response Coalition to determine the feasibility of residential services for substance using women in JMT	Executive Director Coalition members	07/01/2021	06/30/2026
Produce local literature for women who are identified as using substances and	Program Director	07/01/2021	12/31/2021

alcohol on the dangerous effects to newborns			

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Quarterly Progress for _____
Quarterly Progress for _____
Quarterly Progress for _____
Quarterly Progress for _____

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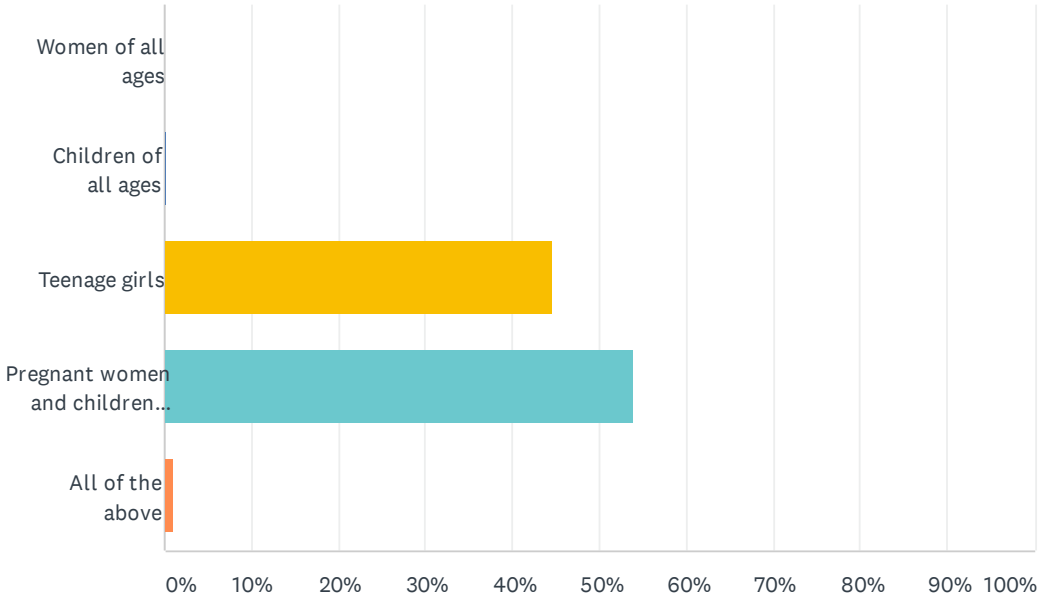
4. REPORTING PHASE ANSWERS: (To be completed for the Annual Action Plan Update)

c. Demonstrate the changes in the system/community.

d. Will you drop/modify/expand/continue strategy next year and explain why?

Q1 Who does Healthy Start provide services to?

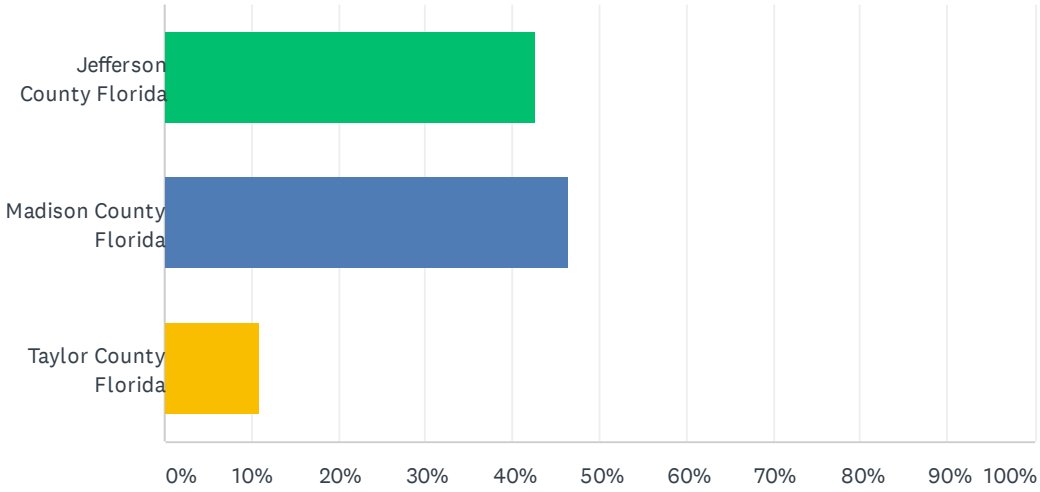
Answered: 744 Skipped: 0



ANSWER CHOICES	RESPONSES	
Women of all ages	0.00%	0
Children of all ages	0.27%	2
Teenage girls	44.62%	332
Pregnant women and children up to age 3	54.03%	402
All of the above	1.08%	8
TOTAL		744

Q2 In what county do you reside?

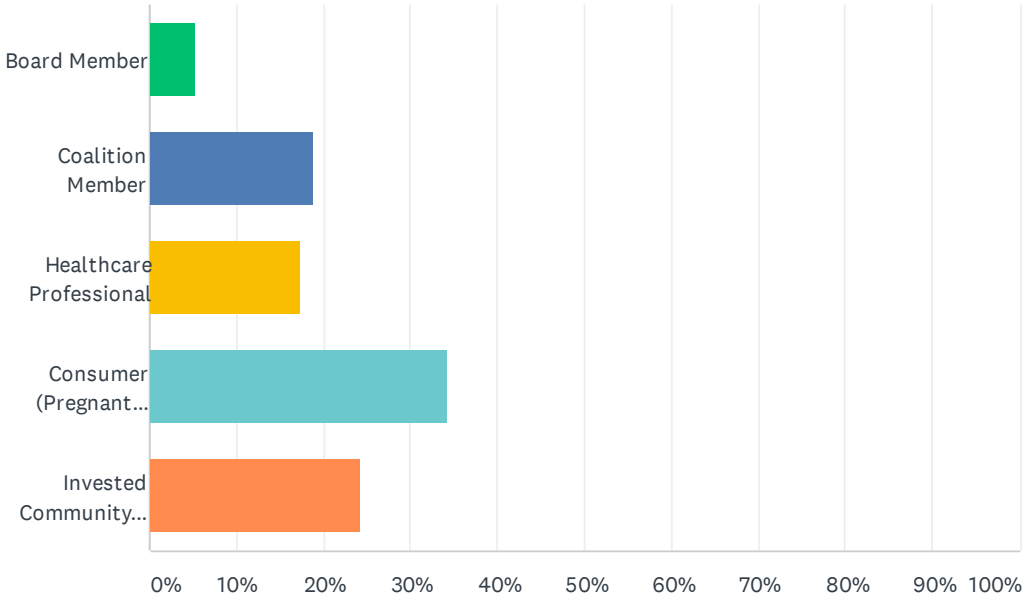
Answered: 347 Skipped: 397



ANSWER CHOICES	RESPONSES	
Jefferson County Florida	42.65%	148
Madison County Florida	46.40%	161
Taylor County Florida	10.95%	38
TOTAL		347

Q3 What part of the community do you represent?

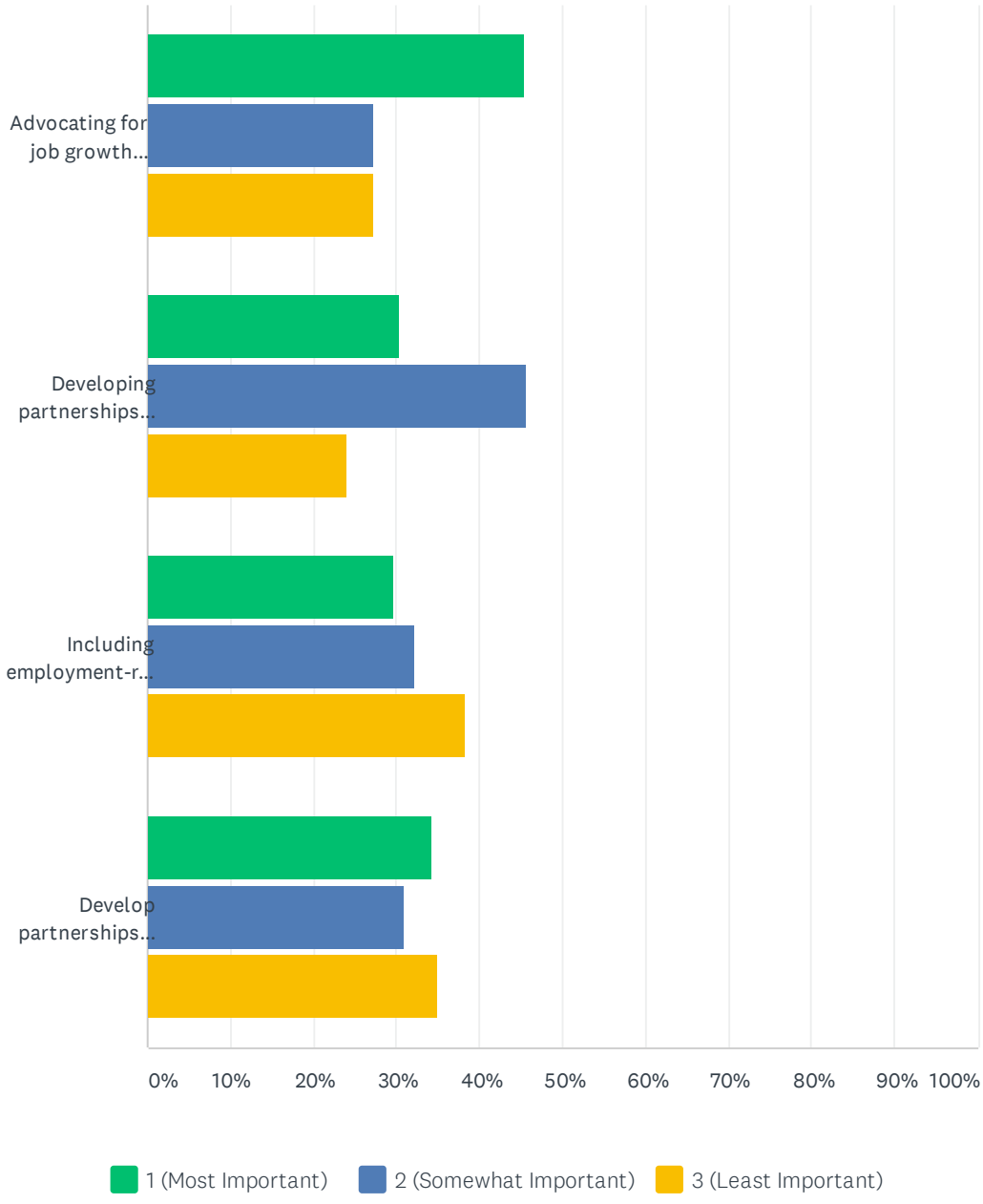
Answered: 350 Skipped: 394



ANSWER CHOICES	RESPONSES	
Board Member	5.14%	18
Coalition Member	18.86%	66
Healthcare Professional	17.43%	61
Consumer (Pregnant Woman/Mother to child under 3 years)	34.29%	120
Invested Community Member	24.29%	85
TOTAL		350

Q4 Economic Stability can greatly contribute to the overall health and wellness of mothers and babies. Of the following categories, which three do you feel the Coalition has the most potential to impact? Please rank them on a scale of 1-3:

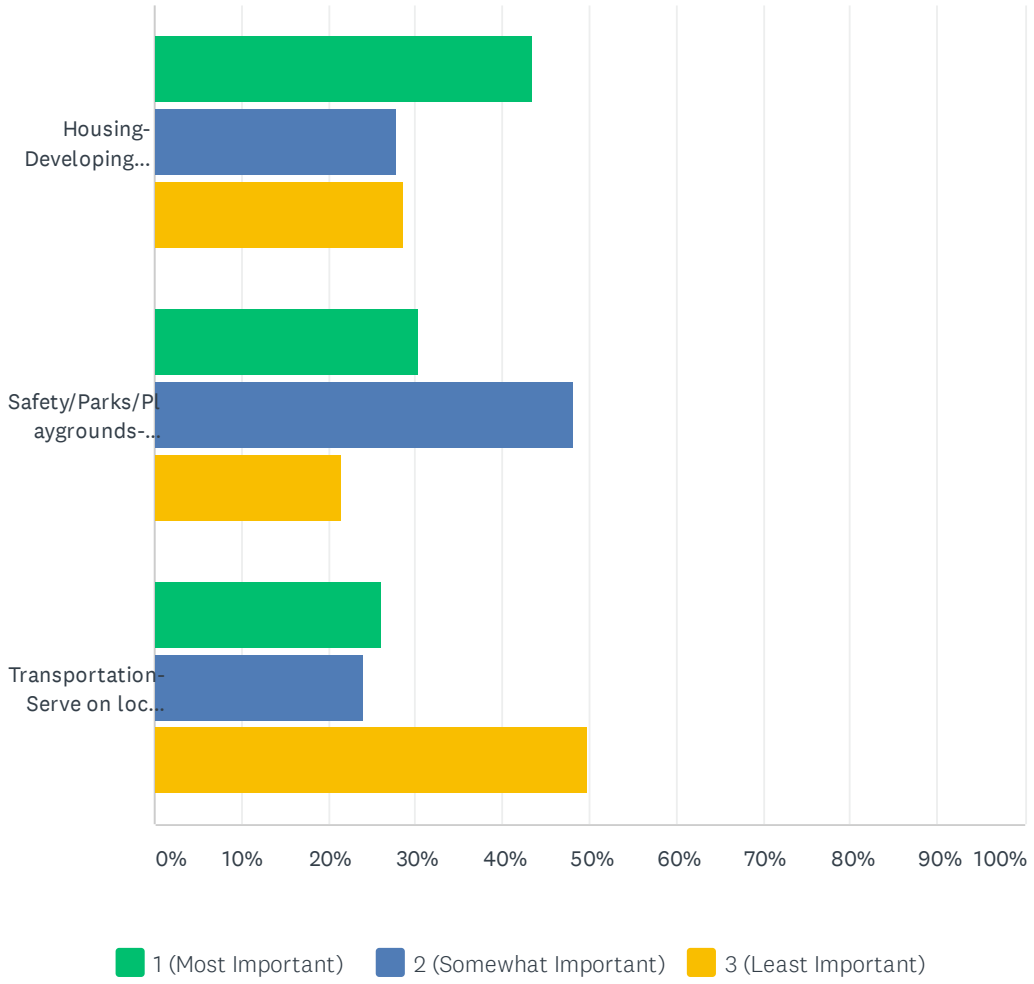
Answered: 237 Skipped: 507



	1 (MOST IMPORTANT)	2 (SOMEWHAT IMPORTANT)	3 (LEAST IMPORTANT)	TOTAL	WEIGHTED AVERAGE
Advocating for job growth through participating in Economic Development Councils	45.45% 70	27.27% 42	27.27% 42	154	1.82
Developing partnerships with CareerSource to expand job opportunities for vulnerable families	30.37% 58	45.55% 87	24.08% 46	191	1.94
Including employment-related goals in home visiting services	29.70% 49	32.12% 53	38.18% 63	165	2.08
Develop partnerships with agencies that provide economic assistance to develop budgeting and life-skills for recipients of assistance	34.23% 51	30.87% 46	34.90% 52	149	2.01

Q5 We know that the environment in which we live can determine our access to healthcare. Of the following categories, which three do you feel the Coalition could impact in support of healthy neighborhood environments? Please rank them on a scale of 1-3:

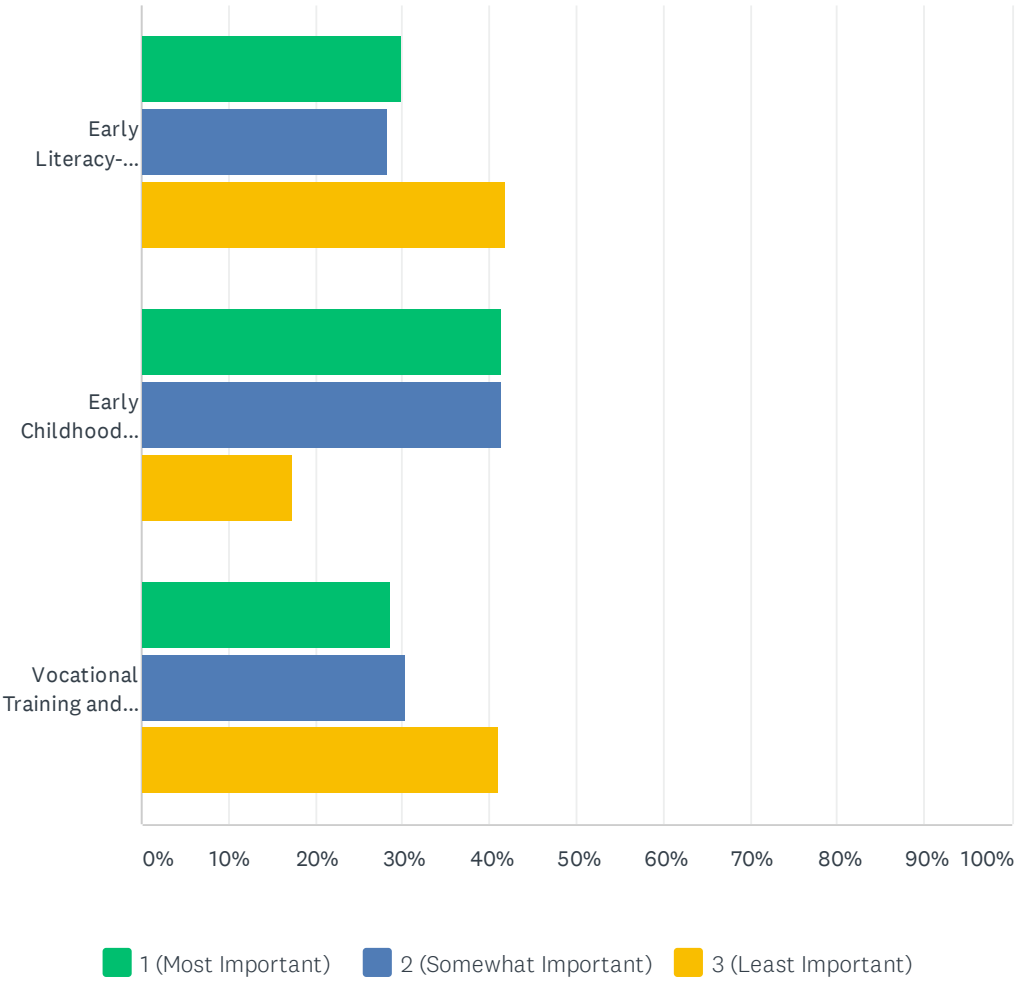
Answered: 237 Skipped: 507



	1 (MOST IMPORTANT)	2 (SOMEWHAT IMPORTANT)	3 (LEAST IMPORTANT)	TOTAL	WEIGHTED AVERAGE
Housing- Developing partnerships with housing authorities and free legal services to address landlord barriers to safe housing	43.46% 103	27.85% 66	28.69% 68	237	1.85
Safety/Parks/Playgrounds- Develop partnerships with local law enforcement to encourage foot patrol in areas with multiple families during peak times (after school, holidays, summer vacation, etc.)	30.38% 72	48.10% 114	21.52% 51	237	1.91
Transportation- Serve on local transportation boards to advocate for women with children	26.16% 62	24.05% 57	49.79% 118	237	2.24

Q6 Access to educational resources is important in ensuring that mothers and babies have the recourses they need to thrive. Of the following categories, which three do you feel the Coalition can support to ensure access to education? Please rank them on a scale of 1-3:

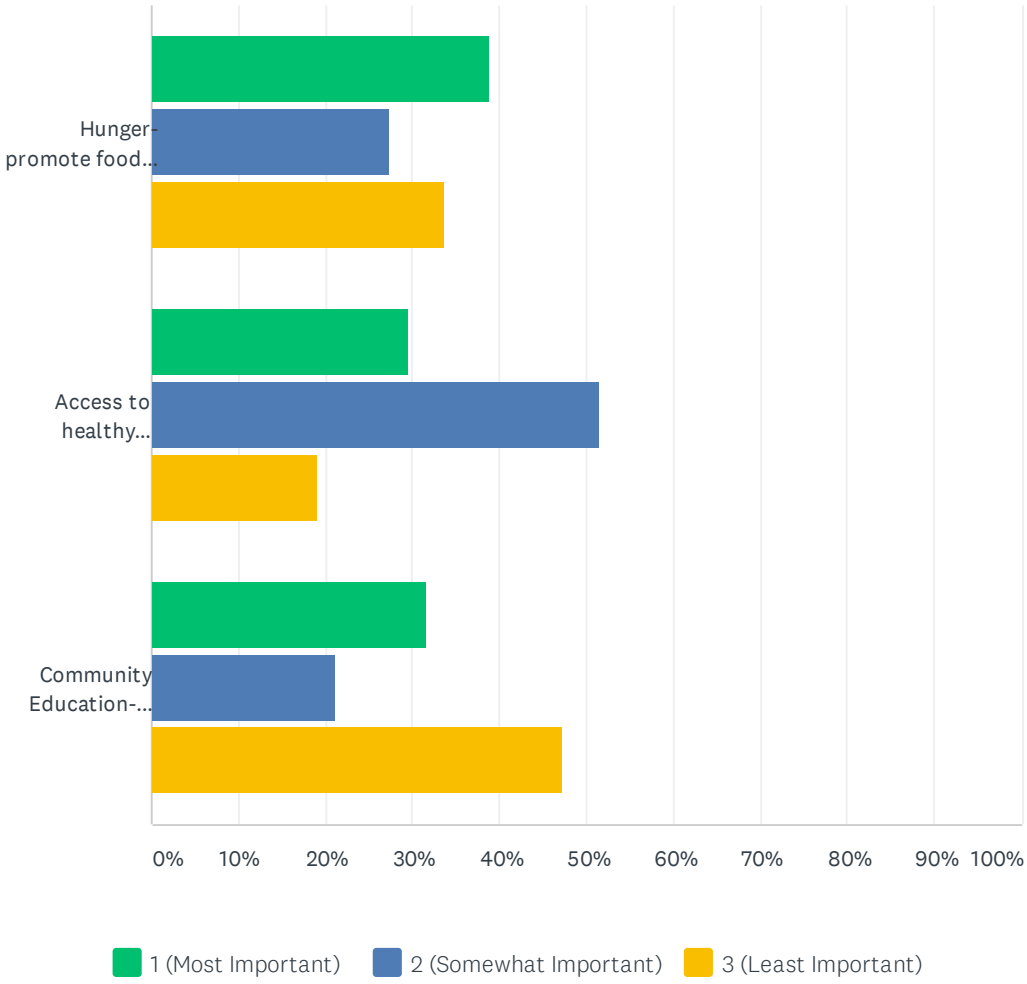
Answered: 237 Skipped: 507



	1 (MOST IMPORTANT)	2 (SOMEWHAT IMPORTANT)	3 (LEAST IMPORTANT)	TOTAL	WEIGHTED AVERAGE
Early Literacy- sponsor book drives for families with young children	29.96% 71	28.27% 67	41.77% 99	237	2.12
Early Childhood Education- advocate for enrollment in early learning centers and the expansion of Early Head Start services	41.35% 98	41.35% 98	17.30% 41	237	1.76
Vocational Training and Higher Education- develop partnerships with local institutions to survey the community on barriers to accessing education	28.69% 68	30.38% 72	40.93% 97	237	2.12

Q7 Proper nutrition is vital to mothers and baby's well-being. Access to food can be a barrier in mothers and babies receiving that nutrition. Of following categories, which three do you feel the Coalition can support to reduce barriers? Please rank them on a scale of 1-3:

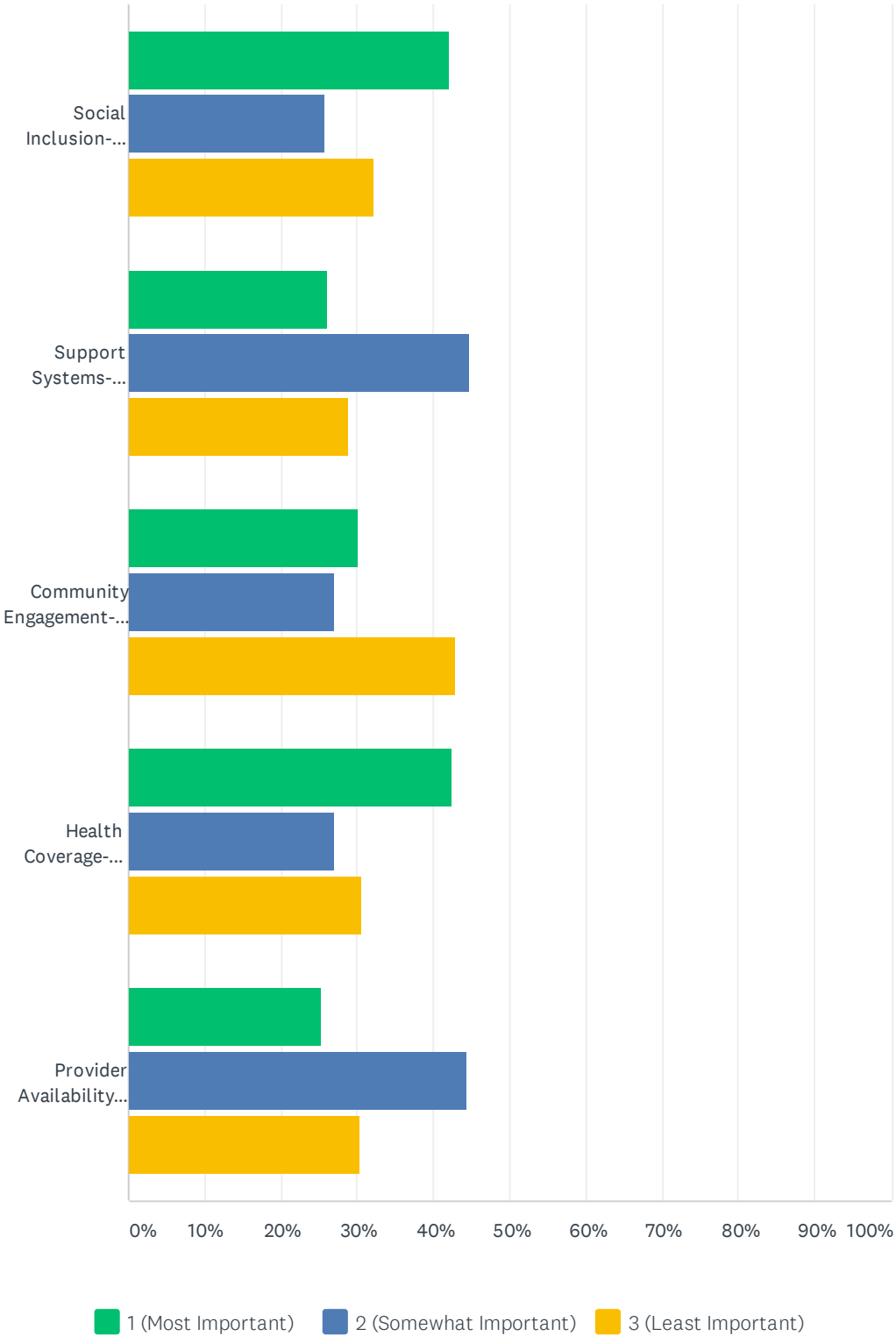
Answered: 237 Skipped: 507



	1 (MOST IMPORTANT)	2 (SOMEWHAT IMPORTANT)	3 (LEAST IMPORTANT)	TOTAL	WEIGHTED AVERAGE
Hunger- promote food pantries with vulnerable families, advocate for delivery or coordinate transportation for food drives	38.82% 92	27.43% 65	33.76% 80	237	1.95
Access to healthy options- advocate for increased availability of fresh options in sparsely populated area with no fresh food access	29.54% 70	51.48% 122	18.99% 45	237	1.89
Community Education- Educate women of childbearing age on proper nutrition using community health educators	31.65% 75	21.10% 50	47.26% 112	237	2.16

Q8 Ensuring that mothers and babies have access to social support and healthcare are two critical factors in determining their quality of life. Of the following categories, which three do you feel the Coalition can address to reduce barriers? Please rank them on a scale of 1-3:

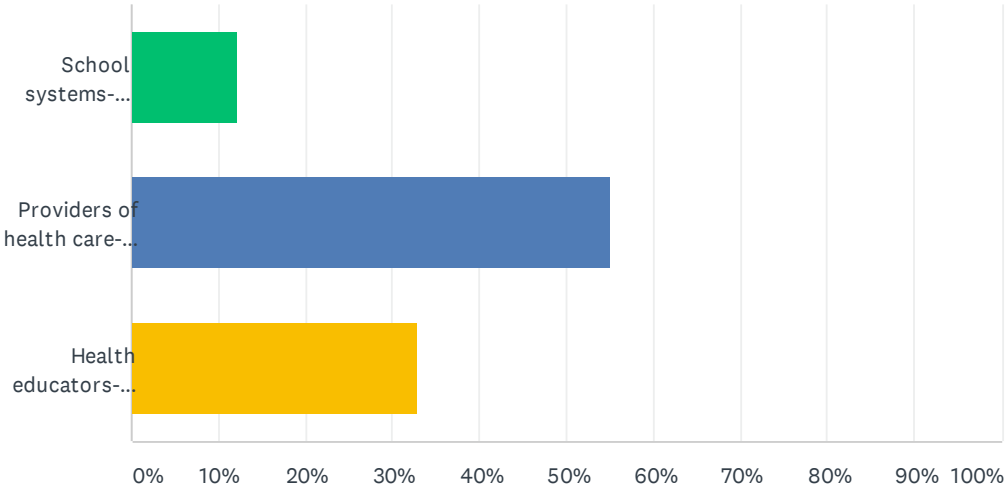
Answered: 237 Skipped: 507


Social Inclusion-...
Support Systems-...
Community Engagement-...
Health Coverage-...
Provider Availability...
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
1 (Most Important)
2 (Somewhat Important)
3 (Least Important)

	1 (MOST IMPORTANT)	2 (SOMEWHAT IMPORTANT)	3 (LEAST IMPORTANT)	TOTAL	WEIGHTED AVERAGE
Social Inclusion- educate parents on leadership opportunities through Circle of Parents® support groups	42.14% 59	25.71% 36	32.14% 45	140	1.90
Support Systems- provide group education on the effects of Toxic Stress to pregnant women and infants	26.21% 38	44.83% 65	28.97% 42	145	2.03
Community Engagement- advocate for health education and health fairs with Coalition membership and local providers	30.06% 49	26.99% 44	42.94% 70	163	2.13
Health Coverage- educate pregnant women and partners regarding Medicaid providers and benefit packages.	42.55% 60	26.95% 38	30.50% 43	141	1.88
Provider Availability- distribute regional provider lists and health care plans that are accepted. Ensure that patients are aware of transportation options as needed.	25.41% 31	44.26% 54	30.33% 37	122	2.05

Q9 Babies that are born too soon and too small are four times more likely to have a delay in development. These counties have the highest rates of Low Birth Weight (less than 5.5lbs) in our state. 190 (11%) babies were born too small in the last three years. Which community members do you think are best equipped to address this issue?

Answered: 222 Skipped: 522

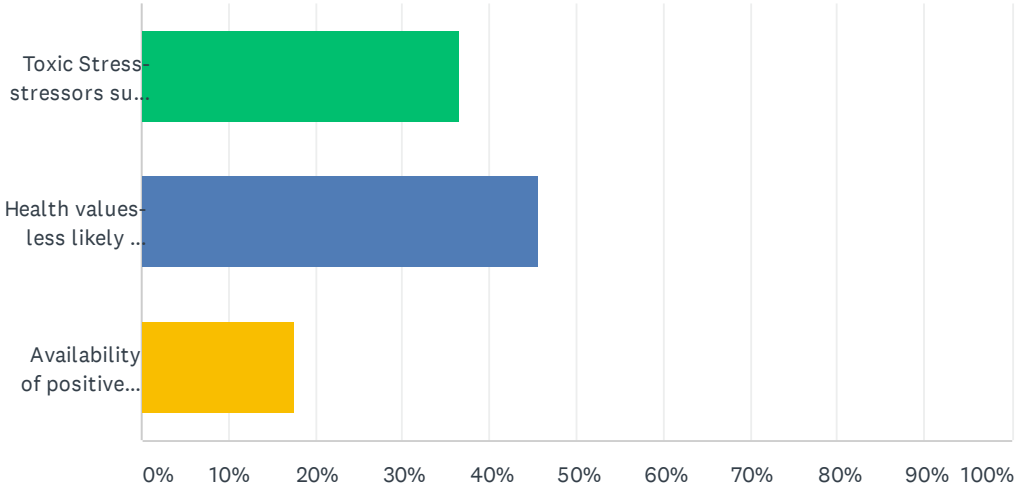


ANSWER CHOICES	RESPONSES	
School systems- children with developmental delays require significant services	12.16%	27
Providers of health care- early detection of developmental delays is important in order to provide services, including routine screening and educating parents on milestones	54.95%	122
Health educators- educating women of child bearing age on the factors that cause preterm and low birth weight has a better chance of preventing low birth weight	32.88%	73
TOTAL		222

#	COMMENTS:	DATE
	There are no responses.	

Q10 Black babies die at a rate three times greater than babies of other races, experience low birth weight twice as often, and are twice as likely to have life-long issues with poor health. Which of the following factors do you think plays the greatest role in this health disparity?

Answered: 221 Skipped: 523

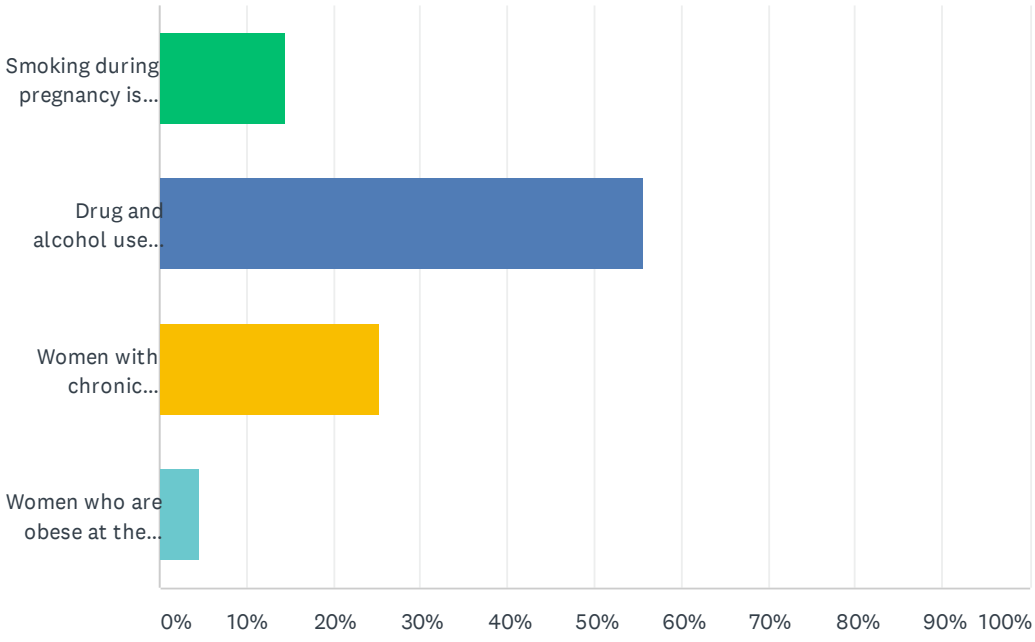


ANSWER CHOICES	RESPONSES	
Toxic Stress- stressors such as poverty and relationships which result in unhealthy pregnancies	36.65%	81
Health values- less likely to access health care services during pregnancy due to apathy (belief that it will not make a difference)	45.70%	101
Availability of positive factors- less access to transportation, fresh food, childcare, and mental health services	17.65%	39
TOTAL		221

#	COMMENTS:	DATE
	There are no responses.	

Q11 Preconception health is considered the health status of women before and between pregnancies. A woman's health status is a major influence on the birth outcome. What are the primary health conditions that the Coalition must prioritize?

Answered: 221 Skipped: 523

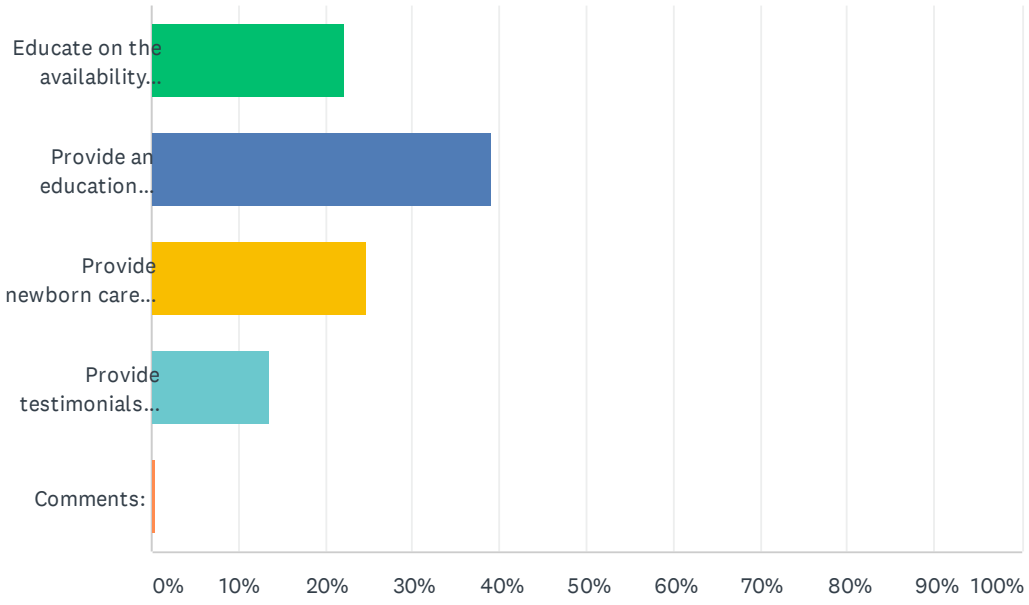


ANSWER CHOICES	RESPONSES	
Smoking during pregnancy is the most important factor to address	14.48%	32
Drug and alcohol use during pregnancy is the most common health problem among pregnant women	55.66%	123
Women with chronic diseases such as diabetes and high blood pressure are the most at-risk for poor outcomes	25.34%	56
Women who are obese at the time of conception are most likely to have an unhealthy pregnancy	4.52%	10
TOTAL		221

#	COMMENTS:	DATE
1	all could factor	4/9/2021 4:42 PM

Q12 Babies are healthier when their mothers space pregnancies at least 18 months apart. The best way to convey this message is:

Answered: 222 Skipped: 522

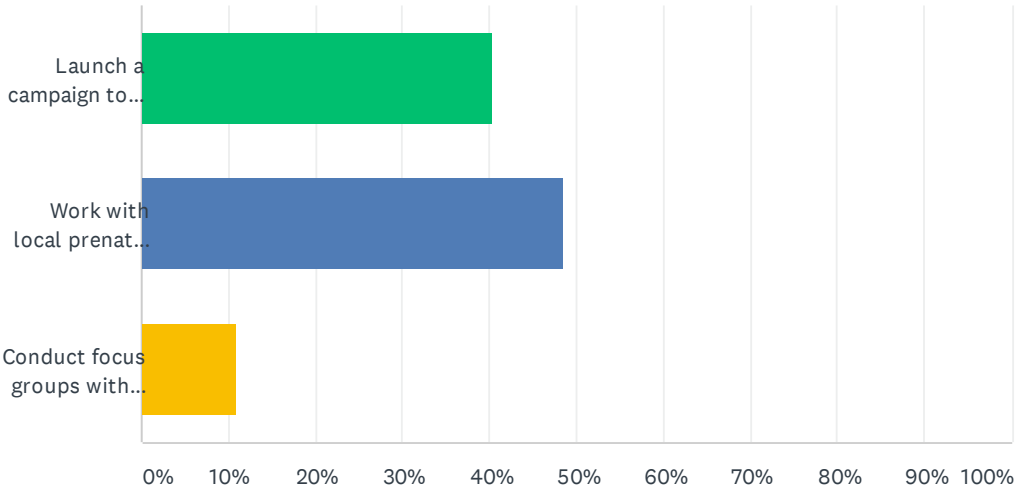


ANSWER CHOICES	RESPONSES	
Educate on the availability of Family Planning services available at the local county health department	22.07%	49
Provide an education campaign for pregnant women on the potential harmful physical effects of inadequate baby spacing	39.19%	87
Provide newborn care classes for new mothers that include contraceptive counseling	24.77%	55
Provide testimonials of parents coping with multiple children of close ages in terms of stress and health outcomes	13.51%	30
Comments:	0.45%	1
TOTAL		222

#	COMMENTS:	DATE
1	Require education in order to receive financial assistance	4/27/2021 5:53 AM

Q13 Early and regular prenatal care is a primary intervention to improve birth outcomes. In 2019, 74% of women received care early. We expect that to be reduced in half due to the pandemic. To reduce the impact, the Coalition should:

Answered: 220 Skipped: 524

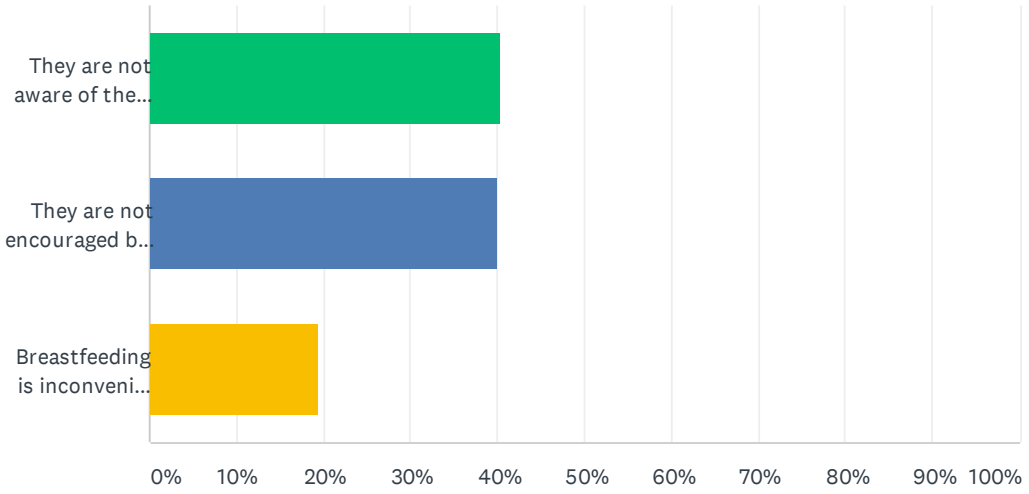


ANSWER CHOICES	RESPONSES	
Launch a campaign to promote early prenatal care, including social media and print material for safe return to healthcare	40.45%	89
Work with local prenatal care providers and insurance companies to promote a rewards system to ensure adequate prenatal care	48.64%	107
Conduct focus groups with pregnant women on their perceived risks for accessing care early, post-pandemic	10.91%	24
TOTAL		220

#	COMMENTS:	DATE
1	Link it to their financial assistance	4/27/2021 5:53 AM
2	It would be beneficial to know their perceived risks of returning to care in order to develop educational materials targeting those perceived risks.	4/9/2021 11:31 AM

Q14 Breastfeeding has the greatest impact on infant health, and 71% of mothers in these counties initiate breastfeeding. However, only 56% of black mothers choose to breastfeed. What is your opinion on why this occurs:

Answered: 220 Skipped: 524

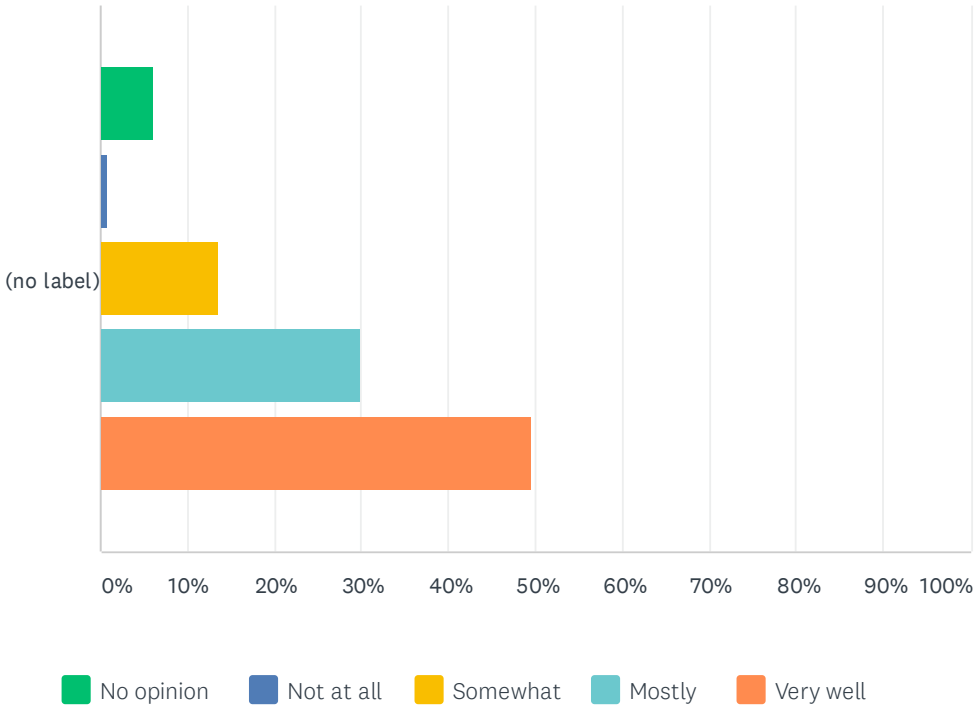


ANSWER CHOICES	RESPONSES	
They are not aware of the benefits of breastfeeding for both mom and infant, and more education is needed	40.45%	89
They are not encouraged by their partners, friends or family to breastfeed, and are under pressure to bottle feed	40.00%	88
Breastfeeding is inconvenient as an on-demand feeding method	19.55%	43
TOTAL		220

#	COMMENTS:	DATE
1	I think it is most likely a combination of all of these.	4/9/2021 11:31 AM

Q15 The Healthy Start Coalition is involved in community projects and endeavors related to maternal and infant health.

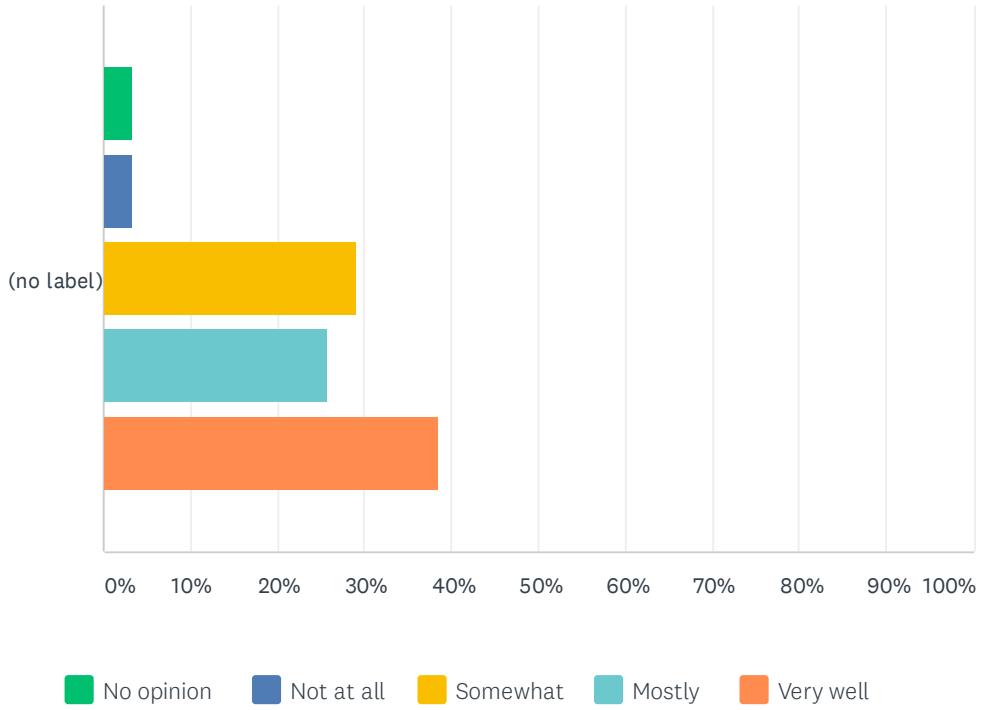
Answered: 117 Skipped: 627



	NO OPINION	NOT AT ALL	SOMEWHAT	MOSTLY	VERY WELL	TOTAL	WEIGHTED AVERAGE
(no label)	5.98% 7	0.85% 1	13.68% 16	29.91% 35	49.57% 58	117	3.16

Q16 The Healthy Start Coalition is visible in the community conducting activities that inform and educate the public about Healthy Start.

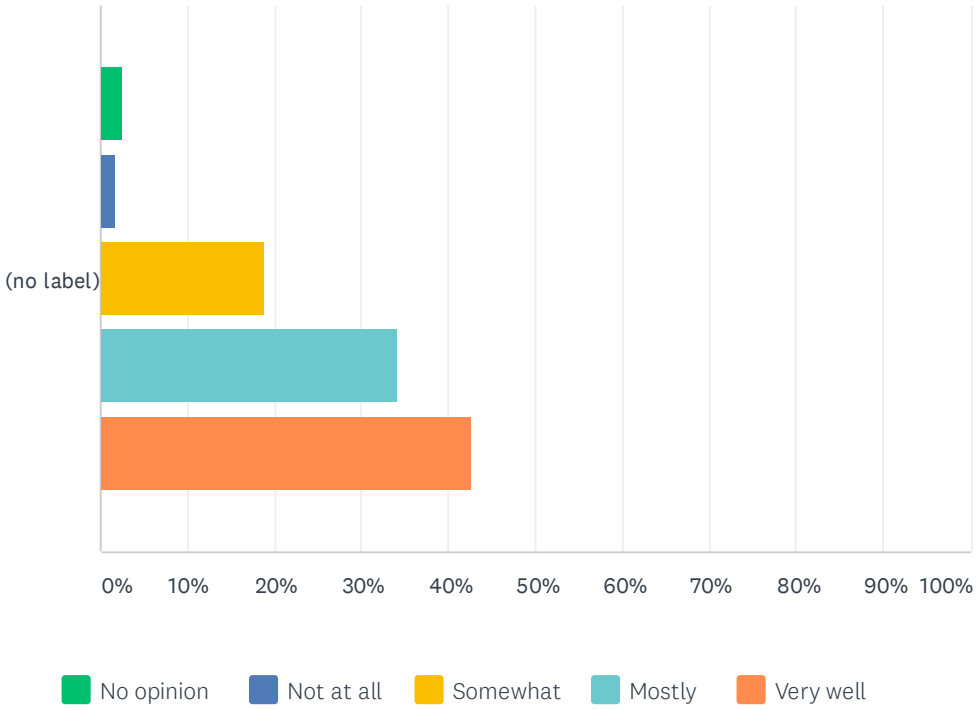
Answered: 117 Skipped: 627



	NO OPINION	NOT AT ALL	SOMEWHAT	MOSTLY	VERY WELL	TOTAL	WEIGHTED AVERAGE
(no label)	3.42% 4	3.42% 4	29.06% 34	25.64% 30	38.46% 45	117	2.92

Q17 The Healthy Start Coalition seeks community input and support in improving maternal and infant health in the county.

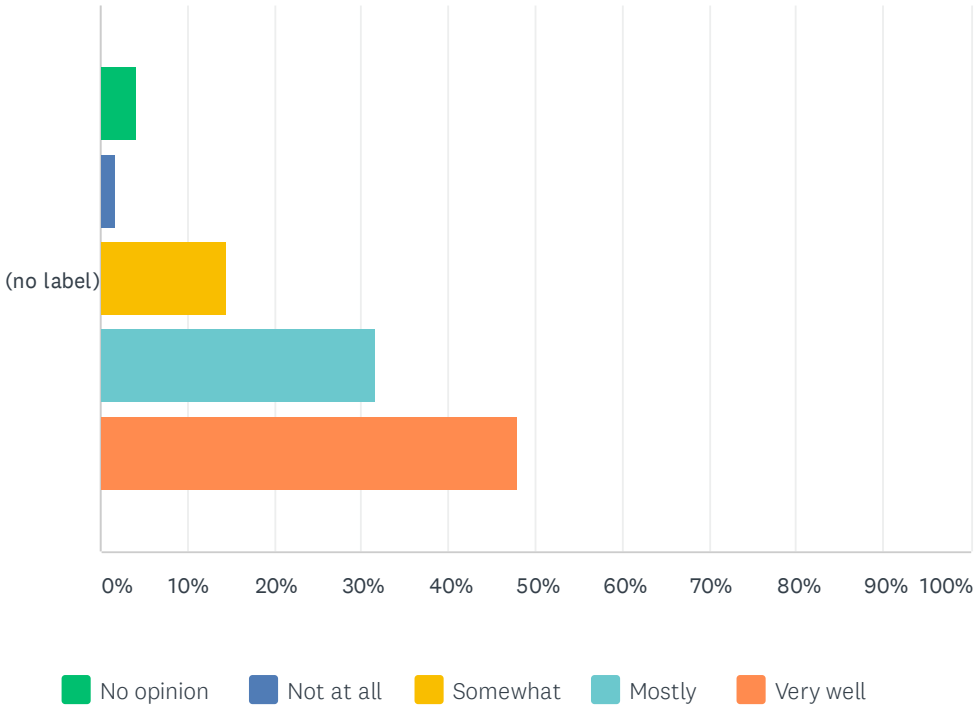
Answered: 117 Skipped: 627



	NO OPINION	NOT AT ALL	SOMEWHAT	MOSTLY	VERY WELL	TOTAL	WEIGHTED AVERAGE
(no label)	2.56% 3	1.71% 2	18.80% 22	34.19% 40	42.74% 50	117	3.13

Q18 The Healthy Start Coalition partners in the coordination of services in Jefferson, Madison & Taylor counties as related to improving maternal and infant health.

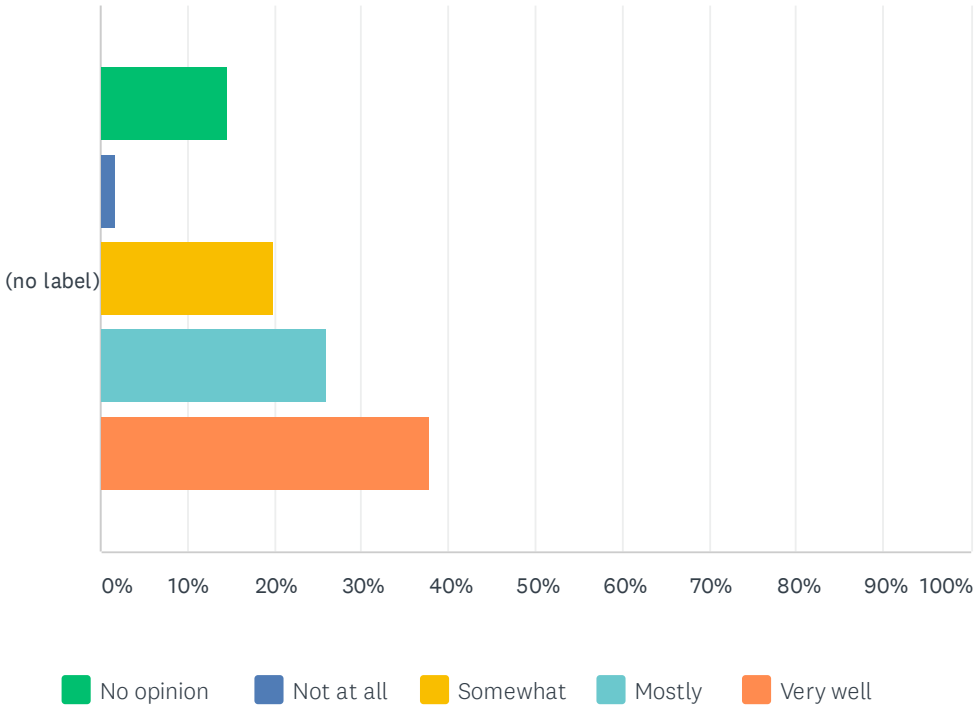
Answered: 117 Skipped: 627



	NO OPINION	NOT AT ALL	SOMEWHAT	MOSTLY	VERY WELL	TOTAL	WEIGHTED AVERAGE
(no label)	4.27% 5	1.71% 2	14.53% 17	31.62% 37	47.86% 56	117	3.17

Q19 The Healthy Start Coalition works to prevent duplication of services in the community.

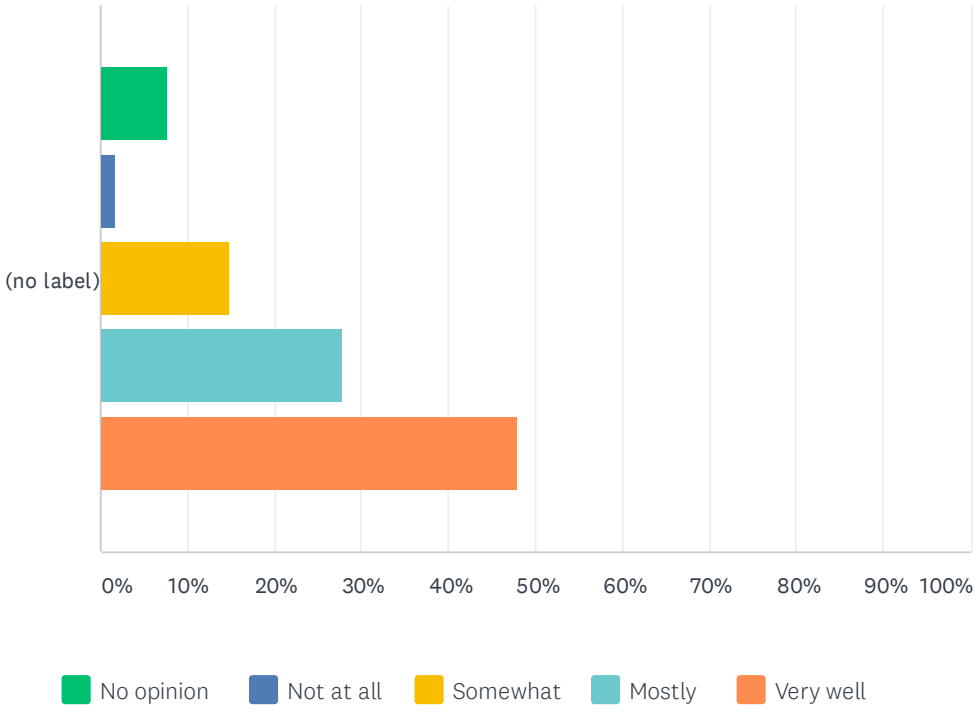
Answered: 116 Skipped: 628



	NO OPINION	NOT AT ALL	SOMEWHAT	MOSTLY	VERY WELL	TOTAL	WEIGHTED AVERAGE
(no label)	14.66% 17	1.72% 2	19.83% 23	25.86% 30	37.93% 44	116	2.71

Q20 The Healthy Start Coalition collaborates with community partners in attaining mutual goals.

Answered: 115 Skipped: 629



	NO OPINION	NOT AT ALL	SOMEWHAT	MOSTLY	VERY WELL	TOTAL	WEIGHTED AVERAGE
(no label)	7.83% 9	1.74% 2	14.78% 17	27.83% 32	47.83% 55	115	3.06

Q21 In order to receive your Amazon gift card via mail, please complete your contact info below:

Answered: 117 Skipped: 627

ANSWER CHOICES	RESPONSES	
Name	100.00%	117
Company	28.21%	33
Address	100.00%	117
Address 2	6.84%	8
City/Town	100.00%	117
State/Province	100.00%	117
ZIP/Postal Code	100.00%	117
Country	62.39%	73
Email Address	100.00%	117
Phone Number	100.00%	117

#	NAME	DATE
1	Lie Ebony Adams	5/13/2021 5:11 PM
2	leander h graves	5/7/2021 9:18 AM
3	Trisha Duggar	5/7/2021 7:00 AM
4	Wanda Violet	5/6/2021 7:29 PM
5	Tammy Brookins	5/1/2021 10:20 AM
6	Nathan Peeler	4/29/2021 11:21 PM
7	Caibre Johnson	4/29/2021 6:44 PM
8	Diane Hester	4/27/2021 6:42 PM
9	Paula Kauffman	4/27/2021 5:55 AM
10	Jamie Andrews	4/26/2021 9:13 PM
11	Brittany Harris	4/26/2021 7:26 PM
12	Memori McGriff	4/26/2021 6:28 PM
13	Mandy rand	4/26/2021 5:47 PM
14	Juan Botino	4/26/2021 5:30 PM
15	Steve Turner	4/26/2021 5:11 PM
16	Jessica Brawner Webb	4/26/2021 5:05 PM
17	Deidre Myers	4/26/2021 4:02 PM
18	Elizabeth King	4/23/2021 11:35 PM
19	Talecia Solomon	4/22/2021 10:55 PM

20	Christy Williams	4/22/2021 12:58 PM
21	T Bell	4/20/2021 8:17 PM
22	Tim A Dunn	4/19/2021 6:01 PM
23	Roe Harris	4/19/2021 10:33 AM
24	Jim Catron	4/19/2021 10:22 AM
25	Rebecca Gonzalez	4/18/2021 7:05 PM
26	Melissa Lynn	4/16/2021 7:02 PM
27	Christina Ash	4/16/2021 11:36 AM
28	Brenda newman	4/16/2021 8:46 AM
29	Angela Culpepper	4/15/2021 9:52 PM
30	Brandi Turner	4/15/2021 5:28 PM
31	Lisa Ann Burnham	4/13/2021 8:48 PM
32	Jennifer Williams	4/13/2021 3:26 PM
33	Elise Albritton	4/13/2021 2:41 PM
34	Kristie Lutz	4/13/2021 2:09 PM
35	Elizabeth Moore	4/13/2021 1:59 PM
36	Shanetha Mitchell	4/13/2021 1:32 PM
37	Elizabeth Gooden	4/13/2021 9:14 AM
38	Pamela	4/13/2021 5:50 AM
39	Zane Schroeder	4/13/2021 3:44 AM
40	Jaxen Delaney	4/13/2021 3:44 AM
41	Sol	4/13/2021 3:44 AM
42	Camden Battle	4/13/2021 3:33 AM
43	Orlando Glass	4/13/2021 3:16 AM
44	Omari Gallegos	4/13/2021 3:13 AM
45	Rogelio Avery	4/13/2021 3:10 AM
46	Kovacek Bates	4/12/2021 9:24 PM
47	Avondika Cherry	4/12/2021 3:02 PM
48	Shileatha Washington	4/12/2021 2:17 PM
49	Doug	4/12/2021 1:52 PM
50	James Bell	4/12/2021 1:30 PM
51	Kristin Searcy	4/12/2021 1:13 PM
52	ineligible	4/12/2021 12:25 PM
53	Sharon Hathcock	4/12/2021 10:50 AM
54	Nikkie	4/12/2021 10:24 AM
55	Linda Jones	4/12/2021 10:20 AM
56	Angelina Curtis	4/12/2021 9:52 AM
57	Tonya Cason	4/12/2021 9:30 AM

58	sebrina mcgill	4/12/2021 9:27 AM
59	Candice Gray	4/12/2021 9:04 AM
60	J'ere Clark	4/12/2021 8:46 AM
61	Lisa Roderick	4/12/2021 8:39 AM
62	Tracy Gallon	4/12/2021 8:37 AM
63	Tammy Hinson	4/12/2021 8:33 AM
64	Sarah Bayes	4/12/2021 8:28 AM
65	Snowey Hagan	4/12/2021 8:17 AM
66	bobby lundy	4/12/2021 7:59 AM
67	Suzanne Godfrey	4/12/2021 7:46 AM
68	Kyle Seachrist	4/12/2021 7:46 AM
69	Lisa Kisamore	4/10/2021 11:29 PM
70	Caroline Blair	4/10/2021 10:32 PM
71	Kayla Shipp	4/10/2021 10:27 AM
72	Tonya B Eudy	4/10/2021 3:56 AM
73	Suzie nelson	4/10/2021 3:39 AM
74	Gerald M Forbes	4/10/2021 3:36 AM
75	Ashlyn Blount	4/10/2021 2:54 AM
76	Michelle M Parsons	4/10/2021 2:24 AM
77	Mary J Mancha	4/10/2021 2:09 AM
78	Sarah E Pierson	4/10/2021 12:55 AM
79	Linda K Campbell	4/10/2021 12:53 AM
80	Amanda R Kinsella	4/10/2021 12:52 AM
81	Cheryl L Glover	4/10/2021 12:51 AM
82	Crystal Mccann	4/9/2021 10:05 PM
83	erik wolfer	4/9/2021 7:22 PM
84	Memori McGriff	4/9/2021 6:00 PM
85	Julius Hackett	4/9/2021 5:22 PM
86	KISHA TOLAR	4/9/2021 4:44 PM
87	Jordan bass	4/9/2021 4:35 PM
88	Kyle L King	4/9/2021 4:33 PM
89	Denise C Dyal	4/9/2021 4:22 PM
90	Tammy Williams	4/9/2021 3:45 PM
91	Kelli OQuinn	4/9/2021 3:45 PM
92	Cynthia Morgan	4/9/2021 3:10 PM
93	Cynthia Parker	4/9/2021 3:07 PM
94	Jane Sadler	4/9/2021 3:06 PM
95	Samantha Roberts	4/9/2021 3:03 PM

96	Wendi Blanton	4/9/2021 2:54 PM
97	Skye Madison	4/9/2021 2:48 PM
98	Vannessa Richard	4/9/2021 2:47 PM
99	Patti Schmidt	4/9/2021 2:46 PM
100	Tashina Hodges	4/9/2021 2:41 PM
101	Mary Smith	4/9/2021 2:40 PM
102	Angela Rhodes	4/9/2021 2:38 PM
103	Melissa Morgan	4/9/2021 2:32 PM
104	Kelsey OQuinn	4/9/2021 2:28 PM
105	Nichole Wilder	4/9/2021 2:21 PM
106	Bryant Christiana	4/9/2021 2:19 PM
107	Jennifer Poore	4/9/2021 2:17 PM
108	Karen Hiers	4/9/2021 2:14 PM
109	Juliana Smith	4/9/2021 2:13 PM
110	Denise Quick	4/9/2021 2:12 PM
111	Angela Hagan	4/9/2021 2:06 PM
112	Amanda Plain	4/9/2021 2:03 PM
113	Jeanine Waters	4/9/2021 2:00 PM
114	Donald Bailey	4/9/2021 1:59 PM
115	Elizabeth Schmidt	4/9/2021 11:34 AM
116	Jana Grubbs	4/9/2021 11:01 AM
117	Devin	4/9/2021 10:33 AM

#	COMPANY	DATE
1	Jefferson county homeschool association	5/1/2021 10:20 AM
2	Mccs	4/27/2021 5:55 AM
3	Corner Grill	4/23/2021 11:35 PM
4	None	4/19/2021 6:01 PM
5	Department of Juvenile Jsutice	4/16/2021 11:36 AM
6	Policyholder - State Farm	4/16/2021 8:46 AM
7	Little Pine Pediatrics	4/15/2021 9:52 PM
8	Healthy Start Coalition	4/15/2021 5:28 PM
9	Saint Leo University WorldWide	4/13/2021 8:48 PM
10	Madison 4-H	4/13/2021 1:59 PM
11	Fl Dept of Health	4/13/2021 1:32 PM
12	Pics for Tots	4/13/2021 9:14 AM
13	Martin	4/13/2021 3:44 AM
14	Madison Therapy & Wellness PLLC	4/12/2021 1:13 PM
15	Taylor County School District	4/12/2021 10:50 AM

16	Kids Incorporated of the Big Bend	4/12/2021 10:20 AM
17	North Florida Child Development, Inc.	4/12/2021 9:27 AM
18	Madison County School District	4/12/2021 8:39 AM
19	Big Bend Cares	4/12/2021 8:37 AM
20	FDOH- Healthy Start	4/12/2021 8:28 AM
21	tri-county electric co-op	4/12/2021 7:59 AM
22	OPFF Contract Specialist	4/12/2021 7:46 AM
23	Teen Challenge	4/12/2021 7:46 AM
24	Apalachee center	4/10/2021 2:54 AM
25	TCEC	4/9/2021 4:44 PM
26	Down Hime Medical	4/9/2021 3:45 PM
27	AOK Electric	4/9/2021 3:45 PM
28	Grandparent	4/9/2021 3:06 PM
29	Kids Incorporated	4/9/2021 2:54 PM
30	Retired Educator	4/9/2021 2:46 PM
31	Board Member	4/9/2021 2:21 PM
32	Lori McCoy Therapy LLC.	4/9/2021 2:06 PM
33	Healthy Start Coalition of Jefferson, Madison, and Taylor	4/9/2021 11:34 AM

#	ADDRESS	DATE
1	302 SW Safari Dr. Apt. 1205	5/13/2021 5:11 PM
2	549 lott lane	5/7/2021 9:18 AM
3	910 Country Hill Rd	5/7/2021 7:00 AM
4	310 NE Dusty Miller Ave	5/6/2021 7:29 PM
5	675 S Waukeenah St	5/1/2021 10:20 AM
6	1045 E. Washington St	4/29/2021 11:21 PM
7	PO Box 9363	4/29/2021 6:44 PM
8	2198 Nw Lovett Rd	4/27/2021 6:42 PM
9	2093 Hwy 90	4/27/2021 5:55 AM
10	423 NE Prairie Rd	4/26/2021 9:13 PM
11	231 NE Green Tree Terrace	4/26/2021 7:26 PM
12	15487 SW CR 14	4/26/2021 6:28 PM
13	999 NE River Trace Trl	4/26/2021 5:47 PM
14	333 NE Biltmore Rd	4/26/2021 5:30 PM
15	386 North Washington Ave.	4/26/2021 5:11 PM
16	9319 S COUNTY ROAD 53	4/26/2021 5:05 PM
17	846 NW Bailey Grade Rd.	4/26/2021 4:02 PM
18	151 NE LIVINGSTON ST	4/23/2021 11:35 PM
19	335 SE Balboa Dr	4/22/2021 10:55 PM

20	3993 Charles Sadler Ln	4/22/2021 12:58 PM
21	105 N Mimosa Lane	4/20/2021 8:17 PM
22	233 NW Armadillo Trail	4/19/2021 6:01 PM
23	3231 NW Concord Church Rd	4/19/2021 10:33 AM
24	225 NE Bevan Loop	4/19/2021 10:22 AM
25	4625 NW US 221	4/18/2021 7:05 PM
26	82 will Clark rs5	4/16/2021 7:02 PM
27	2020 Capital Circle SE	4/16/2021 11:36 AM
28	499 Northwest Whispering Pines Loop	4/16/2021 8:46 AM
29	194 Hancock Ave	4/15/2021 9:52 PM
30	1476 SW Main St	4/15/2021 5:28 PM
31	3694 NW 27th Terrace	4/13/2021 8:48 PM
32	2129 NE Delphinium dr	4/13/2021 3:26 PM
33	PO Box 41	4/13/2021 2:41 PM
34	1215 North Peacock Ave	4/13/2021 2:09 PM
35	184 NW College Loop	4/13/2021 1:59 PM
36	218 SW Third Ave	4/13/2021 1:32 PM
37	2883 NW US 221	4/13/2021 9:14 AM
38	1519 Clarence Court	4/13/2021 5:50 AM
39	4792 Marietta Street	4/13/2021 3:44 AM
40	3811 Virgil Street	4/13/2021 3:44 AM
41	84 Jordan	4/13/2021 3:44 AM
42	4603 White River Way	4/13/2021 3:33 AM
43	557 Morgan Street	4/13/2021 3:16 AM
44	2068 American Drive	4/13/2021 3:13 AM
45	2107 Kyle Street	4/13/2021 3:10 AM
46	710 Harrison St	4/12/2021 9:24 PM
47	705 Selman Road	4/12/2021 3:02 PM
48	928 Redbud Avenue	4/12/2021 2:17 PM
49	2552 E US Hwy 90	4/12/2021 1:52 PM
50	151 SE Chicopee Trail	4/12/2021 1:30 PM
51	235 SW Dade Street	4/12/2021 1:13 PM
52	NA	4/12/2021 12:25 PM
53	Taylor County School District 318 North Clark Street	4/12/2021 10:50 AM
54	Jefferson	4/12/2021 10:24 AM
55	P.O. Box 161	4/12/2021 10:20 AM
56	1368 NE Post Rd	4/12/2021 9:52 AM
57	PO Box 205	4/12/2021 9:30 AM

58	PO Box 38	4/12/2021 9:27 AM
59	5985 Beach Rd	4/12/2021 9:04 AM
60	1815 Hartsfield Rd APT 4	4/12/2021 8:46 AM
61	211	4/12/2021 8:39 AM
62	865 N Waukeenah St	4/12/2021 8:37 AM
63	676 SE Pow Wow St.	4/12/2021 8:33 AM
64	1215 N Peacock Ave	4/12/2021 8:28 AM
65	864 NE POST RD	4/12/2021 8:17 AM
66	2862 west us 90 madison fla.32340	4/12/2021 7:59 AM
67	1522 N State Road 53	4/12/2021 7:46 AM
68	4141 Apalachee Pkwy	4/12/2021 7:46 AM
69	9188 Waukeenah Hwy	4/10/2021 11:29 PM
70	150 ne Cherokee rose way	4/10/2021 10:32 PM
71	187 NE Kel Lane	4/10/2021 10:27 AM
72	4893 Virgil Street	4/10/2021 3:56 AM
73	206 sw gunnals trl	4/10/2021 3:39 AM
74	1520 Todds Lane	4/10/2021 3:36 AM
75	919 NE GLADIOLI DR	4/10/2021 2:54 AM
76	4632 Kemper Lane	4/10/2021 2:24 AM
77	433 Khale Street	4/10/2021 2:09 AM
78	1482 Riverwood Drive	4/10/2021 12:55 AM
79	3741 Fairfield Road	4/10/2021 12:53 AM
80	96 Viking Drive	4/10/2021 12:52 AM
81	2607 Virgil Street	4/10/2021 12:51 AM
82	5184 ne bellville rd	4/9/2021 10:05 PM
83	2959 sw winquepin street	4/9/2021 7:22 PM
84	15487 SW CR 14	4/9/2021 6:00 PM
85	320 Hickory Street	4/9/2021 5:22 PM
86	317 SW OSCEOLA WAY	4/9/2021 4:44 PM
87	1029 sw wonderwood st	4/9/2021 4:35 PM
88	582 NW Bailey Grade Road	4/9/2021 4:33 PM
89	1465 SW Moseley Hall Rd	4/9/2021 4:22 PM
90	256 SW Washington Ave	4/9/2021 3:45 PM
91	421 SW Range Ave	4/9/2021 3:45 PM
92	2345 Sunset Drive	4/9/2021 3:10 PM
93	1670 Lakeland Terrace	4/9/2021 3:07 PM
94	5869 Woods Creek Rd	4/9/2021 3:06 PM
95	Cherry lake	4/9/2021 3:03 PM

96	4029 NE Dusty Miller Ave	4/9/2021 2:54 PM
97	Alexander Rd	4/9/2021 2:48 PM
98	Comfort court	4/9/2021 2:47 PM
99	1221 NW Coachwhip Ave	4/9/2021 2:46 PM
100	2046 sw Moseley hall Rd	4/9/2021 2:41 PM
101	2073 Lauren Drive	4/9/2021 2:40 PM
102	314 Comfort Court	4/9/2021 2:38 PM
103	454 Waukeenah Hwy	4/9/2021 2:32 PM
104	210 SW 1 Federal Rd	4/9/2021 2:28 PM
105	PO Box 45	4/9/2021 2:21 PM
106	523 Prudence Street	4/9/2021 2:19 PM
107	241 SE Cherokee Ave	4/9/2021 2:17 PM
108	325 NW Turner Davis Dr	4/9/2021 2:14 PM
109	843 Bombardier Way	4/9/2021 2:13 PM
110	203 se moore st	4/9/2021 2:12 PM
111	619 NE Evergreen Ave	4/9/2021 2:06 PM
112	298 SE Alafia Ter	4/9/2021 2:03 PM
113	268 ne yellow pine ave	4/9/2021 2:00 PM
114	4385 NE Rocky Ford Rd	4/9/2021 1:59 PM
115	1221 NW Coachwhip Ave.	4/9/2021 11:34 AM
116	555 N. Jefferson St	4/9/2021 11:01 AM
117	384 SE Midway Church Road	4/9/2021 10:33 AM

#	ADDRESS 2	DATE
1	Lot 88	4/22/2021 10:55 PM
2	Apt, suite, bldg	4/19/2021 6:01 PM
3	Alexander Building	4/16/2021 11:36 AM
4	Tallahassee, Florida 32303	4/12/2021 2:17 PM
5	Suite B	4/12/2021 1:13 PM
6	NE Firebrush Trail	4/12/2021 8:39 AM
7	Work	4/12/2021 7:46 AM
8	Bldg 7 Room 711	4/9/2021 2:14 PM

#	CITY/TOWN	DATE
1	Madison	5/13/2021 5:11 PM
2	monticello	5/7/2021 9:18 AM
3	Monticello	5/7/2021 7:00 AM
4	Madison	5/6/2021 7:29 PM
5	Monticello	5/1/2021 10:20 AM
6	Monticello	4/29/2021 11:21 PM

7	Lee	4/29/2021 6:44 PM
8	Greenville	4/27/2021 6:42 PM
9	Madison	4/27/2021 5:55 AM
10	Madison	4/26/2021 9:13 PM
11	Lee	4/26/2021 7:26 PM
12	Greenville	4/26/2021 6:28 PM
13	Lee	4/26/2021 5:47 PM
14	Madison	4/26/2021 5:30 PM
15	Madison	4/26/2021 5:11 PM
16	MADISON	4/26/2021 5:05 PM
17	Greenville	4/26/2021 4:02 PM
18	MADISON	4/23/2021 11:35 PM
19	Madison	4/22/2021 10:55 PM
20	Perry	4/22/2021 12:58 PM
21	Perry	4/20/2021 8:17 PM
22	Madison	4/19/2021 6:01 PM
23	Greenville	4/19/2021 10:33 AM
24	Madison	4/19/2021 10:22 AM
25	Greenville	4/18/2021 7:05 PM
26	Perry	4/16/2021 7:02 PM
27	Tallahassee	4/16/2021 11:36 AM
28	Madison	4/16/2021 8:46 AM
29	Madison	4/15/2021 9:52 PM
30	Greenville	4/15/2021 5:28 PM
31	Jennings	4/13/2021 8:48 PM
32	Madison	4/13/2021 3:26 PM
33	Madison	4/13/2021 2:41 PM
34	Perry	4/13/2021 2:09 PM
35	Madison	4/13/2021 1:59 PM
36	Madison	4/13/2021 1:32 PM
37	Greenville	4/13/2021 9:14 AM
38	Madison County	4/13/2021 5:50 AM
39	Madison	4/13/2021 3:44 AM
40	Madison	4/13/2021 3:44 AM
41	Lamont	4/13/2021 3:44 AM
42	WACISSA	4/13/2021 3:33 AM
43	Madison	4/13/2021 3:16 AM
44	Cherry Lake	4/13/2021 3:13 AM

45	LAMONT	4/13/2021 3:10 AM
46	Madison	4/12/2021 9:24 PM
47	Quincy	4/12/2021 3:02 PM
48	Tallahassee	4/12/2021 2:17 PM
49	Madison	4/12/2021 1:52 PM
50	Lee	4/12/2021 1:30 PM
51	Madison	4/12/2021 1:13 PM
52	Madison	4/12/2021 12:25 PM
53	Perry	4/12/2021 10:50 AM
54	Monticello	4/12/2021 10:24 AM
55	Greenville	4/12/2021 10:20 AM
56	Madison	4/12/2021 9:52 AM
57	Greenville	4/12/2021 9:30 AM
58	Wewahitchka	4/12/2021 9:27 AM
59	Perry	4/12/2021 9:04 AM
60	Tallahassee	4/12/2021 8:46 AM
61	Pinetta	4/12/2021 8:39 AM
62	Monticello	4/12/2021 8:37 AM
63	Lee	4/12/2021 8:33 AM
64	Perry	4/12/2021 8:28 AM
65	Madison	4/12/2021 8:17 AM
66	steinhatchee	4/12/2021 7:59 AM
67	Madison	4/12/2021 7:46 AM
68	Tallahassee	4/12/2021 7:46 AM
69	Monticello	4/10/2021 11:29 PM
70	Madison	4/10/2021 10:32 PM
71	Lee	4/10/2021 10:27 AM
72	Tallahassee	4/10/2021 3:56 AM
73	Madison	4/10/2021 3:39 AM
74	TALLAHASSEE	4/10/2021 3:36 AM
75	Lee	4/10/2021 2:54 AM
76	TALLAHASSEE	4/10/2021 2:24 AM
77	TALLAHASSEE	4/10/2021 2:09 AM
78	TALLAHASSEE	4/10/2021 12:55 AM
79	TALLAHASSEE	4/10/2021 12:53 AM
80	TALLAHASSEE	4/10/2021 12:52 AM
81	Tallahassee	4/10/2021 12:51 AM
82	Pinetta	4/9/2021 10:05 PM

83	lee	4/9/2021 7:22 PM
84	Greenville	4/9/2021 6:00 PM
85	Monticello	4/9/2021 5:22 PM
86	GREENVILLE	4/9/2021 4:44 PM
87	Greenville	4/9/2021 4:35 PM
88	Greenville	4/9/2021 4:33 PM
89	Madison	4/9/2021 4:22 PM
90	Madison	4/9/2021 3:45 PM
91	Madison	4/9/2021 3:45 PM
92	Live Oak	4/9/2021 3:10 PM
93	Perry	4/9/2021 3:07 PM
94	PERRY	4/9/2021 3:06 PM
95	Madison	4/9/2021 3:03 PM
96	Madison	4/9/2021 2:54 PM
97	Madison	4/9/2021 2:48 PM
98	Madison	4/9/2021 2:47 PM
99	Madison	4/9/2021 2:46 PM
100	Madison	4/9/2021 2:41 PM
101	Madison	4/9/2021 2:40 PM
102	Madison	4/9/2021 2:38 PM
103	Monticello	4/9/2021 2:32 PM
104	Greenville	4/9/2021 2:28 PM
105	Perry	4/9/2021 2:21 PM
106	Taylor	4/9/2021 2:19 PM
107	Madison	4/9/2021 2:17 PM
108	Madison	4/9/2021 2:14 PM
109	Taylor	4/9/2021 2:13 PM
110	Madison	4/9/2021 2:12 PM
111	Pinetta	4/9/2021 2:06 PM
112	Lee	4/9/2021 2:03 PM
113	Madison	4/9/2021 2:00 PM
114	Madison	4/9/2021 1:59 PM
115	Madison	4/9/2021 11:34 AM
116	MONTICELLO	4/9/2021 11:01 AM
117	Lee	4/9/2021 10:33 AM

#	STATE/PROVINCE	DATE
1	FL	5/13/2021 5:11 PM
2	FL	5/7/2021 9:18 AM

3	FL	5/7/2021 7:00 AM
4	FL	5/6/2021 7:29 PM
5	FL	5/1/2021 10:20 AM
6	FL	4/29/2021 11:21 PM
7	FL	4/29/2021 6:44 PM
8	FL	4/27/2021 6:42 PM
9	FL	4/27/2021 5:55 AM
10	FL	4/26/2021 9:13 PM
11	FL	4/26/2021 7:26 PM
12	FL	4/26/2021 6:28 PM
13	FL	4/26/2021 5:47 PM
14	FL	4/26/2021 5:30 PM
15	FL	4/26/2021 5:11 PM
16	FL	4/26/2021 5:05 PM
17	FL	4/26/2021 4:02 PM
18	FL	4/23/2021 11:35 PM
19	FL	4/22/2021 10:55 PM
20	FL	4/22/2021 12:58 PM
21	FL	4/20/2021 8:17 PM
22	FL	4/19/2021 6:01 PM
23	FL	4/19/2021 10:33 AM
24	FL	4/19/2021 10:22 AM
25	FL	4/18/2021 7:05 PM
26	FL	4/16/2021 7:02 PM
27	FL	4/16/2021 11:36 AM
28	FL	4/16/2021 8:46 AM
29	FL	4/15/2021 9:52 PM
30	FL	4/15/2021 5:28 PM
31	FL	4/13/2021 8:48 PM
32	FL	4/13/2021 3:26 PM
33	FL	4/13/2021 2:41 PM
34	FL	4/13/2021 2:09 PM
35	FL	4/13/2021 1:59 PM
36	FL	4/13/2021 1:32 PM
37	FL	4/13/2021 9:14 AM
38	FL	4/13/2021 5:50 AM
39	FL	4/13/2021 3:44 AM
40	FL	4/13/2021 3:44 AM

41	FL	4/13/2021 3:44 AM
42	FL	4/13/2021 3:33 AM
43	FL	4/13/2021 3:16 AM
44	FL	4/13/2021 3:13 AM
45	FL	4/13/2021 3:10 AM
46	FL	4/12/2021 9:24 PM
47	FL	4/12/2021 3:02 PM
48	FL	4/12/2021 2:17 PM
49	FL	4/12/2021 1:52 PM
50	FL	4/12/2021 1:30 PM
51	FL	4/12/2021 1:13 PM
52	FL	4/12/2021 12:25 PM
53	FL	4/12/2021 10:50 AM
54	FL	4/12/2021 10:24 AM
55	FL	4/12/2021 10:20 AM
56	FL	4/12/2021 9:52 AM
57	FL	4/12/2021 9:30 AM
58	FL	4/12/2021 9:27 AM
59	FL	4/12/2021 9:04 AM
60	FL	4/12/2021 8:46 AM
61	FL	4/12/2021 8:39 AM
62	FL	4/12/2021 8:37 AM
63	FL	4/12/2021 8:33 AM
64	FL	4/12/2021 8:28 AM
65	FL	4/12/2021 8:17 AM
66	FL	4/12/2021 7:59 AM
67	FL	4/12/2021 7:46 AM
68	FL	4/12/2021 7:46 AM
69	FL	4/10/2021 11:29 PM
70	FL	4/10/2021 10:32 PM
71	FL	4/10/2021 10:27 AM
72	FL	4/10/2021 3:56 AM
73	FL	4/10/2021 3:39 AM
74	FL	4/10/2021 3:36 AM
75	FL	4/10/2021 2:54 AM
76	FL	4/10/2021 2:24 AM
77	FL	4/10/2021 2:09 AM
78	FL	4/10/2021 12:55 AM

79	FL	4/10/2021 12:53 AM
80	FL	4/10/2021 12:52 AM
81	FL	4/10/2021 12:51 AM
82	FL	4/9/2021 10:05 PM
83	FL	4/9/2021 7:22 PM
84	FL	4/9/2021 6:00 PM
85	FL	4/9/2021 5:22 PM
86	FL	4/9/2021 4:44 PM
87	FL	4/9/2021 4:35 PM
88	FL	4/9/2021 4:33 PM
89	FL	4/9/2021 4:22 PM
90	FL	4/9/2021 3:45 PM
91	FL	4/9/2021 3:45 PM
92	FL	4/9/2021 3:10 PM
93	FL	4/9/2021 3:07 PM
94	FL	4/9/2021 3:06 PM
95	FL	4/9/2021 3:03 PM
96	FL	4/9/2021 2:54 PM
97	FL	4/9/2021 2:48 PM
98	FL	4/9/2021 2:47 PM
99	FL	4/9/2021 2:46 PM
100	FL	4/9/2021 2:41 PM
101	FL	4/9/2021 2:40 PM
102	FL	4/9/2021 2:38 PM
103	FL	4/9/2021 2:32 PM
104	FL	4/9/2021 2:28 PM
105	FL	4/9/2021 2:21 PM
106	FL	4/9/2021 2:19 PM
107	FL	4/9/2021 2:17 PM
108	FL	4/9/2021 2:14 PM
109	TX	4/9/2021 2:13 PM
110	FL	4/9/2021 2:12 PM
111	FL	4/9/2021 2:06 PM
112	FL	4/9/2021 2:03 PM
113	FL	4/9/2021 2:00 PM
114	FL	4/9/2021 1:59 PM
115	FL	4/9/2021 11:34 AM
116	FL	4/9/2021 11:01 AM

117	FL	4/9/2021 10:33 AM
#	ZIP/POSTAL CODE	DATE
1	32340	5/13/2021 5:11 PM
2	32344	5/7/2021 9:18 AM
3	32344	5/7/2021 7:00 AM
4	32340	5/6/2021 7:29 PM
5	32344	5/1/2021 10:20 AM
6	32344	4/29/2021 11:21 PM
7	32059	4/29/2021 6:44 PM
8	32331	4/27/2021 6:42 PM
9	32340	4/27/2021 5:55 AM
10	32340	4/26/2021 9:13 PM
11	32059	4/26/2021 7:26 PM
12	32331	4/26/2021 6:28 PM
13	32059	4/26/2021 5:47 PM
14	32340	4/26/2021 5:30 PM
15	32340	4/26/2021 5:11 PM
16	32340	4/26/2021 5:05 PM
17	32331	4/26/2021 4:02 PM
18	32340	4/23/2021 11:35 PM
19	32340	4/22/2021 10:55 PM
20	32348	4/22/2021 12:58 PM
21	32347	4/20/2021 8:17 PM
22	32340	4/19/2021 6:01 PM
23	32331	4/19/2021 10:33 AM
24	32340	4/19/2021 10:22 AM
25	32331	4/18/2021 7:05 PM
26	32347	4/16/2021 7:02 PM
27	32399	4/16/2021 11:36 AM
28	32340-1566	4/16/2021 8:46 AM
29	32340	4/15/2021 9:52 PM
30	32331	4/15/2021 5:28 PM
31	32053	4/13/2021 8:48 PM
32	32340	4/13/2021 3:26 PM
33	32341	4/13/2021 2:41 PM
34	32347	4/13/2021 2:09 PM
35	32340	4/13/2021 1:59 PM
36	32340	4/13/2021 1:32 PM

37	32331	4/13/2021 9:14 AM
38	33631	4/13/2021 5:50 AM
39	32341	4/13/2021 3:44 AM
40	32340	4/13/2021 3:44 AM
41	32336	4/13/2021 3:44 AM
42	32361	4/13/2021 3:33 AM
43	32340	4/13/2021 3:16 AM
44	32340	4/13/2021 3:13 AM
45	32336	4/13/2021 3:10 AM
46	34652	4/12/2021 9:24 PM
47	32351	4/12/2021 3:02 PM
48	32303	4/12/2021 2:17 PM
49	32340	4/12/2021 1:52 PM
50	32059	4/12/2021 1:30 PM
51	32340	4/12/2021 1:13 PM
52	32340	4/12/2021 12:25 PM
53	32348	4/12/2021 10:50 AM
54	32344	4/12/2021 10:24 AM
55	32331	4/12/2021 10:20 AM
56	32340	4/12/2021 9:52 AM
57	32331	4/12/2021 9:30 AM
58	32465	4/12/2021 9:27 AM
59	32348	4/12/2021 9:04 AM
60	32303	4/12/2021 8:46 AM
61	32350	4/12/2021 8:39 AM
62	32344	4/12/2021 8:37 AM
63	32059	4/12/2021 8:33 AM
64	32347	4/12/2021 8:28 AM
65	32331	4/12/2021 8:17 AM
66	32359	4/12/2021 7:59 AM
67	32340	4/12/2021 7:46 AM
68	32311	4/12/2021 7:46 AM
69	32344	4/10/2021 11:29 PM
70	32340	4/10/2021 10:32 PM
71	32059	4/10/2021 10:27 AM
72	32311	4/10/2021 3:56 AM
73	32340	4/10/2021 3:39 AM
74	32310	4/10/2021 3:36 AM

75	32059	4/10/2021 2:54 AM
76	32311	4/10/2021 2:24 AM
77	32306	4/10/2021 2:09 AM
78	32316	4/10/2021 12:55 AM
79	32311	4/10/2021 12:53 AM
80	32308	4/10/2021 12:52 AM
81	32303	4/10/2021 12:51 AM
82	32350	4/9/2021 10:05 PM
83	32059	4/9/2021 7:22 PM
84	32331	4/9/2021 6:00 PM
85	32344	4/9/2021 5:22 PM
86	32331	4/9/2021 4:44 PM
87	32331	4/9/2021 4:35 PM
88	32331	4/9/2021 4:33 PM
89	32340	4/9/2021 4:22 PM
90	32340	4/9/2021 3:45 PM
91	32340	4/9/2021 3:45 PM
92	32064	4/9/2021 3:10 PM
93	32348	4/9/2021 3:07 PM
94	32347	4/9/2021 3:06 PM
95	32314	4/9/2021 3:03 PM
96	32340	4/9/2021 2:54 PM
97	32340	4/9/2021 2:48 PM
98	53703	4/9/2021 2:47 PM
99	32340	4/9/2021 2:46 PM
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101	32341	4/9/2021 2:40 PM
102	32340	4/9/2021 2:38 PM
103	32344	4/9/2021 2:32 PM
104	32331	4/9/2021 2:28 PM
105	32348	4/9/2021 2:21 PM
106	32347	4/9/2021 2:19 PM
107	32340	4/9/2021 2:17 PM
108	32341	4/9/2021 2:14 PM
109	76574	4/9/2021 2:13 PM
110	32340	4/9/2021 2:12 PM
111	32350	4/9/2021 2:06 PM
112	32059	4/9/2021 2:03 PM

113	32340	4/9/2021 2:00 PM
114	32340	4/9/2021 1:59 PM
115	32340	4/9/2021 11:34 AM
116	32344	4/9/2021 11:01 AM
117	32059	4/9/2021 10:33 AM
#	**COUNTRY**	**DATE**
1	USA	5/13/2021 5:11 PM
2	USA	5/7/2021 7:00 AM
3	United States	5/6/2021 7:29 PM
4	United States	5/1/2021 10:20 AM
5	USA	4/29/2021 6:44 PM
6	United States	4/27/2021 6:42 PM
7	United States	4/26/2021 9:13 PM
8	United States	4/26/2021 7:26 PM
9	United States	4/26/2021 6:28 PM
10	U.S.	4/26/2021 5:30 PM
11	USA	4/26/2021 5:11 PM
12	United States	4/26/2021 5:05 PM
13	United States	4/26/2021 4:02 PM
14	United States	4/23/2021 11:35 PM
15	US	4/22/2021 10:55 PM
16	USA	4/22/2021 12:58 PM
17	United States	4/19/2021 6:01 PM
18	United States	4/19/2021 10:33 AM
19	Madison	4/19/2021 10:22 AM
20	United States	4/18/2021 7:05 PM
21	Usa	4/16/2021 7:02 PM
22	Usa	4/15/2021 9:52 PM
23	United States	4/15/2021 5:28 PM
24	USA	4/13/2021 8:48 PM
25	USA	4/13/2021 2:41 PM
26	United States	4/13/2021 1:59 PM
27	United States	4/13/2021 9:14 AM
28	USA	4/13/2021 3:44 AM
29	USA	4/13/2021 3:44 AM
30	USA	4/13/2021 3:33 AM
31	USA	4/13/2021 3:16 AM
32	Florida	4/13/2021 3:13 AM

33	Florida	4/13/2021 3:10 AM
34	United States	4/12/2021 9:24 PM
35	United States	4/12/2021 3:02 PM
36	USA	4/12/2021 2:17 PM
37	USA	4/12/2021 1:52 PM
38	United States	4/12/2021 1:13 PM
39	United States	4/12/2021 10:50 AM
40	United States	4/12/2021 10:20 AM
41	US	4/12/2021 9:52 AM
42	United States	4/12/2021 9:27 AM
43	USA	4/12/2021 9:04 AM
44	United States	4/12/2021 8:39 AM
45	United States	4/12/2021 8:37 AM
46	USA	4/12/2021 8:28 AM
47	United States	4/12/2021 8:17 AM
48	usa	4/12/2021 7:59 AM
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50	Usa	4/10/2021 10:32 PM
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52	United States	4/10/2021 3:39 AM
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56	United States	4/9/2021 5:22 PM
57	us	4/9/2021 4:44 PM
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60	United States	4/9/2021 4:22 PM
61	USA	4/9/2021 3:45 PM
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64	Madison	4/9/2021 2:54 PM
65	United states of America	4/9/2021 2:48 PM
66	United states	4/9/2021 2:47 PM
67	USA	4/9/2021 2:46 PM
68	United States	4/9/2021 2:32 PM
69	US	4/9/2021 2:28 PM
70	Taylor	4/9/2021 2:21 PM

71	US	4/9/2021 2:14 PM
72	USA	4/9/2021 1:59 PM
73	United States	4/9/2021 11:34 AM
#	**EMAIL ADDRESS**	**DATE**
1	ebbie0228@gmail.com	5/13/2021 5:11 PM
2	lhgraves1949@gmail.com	5/7/2021 9:18 AM
3	skeeterbaitgal@yahoo.com	5/7/2021 7:00 AM
4	wv0308@gmail.com	5/6/2021 7:29 PM
5	tammybrookins@gmail.com	5/1/2021 10:20 AM
6	nathan_peeler@yahoo.com	4/29/2021 11:21 PM
7	twinkletoes02@embarqmail.com	4/29/2021 6:44 PM
8	hesterrita46@yahoo.com	4/27/2021 6:42 PM
9	paula.kauffman@mcsbfl.us	4/27/2021 5:55 AM
10	jamiefineandrews@yahoo.com	4/26/2021 9:13 PM
11	brittcc873@gmail.com	4/26/2021 7:26 PM
12	mlmcgriff@gmail.com	4/26/2021 6:28 PM
13	mandy1423@yahoo.com	4/26/2021 5:47 PM
14	jkbotino53@msn.com	4/26/2021 5:30 PM
15	seturner@hiwaay.net	4/26/2021 5:11 PM
16	docjwebb@gmail.com	4/26/2021 5:05 PM
17	dmyers8091@gmail.com	4/26/2021 4:02 PM
18	melizabethking71@gmail.com	4/23/2021 11:35 PM
19	taleciasolomon@yahoo.com	4/22/2021 10:55 PM
20	muddesigns21@gmail.com	4/22/2021 12:58 PM
21	tbell@healthystartjmt.org	4/20/2021 8:17 PM
22	timbert5@yahoo.com	4/19/2021 6:01 PM
23	HarrisHomesteadFL@gmail.com	4/19/2021 10:33 AM
24	Catronj@aol.com	4/19/2021 10:22 AM
25	rebecca.gonzalez@mcsbfl.us	4/18/2021 7:05 PM
26	mlynn148@yahoo.com	4/16/2021 7:02 PM
27	christina.ash@djj.state.fl.us	4/16/2021 11:36 AM
28	Lucille626@outlook.com	4/16/2021 8:46 AM
29	aculpepperlpp@gmail.com	4/15/2021 9:52 PM
30	bturner@healthystartjmt.org	4/15/2021 5:28 PM
31	lisa.burnham@saintleo.edu	4/13/2021 8:48 PM
32	jennifer.williams@mcsbfl.us	4/13/2021 3:26 PM
33	elisealbritton@gmail.com	4/13/2021 2:41 PM
34	kristie.lutz@flhealth.gov	4/13/2021 2:09 PM

35	elizabethmoore@ufl.edu	4/13/2021 1:59 PM
36	shanetha.mitchell@flhealth.gov	4/13/2021 1:32 PM
37	cobbe1962@hotmail.com	4/13/2021 9:14 AM
38	ClementBoswelljP40@yahoo.com	4/13/2021 5:50 AM
39	scchroederzzane@gmail.com	4/13/2021 3:44 AM
40	axendeaney@gmail.com	4/13/2021 3:44 AM
41	SolMartinspm@yahoo.com	4/13/2021 3:44 AM
42	bbatttlecamden@gmail.com	4/13/2021 3:33 AM
43	glassorllanndo@gmail.com	4/13/2021 3:16 AM
44	omaaarigallegos@gmail.com	4/13/2021 3:13 AM
45	averyroogeelio@gmail.com	4/13/2021 3:10 AM
46	batesgujis05@gmail.com	4/12/2021 9:24 PM
47	avondicher@gmail.com	4/12/2021 3:02 PM
48	sywashington2@yahoo.com	4/12/2021 2:17 PM
49	dobro8656@gmail.com	4/12/2021 1:52 PM
50	jebell@embarqmail.com	4/12/2021 1:30 PM
51	madisontherapywellness@gmail.com	4/12/2021 1:13 PM
52	NA	4/12/2021 12:25 PM
53	sharon.hathcock@taylor.k12.fl.us	4/12/2021 10:50 AM
54	nlamar04@gmail.com	4/12/2021 10:24 AM
55	ljones@kidsincorporated.org	4/12/2021 10:20 AM
56	angelinacurtis@aol.com	4/12/2021 9:52 AM
57	tcason@healthystartjmt.org	4/12/2021 9:30 AM
58	smcgill@floridachildren.org	4/12/2021 9:27 AM
59	deogy23@gmail.com	4/12/2021 9:04 AM
60	jere.clark@myflfamilies.com	4/12/2021 8:46 AM
61	lisa.king.roderick@gmail.com	4/12/2021 8:39 AM
62	jytete@aol.com	4/12/2021 8:37 AM
63	tammy.hinson@flhealth.gov	4/12/2021 8:33 AM
64	sarah.bayes@flhealth.gov	4/12/2021 8:28 AM
65	snoweyhagan@gmail.com	4/12/2021 8:17 AM
66	blundy@tcec.com	4/12/2021 7:59 AM
67	sgodfrey@ounce.org	4/12/2021 7:46 AM
68	kyle.seachrist@teenchallenge.cc	4/12/2021 7:46 AM
69	lisarenee1023@yahoo.com	4/10/2021 11:29 PM
70	carolineCblair@yahoo.com	4/10/2021 10:32 PM
71	kknowles1026@gmail.com	4/10/2021 10:27 AM
72	workeradvice3194@gmail.com	4/10/2021 3:56 AM

73	thenelsonway1@aol.com	4/10/2021 3:39 AM
74	politicsdry3248@gmail.com	4/10/2021 3:36 AM
75	Ashlyn.blount@gmail.com	4/10/2021 2:54 AM
76	alisiafcka37@gmail.com	4/10/2021 2:24 AM
77	milagrosvdxe07@gmail.com	4/10/2021 2:09 AM
78	reyestcq37@gmail.com	4/10/2021 12:55 AM
79	groveyhbk65@gmail.com	4/10/2021 12:53 AM
80	melissatlfvc86@gmail.com	4/10/2021 12:52 AM
81	farleypyyp99@gmail.com	4/10/2021 12:51 AM
82	crystalnmccann99@gmail.com	4/9/2021 10:05 PM
83	muffinmanmania@hotmail.com	4/9/2021 7:22 PM
84	mlmcgriff@gmail.com	4/9/2021 6:00 PM
85	jhackett@tcec.com	4/9/2021 5:22 PM
86	ktolar@tcec.com	4/9/2021 4:44 PM
87	jordilee01@gmail.com	4/9/2021 4:35 PM
88	kking@tcec.com	4/9/2021 4:33 PM
89	denise_dyal@yahoo.com	4/9/2021 4:22 PM
90	tammywilliams312@hotmail.com	4/9/2021 3:45 PM
91	aokelectricllc2007@gmail.com	4/9/2021 3:45 PM
92	cynthiamorg369@gmail.com	4/9/2021 3:10 PM
93	cynthiaparker369@gmail.com	4/9/2021 3:07 PM
94	jsadler729@gmail.com	4/9/2021 3:06 PM
95	samantharob613@gmail.com	4/9/2021 3:03 PM
96	wendisweat@yahoo.com	4/9/2021 2:54 PM
97	skyemadison53@gmail.com	4/9/2021 2:48 PM
98	vannessarichard4@gmail.com	4/9/2021 2:47 PM
99	patti_puff@yahoo.com	4/9/2021 2:46 PM
100	tclw38@gmail.com	4/9/2021 2:41 PM
101	marysmith25802@gmail.com	4/9/2021 2:40 PM
102	angelarhodes0128@gmail.com	4/9/2021 2:38 PM
103	mlmorgan2006@gmail.com	4/9/2021 2:32 PM
104	kelsey978@gmail.com	4/9/2021 2:28 PM
105	NIchole.Wilder@djj.state.fl.us	4/9/2021 2:21 PM
106	bryantchristiana24@gmail.com	4/9/2021 2:19 PM
107	pooreme78@gmail.com	4/9/2021 2:17 PM
108	karenphiers@gmail.com	4/9/2021 2:14 PM
109	julianasmith0128@gmail.com	4/9/2021 2:13 PM
110	Ballerboma@gmail.com	4/9/2021 2:12 PM

111	angelahagan17@gmail.com	4/9/2021 2:06 PM
112	MANDAGURL53@AOL.COM	4/9/2021 2:03 PM
113	waters68_68@hotmail.com	4/9/2021 2:00 PM
114	theflaowl1@outlook.com	4/9/2021 1:59 PM
115	eschmidt@healthystartjmt.org	4/9/2021 11:34 AM
116	healthyways01@embarqmail.com	4/9/2021 11:01 AM
117	dthompson@healthystartjmt.org	4/9/2021 10:33 AM

#	PHONE NUMBER	DATE
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2	8509971474	5/7/2021 9:18 AM
3	8506940446	5/7/2021 7:00 AM
4	18509337422	5/6/2021 7:29 PM
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6	6154838950	4/29/2021 11:21 PM
7	8504647692	4/29/2021 6:44 PM
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18	8509737968	4/23/2021 11:35 PM
19	8509737348	4/22/2021 10:55 PM
20	8502955445	4/22/2021 12:58 PM
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25	8506731711	4/18/2021 7:05 PM
26	8508385949	4/16/2021 7:02 PM
27	christina.ash@djj.state.fl.us	4/16/2021 11:36 AM
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43	850-464-3575	4/13/2021 3:16 AM
44	850-929-9517	4/13/2021 3:13 AM
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46	6087091775	4/12/2021 9:24 PM
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75	8505975738	4/10/2021 2:54 AM
76	801-877-3400	4/10/2021 2:24 AM
77	843-556-3037	4/10/2021 2:09 AM
78	530-356-4590	4/10/2021 12:55 AM
79	262-581-8095	4/10/2021 12:53 AM
80	740-742-6036	4/10/2021 12:52 AM
81	850-297-3084	4/10/2021 12:51 AM
82	8506731047	4/9/2021 10:05 PM
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84	8505443823	4/9/2021 6:00 PM
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91	8509489957	4/9/2021 3:45 PM
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93	4783562618	4/9/2021 3:07 PM
94	8503634178	4/9/2021 3:06 PM
95	8500795784	4/9/2021 3:03 PM
96	8504642216	4/9/2021 2:54 PM
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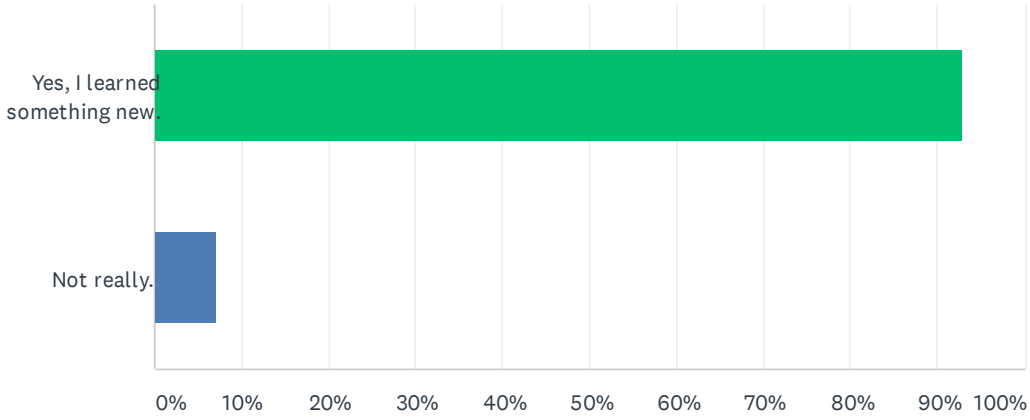
113	2293262431	4/9/2021 2:00 PM
114	8508690513	4/9/2021 1:59 PM
115	8504640279	4/9/2021 11:34 AM
116	8509972644	4/9/2021 11:01 AM
117	8504647945	4/9/2021 10:33 AM

Q22 Did you find value in this video?

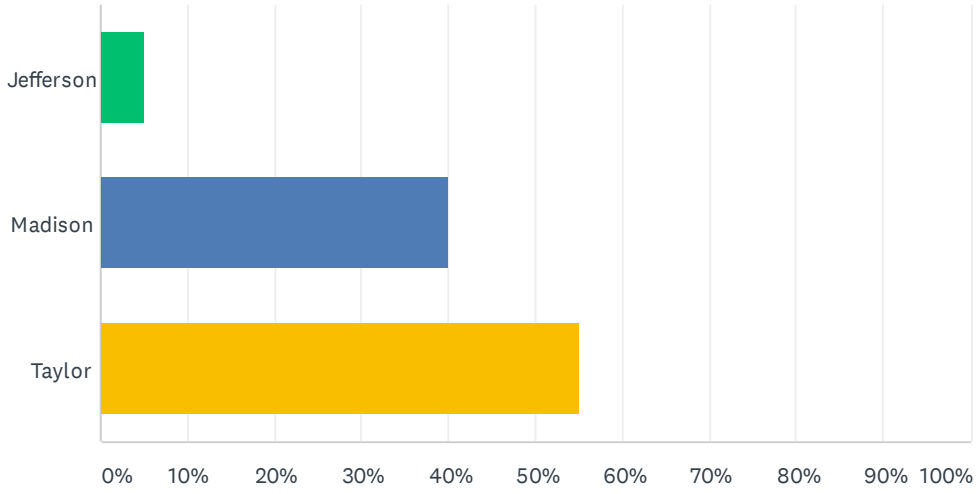
Answered: 111 Skipped: 633



ANSWER CHOICES	RESPONSES	
Yes, I learned something new.	92.79%	103
Not really.	7.21%	8
TOTAL		111

Q1 County

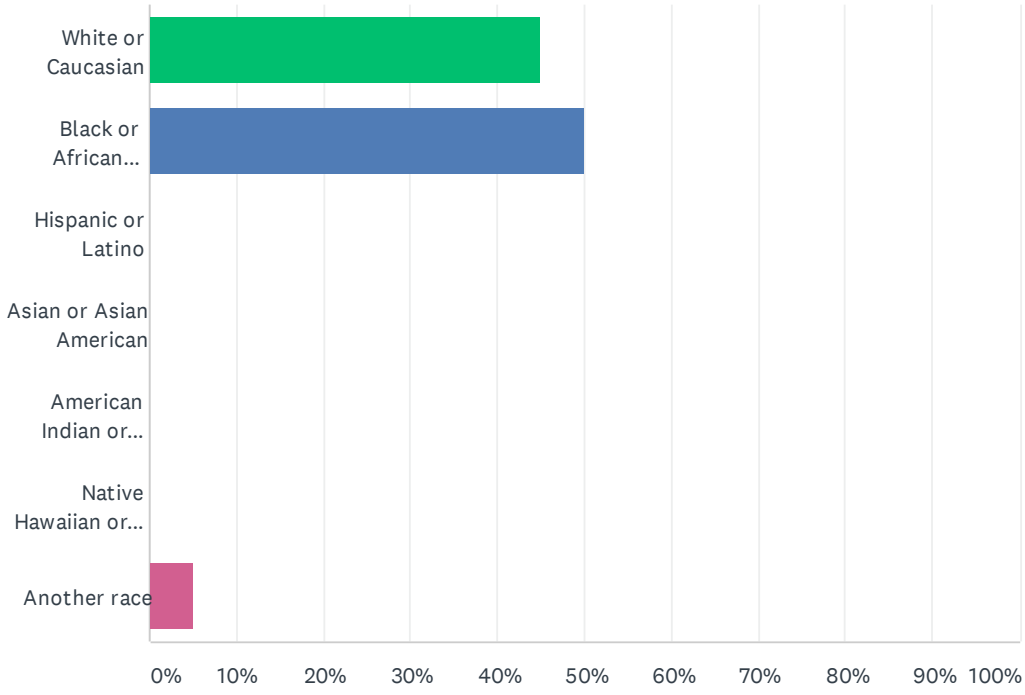
Answered: 20 Skipped: 0



ANSWER CHOICES	RESPONSES	
Jefferson	5.00%	1
Madison	40.00%	8
Taylor	55.00%	11
TOTAL		20

Q2 Race

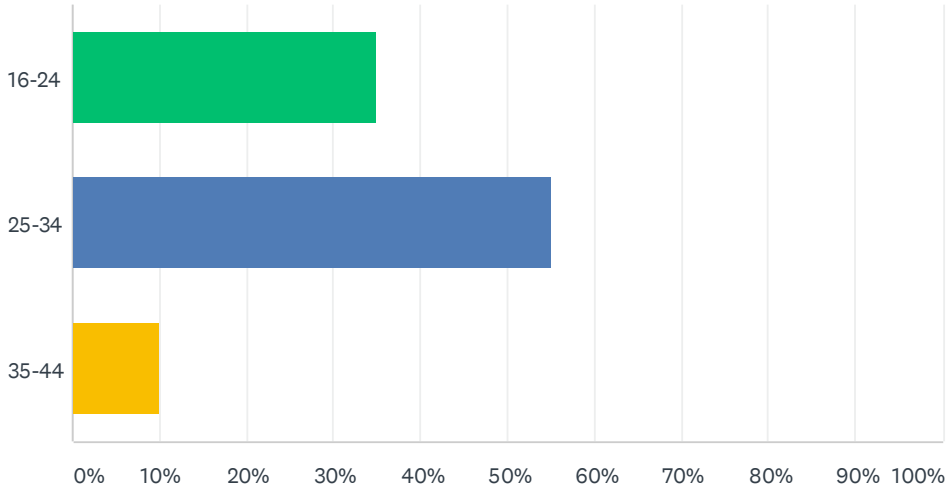
Answered: 20 Skipped: 0



ANSWER CHOICES	RESPONSES	
White or Caucasian	45.00%	9
Black or African American	50.00%	10
Hispanic or Latino	0.00%	0
Asian or Asian American	0.00%	0
American Indian or Alaska Native	0.00%	0
Native Hawaiian or other Pacific Islander	0.00%	0
Another race	5.00%	1
Total Respondents: 20		

Q3 Age

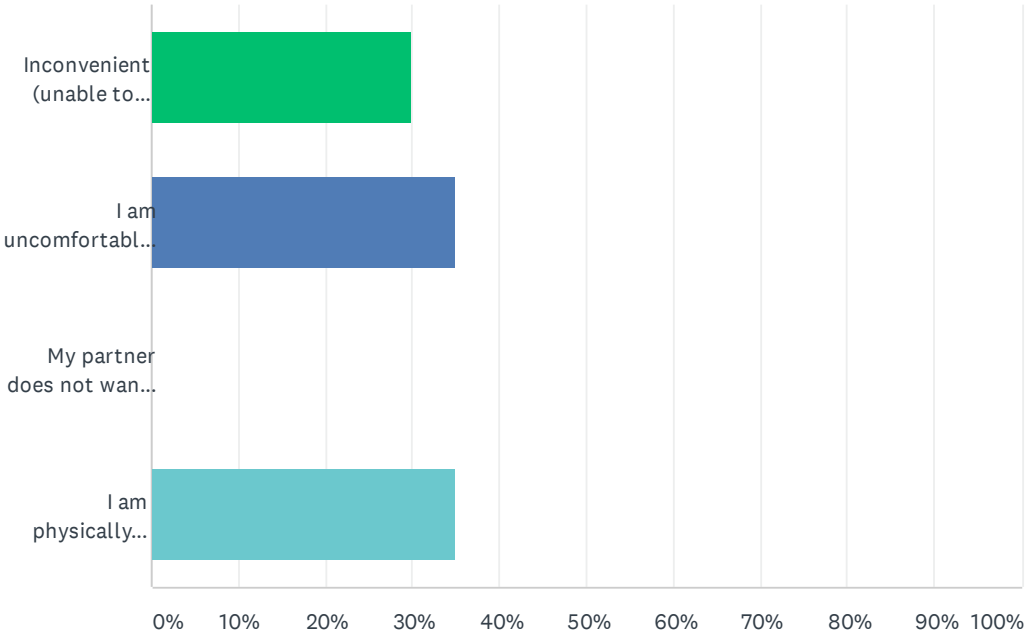
Answered: 20 Skipped: 0



ANSWER CHOICES	RESPONSES	
16-24	35.00%	7
25-34	55.00%	11
35-44	10.00%	2
TOTAL		20

Q4 What is the number ONE reason you chose not to breastfeed?

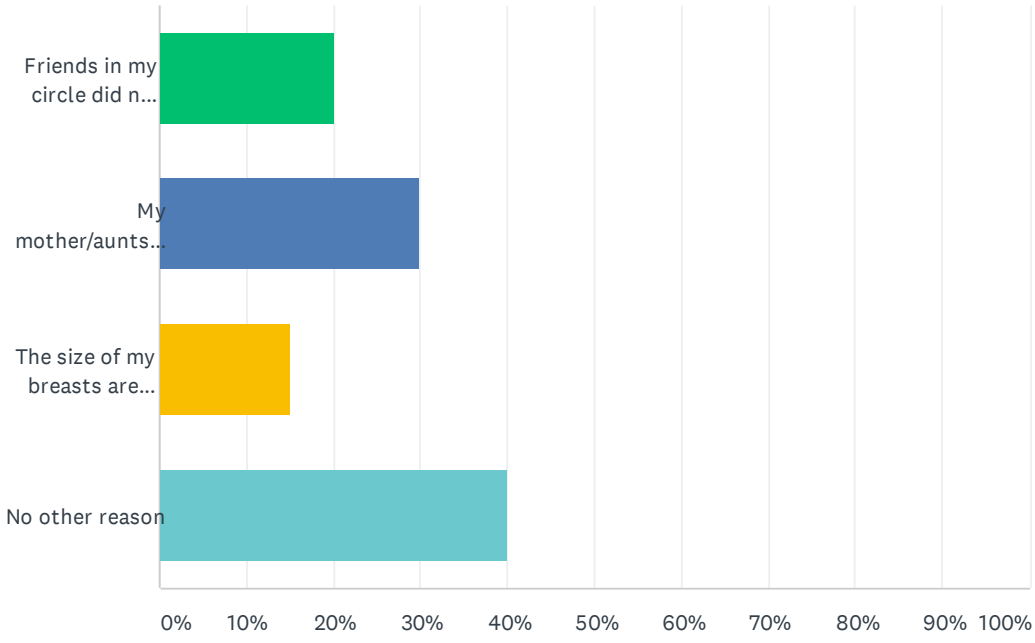
Answered: 20 Skipped: 0



ANSWER CHOICES	RESPONSES	
Inconvenient (unable to leave infant with sitter/constantly "on call"	30.00%	6
I am uncomfortable with an infant on my breast (the sensation is unpleasantor makes me uneasy)	35.00%	7
My partner does not want me to do this	0.00%	0
I am physically unable to breastfeed, due to a medical condition or not having enoough milk	35.00%	7
TOTAL		20

Q5 What are some other reasons that would impact your decision not to breastfeed?

Answered: 20 Skipped: 0



ANSWER CHOICES	RESPONSES	
Friends in my circle did not breastfeed and do not approve	20.00%	4
My mother/aunts/grandmother did not breastfeed	30.00%	6
The size of my breasts are important to me and I do not want to enlarge them	15.00%	3
No other reason	40.00%	8
Total Respondents: 20		

Q6 If there was one thing that may have changed your mind towards breastfeeding, what would it be?

Answered: 17 Skipped: 3

#	RESPONSES	DATE
1	Could not think of anything.	6/18/2020 11:27 AM
2	More people doing it.	6/3/2020 8:16 AM
3	Considering pumping and storing.	6/3/2020 8:15 AM
4	Nothing!	6/3/2020 8:14 AM
5	Communicate with someone else who did breastfeeding, they can tell me.	6/3/2020 8:14 AM
6	If I stayed home with my baby instead of working.	6/3/2020 8:12 AM
7	Bigger breast.	6/3/2020 8:12 AM
8	If baby was allergic to formula.	6/3/2020 8:11 AM
9	Hard to do with no support and milk never came in.	6/3/2020 8:10 AM
10	No	6/3/2020 8:09 AM
11	I breast fed my 13 month old. I wanted to, but am too stressed. I have an 8 yr old daughter who is having problems in school, a 13 month old, this baby and their dad is basically no help and I have high blood pressure.	6/3/2020 8:08 AM
12	I don't know of anything.	6/3/2020 8:06 AM
13	Nothing	6/3/2020 8:05 AM
14	If no formula was available	6/3/2020 8:05 AM
15	I got engorged with first bay and don't want to go through it again. Starting back to school August and starting back to work in 6 weeks and have a 1 year old.	6/3/2020 8:04 AM
16	Worried she may relapse and does not want to breastfeed in case she relapses.	6/3/2020 8:02 AM
17	If more comfortable with feeding and not knowing how much the baby is getting.	6/3/2020 8:01 AM