Healthy Start – MomCare Program
Annual Report

Department of Health in Orange County

Fiscal Year 2012-2013
2012-2013 Annual Report

MESSAGE FROM PROGRAM MANAGER:

I am pleased to present the Department of Health in Orange County, Healthy Start-MomCare Program Annual Report for fiscal year 2012-2013. The report details how services are provided, our progress in achieving contracted performance measures and highlights key initiatives and performance accomplishments.

The MomCare program served 14,000 Medicaid eligible pregnant women and the Healthy Start program served 7,509 pregnant women and 4,223 infants this fiscal year. The services were carried out by 53 women and 3 men dedicated to improving the health and wellbeing of mothers, babies and families.

I am excited to share with you our new mission statement “to protect, promote and improve the health of all people in Florida through integrated state, county and community efforts”. This statement reflects the outstanding relationship and partnership we have maintained for several years. Together, we will continue to strive to protect, promote and improve the health of all Orange County infants by ensuring that:

- Expecting pregnant women know the importance of early prenatal care and access these services within their first trimester.
- Mothers are educated on signs and symptoms of pre-term labor and the importance of seeking medical attention if they are present.
- Infants are born with a healthy weight and survive to celebrate not just their first birthdays but those that follow as well.
- The health, safety and developmental outcomes of infants are improved.
- Women are educated on planning for pregnancy and how being healthy before and between pregnancies improves the chances of having a healthy baby.

This year, we have focused on various methods to better serve our mothers and babies, while increasing services. The staff members of the Department of Health in Orange County Healthy Start-MomCare program have taken special pride in increasing services and encounters, improving quality service, increasing wrap around services and enhancing and implementing new initiatives. Everything we have strived to implement helps give every baby the best start in life.... A Healthy Start!

It is through the continued funding support of the Healthy Start Coalition of Orange County that we are able to provide these services and continue to improve the health of all mothers and babies. The Department of Health in Orange County looks forward to the challenges ahead as we provide evidenced based, innovative and effective methods to ensure that all babies have a Healthy Start.

It is with great pleasure that I present to you the Florida Department of Health in Orange County, Healthy Start-MomCare Annual Report for fiscal year 2012-2013.

Penny R. Smith
Healthy Start Program Manager
# Healthy Start Program Annual Report

Reporting Period: July 1, 2012 - June 30, 2013

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The Healthy Start System

The Healthy Start/MomCare Program at the Florida Department of Health (DOH-Orange) through a Memorandum of an Agreement with the Healthy Start Coalition of Orange County (HSCOC) provides choice counseling, case management and care coordination services to improve maternal and child health outcomes. Our goals are to:

- Reduce infant mortality,
- Decrease the number of low birth weight babies and
- Improve health and developmental outcomes.

The Healthy Start Care Coordination and MomCare programs are available to all women to ensure that all babies are born healthy and are developing age appropriately. In addition, the Healthy Start Care Coordination program provides services using the inter-conceptual curriculum to women who are between pregnancies to ensure that the next pregnancy has a healthy outcome.

MomCare is a Medicaid-funded program authorized by a special waiver from the federal government called the Sixth Omnibus Budget Reconciliation Act (SOBRA). MomCare was developed as a partnership between the Florida Association of Healthy Start Coalitions, Florida Department of Health (DOH), Florida Agency for Healthcare Administration, and the Florida Department of Children and Families. Medicaid eligible clients receive guidance selecting a prenatal care provider, assistance in scheduling initial prenatal visits, and information about state programs for which they may be eligible.

Healthy Start was enacted by state legislature with the goal of reducing infant mortality, the number of low birth weight babies and improving health and developmental outcomes. By legislative mandate, every pregnant woman and infant in Florida is to be offered a Healthy Start Screening at the doctor’s office and birthing facility. This means that Healthy Start is one of the first programs in the community to identify women and babies who are at high risk and need extra care. Care coordination teams assess the client’s needs, and provide mothers and babies with coordinated services that include: linking women to prenatal care providers; home visiting care coordination/case management; referrals to community resources such as housing, food, clothing, child health, immunizations and counseling. They also provide nutrition, smoking cessation, parenting and breastfeeding education as well as childbirth education classes, breastfeeding support and inter-conceptual counseling to meet the individual
needs of each family. Healthy Start is a voluntary program based on risk, not income.

![Chart 1: Infant Mortality](image1)

![Chart 2: Fetal Infant Mortality](image2)
We believe every baby deserves a healthy start in life. Together with various organizations, the Healthy Start/MomCare program brings support and care to pregnant women, infants, and their families. What this means is that our programs support the community by providing education and special programs to make sure each infant receives a Healthy Start. We offer a circle of care to participants depending on their needs and support. Our program focus is to improve maternal and child health outcomes. It is the foundation for early intervention, child protection and school readiness programs. Since its inception
in 1992, Orange County’s Infant Mortality Rate has decreased from 8.1 to 6.9 in 2012.
Outreach – Participant Identification, Provider Recruitment, Community Education & MomCare

**Participant Identification**
The Healthy Start/MomCare program promotes the health of mothers and infants in Orange County through a variety of activities. Case finding is an integral part of the program.

The point of entry into care often starts at pregnancy testing sites. There are eight (8) free pregnancy-testing locations in Orange County. In addition, there are two (2) low cost community testing sites as well as three (3) DOH-Orange sites and five (5) federally qualified health centers that provide pregnancy testing at a reduced cost.

<table>
<thead>
<tr>
<th>TYPE OF PREGNANCY TESTING PROVIDER</th>
<th>NUMBER OF FACILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost Community Testing Sites</td>
<td>2</td>
</tr>
<tr>
<td>Department of Health Centers</td>
<td>3</td>
</tr>
<tr>
<td>Federally Qualified Health Centers</td>
<td>5</td>
</tr>
<tr>
<td>Free Community Testing Sites</td>
<td>8</td>
</tr>
</tbody>
</table>

The Targeted Outreach for Pregnant Women Act (TOPWA) provides free pregnancy testing at the DOH-Orange Immunology clinic if the woman agrees to be tested for HIV at the same time. The Nursing Program Specialist assigned to Prosperitas Leadership Academy, formerly known as Lifeskills Charter School, completes pregnancy testing on an as needed basis for the students attending the academy.

**Provider Recruitment**
The HSCOC Community Liaison visits health care providers and birthing facilities to provide education regarding the importance and benefits of completing the Healthy Start Risk Screening Instrument. On-going education, technical assistance and contacts are furnished to healthcare providers and hospitals in order to encourage screening of all pregnant women and newborns.
During this reporting period, there has been an increase in the number of medical providers for Orange County. 100% of the prenatal care providers and birthing facilities participated in the Healthy Start screening process.

<table>
<thead>
<tr>
<th>Inventory of Type of Provider</th>
<th>Number of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birthing Centers</td>
<td>2</td>
</tr>
<tr>
<td>Federally Qualified Health Center – Central Florida Family</td>
<td>4</td>
</tr>
<tr>
<td>Federally Qualified Health Center - Community Health</td>
<td>7</td>
</tr>
<tr>
<td>Department of Health Centers – Women’s Health</td>
<td>5</td>
</tr>
<tr>
<td>High Risk Clinics</td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td>4</td>
</tr>
<tr>
<td>Pediatricians*</td>
<td>536</td>
</tr>
<tr>
<td>Perinatologist</td>
<td>3</td>
</tr>
</tbody>
</table>

*Data Source: Dept of Medical Quality Assurance

**Community Education**

To improve community collaboration, community education and the identification of potential participants; partnerships with other community related groups who provide services to pregnant women and children were formed. These partnerships have been expanded with community organizations and businesses to increase community awareness of Maternal Child Health issues as well as Healthy Start and MomCare services and benefits.
Healthy Start staff participated and provided representation on the following committees, local inter-agency meetings, and boards:

External:
- Bithlo Christmas Neighborhood Center for Families Community Center
- Community Health Centers Family Planning Advisory Committee
- Fetal and Infant Mortality Review
- HSCOC: Resource Development Committee
- HSCOC: 2013 Annual Stroll for Life Planning Committee
- Infant Mortality Task Force
- Safe Kids Coalition
- Statewide Healthy Start Special Interest Group (SIG)
- Statewide Healthy Start Training Workgroup
- Winnie Palmer Hospital/DOH partnership meetings
- Winter Garden Health Alliance Access Committee

Internal:
- DOH-Orange Health Management System Steering Committee
- DOH-Orange Innovation Committee
- DOH-Orange Quality Council
- DOH-Orange Safety Committee
- DOH-Orange SharePoint Committee
- DOH-Orange Strategic Planning Workgroup
- DOH-Orange Training Committee
- DOH-Orange VOICE Committee

Our joint hospital based program with Vital Statistics and Healthy Start care coordination at Winnie Palmer continues to be a success. After birth, clients are able to purchase and immediately take the infant birth certificate home with them, while the Healthy Start care coordinator promotes screening, completes the initial contact and provides education to clients at their bedside while in the hospital. Families are encouraged to apply for Women, Infants and Children (WIC) services.

Participation in health and community fairs continues to offer an excellent opportunity to educate and inform the public about Healthy Start services and benefits. Literature and information about the Healthy Start/MomCare program is distributed at these events. Information and education on a variety of maternal and child health topics is provided including the importance of early prenatal care, SIDS, immunizations, pre/interconceptional care and the
importance of regular check-ups for children and adults. The health and community fairs and events in which staff participated are listed below.

- 2nd Annual Health and Wellness Fair
- 5th Annual “School Days Are Here Again” Back to School Event
- Babies R Us Community Fair
- Bithlo Neighborhood Center for Families Back to School Fair
- Fatherhood Press Conference
- HSCOC: 2012 Annual Stroll For Life
- Oakridge High School Resource Fair
- Prosperitas Academy Community Resource Fair
- The Summer Party Community Event
- Valencia Community College Health Fair
- Wraparound Orange “Healthy Minds....Healthy Lives Community Resource Event

<table>
<thead>
<tr>
<th># of Services provided</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Services</td>
<td>3,680</td>
<td>3,564</td>
<td>3,296</td>
<td>3,424</td>
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</table>

Data Source: HMCRS Data System Report GH330

In addition to community fairs and events, Healthy Start has three (3) certified passenger safety technicians that participated in car seat safety checkpoints in collaboration with Safe Kids Orange County. The purpose of these checkpoints was to demonstrate the proper manner of installing a child safety seat in the families’ car, as well as providing essential information on car seats and child health. The services and benefits of the Healthy Start/MomCare program are also promoted. This outreach activity is important in that traffic accidents continue to be a leading source of injury for young children. Many of the injuries could have been prevented and/or reduced if the car seat was properly installed. Studies have shown that 4 out of 5 car seats are improperly installed.
The car seat safety checkpoints are held regularly at the Burlington Coat Factory store on East Colonial Drive in Orlando, the Orange County Fire and Rescue Stations, Chick-Fil-A restaurants and other community locations. A total of fifteen (15) car seat checkpoints were held, one hundred sixty-five (165) car seats were checked and two hundred, seventy-one individuals (271), both adults and children, were educated on the importance of car seats and the proper way to install them.

According to Florida Charts, Orange County has the third highest rate for child passengers less than one year of age, injured or killed in motor vehicle crashes. In May 2013, the HSCOC received a grant from State Farm Insurance to provide car safety seats, education on car seat safety and instruction on proper installation of car seats in personal vehicles. In collaboration with the First Life Center for Pregnancy, First Baptist Church of Orlando, these classes and checkpoints were initiated on May 28, 2013 and continue to be held on the 2nd and 4th Tuesdays of each month.

![Chart 7: Motor Vehicle Crashes, Crude Death Rate, Ages 0-1, 3-Year Rolling Rates](image)

**MomCare**

Each Monday, a list from the Agency for Health Care Administration (AHCA) continues to be received of those pregnant women who have been approved for SOBRA Medicaid. The Maternity Care Advisor (MCA) contacts the assigned clients within 5 days to determine if they need help choosing a prenatal provider. They explain the goals and purpose of the MomCare program; how to access prenatal care and any wraparound services, such as childbirth education classes; determine if the client already has a prenatal care provider or needs assistance in identifying one; how to change providers if she is dissatisfied with the care she is receiving and how to register a grievance if needed. The MCA
will also encourage participation in the WIC program. The Healthy Start program is discussed and the client has the opportunity to be referred if she needs more in-depth care coordination. The MCA will also answer questions and address any concerns that the client has at the time of the initial contact. The MCA’s name and telephone number is given to the client so that the pregnant woman will have a point of contact if any issues come up during her pregnancy. If the MCA is unable to reach the client and cannot determine if she has a prenatal provider from other source within the first 30 days, the MCA will assign a provider and notify both the client and the provider of the selection. This contract year, the MomCare program served 14,292 pregnant women.
Administrative Screening Process

**Intake of Screening Forms**

Universal risk screening for pregnant women and infants is a key component of the Healthy Start program. Through this screening, factors which impact birth outcomes and healthy child development are identified and referrals are made for care coordination, follow-up, and other Healthy Start services. Prenatal and infant risk screening is the entry point for Healthy Start care coordination.

Healthy Start screening forms are processed in the client’s county of residence. Due to the close proximity of health care providers in surrounding counties, participants may receive their medical care in one county, but receive Healthy Start services in another. When screens are inadvertently sent to an incorrect county, they are forwarded to the appropriate Healthy Start program. When the prenatal and infant screens are received, they are date stamped, checked for accuracy, separated into referred and not referred and processed by the Healthy Start clerical staff within 5 working days of receipt. Any screening forms that are incomplete are returned to the health care provider for correction and/or completion. If it appears that there are on-going problems with a provider completing the screening form correctly, this information is shared with the HSCOC Community Liaison so that she can provide further training to those providers.

![Chart 10: Healthy Start Prenatal & Postnatal Screenings Processed](chart10.png)

Since Healthy Start is a voluntary program, screening rates are influenced by both the screening offer rates and the screening refusal rates. It is essential
that screening be offered in a manner that provides key information on risk, available services and encourages women to participate in the screening process. The goal is to encourage and empower families, whether this is the first pregnancy or the fourth infant born, to say “yes” to the completion of the Healthy Start screen when offered, and to help families understand the importance and benefits of early identification of risk factors. These rates are dependent on a partnership with public and private healthcare providers, as our goal is for all pregnant women to be screened at their initial prenatal visit and infants screened before their discharge from the birthing facility.

Chart 11: Healthy Start Prenatal Screening

<table>
<thead>
<tr>
<th>Year</th>
<th>Offered Rate</th>
<th>Screening Rate</th>
<th>Consent Rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08</td>
<td>96.68</td>
<td>81.96</td>
<td>84.78</td>
</tr>
<tr>
<td>2008-09</td>
<td>90.5</td>
<td>80.38</td>
<td>88.62</td>
</tr>
<tr>
<td>2009-10</td>
<td>92.36</td>
<td>86.98</td>
<td>94.17</td>
</tr>
<tr>
<td>2010-11</td>
<td>88.93</td>
<td>84.68</td>
<td>95.22</td>
</tr>
<tr>
<td>2011-12</td>
<td>83.99</td>
<td>79.84</td>
<td>95.06</td>
</tr>
<tr>
<td>2012-13</td>
<td>81.73</td>
<td>74.49</td>
<td>91.15</td>
</tr>
</tbody>
</table>

Data Source: Prenatal Executive Summary Report

Chart 12: Healthy Start Postnatal Screening

<table>
<thead>
<tr>
<th>Year</th>
<th>Screening Rate</th>
<th>Infants with positive screens</th>
<th>Consenting to HS Program participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08</td>
<td>67.77</td>
<td>16.74</td>
<td>89</td>
</tr>
<tr>
<td>2008-09</td>
<td>87</td>
<td>16.88</td>
<td>80.4</td>
</tr>
<tr>
<td>2009-10</td>
<td>82.04</td>
<td>16.67</td>
<td>91.05</td>
</tr>
<tr>
<td>2010-11</td>
<td>82.56</td>
<td>15.97</td>
<td>85.26</td>
</tr>
<tr>
<td>2011-12</td>
<td>89.16</td>
<td>14.16</td>
<td>75.11</td>
</tr>
<tr>
<td>2012-13</td>
<td>96.15</td>
<td>14.16</td>
<td>81.88</td>
</tr>
</tbody>
</table>

Data Source: Infant Executive Summary Report
Prenatal Screening

The Healthy Start Prenatal Risk Screening Instrument is administered during the first prenatal care visit. This instrument screens pregnant women for the presence of risk factors associated with adverse birth outcomes. These risk factors include the following:

- Age (less than 18)
- Race
- Tobacco use
- Alcohol use
- First pregnancy
- Marital status
- Trimester of pregnancy
- BMI <19.8 or > 35.0
- Educational level
- History of previous premature or low birth weight infant
- Feeling down, depressed or hopeless
- Undesired pregnancy versus desired
- Pregnancy interval less than 18 months
- History of chronic diseases

According to Florida Statute Chapter 383.14 and the Florida Administrative Code (F.A.C.), all prenatal screening instruments whether referred, not referred or declined screening, completed by prenatal providers are forwarded to the appropriate County Department of Health and are entered into the statewide Health Management System by Healthy Start clerical staff in less than five (5) working days of receipt. This information is used for data collection purposes. The “referred” screening forms are assigned to a care coordinator. The “not referred” and “declined” screening forms are filed.

![Chart 13: Healthy Start Prenatal Screening](chart_13.png)

Data Source: Prenatal Executive Summary Report
Infant Screening
The Healthy Start Infant Risk Screening Instrument is administered in the hospital or birthing facility at the time the infant is born. Infants are screened based on maternal risk factors including the mother’s age, race, marital status, involvement of father, time of entry into prenatal care, Medicaid as the principal source of payment, and use of tobacco during pregnancy. Neonatal risk factors include:

- Low birth weight
- Abnormal conditions of the newborn
- Transfer of infant within 24 hours of delivery

The Department of Vital Statistics compiles the infant screening information directly from birth certificates. At the state level, information from the birth certificates is compiled to identify risk factors, developing trends and to determine if the infant screening instrument needs modified. The Healthy Start infant screening form is populated with the demographic and risk information from the birth certificate using the E-Vault system. All the hospitals located in Orange County are using the E-Vault system to process birth certificates and Healthy Start infant screening forms. The infant screening forms are directly imported into the Health Management System from E-Vault. The Healthy Start clerical staff at the Florida Department of Health in Orange County print out the infant screening form for all births daily. Because of this system, infant screens are received overnight by the DOH-Orange. The “referred” screening forms are assigned to a care coordinator and demographic information is entered into the Health Management System in less than five (5) working days of receipt. The “not referred” or “declined” screening forms are filed. Birthing centers not using E-Vault will have families complete the infant screening form and will send the form to the appropriate County Department of Health for processing.
Points are assigned to each risk factor on both the prenatal and infant screening forms. A participant is eligible for Healthy Start Care Coordination if she scores a total of six (6) or more points on the prenatal screening form or four (4) or more points on the infant screening form. The health care provider may also refer clients who score less using their professional judgment. However, the participant also has the right to decline the Healthy Start screening process at any time.

Assignment of Healthy Start Screens
Intake staff, known as Human Services Counselors I’s, are assigned all screening forms, prenatal and infant, no matter what the score or risk is as referred by the healthcare provider. Staff makes the required contact attempts and, if unable to reach the client, gives the record to a supervisor who will determine if the case requires a face-to-face contact attempt based on the triage policy. If not, it is returned to the intake staff member to close after the appropriate deadline. However, the goal is to complete the initial contact to determine if the client is in need of on-going care coordination services. If this is determined, the client is transferred to a professional care coordinator who provides an initial assessment and more intensive services. This system allows the care coordinators the opportunity to provide risk appropriate care, while also ensuring that clients with lesser needs receive appropriate information and referrals to community resources. This has been effective in increasing the number of completed initial contact services.
Clients are assigned to professional care coordinators based on medical or social needs. Utilizing this criteria, clients with medical needs (e.g. substance exposed newborns (SEN), diabetes, birth defects, and low birth weight) are assigned to a Nursing Program Specialist, while clients with social needs are assigned to a Human Services Counselor II or III (e.g. teens, domestic violence).

<table>
<thead>
<tr>
<th>Type of Risk</th>
<th>Type of Care Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Substance Exposed</td>
<td>823</td>
</tr>
<tr>
<td>Social</td>
<td>0</td>
</tr>
<tr>
<td>Social</td>
<td>1,109</td>
</tr>
</tbody>
</table>

Care coordinators are assigned into seven (7) geographic teams. These teams are comprised of Nursing Program Specialists, Human Services Counselors II or III, and MomCare Maternity Care Advisors. Staff works together within each team to best meet the needs of the clients and transfer cases to the most appropriate care coordinator. Healthy Start supervisors are responsible for supervision of staff in either the west, central or eastern areas of the county.

In addition to the Healthy Start care coordination teams, Healthy Start staff are integrated into three (3) Florida Department of Health in Orange County Health Centers. The DOH-Orange provides Maternity and Family Planning services according to American Congress of Obstetricians and Gynecologists (ACOG) recommendations, Medicaid guidelines, Title X and DOH-Orange protocols. Low income families, including migrant and undocumented residents, are eligible for clinic services on a sliding scale fee for Family Planning services and maternity clients not eligible for Medicaid are encouraged to apply for the Prenatal Package. The following is a listing of DOH-Orange Women’s Health Centers and hours of operations:

<table>
<thead>
<tr>
<th>Site</th>
<th>Address</th>
<th>Hours of Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Prenatal Express Clinic</td>
<td>832 W. Central Boulevard, Orlando, FL 32805</td>
<td>Monday -Thursday 7:30am - 4:30pm; Fridays 7:30 – 11:30am</td>
</tr>
<tr>
<td>Eastside Health Center</td>
<td>12050 E. Colonial Drive, Orlando, FL 32826</td>
<td>Monday -Thursday 7:30am - 5:30pm; Fridays 7:30 – 11:30am (by appointment only)</td>
</tr>
<tr>
<td>Lake Underhill Health Center</td>
<td>5730 Lake Underhill, Orlando, FL 32825</td>
<td>Monday -Thursday 7:30am - 5:00pm; Fridays 7:30 – 11:30am (by appointment only)</td>
</tr>
<tr>
<td>Lila Mitchell Health Center</td>
<td>5151 Raleigh Street, Orlando, FL 32811</td>
<td>Monday -Thursday 7:30am - 5:30pm; Fridays 7:30 – 11:30am (by appointment only)</td>
</tr>
<tr>
<td>Southside Health Center</td>
<td>6101 Lake Ellenor Drive, Orlando, FL 32809</td>
<td>Monday -Thursday 7:30am - 5:30pm; Fridays 7:30 – 11:30am (by appointment only)</td>
</tr>
</tbody>
</table>
The Department of Children and Families (DCF) and their contracted providers refer newborns exposed to illegal or controlled substances to the Healthy Start Program. All substance exposed newborns (SEN) and their families are assigned to the Nursing Program Specialist responsible for the zip code where the newborn resides. The newborn could be residing with a foster family or another relative. The nurse will make every attempt to include the mother of the baby in the care coordination services offered to the infant, whether the mother lives under the same roof or not. These clients receive intensive services for the purpose of monitoring growth and developmental milestones, as well as prevention of abuse. Substance exposed newborns receive Healthy Start care coordination services for three years, unless the case is closed by DCF and the client declines further voluntary services. There were 135 new SEN referrals during this contract year.

Mothers receive support and health education on a one-to-one basis. Research has proven this to be the most effective factor in facilitating permanent changes in behaviors and actions. All SEN’s receive a head-to-toe unclothed examination and a thorough nursing assessment at each visit. Growth and development of infants are monitored closely through the use of the Ages and Stages Questionnaire (ASQ) and any deviations from the norm are referred for further evaluation. The nurse and the DCF Protective Investigator keep in close contact with one another in order to provide coordinated services to the infant and the family. The Department of Children and Families invites Healthy Start care coordinators to attend their monthly staffing for clients in their Specialized
Medical Unit which includes Substance Exposed Newborns, as well as infants with medical issues.

Substance use or abuse among pregnant women continues to present a significant challenge that impacts our community. As illustrated in Chart 17, the most commonly reported drug usage is marijuana followed by multiple drugs.

![Chart 17: Substance Exposed Newborn Reported Type of Drug Usage](image)

This does not necessarily reflect trends for Orange County since universal testing of mothers does not occur during pregnancy or after the birth of the infant. At present, only cases identified and reported by the Department of Children and Families, with a positive toxicology test are identified as an SEN. A concern is that hospitals are missing many SEN’s who should be identified and referred for services.
Case Management / Care Coordination –
MomCare and Healthy Start

MomCare
Periodically, the Maternity Care Advisor (MCA) will contact the client during her pregnancy. The MCA will try to contact those clients they were unsuccessful in contacting within the first 30 days. This additional contact will be between the 31st day and the 150th day the client is eligible to receive services. If mail has been returned, the MCA is required to contact the client to find out if she has moved and verify her new address. The MCA can also use the Florida Medicaid and WIC system to see if there is any new information on the client.

They attempt to contact those clients where information has been received that the client has not kept her prenatal appointment. The MCA establishes contact with the client to determine why they failed their appointment. A discussion with the client referencing barriers to prenatal care is ensued and the MCA will work with the client towards a solution. If the MCA discovers that the client has already delivered, miscarried or is receiving care from another provider, the prenatal health care provider and/or Medicaid is notified in order to update their records.

Starting in the 6th month of pregnancy, the client is contacted to determine if she is keeping her prenatal appointments, understands eligibility for Family Planning Medicaid, has chosen a medical provider for the infant, and knows how to activate the child’s Medicaid application after birth. The MCA will also assist her in choosing a provider for the infant. If the MCA is unable to speak to the client, information on Family Planning Medicaid and how to apply for her baby’s Medicaid along with a list of providers that provide health care services to infants is provided via mail. After the infant is born, the MCA will contact the client to determine birth outcomes. The record is closed when SOBRA Medicaid has ended.

The MomCare program uses an electronic record in which all documentation is entered into the MomCare Information System (MIS) system.
Healthy Start

Initial Contact
The initial contact is completed to determine whether ongoing care coordination is needed after screening pregnant women and babies for Healthy Start services has been initiated. Upon receipt of the screening form by the care coordinator, the initial contact with the client is attempted within five working days. When the client is contacted, the care coordinator provides services including information, support, referrals and education on various health related issues. Care coordination can be accomplished via home, clinic, office visit and/or telephone contact.

The initial contact is the gateway into Healthy Start services. A discussion takes place about the risks on the screening form that will impact the health outcomes of the pregnant woman or infant. Ways to decrease these risks are also discussed and referrals are given for appropriate services. At the initial contact visit, a determination is made as to the appropriate level of care the client will receive. This level may change upon further assessment of the client or as situations change.

Core Healthy Start services provided to clients at the initial contact includes:

- Assessment of ability to access medical care
- Family planning counseling
- Smoking cessation education
- Enhancement of parenting skills
- Nutrition education
- Education on sexually transmitted diseases
- Violence prevention
- Substance abuse counseling
- Ability to access food stamps and other social services
- Provision of bus passes for those with transportation problems
- Home visiting for support, education and counseling, and
- Enrollment in Childbirth Education and other Healthy Start classes

Upon completion of the initial contact with a client, a letter is sent to the medical provider informing him/her that their client is receiving Healthy Start services. These letters also identify the specific services the client will receive. If a client moves or is difficult to locate, the provider's office is contacted by telephone or mail to obtain a correct address. A call may be placed to WIC, as well as a
request for a search of the Department of Children and Families Economic Self-Sufficiency/Medicaid data base for client demographics. A letter is mailed to the client’s last known address on the premise that it will be forwarded to their new location and hopefully the client will then contact the care coordinator with the new address. After waiting the appropriate timeframe, if there is no response from either the client or provider, and no new information is discovered, the client is closed to Healthy Start. The medical provider is sent a letter informing them that the case is closed to Healthy Start.

4,805 pregnant women and 2,702 infants for a total of 7,507 families received an initial contact. This represents a fifteen percent increase in initial contacts from the previous fiscal year.

![Chart 18: Healthy Start Initial Contacts](image)

<table>
<thead>
<tr>
<th>Year</th>
<th>Prenatal</th>
<th>Postnatal</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2007-08</td>
<td>49.77</td>
<td>70.16</td>
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<td>FY2008-09</td>
<td>47.6</td>
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<td>FY2010-11</td>
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<td>FY2011-12</td>
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<td>79.52</td>
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<tr>
<td>FY2012-13</td>
<td>81.8</td>
<td>70.33</td>
</tr>
</tbody>
</table>

Data Source: Healthy Start Prenatal Executive Summary Report

**Initial Assessment**

The initial assessment can be completed at the time of initial contact, but, unlike the initial contact which can be completed over the telephone, the initial assessment must be completed in a face-to-face interview. If the initial contact is completed at a separate time, the initial assessment must be completed or attempted within ten (10) working days. Best practice indicates that initial assessment should be completed in the client’s home as this is the best way to assess the client’s situation. But the initial assessment can be completed anywhere the client is comfortable – at the clinic, doctor or WIC appointment, a friend’s home, the client’s school or work place, even at the library or a
restaurant. The level of care is re-evaluated and can be moved up or down based on the clients’ strengths, needs and safety risks.

Core Healthy Start services provided to the client at the initial assessment includes:
- Discussion of unresolved risk factors, corresponding need and potential change
- Client’s/family’s concerns, priorities and resources
- Child’s or women’s physical and emotional well-being, safety and general appearance
- Regular participation in on-going health care including past appointment history
- Compliance with recommended treatments such as bed rest, medicine, etc.
- Type of housing, age and gender or occupants and home environment
- Client/family knowledge, attitudes about pregnancy, childbirth, parenting and family life
- Mother and child interaction
- Potential for child abuse and neglect
- Plans to establish paternity, child support and father involvement, if unmarried
- Availability of a social support system
- Education on parenting, nutrition, family planning, exercise, breastfeeding, childbirth, disaster and safety planning, immunizations, pre-term labor and danger signs of pregnancy, smoking cessation education, second hand smoking information, shaken baby prevention, and SIDS risk reduction

832 pregnant women and 348 infants for a total of 1,180 families received an initial assessment. The Healthy Start prenatal initial assessment rate increased from 70.16% to 81.09%. The percentage of postnatal initial assessments also increased from 85.86% to 99.43%. After the initial contact is completed by paraprofessional staff, a commitment to ongoing services is discussed with the client, which increases the percentage of clients receiving services. Professional care coordinators receive records for those clients determined to be in need of an in depth assessment and provide education, information and referrals to community resources.
Levels of Care
Frequency of care coordination contacts is determined by the acuity of the participant’s level of care. A level of care is assigned to each participant at the time of the completion of the initial contact. The level of care is re-evaluated at the initial assessment and at each on-going contact. The level of Healthy Start care coordination may increase or decrease in intensity depending on clients’ circumstances and as they accomplish various goals.

Some of the factors to be considered when determining the level of care are as follows:

- Participants’ or family’s desires
- Participant’s risk level
- Immediacy of need
- Professional judgment
- Local targeting policies and resources
- Collaboration with the family
- Availability of other providers of care coordination in the community
- The client’s or family’s motivation to change

The levels of care include:

- Level P
  These are clients that have been referred to a care coordinator and the level is still pending because the care coordinator is still in the process of trying to reach the client, the client refused to complete an initial contact with the care coordinator, or the record has been closed as “unable to locate.” The record is closed only after every effort to contact the client is made (per Healthy Start Standards and Guidelines) and documented, including letters,
telephone calls and attempts to make face-to-face contact. Care coordinators have been trained on how to conduct a diligent search of various public domain websites to obtain additional ways to contact the client. A Healthy Start record that has been assigned to one of the care coordinators cannot be closed until a minimum of three (3) attempts to contact has been made.

- **Level E**
  These are clients who require only an initial contact; although an initial assessment may also be completed during the same encounter. Education, counseling, and referrals to community resources may be given. These clients are typically self-sufficient and the record is closed after one (1) direct service encounter.

- **Level 1**
  These are clients with low need for Healthy Start services. Clients typically function fairly independently, but may not have adequate knowledge about community resources or may have additional barriers accessing, participating in or coordinating services for themselves or their child. Clients require short-term follow-up on the ability to successfully access services. There should be one (1) encounter by the second month of service. Clients do not stay in this level longer than four (4) months before a determination is made to close to Healthy Start services or reassign to a higher level if services continue to be necessary. Education, counseling and referrals to community resources are given.

- **Level 2**
  These are clients with medium need for Healthy Start services. Clients typically function fairly independently, but may not have adequate knowledge about community services or may have additional barriers accessing,
participating in or coordinating services for themselves or their child. These clients receive an initial contact and assessment. Care coordination is necessary, as the client needs additional education, counseling, support, and referrals to community resources. There should be at least one (1) encounter every thirty (30) days.

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**Level 3**

These are clients who need intensive Healthy Start services. The clients and/or their families are experiencing multiple concerns and need frequent service coordination. Safety concerns and crisis intervention are often characteristics of clients at this level. Education, counseling, support and referrals to community resources are given. A family support plan is initiated and is updated at each encounter. There should be two (2) encounters every thirty (30) days for these clients.

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All Level 2 and Level 3 clients receive face-to-face ongoing care coordination services.
Individual Plan of Care
The Individual Plan of Care (IPC) is initiated at the time of the initial contact, updated at the initial assessment, and reviewed or updated at each completed encounter. It is a written plan of identified needs, goals, interventions, and progress towards meeting the goal(s) based on the care coordinator’s evaluation of the client risks and needs. It also reflects future plans that the care coordinator has made with the assistance of the client. The IPC can be completed or updated during a face-to-face contact or over the telephone.

Family Support Plan
The Family Support Plan (FSP) process is utilized for those clients determined to require the most intensive level of intervention services (Level 3 clients). It must include active participation of the client. The client, with the assistance of the care coordinator, sets goals, designs an individualized FSP, and approves via signature after completion of the form. This initial meeting must be a face-to-face meeting. A copy of the FSP is then retained by the client. The support plan may be altered as needs change and as the client and care coordinator develop a higher level of trust. All plans are reviewed and updated with information from the client at each face-to-face encounter after that. The FSP can only be updated when the client and care coordinator are in a face-to-face interview, but can be reviewed with the client by telephone.

Ongoing Care Coordination
The care coordinator plans all prenatal and postnatal services with the client at the time of the initial contact or after performing an initial assessment. Ongoing care coordination may include any of the above services and/or the following activities:
- Initial and on-going identification of:
  - participant or family concerns
  - priorities
  - strengths and resources
- Reinforcing the health care regimen
- Providing anticipatory guidance
- Advocacy on behalf of the participant and family

Potential referrals and options are discussed together with the client/family and the best resource for the family is selected. The participant is given the information necessary to access the service. The client and/or the care coordinator then contact the outside organizations or agencies. This can occur during the initial contact, the initial assessment visit or at a later time. Joint home visits are made with the referral agency if this is in the best interest of the
client or if requested by the referral agency. The care coordinator contacts the referral agency to discuss assessment information, to monitor, and to follow up on services provided with the client’s permission. The care coordinator and the client discuss the progress achieved and the resulting effectiveness in meeting the client needs. This is an on-going process as needs and goals evolve.

All referrals are noted on the IPC form or the single agency FSP form. Both forms are updated at each visit/contact noting if the participant obtained the needed service and the level of satisfaction with the provider of that service. Referrals are also documented in the Health Management System and tracked as to their outcome.

Needs and concerns of the client as well as appropriate risk factors are noted on the IPC or FSP. At each contact, these areas are addressed and documented with the client again.

Post-partum/family planning services are included to encourage pregnancy spacing and to ensure that clients have access to continuous family planning services.

Individual documentation records one-on-one education and support services (e.g. breastfeeding, parenting, smoking cessation and interconceptional counseling). These services are on-going and provide the care coordinator the opportunity to provide education in the home and offer healthy lifestyle choices.

Appropriate closure to Healthy Start includes: those lost to follow-up, unable to locate, no further services needed, transferred to another provider, moved out of county or state, ineligible for services or declines services. At the time of closure, the care coordinator explores on-going support with participants.

In addition to the provision of Healthy Start care coordination, Healthy Start staff provide follow-up for Healthy Start maternity clients if they receive information that the client has not kept their maternity care appointment. The care coordinator establishes contact to determine why they failed their appointment and how to decrease the barriers that prevented her from receiving care. If care coordination staff discovers that the client has already delivered, has miscarried or is receiving care from another provider, the prenatal care provider is notified in order to update their records.

All the services are recorded in the Health Management System by the care coordinator within three (3) business days from the date of service. A care plan report is printed out and included in the client’s record. This report shows all the services coded to an individual client, the date of service, the number of
services and the documentation of comments describing the service and what took place. For this reporting period, 11,795 women and infants received a Healthy Start service. This represents an 11% increase in services.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total # of Clients Served</th>
<th># Pregnant Women</th>
<th># Infants</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08</td>
<td>12,754</td>
<td>7,484</td>
<td>5,269</td>
</tr>
<tr>
<td>2008-09</td>
<td>10,779</td>
<td>7,081</td>
<td>3,694</td>
</tr>
<tr>
<td>2009-10</td>
<td>12,422</td>
<td>7,804</td>
<td>4,596</td>
</tr>
<tr>
<td>2010-11</td>
<td>11,790</td>
<td>7,996</td>
<td>3,724</td>
</tr>
<tr>
<td>2011-12</td>
<td>10,642</td>
<td>7,752</td>
<td>2,811</td>
</tr>
<tr>
<td>2012-13</td>
<td>11,795</td>
<td>7,509</td>
<td>4,223</td>
</tr>
</tbody>
</table>

Data Source: Healthy Start Prenatal, Postnatal & Inter-conceptual Care Executive Summary Report

**Care Coordination Activities**

Adherence to time frames specified in the Healthy Start Standards and Guidelines manual written by the Department of Health occurs in the provision of all services. Only approved forms are utilized in completing and documenting the service plan and care coordination activities. All Healthy Start staff receives extensive training in Healthy Start policies, procedures and utilizes the Healthy Baby Curriculum and Healthy Start Protocols in the Keep It Simple Series, *The Guide to Pregnancy* and *The Guide to Baby and Child Care*.

**Care Coordination Record**

The Healthy Start record includes: the screening form, initial contact form, initial assessment form, Individual Plan of Care, Family Support Plan if Level 3, care plan report summaries, and copies of correspondence with providers and clients. All care coordinators enter client information directly into the Healthy Start Module in the statewide Health Management System computer program. Copies of the electronic forms are printed out and placed in the client’s record. These records are confidential and handled according to DOH-Orange Security and Confidentiality protocol. Following the Healthy Start Standards and Guidelines, the Healthy Start supervisors, with input from staff, determine which forms and information are included in a client record and how the care coordination record
is formatted. The Healthy Start program is moving towards utilizing the Electronic Health Record (EHR) and is working diligently with the Information Technology DOH-Orange to achieve this. The program is also working with the Electronic Health Records Committee to determine the best way to utilize the modules already in the Health Management System. All equipment and educational materials meet satisfactory standards to provide quality service. Health education materials are available in English, Spanish and Creole.

DOH-Orange continues to provide data to the Healthy Start Coalition of Orange County for data analysis and evaluation. The Healthy Start/MomCare program is developing surveys and procedures so that participants of the various classes and care coordination/case management can access the surveys on-line. This will provide the Healthy Start/MomCare program and Coalition with more accurate data to better evaluate and monitor the services that clients receive.
Initiatives

Integration of Care Coordination Services
Healthy Start Human Services Counselor I’s are located at the Lila Mitchell and Southside Health Centers, and the Central Prenatal Express Clinic. Their responsibility is to interview the client and complete the prenatal screening form. If the client accepts Healthy Start participation and is referred to the program, the Human Services Counselor I completes the initial contact and determines if the client needs further assessment by a professional care coordinator. If she determines that the client does not need further assessment, the initial contact is completed and the client is provided information, education, and referrals to community agencies and other Healthy Start services needed to ensure a healthy pregnancy. The care coordinator gives the client her name and telephone number so that if the client has any questions or concerns during their pregnancy, they have a point of contact. The care coordinator also works closely with the DOH-Orange health center staff to provide care for all clients. They will also act as translators as needed. If the clinic staff is unable to contact a client with a medical issue, a Healthy Start care coordinator is requested to make a home visit to locate the client and give her the needed information.

A Human Services Counselors I and a Senior Licensed Practical Nurse share care coordinator responsibilities at Winnie Palmer Hospital. Daily they receive notification of clients who are referred to Healthy Start from the Birth Registry. All clients are contacted, either at the bedside if the mother and baby have not been discharged or by telephone if they have left the hospital. During this encounter they will complete the initial contact, and if the client needs further assessment they will refer the client to either a Nursing Program Specialist or Human Services Counselor II or III. If the client does not need any further services, because the family strengths exceed their risks or the client declines services, the care coordinator provides the family with information, education and referrals ensuring that the family has all the information needed to make informed decisions about the infant’s continued health. The two care coordinators completed 1,139 initial contacts at Winnie Palmer from July 1, 2012 to June 30, 2013.

Effective April 2013, a Nursing Program Specialist was assigned to Winnie Palmer Hospital to provide care coordination for infants who have been admitted to the Newborn Intensive Care Unit (NICU). This nurse will complete with the
families an initial contact, initial assessment, and will provide follow-up care coordination as long as the infant remains in the NICU. Once the infant is discharged, the nurse will contact the family to assess how the family is coping and if they want to continue Healthy Start services. If the family does not want any further services, the record will be closed. However if the family wants to continue services, the record will be transferred to the Nursing Program Specialist assigned to the family’s zip code. This nurse also assists the other care coordinators at Winnie Palmer in providing services to families whose infants are not in the NICU. During the period of April 2013 through June 2013, the nurse completed forty-three (43) initial contacts, of which nineteen (19) received on-going care coordination.

The Orange County Female Detention Center provides medical care to incarcerated pregnant women. The facility is equipped with a total of 652 beds. The Healthy Start program uses outreach care coordination services to increase access to and receipt of maternity services. A Human Services Counselor II is assigned to the Orange County Female Detention Center on a part-time basis. She goes to the detention center every week to provide care coordination services to the pregnant inmates. She completes the prenatal screening form, initial contact, initial assessment and will follow up with the pregnant woman until she is released from incarceration. At that time, the client is contacted to determine if she wishes to continue Healthy Start services, ensuring that she continues with prenatal care and refers her to different agencies for needed services. If she wants to continue services, this counselor will either keep seeing the client at her home or transfer the record to the care coordinator assigned to the client’s zip code. If the client has re-located out of county, the record will be transferred to the appropriate Healthy Start Coalition. During this fiscal year, fifty-five (55) pregnant women received care coordination services while incarcerated.

![Chart 24: Healthy Start Female Detention Center Care Coordination](image)
In September 2012, an initiative was started in collaboration with The Birth Place (a birthing center in Winter Garden) to record wraparound services to their patients. The Birth Place will send a printout to the Healthy Start program showing client’s name and the services provided at each visit. The Healthy Start clinical staff will input these services into the DOH-Orange Health Management System.

A Nursing Program Specialist is assigned to the Prosperitas Leadership Academy, formerly known as Lifeskills Charter School. The students attending this center are at risk of dropping out of school. The nurse provides intensive care coordination services (initial contact, initial assessment, and follow up) to pregnant and inter-conceptual teens. Inter-conceptual teens are young women who are not pregnant and have either experienced a loss (miscarriage, stillborn, or infant is no longer in the home through death, adoption or legal issues) or they are parenting a young child. These clients have many risks that impacted their recent pregnancy or a future one. By working with the nurse, teens receive information, education, referral and, most of all, support to make healthy decisions about their pregnancy, infant, and future. If they do not come to school, the nurse will contact them to find out the reason they have missed class and if needed a home visit is conducted. Together, they address the barriers and find a solution. If the client has left the Prosperitas Leadership Academy, the nurse will contact her to find out if she is still interested in receiving Healthy Start services and if so, will transfer the record to the care coordinator assigned to the client’s zip code. If not, the record will be closed until the client returns to the Prosperitas Leadership Academy. A total of thirty (30) clients received care coordination services at the Prosperitas Leadership Academy during this contract year. 90.9% (ten (10) out of eleven (11)) pregnant teens followed by the nurse had healthy deliveries. One (1) delivered a stillborn infant. Three (3) of these clients graduated as they remained in school and met graduation requirements. The remaining are freshmen’s, sophomores and juniors.
The Sisters Companeros provide Healthy Start services at the Apopka Family Health Center. They complete the prenatal screening form, interview the client, and complete the initial contact. They do not have access to the Health Management System so they complete everything in writing and courier the screening form and initial contact to the Healthy Start program. Services and documentation is recorded by program staff. If the client needs further assessment, the record is transferred to the care coordinator who is assigned to the client’s zip code. If the client needs no further services, the initial contact is inputted with the services and documented. A record is made and filed to be archived at a later date. Clients receive information on their risks and how to decrease them through education on pre-term labor, baby spacing, birth control, SIDS, and shaken baby. They also receive a referral to the WIC program. One hundred, thirteen (113) initial contacts were completed at the Apopka Family Health Center this fiscal year.

**Healthy Start Mall**

The Healthy Start Mall was started in July 2008 as a result of feedback and assessment that the Healthy Start Coalition conducted with care coordinators. Staff shared that clients should be able to earn something for accomplishing steps towards their goals for themselves and their babies. Clients earn points for various activities, such as keeping appointments with their care coordinator or medical provider, attending childbirth education, breastfeeding or parenting classes, taking their prenatal vitamins, or keeping their infants’ immunizations up-to-date. They can redeem these points for items from the Healthy Start Mall. Some of the items include: a pack of washcloths, pacifiers, infant...
bodysuits, a pack of diapers, Tummy Time mats, or a Boppy Pillow. The more expensive the item, the more points the client will need to redeem. A committee of care coordinators met this year to re-evaluate the point system and the activities to earn points, as well as reviewed the items the clients can receive. Although some changes were made to both the activities and items, the goal to reward the clients for all their successes, both large and small, was maintained. During this fiscal year, participants redeemed three hundred, thirty-five (335) items from the Healthy Start Mall.
Other Healthy Start Services

Every Healthy Start participant with targeted risk factors (defined as: teen client, domestic violence, substance abuse, low birth weight, an illness that requires continuing medical care, and those clients who lack basic needs) receives a home visit. During the home visit, the care coordinator provides the participant with information on parenting education, the dangers of smoking, second hand smoke and breastfeeding counseling and support. Prenatal participants and their significant other/coach are invited to participate in childbirth education classes, Boot Camp For New Dads, and the Happiest Baby on the Block classes. All participants, if applicable, are offered psychosocial counseling and referred to the Therapeutic Intervention Program (TIP) through Lakeside Behavioral Healthcare. They are also encouraged to attend the Healthy Start Parenting classes and the Car Seat Safety class. If there are any other needs, clients are referred to other agencies or organizations for further education, counseling and support where appropriate. Clients with identified problems receive early intervention services, thus reducing medical costs for individual families as well as the community. Other Healthy Start services include:

Nutrition Assessment and Counseling
Care Coordinators encourage the “5 A Day” program with added emphasis on nutritional needs of the pregnant woman. Protocols for instructing clients on infant nutrition are followed per their health care provider.

All Healthy Start clients are referred to WIC at the initial contact and, if provided on-going care coordination, the referral is tracked until the client either receives or declines WIC services. These services are provided at various WIC locations throughout Orange County. During the first certification appointment for WIC, the nutritionist provides dietary counseling services. If the care coordinator feels the client needs additional counseling, she will communicate this to the WIC supervisor at the site the client is receiving services and additional education will be provided to the client. An example of this is when a client is diagnosed as having gestational diabetes. Also, if a counselor is following this client, she will transfer the client to a nurse to provide medical instruction to the client.

Psychosocial Counseling
The Healthy Start Coalition of Orange County contracts with Lakeside Behavioral Healthcare to provide psychosocial counseling to Healthy Start clients throughout Orange County through the Therapeutic Intervention Program (TIP).
Three (3) mental health counselors provide in home counseling to those clients identified with a variety of mental health concerns such as depression, relationship problems, and anger management issues. Although individual counseling usually takes place in the client’s home, it can also be conducted wherever the client feels comfortable – in the counselor’s office at Lakeside Behavioral Healthcare or a friend’s home for example. During this fiscal year 4,538 counseling services were provided. In 2012, the TIP mental health counselors conducted group therapy sessions with nine (9) students from the Prosperitas Leadership Academy. Five (5) of the students were pregnant and four (4) were Inter-conceptual clients.

### Chart 26: Psychosocial Counseling

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<th></th>
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<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
</tr>
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<tbody>
<tr>
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<td>3,879</td>
<td>3,427</td>
<td>4,026</td>
<td>4,538</td>
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Data Source: HMCRS Data System Report GH330

**Parenting Education and Support**

Care coordinators offer parenting education during home visit(s). This can include SIDS, Back to Sleep, and Shaken Baby information. The care coordinators also utilize the Ages and Stages Questionnaire 3 (ASQ3) to provide parents with information on how their baby is meeting developmental milestones. These include communication, gross motor coordination, fine motor coordination, problem solving and personal-social milestones. This questionnaire is completed with the assistance of the parents and a copy of the summary is sent to the child’s medical provider to assist in the health care of the infant. The questionnaire is completed every two months starting at two months of age.
The Healthy Start Health Educator provides monthly parenting classes to Healthy Start and MomCare clients. These classes started in February 2013. Topics that are discussed are as follows:

- Basic Baby Care
- Car Seat Safety and Safety in the Home
- Sudden Infant Death Syndrome and Risks of Tobacco
- Benefits of Breastfeeding and Benefits of Folic Acid
- Birthing Techniques and Developmental Milestones
- Positive Thinking

Five (5) classes have been held and eighteen (18) Healthy Start and MomCare participants attended. When the Health Educator followed-up with the clients, who were registered but did not attend, the barriers identified were childcare and/or transportation, even though bus passes are available and attendance of infants and siblings is not prohibited. The classes have since been opened to the community to see if attendance will improve.

Community Partnership Classes

The Healthy Start Health Educator provides parenting classes in the community. These classes provide information and education on topics such as SIDS, Car Seat Safety, Breastfeeding and Developmental Milestones in Infants in group settings. The classes have been held at the Prosperitas Leadership Academy, the Center for Pregnancy, DOH-Orange Maternity Centering Group, Accept Pregnancy Center, A Center for Women and other community agencies. Education is also provided on infant care and car seat safety during the final childbirth education class at the Orlando Health-Health Central Hospital. Ninety-three (93) classes have been completed with five hundred, sixty-four (564) participants receiving this essential education. In addition, the health educator has presented information on the Healthy Start and MomCare programs to
various groups to inform them about the services and benefits of the program and how to make a referral. Fourteen (14) presentations were given with two hundred, seventy-two (272) individuals receiving information on the Healthy Start and MomCare programs.

The Health Educator also provides “Shower Power” to Healthy Start/MomCare pregnant women. She attends client’s scheduled baby showers and provides information and education to guests in the form of games and a health education presentation on SIDS and/or car seat safety. The client receives a $25.00 gift certificate for allowing Healthy Start the opportunity to educate her shower attendees. The Health Educator attended eighteen (18) Shower Powers and educated three hundred, eighty-five (385) attendees this year.

Orange County Sudden Infant Death Syndrome (SIDS) rate doubled since last year. The Healthy Start program has three (3) certified SIDS educators. They provide SIDS education at childbirth education classes and are available to provide it at various community agencies and schools in Orange County as requested. SIDS education is also an integral part of Boot Camp for New Dads. The risks of co-sleeping are also discussed. SIDS was presented at twenty-five (25) childbirth education classes and three hundred, twenty-three participants (323) were educated on how to reduce the risk of SIDS.

![Chart 29: SIDS Death (Single-Year Rates)](chart.png)

**Orange County Female Detention Center**

The Healthy Start program has a Human Services Counselor II assigned to provide health education classes to the pregnant women incarcerated in the Orange County Female Detention Center. These classes are open to any incarcerated pregnant and childbearing age women and deal with a wide variety
of topics, including but not limited to, interconceptional care, nutrition during and after pregnancy, family planning, parenting and relationships. The Counselor encourages open discussion on the topics, and classes are participant driven with women giving suggestions for future classes. Additionally, since the women see the Counselor II in another less formal setting, communication has increased with the care coordinator after their release from jail. During the period of time that the Counselor II was not available to facilitate these classes, the Health Educator was able to step in and provide the classes to these at-risk women. During this contract year, thirty (30) classes were held and two hundred, twenty-four (224) women received education.

**Boot Camp for New Dads Workshops**

A Healthy Start male care coordinator teaches these workshops. They are part of the childbirth education classes at the Woodhill Apartments, Florida Hospital East (English class) and Orlando Health-Health Central Hospital. A partnership was also created with Orlando Regional Juvenile Detention Center to conduct classes twice a month. However, due to decreasing attendance, the Boot Camp at the Juvenile Detention Center was discontinued in September 2012 and the Boot Camp at Woodhill Apartments was ended in January 2013. Boot Camps remain an integral part of the childbirth education classes at Florida Hospital East and Orlando Health-Health Central Hospital. The Healthy Start Coalition of Orange County also has a Boot Camp for New Dads facilitator. The two facilitators work closely together to refer fathers to each other’s classes when appropriate and participate in community events. “Boot Camp for New Dads” prepares men to be dads in all respects, starting with holding and comforting a real baby. Dads learn how to burp, change diapers, swaddling as well as “trouble shooting techniques” for crying babies, etc. Dads are also taught how to deal with a broad set of issues including bonding, balancing work hours, forming a parenting team, safety, preventing child abuse, interacting with relatives and more.

Ninety-eight (98) male participants attended seventeen (17) “Boot Camp for New Dads Workshops”. 93.8% of satisfaction surveys were returned and a 100% strongly agreed/agreed that the workshops provided good information and were worth recommending to someone else. This information is pertinent to the facilitator that is part of the Healthy Start/MomCare program.
"Happiest Baby on the Block" parenting classes are provided for Healthy Start and non-Healthy Start participants. They are held once a month on Mondays from 6:30 p.m. to 8:30 p.m. at the DOH-Orange Health Center with the last class held at the Orlando Health-Health Central Hospital. These classes are free to Healthy Start and MomCare clients and are provided to general population at $10.00 per class. The “Happiest Baby on the Block” is a national program developed by Dr. Harvey Karp, noted pediatrician and child development expert. Class participants learn amazing secret used for centuries by the world’s top parents... the calming reflex. This extraordinary reflex is literally an “off-switch” for baby’s crying and “on-switch” for sleep. One hundred, ninety-five (195) participants learned these remarkable techniques during this contract year.
In addition to the class, parents also receive a complimentary “Happiest Baby on the Block” kit which includes a “Super Soothing Sounds” CD. These incentives continue to be made possible with funding from the Early Learning Coalition. One hundred, thirty-six surveys were returned and 100% rated the class as either “excellent” or “good”. A sampling of the comments written by the participants is as follows:

- “Good review since it’s been 8 years since I had a baby.”
- “I benefited from the information about swaddling and also keeping the baby calm with the side stomach position.”
- “Gave me a sense that I have useful tools to not become overwhelmed.”
- “I liked how quickly and easily you can soothe and calm a baby. Since this is my first baby, I was unsure of what to ask. Everything was very informative to me.”

**Childbirth Education**

Since the Healthy Start Coalition of Orange County believes that every pregnant woman should receive information on labor and delivery; childbirth education classes are available for Healthy Start, MomCare and non-Healthy Start participants. A change that was started this year was that the class series is free to Healthy Start and MomCare participants and are offered to the general public for $25.00/class series. Presentations are given on breastfeeding, nutrition, immunizations, SIDS, fatherhood, labor and delivery, medications given during delivery, post-partum and infant care. For the seven class series, classes are three (3) hours in length and are held for four (4) consecutive weeks. In March 2013, a one-day Saturday class was added at the Orlando
Health- Health Central Hospital site. This addition was initiated due to the response from clients and care coordinators stating that weekend classes were needed for those pregnant women and coaches who worked during the week. Classes are held continuously during the year at the locations and times shown in Table 5.

### Table 5: Childbirth Education Classes Location and Times

<table>
<thead>
<tr>
<th>Site</th>
<th>Address</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOH-Orange Central Health Center</td>
<td>832 W. Central Blvd., Orlando, FL 32805</td>
<td>Thursdays 6:30pm - 9:30pm</td>
</tr>
<tr>
<td>DOH-Orange Southside Health Center</td>
<td>6101 Lake Ellenor Dr., Orlando, FL 32809</td>
<td>Wednesdays 6:30pm - 9:30pm</td>
</tr>
<tr>
<td>Orlando Health - Health Central Hospital</td>
<td>10,000 W. Colonial Dr., Ocoee, FL 34761</td>
<td>Tuesdays 6:30pm - 9:30pm and 3rd Saturdays 9:00am – 4:00pm</td>
</tr>
<tr>
<td>Florida Hospital East (English Class)</td>
<td>7727 Lake Underhill Rd., Orlando, FL 32822</td>
<td>Fridays 7:00pm - 10:00pm</td>
</tr>
<tr>
<td>Florida Hospital East (Spanish Class)</td>
<td>7727 Lake Underhill Rd., Orlando, FL 32822</td>
<td>Mondays 6:00pm - 9:00pm</td>
</tr>
<tr>
<td>Winter Garden Health Alliance</td>
<td>210 E. Plant Street, Winter Garden, FL 34787</td>
<td>Tuesdays 6:30pm - 9:30pm</td>
</tr>
<tr>
<td>Florida Hospital Orlando</td>
<td>2520 North Orange Ave., Orlando FL 32803</td>
<td>Fridays 6:30pm - 9:30pm</td>
</tr>
<tr>
<td>Woodridge Apartments</td>
<td>7351 Woodridge Park Dr., Orlando, FL 32818</td>
<td>Thursdays 6:30pm - 9:30pm and 9:00am – 4:00pm</td>
</tr>
</tbody>
</table>

Eight hundred, eighty (880) participants attended childbirth classes and 9,612 services were provided. Three hundred, eighteen (318) satisfaction surveys were returned showing that 100% of the participants rated the classes as “excellent” or “good”. A sampling of comments written by participants is as follows:

- “I liked the overall information given. I have learned so much and appreciate this class.”
- “All of the classes offer very important information that have helped me to be prepared for the arrival of my baby. The baby’s dad has also been able to learn a lot.”
- “She answered questions I wouldn’t think to ask.”
- “I liked the open feeling of the class. I felt extremely comfortable asking questions and giving my opinion on topics we discussed.”
Chart 31: Childbirth Class Participation by Site

Data Source: Class Attendance Sign-in Sheets

Chart 32: Childbirth Education

Data Source: HMCRS Data System Report GH330
Breastfeeding Education and Support

Care Coordinators provide breastfeeding education and support during the home visit on an individual basis.

Clients are referred to breastfeeding classes taught by the DOH-Orange Lactation Specialist and Peer Counselors. These classes are available at a variety of times and locations to accommodate the needs of pregnant women who are considering breastfeeding. The classes are also provided in English, Spanish and Creole.

The DOH-Orange Lactation Specialist or Peer Counselor also provides breastfeeding information during one of the childbirth education classes. Mothers breastfeeding initiation increased from 86.6 in 2011 to 89.3 in 2012.
Smoking Cessation Counseling

Care Coordinators provide counseling in the home using the “Make Yours A Fresh Start Family” program and the “5 A’s” program. This encourages participants to quit smoking, and to inform them of the dangers of second hand and third hand smoke to themselves, as well as their fetus/infant.

Care Coordinators provide clients with information/referrals regarding the “Quit Line”, a telephone-based smoking cessation program sponsored by the Florida Department of Health that has helped thousands of people double their chances of quitting for good. Births to mother’s who smoked during pregnancy decreased from 7.4 in 2011 to 6.7 in 2012.

Before July 2013, care coordinators were trained that they could code smoking cessation education if they reviewed the risks of smoking with the client and family. Included in the discussion would be a review of the risks of second and third hand smoke. At the refresher training in July 2013, the trainer explained that smoking cessation counseling could only be coded if a specific curriculum, such as the 5 A’s or “Make Yours A Fresh Start Family” was used. This coding change caused the number of services to decrease for this fiscal year.
**Inter-conceptual Care Counseling**

Care coordinators provide education and counseling on inter-conceptual care to pregnant women and women who are between pregnancies. This counseling addresses risk factors for poor infant and maternal outcomes in subsequent pregnancies. In addition, the education also supports the woman in maintaining lifelong health for herself and her family. Topics include access to healthcare, baby spacing, nutrition (including folic acid education), physical activity, healthy relationships, maternal infections (including periodontal disease), chronic health conditions, substance abuse, smoking, mental and emotional health and environmental risk factors. This fiscal year, 10,892 inter-conceptual services were provided.

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**Chart 38: Breastfeeding Education and Support**

<table>
<thead>
<tr>
<th>Year</th>
<th># of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-10</td>
<td>3,896</td>
</tr>
<tr>
<td>2010-11</td>
<td>3,966</td>
</tr>
<tr>
<td>2011-12</td>
<td>7,712</td>
</tr>
<tr>
<td>2012-13</td>
<td>8,055</td>
</tr>
</tbody>
</table>

Data Source: HMCRS Data System Report GH330

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**Chart 39: Mothers Breastfeeding Initiation**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>84.9</td>
</tr>
<tr>
<td>2010</td>
<td>86.8</td>
</tr>
<tr>
<td>2011</td>
<td>86.6</td>
</tr>
<tr>
<td>2012</td>
<td>89.3</td>
</tr>
</tbody>
</table>

**Orange**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>78.8</td>
</tr>
<tr>
<td>2010</td>
<td>80.1</td>
</tr>
<tr>
<td>2011</td>
<td>79.6</td>
</tr>
<tr>
<td>2012</td>
<td>81.0</td>
</tr>
</tbody>
</table>

Data Source: Florida Charts
Community Involvement and Collaborations

Healthy Start continues to be actively involved in promoting collaborative efforts in the community. A community linkage has been developed with other social service agencies to ensure that a system of care is available for Healthy Start clients.

The following list identifies some of the community programs to which the Healthy Start and MomCare care coordinators refer clients and their relationship with the Healthy Start/MomCare Program:

Counseling
Lakeside Behavioral Healthcare, Catholic Charities, BETA (for teens), Metropolitan Urban League, and Devereux provide individual, marriage and family comprehensive mental health and substance abuse counseling.

Crisis Services
Family Source of Florida Crisis Assistance and Life Line of Central Florida provide clients with 24 hour assistance in a crisis situation.

Education
Orange County Public Schools, B.E.T.A., Frontline Outreach, High School Teen Moms Program, the Drop Back In program and Orange County Department of Community Affairs provide educational programs and lifelong learning for teens and adult clients. In addition, classes in English as a second language are provided.

Emergency Financial/Clothing/Food Assistance
The Hope Program, Loaves and Fishes, JMJ Life Center, Mustard Seed, B.E.T.A., Human Crisis Council, Catholic Charities, Christian Service Center, Department of Children and Families Economic Self-Sufficiency and Orange County Social Services Department provide Healthy Start clients with short-term assistance, if they meet eligibility criteria. Low-income county residents are assisted in restoring their social and economic independence. These agencies will also assist clients with clothing, baby food and formula.

Employment/Job Training
The Agency for Workforce Innovation, Metropolitan Urban League, the Goodwill Self-Sufficiency Center, Orange County Public Schools and Vocational Technical Schools provide clients with marketable skills, assessment, career counseling, job training and assistance in obtaining employment.
**Legal Assistance**
GOALS (Greater Orlando Area Legal Services) and Legal Aid Society of the Orange County Bar Association, Inc. provide clients with free legal services if they meet income eligibility criteria. Their services include legal advice, referrals and litigation assistance.

**Medical Services**
The Florida Department of Health in Orange County, Children’s Medical Services, Orange County Medical Clinic, Federally Qualified Community Health Centers, Grace Medical Center, Shepherd’s Hope Clinics and all local hospitals and clinics provide varying types of medical services and/or treatment.

**Parenting Skills Training**
B.E.T.A., Children’s Home Society, Florida Hospital Baby Care Classes, Gorman Life Center and Orange County Cooperative Extension provide clients with parenting enhancement skills, home management training and support groups either in the office or through home visits.

**Shelter/Housing Assistance**
Central Florida Coalition for the Homeless, Orlando Union Rescue Mission, The Salvation Army, Harbor House, Covenant House and Women’s Residential Crisis Center provide hope and opportunity to homeless clients. They offer shelter, food, advocacy, housing, education, support services and case management. The main focus is on returning the client to self-sufficiency.

**Substance Abuse**
Alcoholics Anonymous, Center for Drug Free Living, Narcotics Anonymous and Specialized Treatment Education and Prevention Services (STEPS) provide out-patient and in-patient treatment, education, support and assistance to clients with alcohol and drug addictions.

**Healthy Families Orange**
Healthy Start and Healthy Families Orange (HFO) work together to ensure clients residing in zip codes 32703, 32712, 32801, 32805, 32808, 32818, and 32811 have access to needed services. HFO staff makes referrals to the Healthy Start program for clients who are high risk or not served by HFO. Healthy Start staff is available to provide HFO participants with home visits, nursing assessments and health education as needed. In order to avoid duplication of services, clients identified as receiving HFO services are closed unless services provided are not available through HFO.
Neighborhood Centers for Families Collaborative
Centers located at Englewood, Union Park, Bithlo/Christmas and Taft provide services by DOH-Orange nursing staff. These nurses actively collaborate with local elementary school and community leaders. Healthy Start care coordinators refer clients to the Neighborhood Center for Families for appropriate services. The DOH-Orange plans to continue its involvement with this project funded by the Citizens Commission for Children.

The Developmental Center for Infants and Children (Early Steps)
As the parent and the care coordinator complete the Ages and Stages Questionnaire 3, the infant’s developmental milestones are evaluated. If the infant appears to be developmentally delayed in any area, the care coordinator will make referrals to Early Steps.
Staffing & Staff Development

Staffing

The Healthy Start program has 55.5 full time and part time positions providing Healthy Start, and MomCare services.

<table>
<thead>
<tr>
<th># FTE</th>
<th>Position Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Administrative</td>
</tr>
<tr>
<td>1</td>
<td>Senior Management Analyst II (Program Manager)</td>
</tr>
<tr>
<td>2</td>
<td>Senior Community Health Nursing Supervisors</td>
</tr>
<tr>
<td>1</td>
<td>Senior Human Services Counselor Administrator</td>
</tr>
<tr>
<td>1</td>
<td>Senior Human Services Counselor Supervisor</td>
</tr>
<tr>
<td>1</td>
<td>Administrative Assistant I - SES (Clerical Supervisor)</td>
</tr>
<tr>
<td></td>
<td>Care Coordination</td>
</tr>
<tr>
<td>7.5</td>
<td>Nursing Program Specialists</td>
</tr>
<tr>
<td>12</td>
<td>Human Service Counselor III</td>
</tr>
<tr>
<td>18</td>
<td>Human Services Counselor I (includes 7 MomCare)</td>
</tr>
<tr>
<td>2</td>
<td>Human Services Counselor II</td>
</tr>
<tr>
<td>1</td>
<td>Senior LPN</td>
</tr>
<tr>
<td>1</td>
<td>Health Educator</td>
</tr>
<tr>
<td></td>
<td>Clerical Support</td>
</tr>
<tr>
<td>6</td>
<td>Senior Clerks (includes 1 MomCare)</td>
</tr>
<tr>
<td>1</td>
<td>Office Automation Specialist</td>
</tr>
<tr>
<td>1</td>
<td>Administrative Assistant</td>
</tr>
</tbody>
</table>

Professional Qualification

All Healthy Start staff members providing client services meet and/or exceed the necessary experience and requirements for their positions according to the Healthy Start Standards and Guidelines. Staff members receive on-going training to enhance their skills at conferences, seminars and in-services. Three (3) staff members received additional certification in car seat safety and SIDS education and continue to maintain their certification by completing continuing education credits. During this contract year, they participated in the Webinar “Tech Update: The Front Center Airbag from General Motors” and “Beyond Inspections: Technicians Providing Functional Awareness Education”. Both trainings assisted the technicians to gain the continuing education credits they needed for re-certification.
Staff Satisfaction
Healthy Start staff continues to exercise the option of working a flex time schedule working eight, nine or ten hour days (40 hours total per week). Feedback from staff remains positive regarding personal satisfaction, as well as increased opportunity to reach clients before and after regular working hours. The Department of Health, DOH-Orange, and the Healthy Start Coalition of Orange County continue to survey staff regarding job satisfaction, trust and respect for management staff, including immediate supervisors and senior management staff, and the working environment. The Healthy Start Coalition of Orange County has quarterly meetings with front-line staff to get their feedback on operation of the program, service barriers and how to improve services to clients.

Staff Supervision
The DOH-Orange Healthy Start and MomCare Programs are overseen by the Director of Nursing, a Program Manager and five (5) supervisors. The supervisor who oversees the clerical staff provides guidance for the processing of screening forms, assignment of care coordinators, verification of Medicaid numbers and current addresses, and completion of screening forms in query status. In addition, the clerical staff types all travel forms, inventories and orders supplies, makes care coordination folders, inputs health outcomes of infants born to referred and non-referred clients into both the Health Management System and MomCare Information System and performs reception duties. Supervisors motivate employees to improve the quality and quantity of work performed. Supervisors plan caseloads, workflow, deadlines, performance standards and time management strategies with all staff. The leaders communicate regularly with employees both individually and at monthly home team meetings to address issues effectively and efficiently. Supervisors evaluate the accuracy of service delivery by accompanying care coordinators on visits to client homes and reviewing client satisfaction surveys. Reviews of screening forms, client demographics, and MomCare and Healthy Start care coordination records are conducted regularly to ensure that quality improvement procedures and proper documentation are in place.

Staff Development
All new Healthy Start and MomCare care coordinators receive an extensive pre-service orientation prior to being assigned to their individual caseload. Pre-service orientation is intended to provide an overview of the history of Healthy Start, the services and benefits and an understanding of the responsibilities of the care coordinator.
The various training components include:

- Overview of the Healthy Start and MomCare program, goals, components and the Healthy Start Coalition of Orange County
- Review and understanding of the screening process, possible underlying situations and related risks that need evaluation and possible intervention
- How to complete the evaluation of service needs
- Planning, reporting of services and management accountability
- Preparing and understanding the “Family Support Plan” and “Individual Plan of Care”
- Developing a plan of action
- Assessing, evaluating and assisting special populations: substance abusers, and developmental delays in infants
- Care coordinators’ responsibilities
- Safety guidelines for home visiting/outreach services
- Assessing and referring for enhanced wrap around services: Breastfeeding, Childbirth, Nutrition, Parenting, Psychosocial and Smoking Cessation, Interconceptional Counseling and Community Referrals
- Intervention and curriculum training
- Documentation and coding into the Health Management System and MomCare Information System.
- Observation in WIC and the DOH-Orange Maternity Eligibility.
- Observation of experienced care coordinators in Healthy Start and MomCare both in the office and on home visits.
- Maternal and Child Health didactic videos which include “Your Healthy Pregnancy – Nutrition and Exercise”, “The Stages of Labor”, “Recognizing and Treating Postpartum Depression” and “Safety Starts at Home” to name a few.

New staff are under close supervision until accuracy and proficiency is demonstrated in plan formulation, record documentation, service delivery, referrals, counseling, support and follow-up.

In order to expand the care coordinators’ knowledge, monthly Healthy Start in-services are provided. Topics this past year included:

- 5A’s (Smoking Cessation Education)
- Electronic Health Record
- Employee Satisfaction Survey Results
- First Life Center for Pregnancy
- Gift of Life Adoption Agency
- Healthy Start Coding
- Nutrition
- Perinatal Hepatitis B program
- Save Our Babies
- Sexual Harassment
- UCF Project Together
Monthly Nursing in-services also provided training for staff. Topics included:

- “To C or Not To C” – Reducing C Section Rates
- Childhood Obesity
- Emergency Operations Shelter Drill and Special Needs Shelter Update
- HIV Update
- Nurse Practice Acts Review
- VITAS - Hospice

The Florida Department of Health in Orange County also required employees to complete the following training:

- All Hazard Preparedness – CDC Core Competencies
- Bloodborne Pathogen “OSHA” Training (updated annually)
- Code of Ethics (updated annually)
- Confidentiality and Security Training (updated annually)
- Electronic Health Record (EHR) training (for those employees using the EHR)
- HIV/AIDS 500
- Introduction to the Incident Command System 100, 200, 700, and 800
- Sexual Harassment (updated annually)
- Violence in the Workplace (updated annually)

During this contract year, the Healthy Start/MomCare staff were able to participate in seven (7) specialized trainings:

- Early Childhood Development
- Florida Association of Healthy Start Coalitions Annual Meeting and Training
- Infant Mental Health Training
- Infant Mental Health Training for Frontline Providers
- Understanding Infant Adoption
- Undoing Racism Workshop
- Making the Link – Prevent Prenatal Substance Abuse

Various staff members participated in Webinars throughout the contract year to increase their understanding of the following topics:

- Beyond Back to Sleep
- Core Competencies for Public Health
- Sudden Unexpected Infant Deaths
- Sugary Drinks – Why the Fuss and What You Can Do
Annually, the Healthy Start/MomCare program holds staff development training. Team building activities are conducted. It is also a time for staff to share in the planning for the next year’s activities and provide input on what can be improved regarding the delivery of services, job satisfaction and their own working environment.
Quality Management & Improvement

Continuous evaluation/monitoring of the provision of Healthy Start services are accomplished in several ways. The Senior Human Services Counselor Administrator has been designated to conduct all on-going reviews of documentation for the MomCare, Human Services Counselors I, II and III and Nursing Program Specialists. Although the Healthy Start/ MomCare supervisors strive to be consistent in reviewing records, by having one staff member review records for all Healthy Start care coordinators, a level of consistency is achieved.

The Clerical Supervisor reviews the job performance of the clerical staff. She reviews the accuracy of input of screening forms, client demographics and Medicaid information in the Health Management System and the timeliness of input for all screening forms.

The results of these reviews are shared with staff at their quarterly conferences to acknowledge their satisfactory performance and to improve quality of services.

A QA/QI presentation is given at the monthly in-services to keep the care coordinators informed of any major errors that are occurring program wide. This is also a time that care coordinators can get clarifications on coding issues and updates on any programmatic changes.

The supervisor observes Healthy Start and MomCare staff annually or more frequently if needed on field/outreach visits. This allows the supervisors to observe how the care coordinator plans their travel, what supplies he/she brings, how they protect client confidentiality if the client is not home and what information is given to the client during the interview. The results of this observation are discussed with the care coordinator, identifying strengths and opportunities for improvement. A monthly progress report is submitted to the program manager to inform of completed quality assurance activities, performance deficiencies including status updates and plans for identified challenges.

The Healthy Start Coalition conducts one record review per contract year. The Department of Health/State Health Office conducts record reviews according to its Quality Improvement Site Review schedule. Forms are revised when necessary to meet the needs of care coordination and to comply with State protocols.
Client Satisfaction Surveys are used as a method of quality assurance and to evaluate Healthy Start/MomCare services. MomCare will send surveys to the client after completion of the initial contact.

One hundred, fifteen (115) surveys were received back from MomCare participants and 99.13% reported that they were treated with respect while 100% reported that the MCA was friendly and helpful.

Some comments from the MomCare surveys are:

- “The MCA was very helpful and I look forward to talking to her throughout the remainder of my pregnancy.”
- “The MCA was amazing at making me feel better about my first pregnancy. Thank you for having this service available.”
- “The MCA takes her time to tell me all about MomCare and answers my questions. I really appreciate what she is doing. Out of 1 to 10, I would give her 10.”
- “The MCA was a wealth of knowledge. She helped navigate us through uncharted areas of our healthcare system. MCA was passionate and extremely caring towards our needs. I highly recommend her. A wonderful experience so far.”

Healthy Start provides or mails a client survey at the time of the record closure. This is to evaluate how the client feels about the care coordination services she received from start to finish.

This past year, one hundred, ten (110) surveys were returned to the Healthy Start program with 100% indicated an overall satisfaction rating of “good” to “excellent”. In addition to selecting rating scales, clients are also asked to describe why they think they were invited to join the Healthy Start program. Overwhelmingly, clients responded that they consented to the program in order to achieve a healthy pregnancy and/or a healthy infant, as well as to obtain support and information. Several others stated that the presence of risk factors influenced their decision to participate. All surveys are available for review.

Some of the comments from the Healthy Start surveys are:

- “I think visiting people’s houses is the best way and I really appreciated it because it helps a lot.”
- “It’s a great program and no changes are needed. The care coordinator was kind, wonderful and knowledgeable.”
- “I think the program is just fine the way it is.”
- “I am/was very satisfied and do not see any way to make it better.”
Healthy Start and MomCare clients also have the opportunity to suggest improvements to the Healthy Start/MomCare program. Many clients specifically stated that they were totally satisfied with the program and had no suggestions for improvement, while others suggested the need for more community resources such as housing, jobs, and child care.
Strengths, Weakness, Threats & Opportunity Analysis

**Strengths**

Strengths are the greatest resources and capabilities that the program plans to use as a basis for maintaining competitive advantage. Examples of such strengths include:

- **Quality** – Healthy Start and MomCare staff offer extensive, quality care coordination to program participants. The Maternity Care Advisors and Care Coordinators do everything they can to provide whatever is necessary so that families have a healthy outcome. They go above and beyond, making home visits, developing individual care plans and following up with clients. They are compassionate about the situation of every participant, as well as objective. The free and low-cost enhanced wrap-around services provided are beneficial (i.e. childbirth education classes, parenting and transportation assistance) in encouraging all pregnant and parenting women to learn how to give their babies a healthy start in life.

- **Professionalism** – The majority of care coordinators, supervisors and manager possess a Bachelor’s degree or higher level of education, as well as public health and other diversified experience. They provide mentoring and act as preceptors for hospital residents, student nurses and social workers. In addition to other work experience, many staff members have ten (10) or more years’ experience in the Healthy Start program. This means there is experienced staff to assist in the training and mentoring of new staff joining the program.

- **Orientation** – The new employee orientation is extensive combining theory with hands-on training in the Health Management System Training site as well as many opportunities to shadow the more experienced staff as training progresses. In addition, the new employee has an opportunity to shadow workers in the Women, Infants, and Children (WIC) program and the Maternity Eligibility department to understand what these programs provide to the clients and the process client’s experience.

- **Customer Service** – MomCare and Healthy Start staff work flexible hours including weekends to ensure successful facilitation of services to participants. Participants’ perception about the services they receive from Healthy Start as well as MomCare is repeatedly reported by customer satisfaction surveys as “Excellent” to “Satisfactory”. Additionally, staff feedback is solicited on practices, policies and procedures. Employees
consistently express confidence in supervisors’ and manager’s ability and success in managing the programs.

- **Diversity** – Supervisors and managers are committed to an inclusive environment where all employees are treated with respect, are valued, and have the opportunity to contribute to their fullest potential. Orange County is a diverse community. Language barriers are minimized since MomCare and Healthy Start Care Coordinators are multilingual. The two programs collaboratively work to ensure that participants receive optimal services.

- **Community** - Strong partnerships have been created and maintained with local schools, hospitals, the Orange County Female Detention Center, apartment complexes, maternal child health agencies, healthcare providers and others.

- **Operations** – The operations of the program is professional, organized and seamless. Staff often lead the way in piloting new technology, apps and other devices. They are innovative and always seeking methods to improve efficiency.

- **Financial Resources** – Since its inception the Healthy Start Coalition of Orange County has allocated resources to support both the Healthy Start and MomCare programs. They also continue to provide resources for the Healthy Start Mall (client incentive program to encourage compliance with visits, education and parenting). The Coalition is always on the lookout for other grants and contracts to expand the services to clients. The budget is shared and discussed with staff so that they are aware of how much money is allotted to the program and how much money is in each category. In this way, they participate in the planning of the next year’s budget and realize the need for certain measures: in fact, in some cases they will suggest ways to save money for the program.

- **Representation** – The manager and supervisors recognize that staff needs to be involved with the community and the Florida Department of Health in Orange County. Accordingly, staff are encouraged to attend community meetings and become involved with health department workgroups so that their input is heard.

### Weaknesses

Weaknesses are those things that place the Healthy Start / MomCare program at a disadvantage. Some examples are:

- **Customer Service** – Although the Healthy Start has been moving to a totally electronic record, there are important portions of the record that have not been incorporated electronically, such as the Individual Plan of Care and the Family Support Plan. While a care coordinator, not assigned to the record, can tell in general terms what has been discussed with the client and could document their conversation with the client, without the physical record, it would be difficult for them to complete all the activities associated with care
coordination. Also, there are portions that are duplicated between the maternal electronic record modules and the documentation in the Healthy Start module. Until the two modules are linked and information could be transferred from one to another, it might cause the care coordinator to complete duplicate entries, a time consuming activity.

- Incentives – As Department of Health employees, staff are unable to solicit local businesses for items they know their clients need as part of the DOH Code of Ethics. In addition, the program is unable to compete with private companies in regards to pay, incentives/bonuses and raises.

- Data Collection – While the Health Management System can be used to obtain some data needed for grants, etc., it is limited in the types of data that can be obtained. For example, it is impossible to get data on the mothers of infants if only the infant is the client. The mother’s information is not recorded into the system.

**Opportunities**

Opportunities are external chances to expand services in the environment. Some of the examples given by the staff are as follows:

- Customer Service – Because Healthy Start has a limited electronic record, a care coordinator is able to look at the record documentation in the Health Management System and understand basically what is going on with the client and how to assist the family without having a physical record. The care coordinator can also document and code their service without the physical record.

- Operations – Because a number of the staff members (clerical, care coordinators as well as supervisors) will be retiring in the next two (2) to five (5) years, succession planning is vital to the program. Experience and knowledge must be transferred on to other staff timely so that vital services can continue.

- Partnership – Due to diminishing resources, there is a need to seek and apply for grant opportunities that support maternal child health activities to ensure financial sustainability. Staff is encouraged to “think outside the box” to do more with less.

- Electronic Health Record – Electronic Health Record – The Healthy Start program has been striving towards a totally electronic record. Although this evolution has created challenges in documentation, staff are already experiencing some of the benefits of an Electronic Health Record. If the client is a patient of DOH-Orange, the care coordinator can access information on her medical record that was not previously available without physically visiting the client’s clinic site and retrieving her chart from medical records.
Financial Resources – Although the bus pass program will continue to serve transportation to disadvantaged clients, staff will distribute only to those truly in need and advise those clients that are able to request transportation from Lynx (if eligible), friends, neighbors and church members to do so this will reduce costs and ensure that those truly in need will continue to receive bus passes.

**Threats**

Threats are external elements in the environment that could cause challenges for the program. Examples of these are:

- **Customer Service/Operations** – Since we are a home visiting program, staff safety and security in the community remains an ongoing threat and concern.
- **Legislative concerns** – Funding is always in question since the money for the program is legislated by the government in Tallahassee. In addition, legislative mandates have been ordered without regard as to how this will affect a program at the local level.
- **Quality of Services** – As funding is decreased, the quality and diversity of services can be affected.
## Future Planning

Some of the program’s future plans include:

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| DOH-Orange Strategic Plan HS1.7 | **HP 2020: MICH-10.2** **CDC 10 Essentials Public Health Services: #.7** | • Linking pregnant women to early and adequate prenatal care.  
• Linking postpartum women to family planning services and providing inter-conceptual education and counseling. |
| DOH-Orange Strategic Plan HS1.7 | **HP 2020: _AH-1** **CDC 10 Essentials Public Health Services: #.7** | • Leadership Prosperitas Academy students will continue to be educated on inter-conceptual care and be encouraged to receive a well woman’s examination.  
• Maintain and expand partnerships with public, private sectors to provide clientele with care coordination services.  
• Execute the Memorandum of Understanding between Department of Children and Families, HSCOC and DOH-Orange Healthy Start/MomCare. |
| DOH-Orange Strategic Plan HS1.7 | **HP 2020: IVP-16** **CDC 10 Essentials Public Health Services: #.3** | • Decrease number of unintentional injuries by increasing knowledge on how to properly install child restraints through local scheduled “Car Seat Checkpoints”  
• Educate participants attending childbirth education classes, car seat safety class, parenting classes, and health education presentations, including Shower Powers, on how to properly install car seats. |
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<tr>
<td>DOH-Orange Strategic</td>
<td>HP 2020: MICH-20, CDC 10 Essentials Public Health Services: # 1 &amp; 3</td>
<td>• Continue to increase community awareness of the importance of placing infants on their backs to sleep.</td>
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<tr>
<td>Plan HS1.7</td>
<td>Maternal, Infant, and Child Health (MICH-20)</td>
<td>• Maintain or reduce infant mortality rates.</td>
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<td>• Reduce number of preterm and low birth weight infants.</td>
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<td>• Continue to provide smoking cessation education and counseling during pregnancy.</td>
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<td>• Monitor health status by documenting vital statistics birth data in HMS Healthy Start Prenatal Module and MomCare MIS on all participants.</td>
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<td>• Plan, implement and facilitate a resource fair of community agencies and programs to showcase their programs and services to Healthy Start care coordinators.</td>
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<td>• Maintain and/or increase health education and health promotion “Shower Powers” program partnerships with universities/colleges, faith communities, hotel/motel industry and prenatal care providers.</td>
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| DOH-Orange Strategic     | HP 2020: MICH-12, CDC 10 Essentials Public Health Services: # 3         | • Increase the number of pregnant women and their coaches who attend a series of childbirth education classes.                          |
| Plan HS1.7              |                                                                         | • Expand childbirth education classes by including an additional full day comprehensive weekend class at a site located on the eastside of Orange County. Classes to be held monthly unless it is shown to be needed bi-monthly. |

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<tr>
<td>DOH-Orange Strategic Plan MVV2.1</td>
<td>CDC 10 Essentials Public Health Services: #.8</td>
<td>• Ensure a competent workforce by providing ongoing education, training, assessment, credentialing and staff and leadership development.</td>
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<td>• Train care coordinators in evidenced-based client education as developed by the Healthy Start re-design, for example, Prenatal Plus, SOPHE Script (smoking cessation education).</td>
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<td>• Train care coordinators to practice motivational interviewing techniques.</td>
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<td>• Re-fresher training in Florida State University Healthy Baby Curriculum.</td>
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<td>• Develop a standard operating procedure for care coordinator’s use detailing when to use specific Healthy Start codes, what methods of contacting clients should be used, and time frames for contact.</td>
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<tr>
<td>DOH-Orange Strategic Plan HS3.1</td>
<td></td>
<td>• Continue to move forward with plans for electronic health records (a paperless system) and its implementation.</td>
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## Outcome Measures

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<td><strong>MomCare</strong></td>
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<tr>
<td>75% of enrollees shall receive an attempt to contact within 5 working days of referral</td>
<td>98.88%</td>
<td>99.12%</td>
<td>99.32%</td>
<td>99.53%</td>
<td>99.72%</td>
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<td>85% of auto-assigned enrollees shall receive three documented attempts to contact</td>
<td>97.51%</td>
<td>95.98%</td>
<td>97.64%</td>
<td>98.76%</td>
<td>99.17%</td>
</tr>
<tr>
<td>85% of enrollees shall be enrolled with a prenatal care provider within 30 days</td>
<td>97.33%</td>
<td>95.53%</td>
<td>96.07%</td>
<td>97.13%</td>
<td>97.92%</td>
</tr>
<tr>
<td>85% of enrollees successfully contacted shall receive, or shall have already received WIC information</td>
<td>97.28%</td>
<td>94.23%</td>
<td>92.80%</td>
<td>94.45%</td>
<td>94.49%</td>
</tr>
<tr>
<td>70% of recipients that have been auto-assigned or not verbally contacted, but their provider choice registered, shall receive an additional attempt to communicate (by letter, phone, or face-to-face) between 31st day and fifth month of pregnancy</td>
<td>82.78%</td>
<td>72.64%</td>
<td>69.71% (not met)</td>
<td>92.01%</td>
<td>84.73%</td>
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<tr>
<td>Healthy Start Care Coordination</td>
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<tr>
<td>HSCOC and DOH-Orange will work collaboratively to assure that the prenatal screening rate will increase to 72 percent.</td>
<td>75.4%</td>
<td>85.4%</td>
<td>85.42%</td>
<td>79.84%</td>
<td>74.49%</td>
</tr>
<tr>
<td>HSCOC and DOH-Orange will work collaboratively to assure that the infant screening rate will increase to 76 percent.</td>
<td>86.97%</td>
<td>82.1%</td>
<td>82.56%</td>
<td>89.16%</td>
<td>96.15%</td>
</tr>
<tr>
<td>Percentage of women consenting to prenatal screen will increase to 85%</td>
<td>88.7%</td>
<td>94.1%</td>
<td>95.20%</td>
<td>96%</td>
<td>91.15%</td>
</tr>
<tr>
<td>Percentage of Healthy Start eligible participants, referred to the program, who consent to participation in Healthy Start at time of Initial Contact, will exceed 93%</td>
<td>97.5%</td>
<td>97%</td>
<td>98.10%</td>
<td>97%</td>
<td>98.19%</td>
</tr>
<tr>
<td>At least 93% of Healthy Start participants will receive an Initial Contact, or an attempt to contact within 5 working days of receipt of screening form</td>
<td>97%</td>
<td>99%</td>
<td>96.80%</td>
<td>98%</td>
<td>98.75%</td>
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<tr>
<td>At least 93% of Healthy Start participants, determined to be in need of an Initial Assessment, will receive an Initial Assessment, or an attempt to assess, within 10 working days of initial contact</td>
<td>98%</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>At least 93% of Healthy Start records will contain documentation that status of Initial Contact has been sent to the healthcare provider within 30 calendar days from first attempt to contact</td>
<td>97%</td>
<td>99%</td>
<td>96.80%</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>At least 93% of Healthy Start records with a documented Initial Contact will contain documentation of an Individual Plan of Care at the Initial Contact</td>
<td>98.5%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Healthy Start prenatal participants shall receive care coordination face-to-face services with a family support plan at a rate of 7.5%</td>
<td>6.68</td>
<td>8.02</td>
<td>8.04</td>
<td>6.89%</td>
<td>9.26%</td>
</tr>
<tr>
<td>Healthy Start infant participants shall receive care coordination face-to-face services with a family support plan at a rate of 6.0%</td>
<td>10.02</td>
<td>7.38</td>
<td>8.08</td>
<td>11.24%</td>
<td>9.05%</td>
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Accomplishments

The following is the accomplishments identified from fiscal year 2011-12 to fiscal year 2012-13.

- Fetal infant mortality rate decreased from 6.6 to 5.0.
- Postnatal Healthy Start Screening rate increased from 89.16% to 96.15%.
- Parents of infants consenting to Healthy Start program participation increased from 75.11% to 81.88%.
- Prenatal initial contacts to clients (pregnant women entry into Healthy Start services) increased from 70.77% to 81.80%.
- Prenatal initial assessments to clients increased from 70.22% to 81.06%.
- Infant initial contacts at Winnie Palmer Hospital increased from 773 to 1,139, a 47% increase.
- Infant initial assessments to clients increased from 85.86% to 99.43%
- Number of clients who received a Healthy Start services increased from 10,566 to 11,732, an 11% increase in services.
- Number of encounters to Healthy Start clients increased from 41,978 to 59,186, a 40% increase in the number of encounters.
- Number of services to Healthy Start clients increased from 139,572 to 222,949, a 60% increase.
- Women and infants receiving intensive Level 3 care coordination services increased from 960 to 1,078. As a result the total number of services increased 70% and encounters to this targeted high risk population increased 41%.
- Psychosocial counseling services continue to increase from 4,026 services to 4,291, a 13% increase.
- Happiest Baby on the Block class attendance increased by 160%.
- The number of breastfeeding services increased from 7,712 to 8,055, a 4.45% increase.
- Percentage of mothers initiating breastfeeding increased from 86.6% to 89.3% and remains higher than the State percentage 81%.

- Percentage of births with 1st trimester prenatal care was 84.1% which is above the State percentage of 79.9%.

- Interconceptional education services increased 45% from 7,508 to 10,892 services.

- Percentages of births to teen mothers, age 10 to 18 dropped from 10% to 8.6%.

- Percentage of births to mothers with inter-pregnancy interval of less than 18 months was 32.6% which is lower than the State comparison of 35.3%.

- Percentage of births to mothers who smoke during pregnancy decreased from 7.4% to 6.7%.

- Initiated a monthly Saturday one-day childbirth education class at Orlando Health-Health Central Hospital.

- Effective May 28, 2013, a car seat safety class was implemented in collaboration with First Life Center of Pregnancy of the First Baptist Church of Orlando. Through a State Farm Insurance grant received by the Healthy Start Coalition of Orange County, low cost car safety seats are available for purchase to eligible participants. The car safety seats are installed in their personal vehicles by the participants and installation is inspected by one of the Healthy Start certified passenger safety technicians.
Testimonials

From Client

Dear Healthy Start-MomCare,

I don’t know where we’d be without the Healthy Start - MomCare Program. After 7 years of trying for a baby it’s easy to lose hope. So we were very pleasantly surprised when I became pregnant! Unfortunately it was during a time where we had limited insurance. We did what we could to pay out of pocket for prenatal care, but at 6 months we were denied continued care at not one but two OB/GYN’S because of our limited insurance and our inability to pay thousands for delivery costs. As first time parents we didn’t know what to do, our happiness soon became a stressful struggle. We had no idea we qualified for so much help available to us until the Healthy Start- MomCare Program contacted us. They helped us receive continued prenatal care for the baby and additional care for my health concerns. They also told us step by step where we needed to go, a schedule of all the birth, daddy boot camp, and nursing classes as well as any additional concerns we had. Suddenly we had someone to guide us through the whole way and find solutions for any concerns we had. We did it all and learned so much that by the time it came to meet our precious angel, we were confident and ready! I thank the Healthy Start-MomCare program for allowing me and my baby a peaceful, happy, and HEALTHY pregnancy. There is help out there and Healthy Start-MomCare guides you to it.

Thank You!
Kairi & Emely Woeber
Dear Healthy Start:

When I started your program I was a depressed, weeping and a sobbing new mother of a son who was taken away from me due to my drug usage during pregnancy. I felt hopeless with nowhere to turn for help.

I remember lying on my sofa weeping and sobbing. I was crying because the week before I gave birth to my son I used drugs. My son was taken from me at birth by the Department of Children and Families. I felt very depressed and did not know exactly what was going on and what steps I had to take to try to get my son back. I wanted help but all of the numbers I called were useless. As I laid there crying and not knowing what the outcome would undoubtedly be made me want to engage in more drug usage.

As I was contemplating what to do the Healthy Start nurse came to visit me. She had been assigned to my case. I believe she really touched me because she told me she saw my son and he was okay and that I could really get through everything if I was willing to make some changes in my life. She gave me referrals to outside services that could help me with things that I would need for my baby once he returned. We talked about drug treatment, birth control, parenting and a lot of other issues too. She visited with me once a month and we talked about how my son was progressing. Due to her encouragement that I could regain custody of my son I started drug treatment, I learned parenting skills and more about my dependency problem. In 7 months I graduated from drug rehabilitation and regained custody of my baby boy. I found a great job and love life again.

I’m appreciative to the Healthy Start Program, Department of Children and Families and the Bridge’s program. I’m proud of myself. I know for a fact that I would never have been able to accomplish all of this without the love and support of my family and the community providers sent my way. Because of them I am drug free and a successful mother.

Thank!
From Community Partner

I am writing this letter of recommendation on behalf of Charity Jones, whom I have known for the past three years. For the past two years, Ms. Jones has served as a member of our Safe Kids Orange County Coalition. As a member she has not only provided exceptional assistance to our organization, but has also exceeded our expectations.

As the Coalition Coordinator of the Safe Kids Orange County Coalition it is my responsibility to ensure that we have members who are dedicated to injury prevention and safety education for young children and who can work tirelessly to help area families and school children. Ms. Jones is one of our involved members under our Safe Kids Buckle Up program. I had the distinct honor of having Ms. Jones as a student in my 2010 Child Passenger Safety Technician Certification class. Since then at every opportunity, Ms. Jones has volunteered her professional time and services to assist with our Child Passenger Safety car seat checkup events under our Buckle Up program. I have worked with many people over the years, but few have had the kindness and patience of Ms. Jones. She is an upstanding individual who is always ready to lend a supportive hand and to serve her community.
APPENDIX A

Glossary Terms and Definitions:

**Agency for Health Care Administration (AHCA)** – The Agency for Health Care Administration that is responsible for the oversight of Medicaid services and payments.

**At-risk** – Participants who have factors in their lives that predispose them to risk for adverse outcomes. This is determined using research and statistics along with professional judgment.

**Care Coordination** – The coordination, facilitation, and provision of care services identified through screening, evaluation of service need and assessment that are aimed at reducing participant risk and maximizing outcome.

**Care coordinators** – Health care providers, health-related professionals, or paraprofessionals working under the supervision of a professional who function in partnership with the participant or family for the provision of care coordination and other Healthy Start services.

**Choice counseling** – A process focused on helping a participant choose a provider based on certain criteria or aspects they may be seeking (e.g. location, language, professional type and etc...).

**Community Liaison** – HSCOC staff who is identified as the contact person for Obstetrical/Gynecologist and birthing facilities and who responsible to train and educate on Healthy Start Risk Screening Instruments, as well as the provision of technical assistance as needed and requested.

**Department of Children and Families (DCF)** - Protects the vulnerable, promote strong and economically self-sufficient families, and advance personal and family recovery and resiliency. Protect children, the elderly and the disabled from abuse and neglect. Responsible for nearly 19,000 children in foster care, and find permanent homes for children who cannot safety be reunited with their families. Also provides services that help families on a day-to-day basis. Provide food stamps and temporary cash assistance and determine eligibility for Medicaid. Provide access to substance abuse and mental health treatment and work with community partners who provide services to families threatened by homelessness and domestic violence.

**Department of Health (DOH)** - To protect and promote the health of all residents and visitors in Orange County. Services include health education, maternal and child health, epidemiology, environmental health, school health, dental care services, and a variety of other programs. Receives funding to provide Healthy Start Care Coordination and MomCare services to eligible participants.
**Direct Service Encounter** - Direct contact with a participant or a provider with the participant via the telephone and/or face-to-face communication.

**Face-to-Face** - Interaction that occurs in person with the enrollee.

**Family Support Plan** - A written document that provides direction for care coordination based on the participant/family’s concerns, priorities, and resources. It is a participant centered plan that helps participants/families create and live their own goals/dreams.

**Health Insurance Portability and Accountability Act (HIPAA)** - A Privacy Rule that regulates the use and disclosure of certain information held by "covered entities" (generally, health care clearinghouses, employer sponsored health plans, health insurers, and medical service providers that engage in certain transactions.) It establishes regulations for the use and disclosure of Protected Health Information (PHI).

**Health Management System (HMS)** – A uniform, computerized service reporting system that compiles all Healthy Start client service encounters.

**Healthy Start Participant** - May includes:

- A pregnant women or child up to age three who may be at increased risk of pregnancy complications or poor birth outcomes or for impairment in health, intellect, or functional ability due to environmental, medical, nutritional, behavioral, or developmental risk factors as determined by the department’s prenatal and/or postnatal (infant) risk screening instrument, or by risk assessments conducted subsequent to the initial contact or as determined by factors other than the score at the time of screening or subsequent to the initial screen;
- A non-pregnant woman who has risk factors that may lead to a poor subsequent pregnancy outcome, but has no infant to code services to due to pregnancy loss, miscarriage, fetal death, infant death, or an infant who was adopted or removed from the home. Women are eligible for Healthy Start services during the interconception period up to three years post-delivery.

**Home visiting** – Is a mechanism for providing care coordination and other Healthy Start services in a location that best meets the concerns, priorities and resources of the participant and family. It is a place of service or a strategy for service delivery.

**Individualized Plan of Care (IPC)** – A written plan of the interventions needed based on the evaluation of the Healthy Start participant’s risks and needs, and the plan for the next encounter.

**Initial assessment** - Is a face-to-face assessment of participant risks and service needs. This assessment is completed by a face-to-face evaluation in collaboration with the participant and family if appropriate. This face-to-face assessment is usually done after the initial contact.

**Initial contact** – The point-of-entry into Healthy Start care coordination. The initial contact is an evaluation of service needs. It may be accomplished by telephone contact or through a face-to-face encounter.
Leveling – An approach to care coordination and caseload management whereby participants are assigned a level of service delivery that corresponds to the intensity and duration of service required to address the participant’s risk and need for services. A participant level can change between levels whenever risk and service needs change.

Maternity Care Advisor (MCA) – The personnel who provides choice counseling services for the MomCare program.

MomCare – The official name of the SOBRA Prenatal Care Outreach Program.

MomCare Information System (MIS) – The web-based information system, owned by the Florida Association of Healthy Start Coalitions, by which MomCare enrollees are tracked.

Healthy Start Coalition of Orange County (HSCOC) – Provides funding to the OCHD to provide Healthy Start Care Coordination and MomCare services.

Ongoing care coordination – A process by which families are assisted with locating, coordinating and monitoring needed services and learning what they can to maximize their health and well-being. Activities range from tracking to intensive coordination of services addressing complex problems, using a family support plan and reevaluating the individualized Plan of Care and the participant’s level.

Outreach – A systematic, family-centered, community-based activity that promotes improved pregnancies and infant health outcomes through public awareness, education and access to services. This includes participant identification and education; provide recruitment and retention, and community education. All these efforts are designed to increase participant, provider and community awareness in an effort to link pregnant women and infants to needed services, and/or make these services more accessible.

Performance Measure – An indicator of how well the program is doing in terms of quality performance related to service delivery.

Presumptive Eligibility for Pregnant Women (PEPW) – The temporary Medicaid insurance program that covers a woman’s pregnancy for 45 days or until a decision is made by Medicaid for eligibility for continuous Medicaid coverage.

Prioritization – A decision-making method whereby services are delivered based on order of importance or urgency.

Protected Health Information (PHI) - Is any information held by a covered entity which concerns health status, provision of health care, or payment for health care that can be linked to an individual.

Risk Appropriate Care – Risk appropriate care is the provision of supports and services that directly address identified risk factors that participants or families are unable to resolve without assistance. Risk appropriate care targets risk reduction services to improve outcomes.

Risk Screen – The Healthy Start instruments designed to identify pregnant women and infants who are most likely to be at risk for poor health outcomes.
**Screening** – The process of identifying pregnant women and infants who are most likely to be at risk for poor health outcomes.

**Simplified Eligibility** – Provides expedited Medicaid prenatal care coverage for eligible pregnant women. The Medicaid eligibility for pregnant women is processed utilizing different verification requirements, and can be completed in a shorter time frame. Provides Medicaid coverage for pregnant women for all her Medicaid billable services.

**Sixth Omnibus Budget Reconciliation Act (SOBRA)** – Provides funding for women identified as eligible for health care services based on their pregnancy.

**Substance Exposed Newborn (SEN)** – Infants with a positive drug test following birth and referred to the program for follow-up care coordination by the birthing facility and/or DCF.

**Sudden Infant Death Syndrome (SIDS)** – Is marked by the sudden death of an infant that is unexpected by medical history, and remains unexplained after a thorough forensic autopsy and a detailed death scene investigation.

**Targeted Outreach for Pregnant Women Act (TOPWA)** – The Targeted Outreach for Pregnant Women Act (TOPWA) program was funded by the Legislature in 1998 to reach high-risk or HIV-infected pregnant women not receiving adequate prenatal care. The purpose of the program is to lower the number of babies born with prenatal drug exposure and HIV infection.

**Target population** - Those determined to be at highest risk and most in need and who will derive the most benefit from services.

**Therapeutic Intervention Program (TIP)** – A program funded by HSCOC that involves using professional mental health counselors to work with referred individuals/families for the purpose of improving well-being, alleviating distress, and enhancing coping skills. These interventions are provided at home and/or clinic.

**Triage** – A decision-making method whereby scarce service delivery resources are allocated based on who is most able to derive benefit from them.

**Women Infants and Children (WIC)** - The federal supplemental nutrition program for women, infants and children.