

Professions and Public Health Subcommittee

Wednesday, February 10, 2021
10:00 AM - 11:30 AM
Webster Hall (212 Knott)

Meeting Packet

Chris Sprowls
Speaker

Will Robinson
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Professions & Public Health Subcommittee

Start Date and Time: Wednesday, February 10, 2021 10:00 am

End Date and Time: Wednesday, February 10, 2021 11:30 am

Location: Webster Hall (212 Knott)

Duration: 1.50 hrs

Workshop on Florida Pregnancy-Associated Mortality

- Deborah Burch, DNP, RN, Program Administrator, Maternal and Child Health, Florida Department of Health

- William Sappenfield, MD, MPH, CPH, Director, Florida Perinatal Quality Collaborative, University of South Florida

- Cathy Timuta, Chief Executive Officer, Florida Association of Healthy Start Coalitions, Inc.

This meeting will be live-streamed on https://thefloridachannel.org/. As no filed bills or draft legislation will be considered at this meeting, public testimony will not be solicited and seating will be limited to the Members, invited presenters, and the press. As always, you may contact any Representative prior to the start of the meeting. Contact information may be found at https://www.myfloridahouse.gov/Representatives.

NOTICE FINALIZED on 02/03/2021 4:09PM by Osborne.Erin

Deborah Burch, DOH

Department of Health

The Florida Pregnancy-Associated Mortality Review (PAMR)

The Florida Pregnancy-Associated Mortality Review (PAMR)

Deborah Burch, DNP, RN
Maternal and Child Health (MCH)
Program Administrator
February 10, 2021

Definitions

Maternal Mortality – The death of a woman while pregnant or within 42 days of the pregnancy ending, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (World Health Organization).

Pregnancy-Associated Death (PAD) – A death of a woman from any cause, while she is pregnant or within one year of termination of pregnancy, regardless of the duration and site of pregnancy (Centers for Disease Control and Prevention [CDC]).

Pregnancy-Related Death (PRD) – A pregnancy-associated death directly attributed to pregnancy and/or childbirth (CDC).

Definitions, Continued

Maternal Mortality Rate (MMR) – The number of maternal deaths within 42 days of the ending of a pregnancy per 100,000 live births, from a cause related to the pregnancy (National Center for Health Statistics).

Pregnancy-Associated Mortality Ratio (PAR) – The number of pregnancy-associated deaths per 100,000 live births (CDC).

Pregnancy-Related Mortality Ratio (PRMR) – The number of pregnancy-related deaths per 100,000 live births (CDC).

Methods of Maternal Mortality Review

	CDC – National Center for Health Statistics (NCHS)	CDC – Pregnancy Mortality Surveillance System (PMSS)	Maternal Mortality Review Committees
Data Source	Death certificates	Death certificates linked to fetal death and birth certificates	Death certificates linked to **fetal death and birth certificates, medical records, social service records, autopsy, informant interviews…**
Time Frame	During pregnancy – 42 days	During pregnancy – 365 days	During pregnancy – 365 days
Source of Classification	ICD-10 codes	Medical epidemiologists (PMSS-MM)	**Multidisciplinary committees**
Purpose	Show national trends and provide a basis for international comparison	Analyze clinical factors associated with deaths, publish information that may lead to prevention strategies	**Understand medical and non-medical contributors to deaths, prioritize interventions that effectively reduce maternal deaths**

Sourced from: St Pierre A, Zaharatos J., Goodman D, Callaghan W.M., Challenges and opportunities in identifying, reviewing, and preventing maternal deaths. Obstetrics & Gynecology, 2018. 131(1): p. 138-142.

Florida PAMR

Initiated:

- By the Florida Department of Health in 1996 to improve surveillance and analysis of pregnancy-related deaths in Florida.
  - Funded through Title V (MCH) Block Grant and the American College of Obstetricians and Gynecologists (ACOG) District XII
  - Florida statutory authority: 395.3025, 405.01, 766.101

Purpose:

- To discover gaps in care, identify systemic service delivery issues and make recommendations to facilitate improvements in the overall systems of care.

Florida PAMR Process

1. Identify all pregnancy-associated deaths.
   - Death certificate with a cause of death in the category of Pregnancy, Childbirth and Puerperium
   - Universal Prenatal Risk Screen
   - Linked infant birth certificate or fetal death certificate
   - Pregnancy check-box on death certificate

2. Perform thorough record abstraction (using a variety of record sources).

Florida PAMR Process, Continued

3. Perform a multidisciplinary committee review.
   - Determine the underlying cause of death and preventability.
   - Identify contributing factors.
   - Recommend improvements to care.

4. Translate findings and recommendations into quality improvement strategies.

Florida PAMR Process, Continued

5. Disseminate Information.
    - Reports (annual and multi-year)
    - Briefs focused on specific causes of death
    - Urgent Maternal Mortality Messages (UMMM)
    - Presentations at national, state and local forums
    - Publications in peer reviewed journals

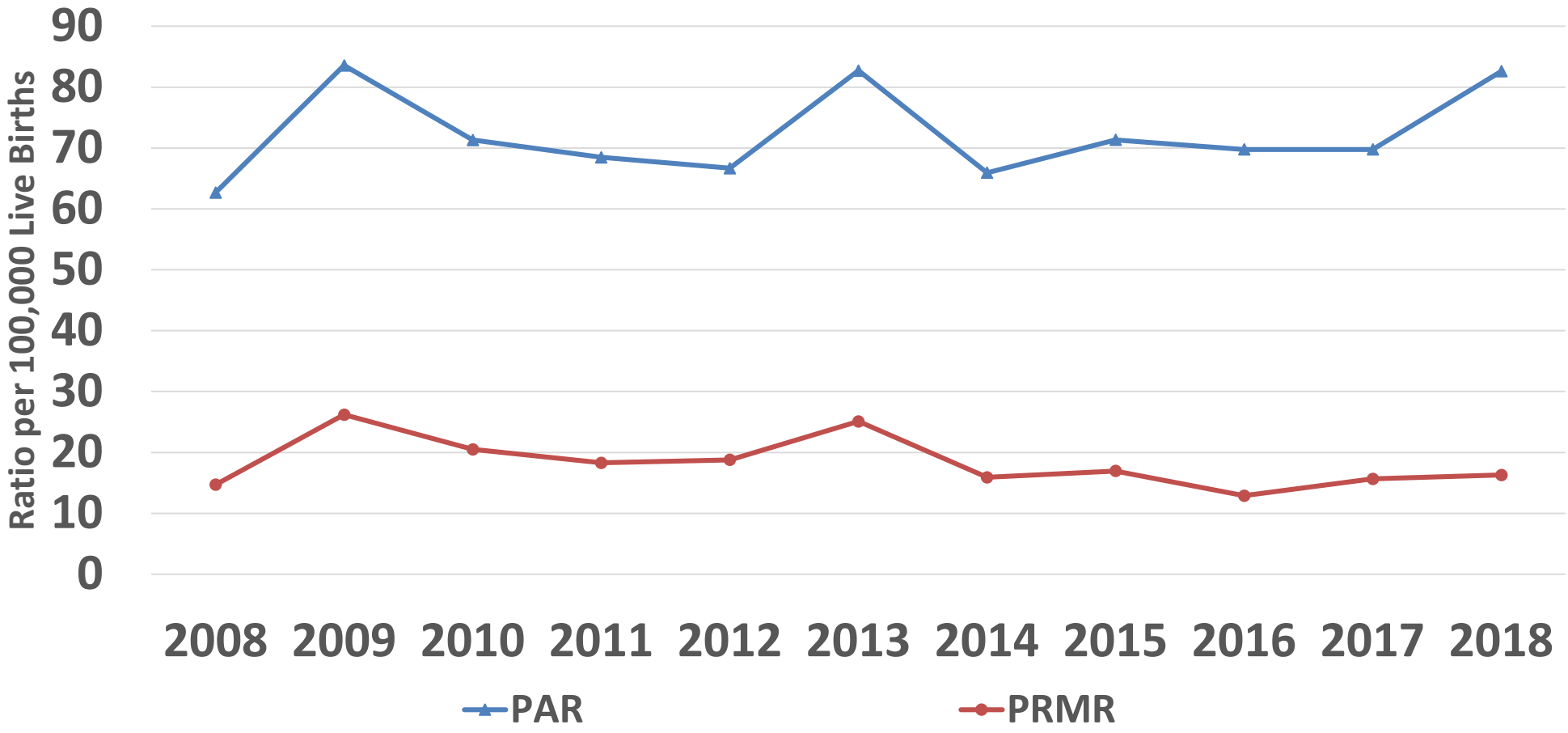
Florida PAMR Data Findings

Background and Significance

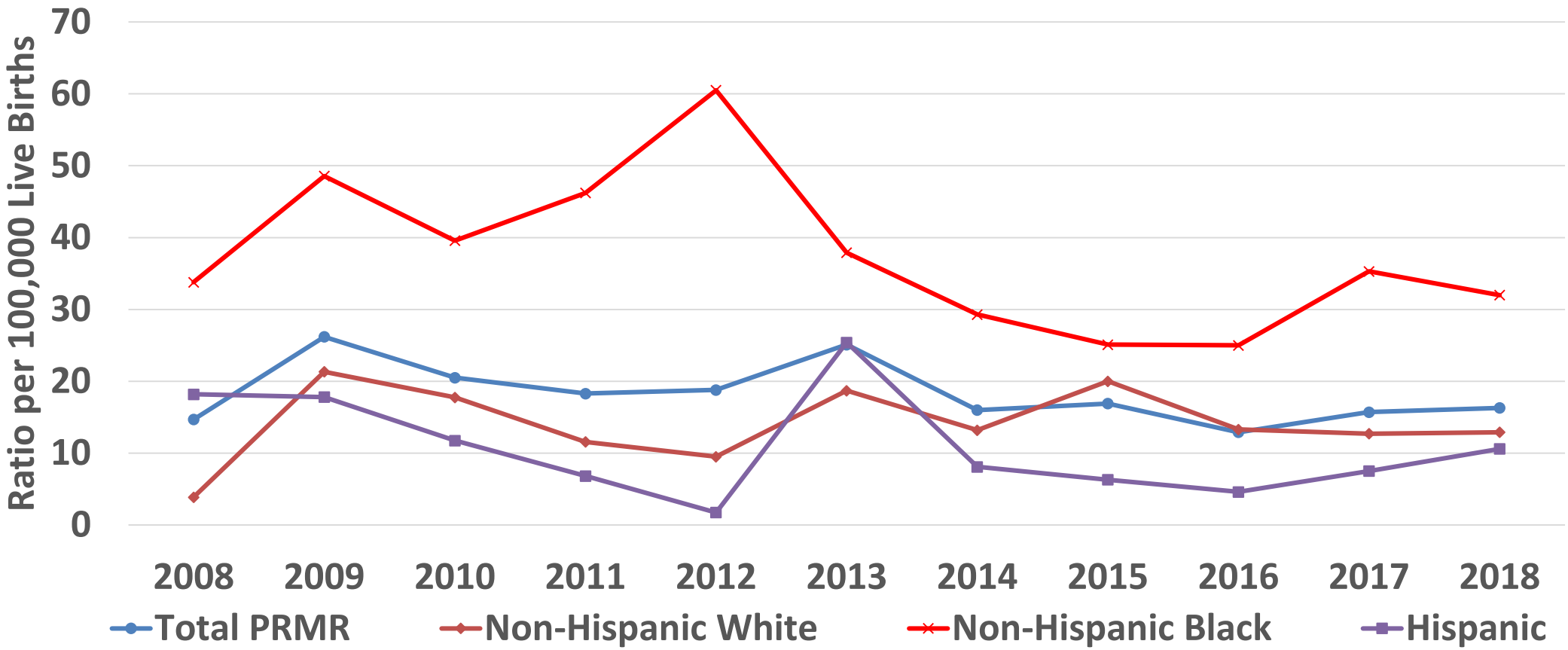
- In Florida, from 2008-2018:
  - An average of 40 women died per year due to complications of pregnancy = 1 woman dying every 9 days.

- 69% of the pregnancy related deaths in 2018 were determined to be preventable.

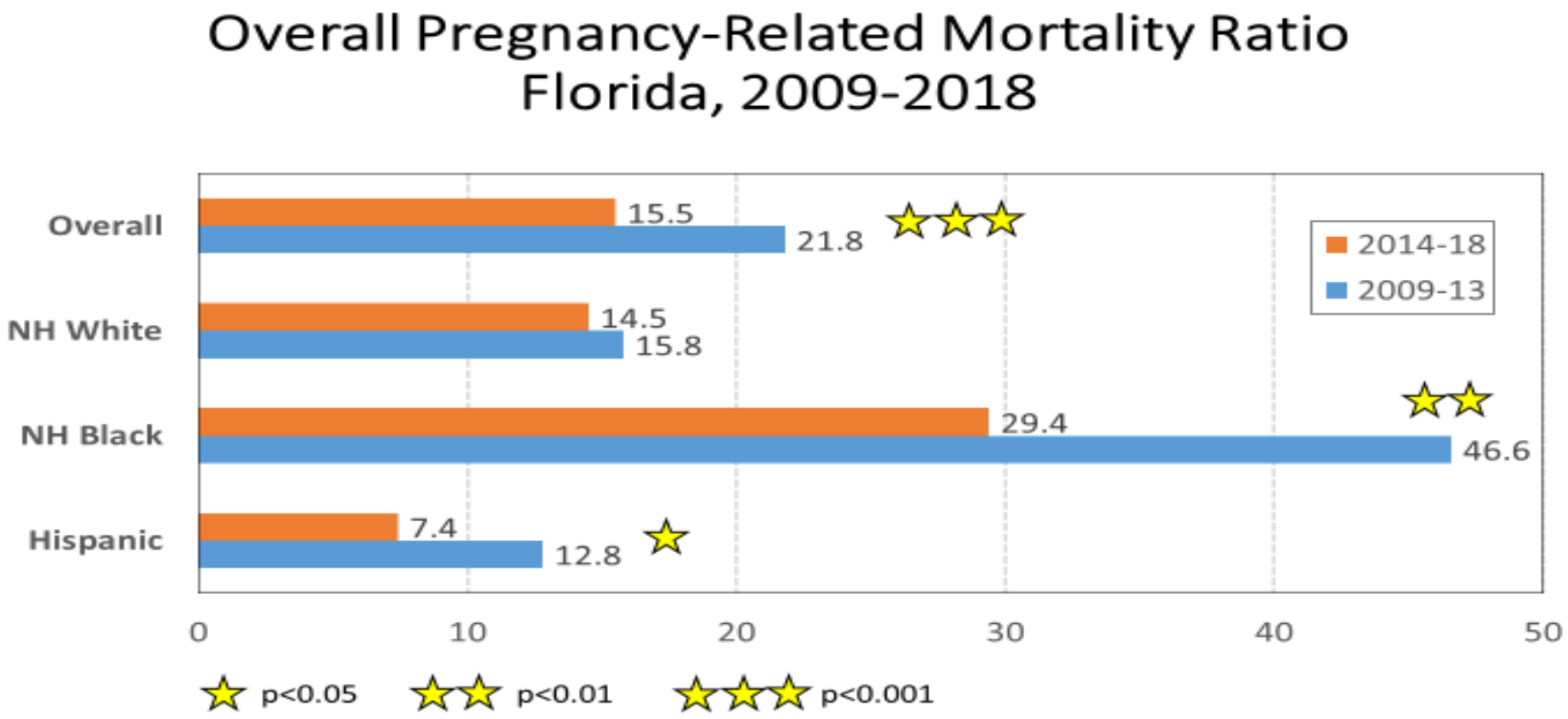
Pregnancy-Associated Mortality Ratios (PAR) and Pregnancy-Related Mortality Ratios (PRMR), Florida, 2008–2018



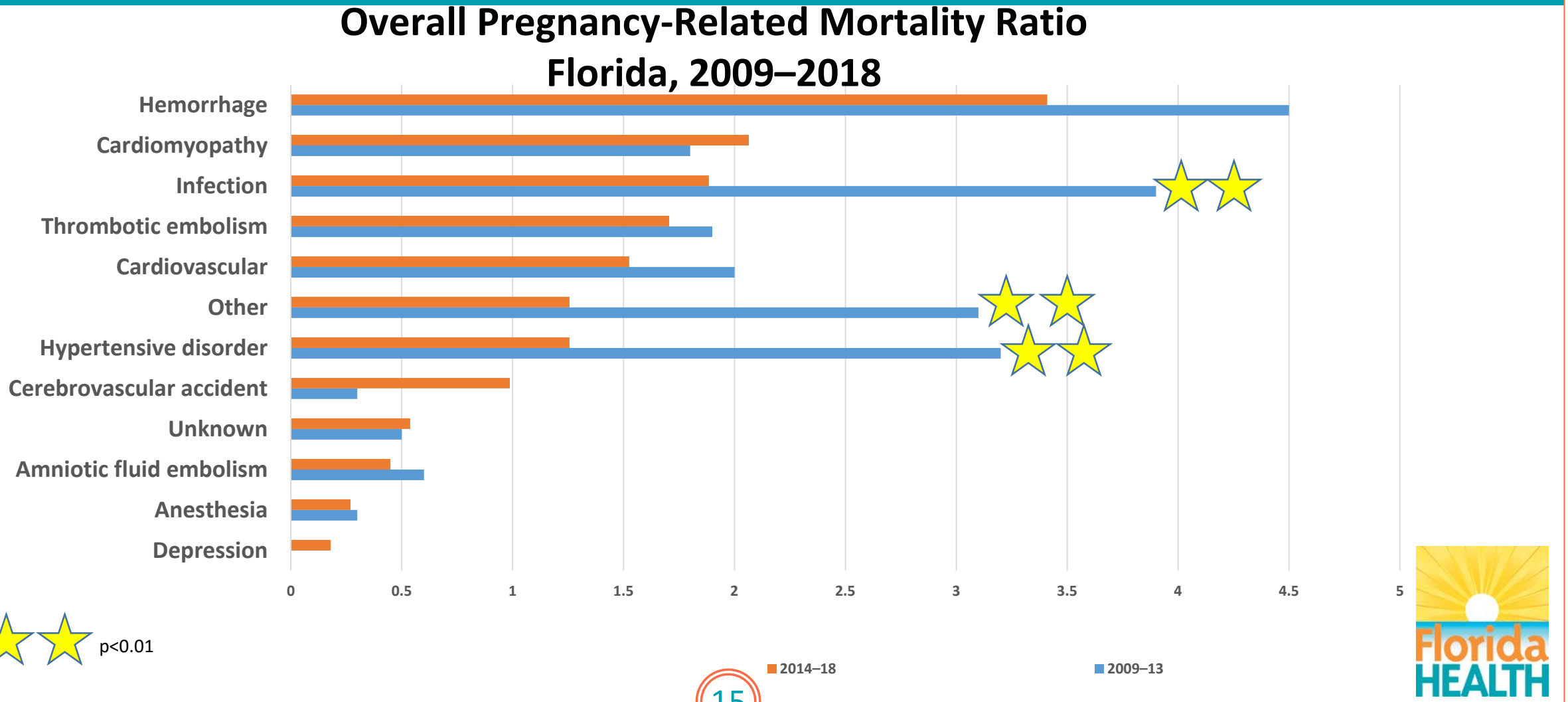
Pregnancy-Related Mortality Ratios by Race/Ethnicity, Florida, 2008–2018



Comparison of Two 5-Year Periods: Race and Ethnicity



Comparison of Two 5-Year Periods: Cause of Death



Florida PAMR 2018 Findings

The leading pregnancy-related causes of death in 2018 were:

- Cardiomyopathy (19.4%)
- Hemorrhage (16.7%)
- Thrombotic Embolism (11.1%)
- Infection (11.1%)
- Cardiovascular Diseases (8.3%)
- Hypertensive Disorder (8.3%)

Most PRDs (80.6%) occurred during the postpartum period. Of this percentage:

- 25.0% occurred prior to hospital discharge
- 55.6% occurred after hospital discharge

Florida PAMR: Recommendations to Actions

Key Partnerships:

- American College of Obstetricians and Gynecologists (ACOG) District XII
- Florida Perinatal Quality Collaborative (FPQC)

Florida PAMR: Recommendations to Actions, Continued

Past FPQC Quality Improvement Initiatives:

- Obstetric Hemorrhage Initiative (OHI)
- Hypertension in Pregnancy (HIP) Initiative
- Access Postpartum Long-Acting Reversible Contraceptive (LARC) Initiative

Florida PAMR: Recommendations to Actions, Continued

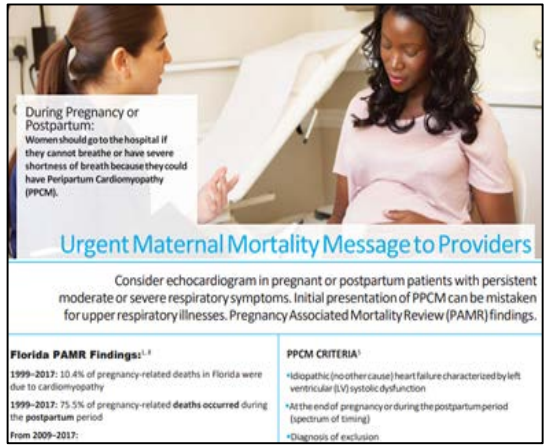
Current FPQC Quality Improvement Initiatives:

- Promoting Vaginal Deliveries (PROVIDE) Initiative
- Maternal Opioid Recovery Effort (MORE) Initiative

Florida PAMR: Recommendations to Actions, Continued

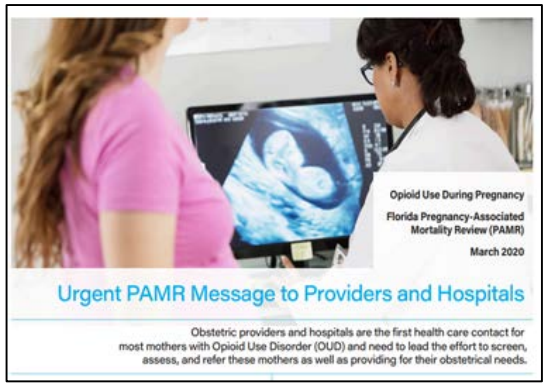
Urgent Maternal Mortality Messages:

- Hemorrhage and Placental Disorders
- Peripartum Cardiomyopathy
- Maternal Early Warning System (MEWS)
- Opioid Use During Pregnancy









PAMR Successes

- A significant decrease in the Black-White racial disparity gap from 8.7 to 2.5.
- Overall reduction in PRMR: 21.8 down to 15.5.
- Reduction in PRMR in Black women 46.6 down to 29.4.
- Reduction in PRMR in Hispanic women 12.8 down to 7.4.
- Reduction in PRMR in White women 15.8 down to 14.5.

PAMR Successes

- FL PAMR has served as a model program for the country
- PAMR members are content experts (sharing tools, resources and insight) for the CDCs national initiative *Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (*ERASE MM)
- FL PAMR was one of the first MMRCs to adopt the CDC hosted Maternal Mortality Review Information Application (MMRIA) national database.

PAMR Successes

- Consistent and standardized process over 25 years.
- PAMR members share findings and promote change through conferences, newsletters, Grand Rounds, Urgent Maternal Mortality Messages, and scholarly publications.
- Florida Association of Healthy Start Coalitions and one Federal Healthy Start project have implemented PAMR recommendations into their guidelines for care.

Florida PAMR

For more information, visit the PAMR website

http://www.floridahealth.gov/statistics-and-data/PAMR/index.html

For questions, please contact:

Deborah Burch DNP, RN

Deborah.Burch@flhealth.gov

Dr. William Sappenfield,
USF

William Sappenfield, MD, MPH, CPH
Professor, Director of Chiles Center, University of South Florida

William M. Sappenfield, MD, MPH is professor and chair of the Department of Community and Family Health and Director of the Lawton and Rhea Chiles Center for Healthy Mothers and Babies at the College of Public Health, University of South Florida. He just started this new career opportunity at USF to teach and develop new professionals in December 2011. His vision is to make the Chiles Center one of the leading national centers in maternal and child health practice and research.

As both a pediatrician and an epidemiologist, Dr. Bill Sappenfield has more than 27 years of experience in epidemiological teaching, research and practice in maternal and child health at a local, state and national level. Dr. Sappenfield received his medical degree from Louisiana State University Health Sciences Center in New Orleans in 1980 and his masters of public health with a concentration on epidemiology from Harvard University in 1984. He completed his pediatric residency training at Vanderbilt University Medical Center in 1983 and his preventive medicine residency training at the Centers for Disease Control and Prevention (CDC) in 1987. He also received applied epidemiology training through CDC's Epidemic Intelligence Service (EIS) program from 1984 to 1986.

As a nationally recognized leader in the field of maternal and child health epidemiology, Dr. Sappenfield spent the first 21 years of his career as a CDC epidemiologist working with state and local public health agencies to enhance their capacity to use epidemiology to improve the health of the women and children. This included being assigned to state public health agencies in Massachusetts, Mississippi and South Carolina. He was also assigned to work at CityMatCH—a national public health organization working with MCH Leaders in urban public health agencies, at the University of Nebraska Medical Center. He completed his CDC career serving four years as Team Leader of their MCH Epidemiology Program directly responsible for the national MCH EPI effort including mentoring senior MCH epidemiologists assigned around the nation.

For the next six years, Dr. Sappenfield served at the Florida Department of Health as the State MCH Epidemiologist and as Unit Director for the MCH Practice and Analysis Unit. His responsibilities include leading the Department's MCH epidemiology and evaluation efforts including directing a unit of six epidemiologists; working with MCH programs in Family Health and other divisions; collaborating with state agencies, organizations, and universities; and assisting County Health Departments and community partners.

Dr. Sappenfield's major contributions to the MCH field include early efforts to develop community-based fetal and infant mortality reviews, to adapt the perinatal periods of risk approach to assess infant mortality in U.S. communities, to propose state preconception health indicators and to shape best practices in applied MCH epidemiology. His current research projects include: maternal and infant mortality, chronic diseases during pregnancy, assistive reproductive technology, unintended pregnancy and contraceptive use, non-medically indicated deliveries prior to 39 weeks, population-based perinatal quality improvement efforts, access to childhood preventive dental care, and use of data file linkages in maternal and child health. He continues to mentor both young and senior MCH epidemiologist in public health practice around the nation.

Dr. Sappenfield has received several national and state awards. In 2003, he received the National MCH Epidemiology Award for Outstanding Leadership sponsored by 16 national health organizations.

Florida Perinatal Quality Collaborative (FPQC):
Improving the Health & Health Care of Florida's Mothers & Babies

William M. Sappenfield, MD, MPH, CPH

Professor & Director

Florida Perinatal Quality Collaborative

USF HEALTH COLLEGE OF PUBLIC HEALTH
UNIVERSITY OF SOUTH FLORIDA



Vision

"All of Florida's mothers and infants will have the best health outcomes possible through receiving high quality evidence-based perinatal care."

Values

- Data-Driven
- Voluntary
- Population-Based
- Evidence-Based
- Value Added

FPQC Partners & Funders

Florida HEALTH

CDC
Centers for Disease Control and Prevention

Agency for Health Care Administration

Alliance for Innovation on Maternal Health AIM

USF HEALTH

The American College of Obstetricians and Gynecologists
Women's Health Care Physicians

AWHONN
Florida
Promoting the Health of Women and Newborns

Florida Affiliate of the American College of Nurse-Midwives
With women, for a lifetime®

Florida Association of Healthy Start Coalitions, Inc.
Every baby deserves a healthy start

Florida Society of Neonatologists
Advancing the Care of Neonates in the Sunshine State

Florida Academy of Family Physicians
Support Florida's Family Physicians

March of Dimes

Florida Blue

Florida Hospital Association
Mission to Care. Vision to Lead.

Preeclampsia Foundation

Florida Alliance for Healthcare Value

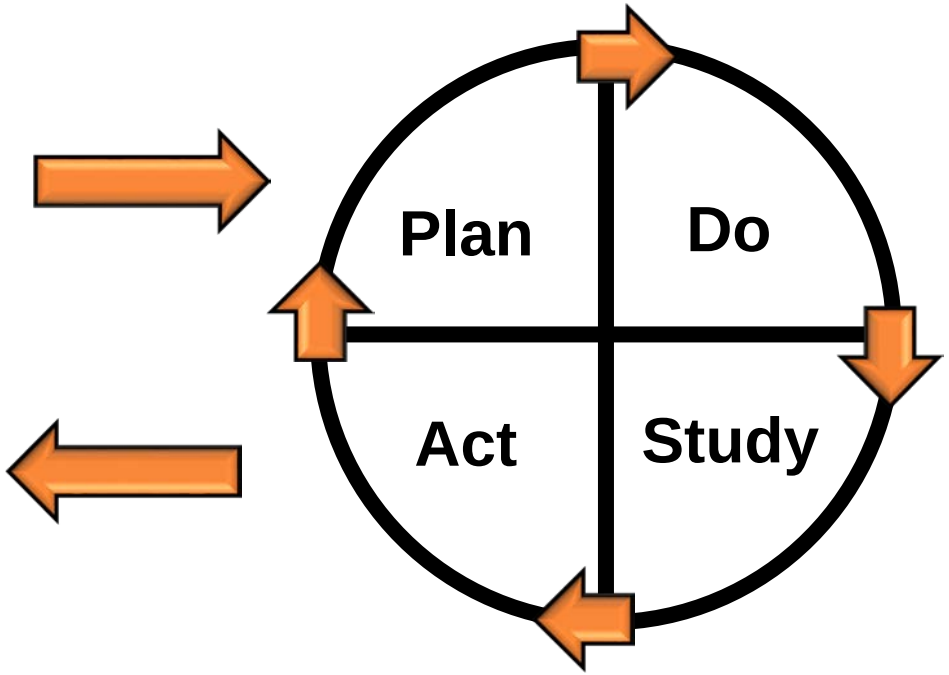
Quality Improvement

The Framework for QI

What are we trying to accomplish?

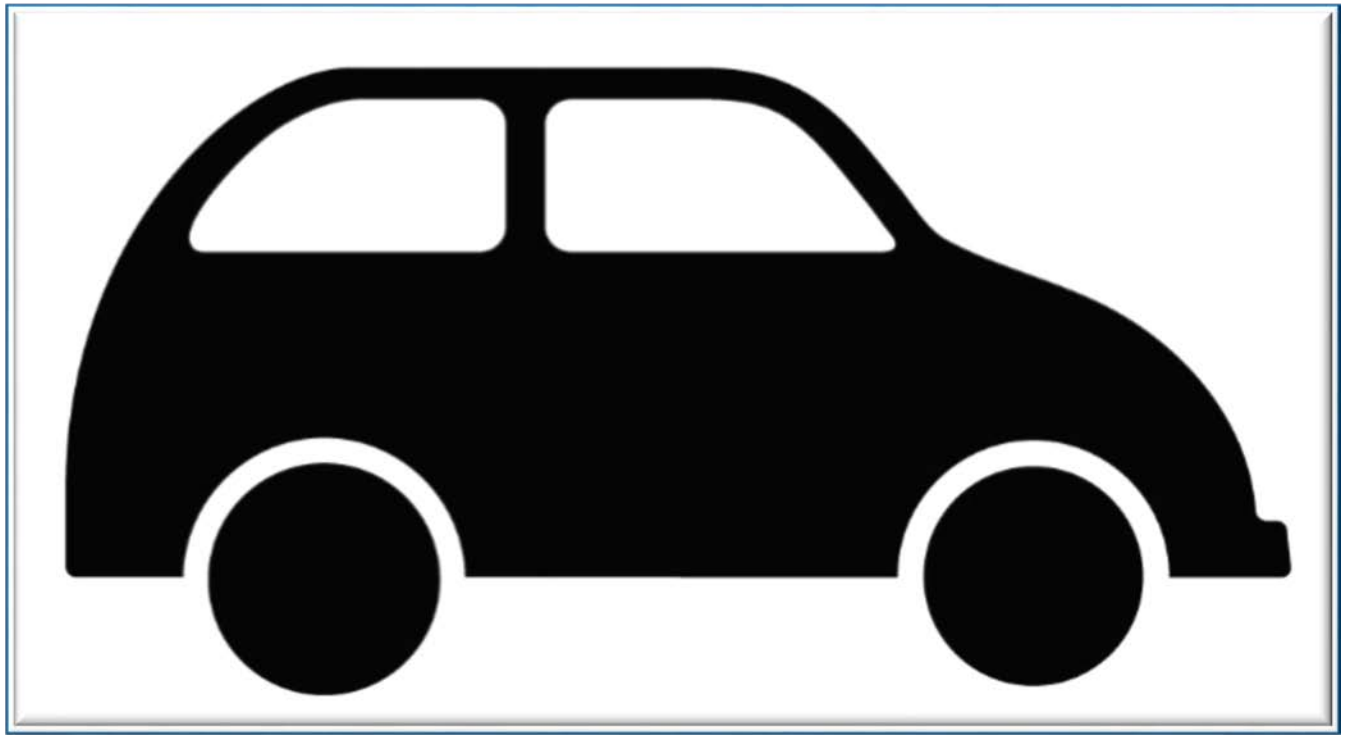
How will we know that a change is an improvement?

What change can we make that will result in improvement?



Associates in Process Improvement: Model for Improvement

"A Quality Collaborative is like a Car…"



FPQC Initiative Resources

Technical Assistance

from FPQC staff, state Clinical Advisors, and National Experts

Project-wide in-person collaboration meetings

Educational sessions, videos, and resources

Monthly and Quarterly QI Data Reports

Monthly e-mail blasts

Custom, Personalized Consultations & Grand Rounds Education

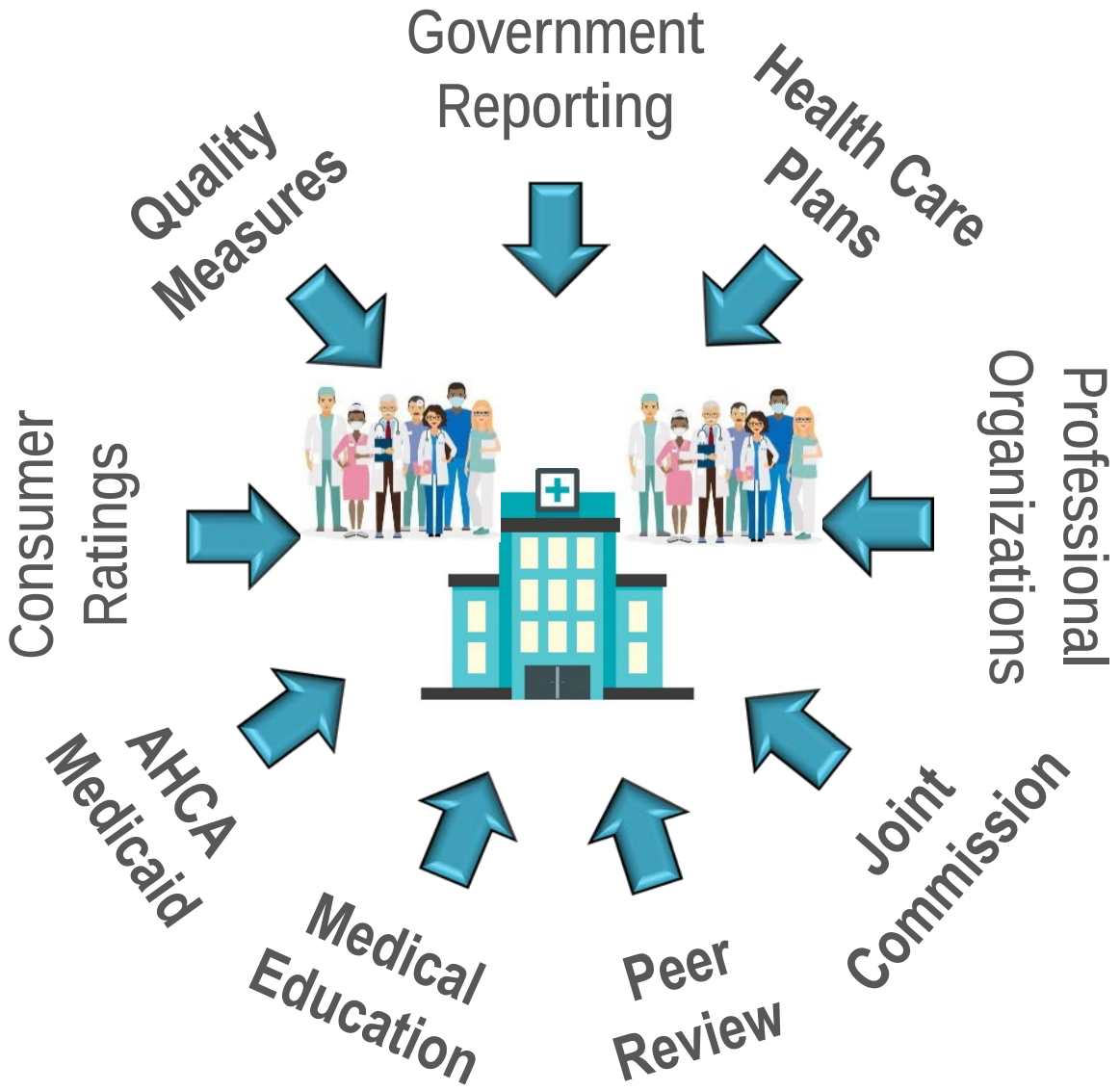
Monthly Collaboration Calls with hospitals state-wide

Online Tool Box

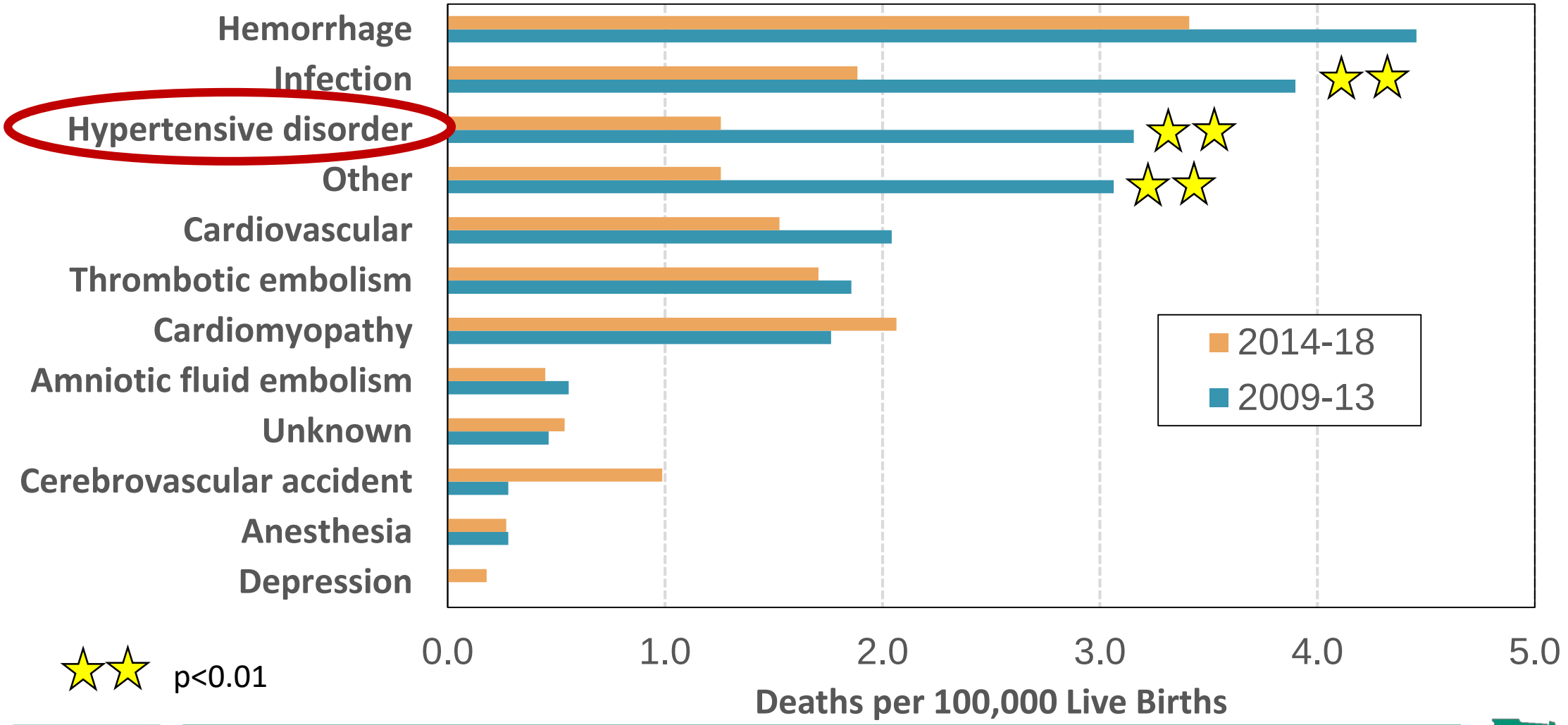
Algorithms, Sample protocols, Maternal education tools, Slide sets, etc.

FPQC

Multiple Pressure Points to Improve Quality



Pregnancy-Related Mortality Ratios by Underlying Cause Florida, 2009-2018



Hypertension in Pregnancy (HIP) Change Package Elements

Readiness

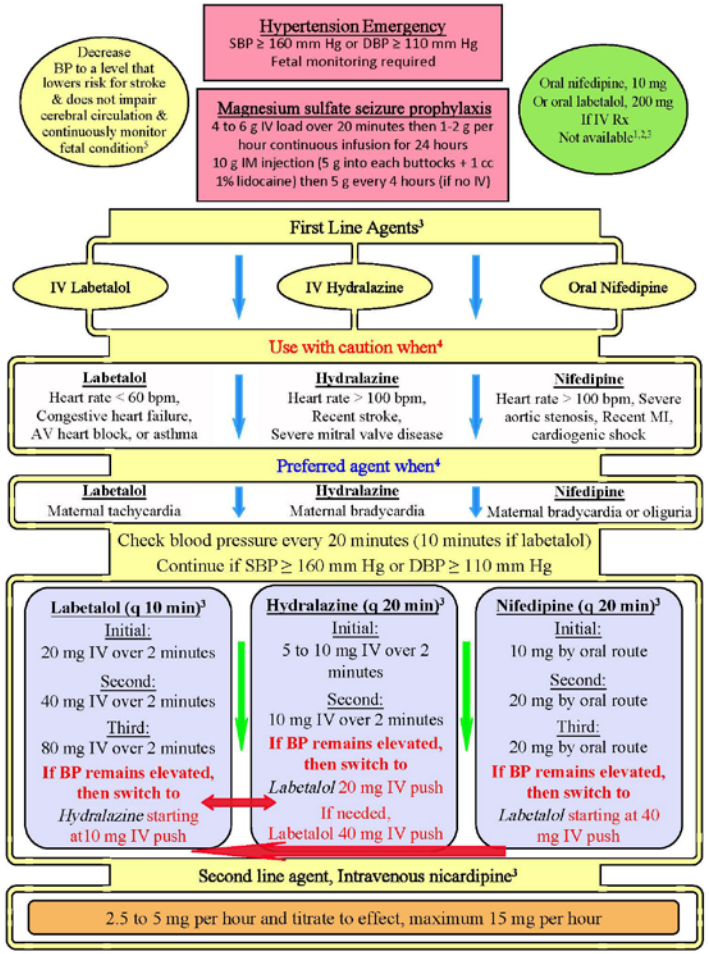
- Diagnostic criteria, monitoring and treatment
- Timely triage from ER and outpatient
- Rapid access to medications

Recognition

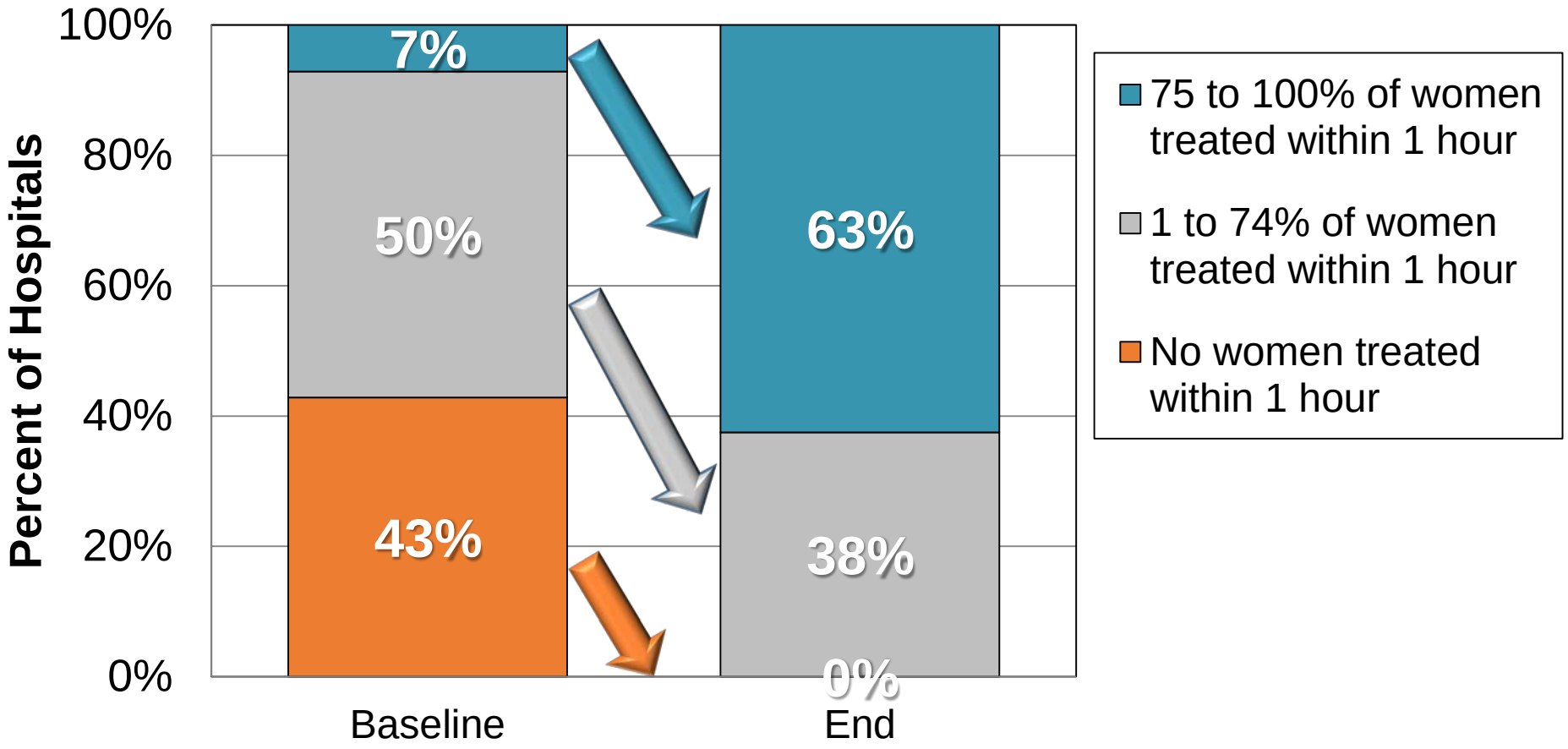
- Assessment protocols
- Response to early warning criteria
- Educating women on signs and symptoms

Response

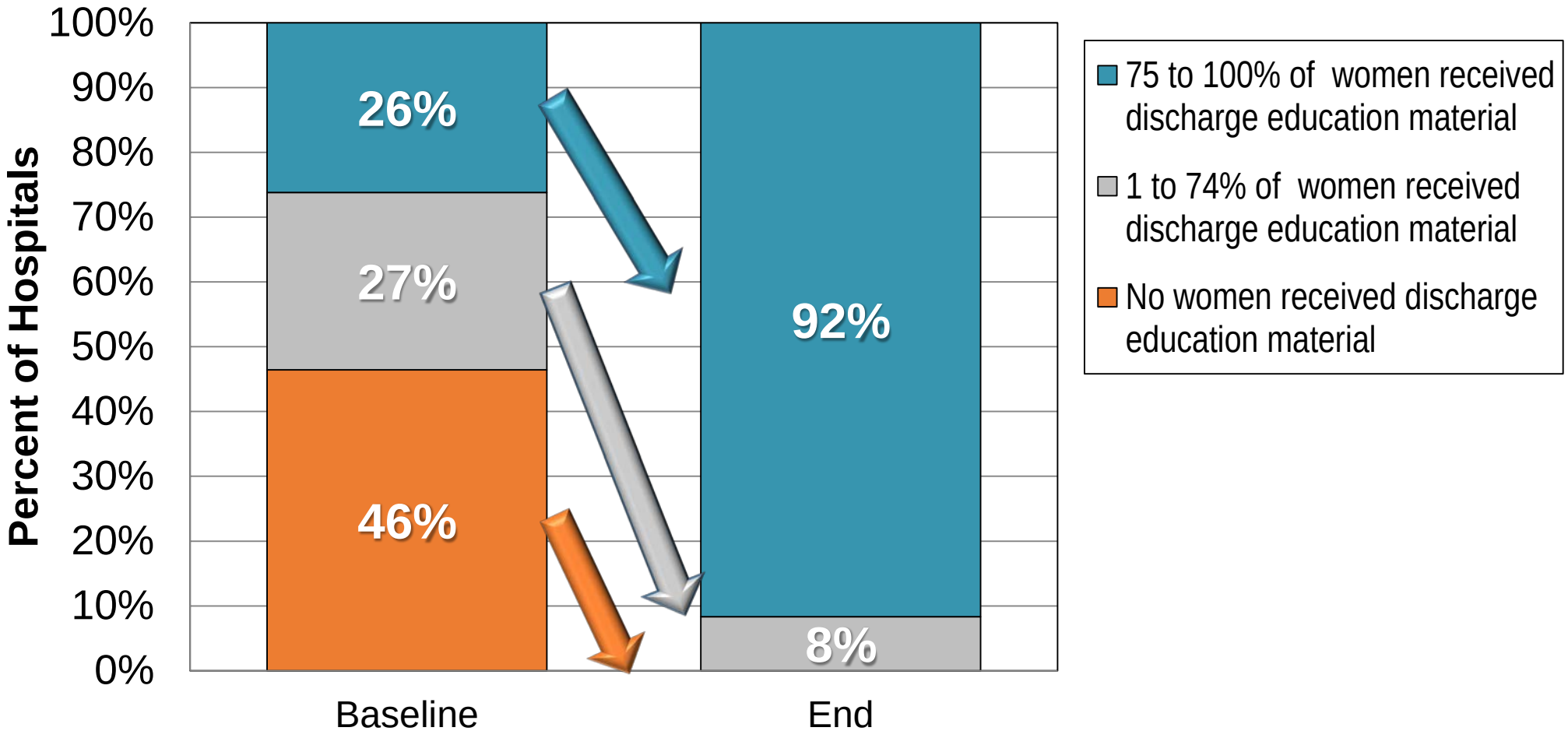
- Protocols for management/treatment
- Support plans for patients, families & staff
- Simulations
- Debriefs



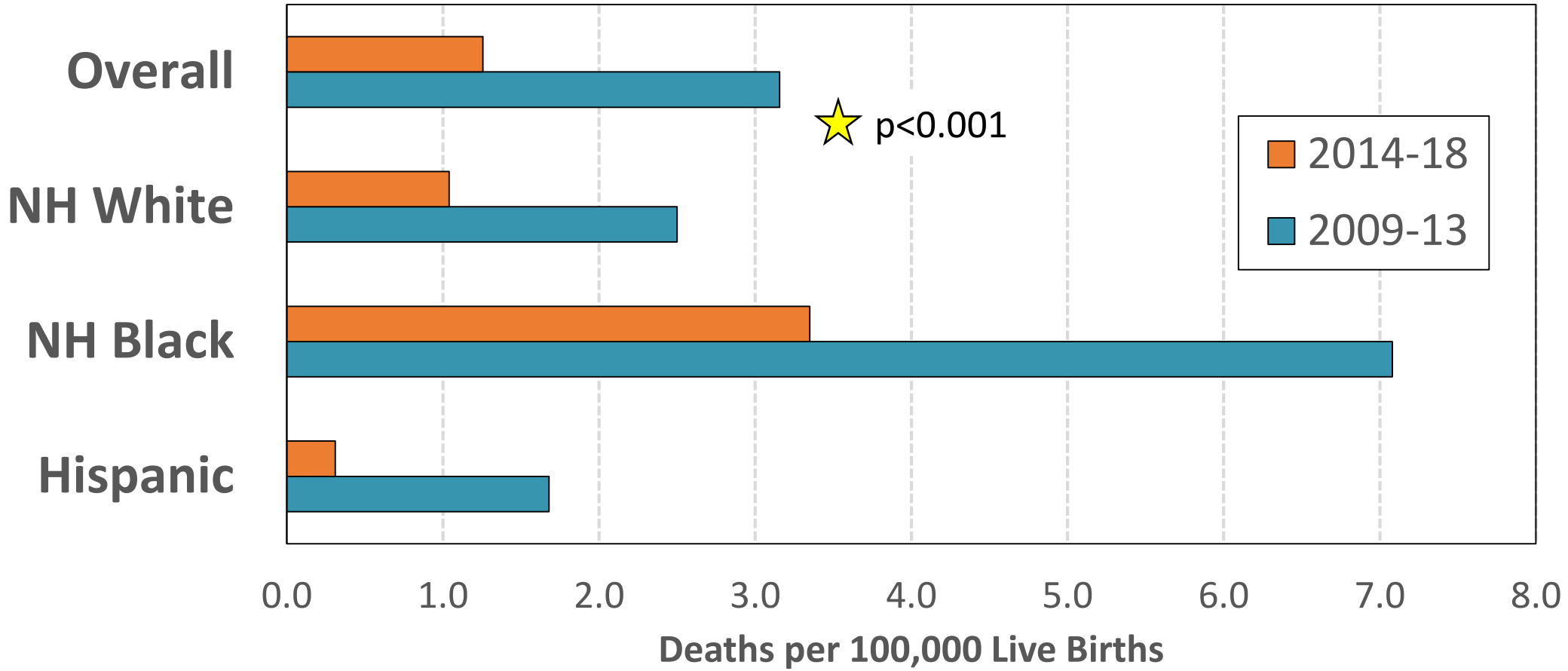
Percent of HIP Hospitals that Treated Women with Persistent New-Onset Severe HTN in 1 hour



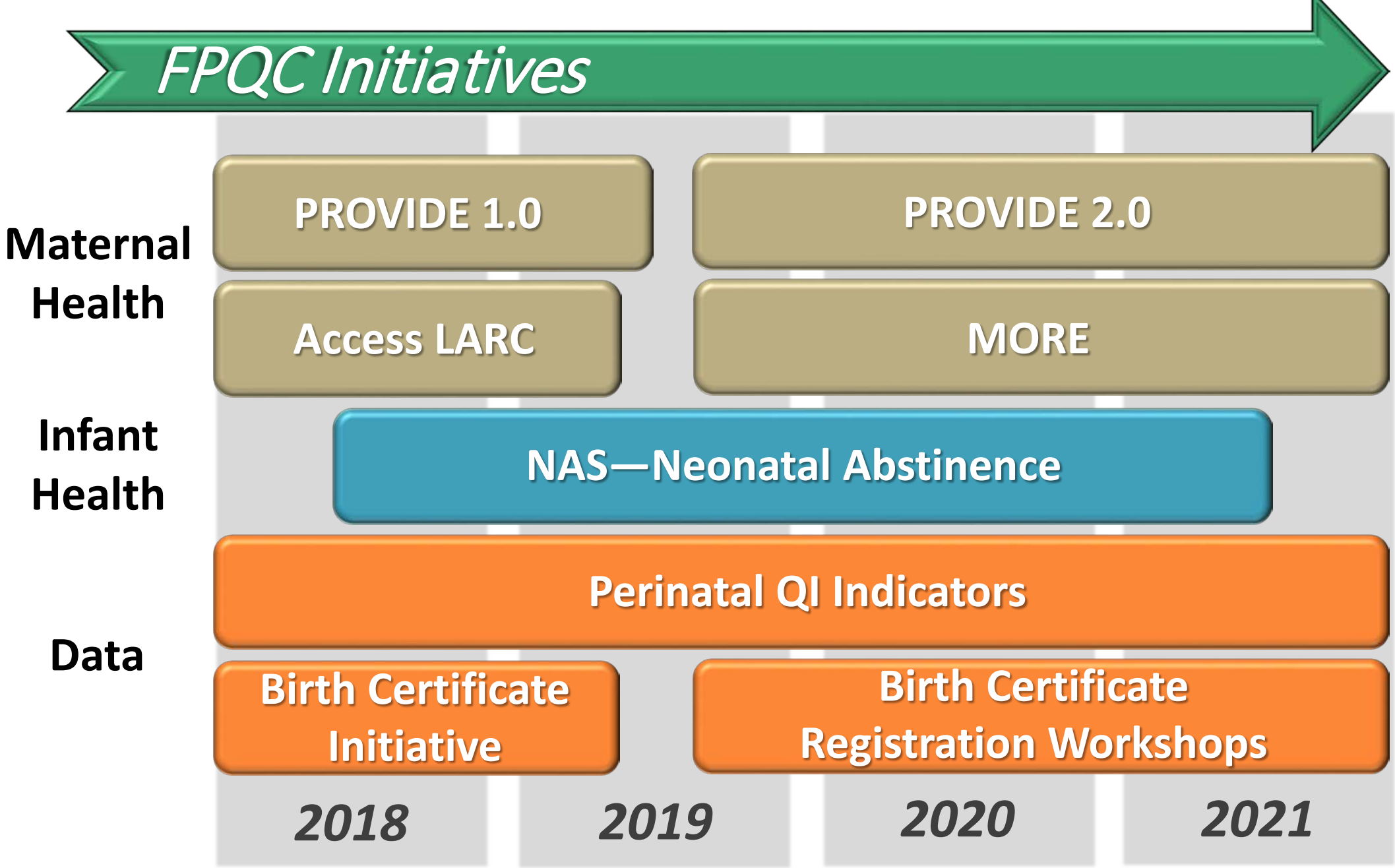
Percent of HIP Hospitals Where Women Received Discharge Education Material



Florida Pregnancy-Related Mortality Ratio Due to Hypertension, 2009-2018



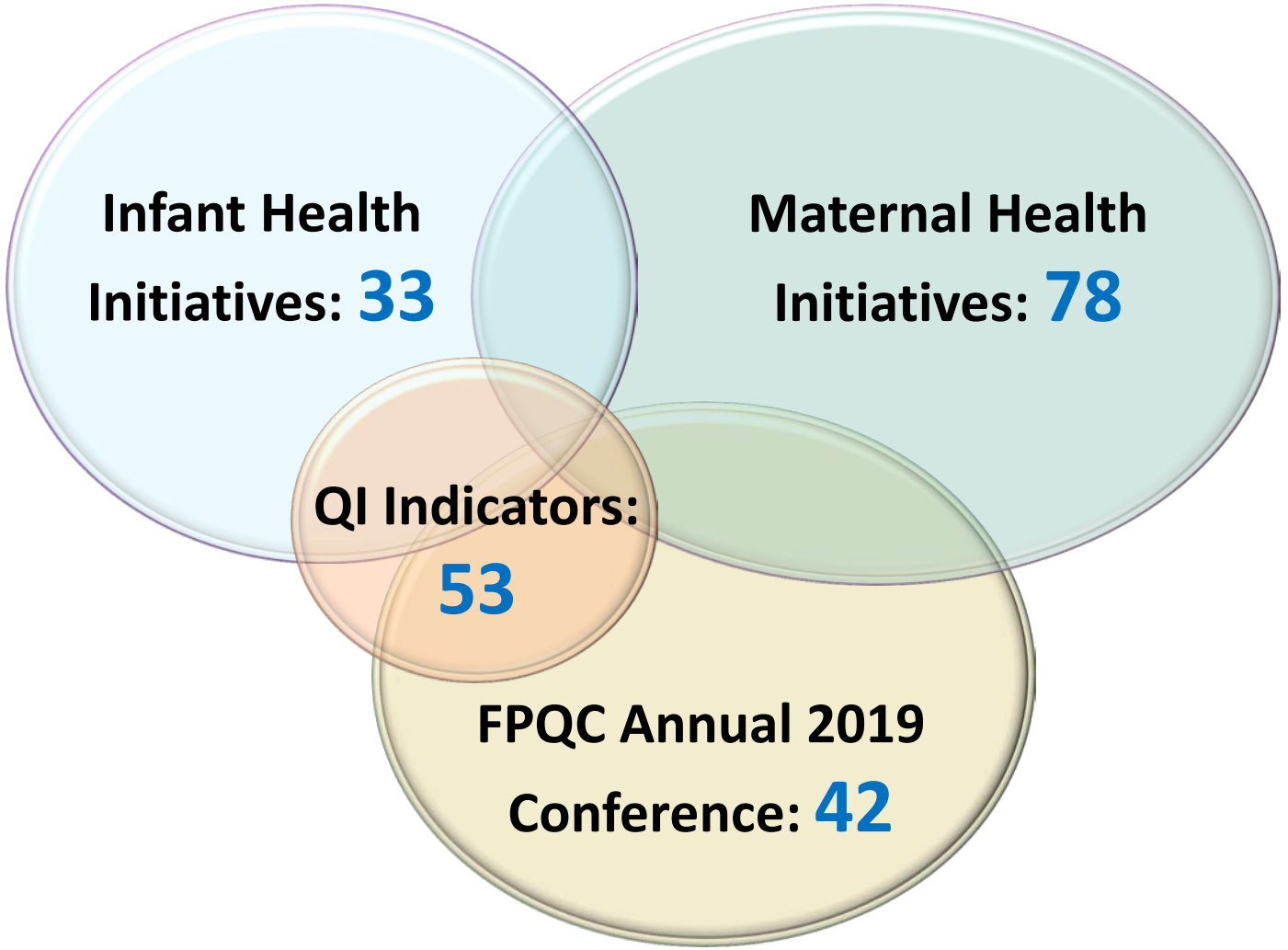
FPQC Initiatives



FPQC Hospital Participation—2020

113 Florida Maternity Hospitals

74 Florida Level II & III NICUs

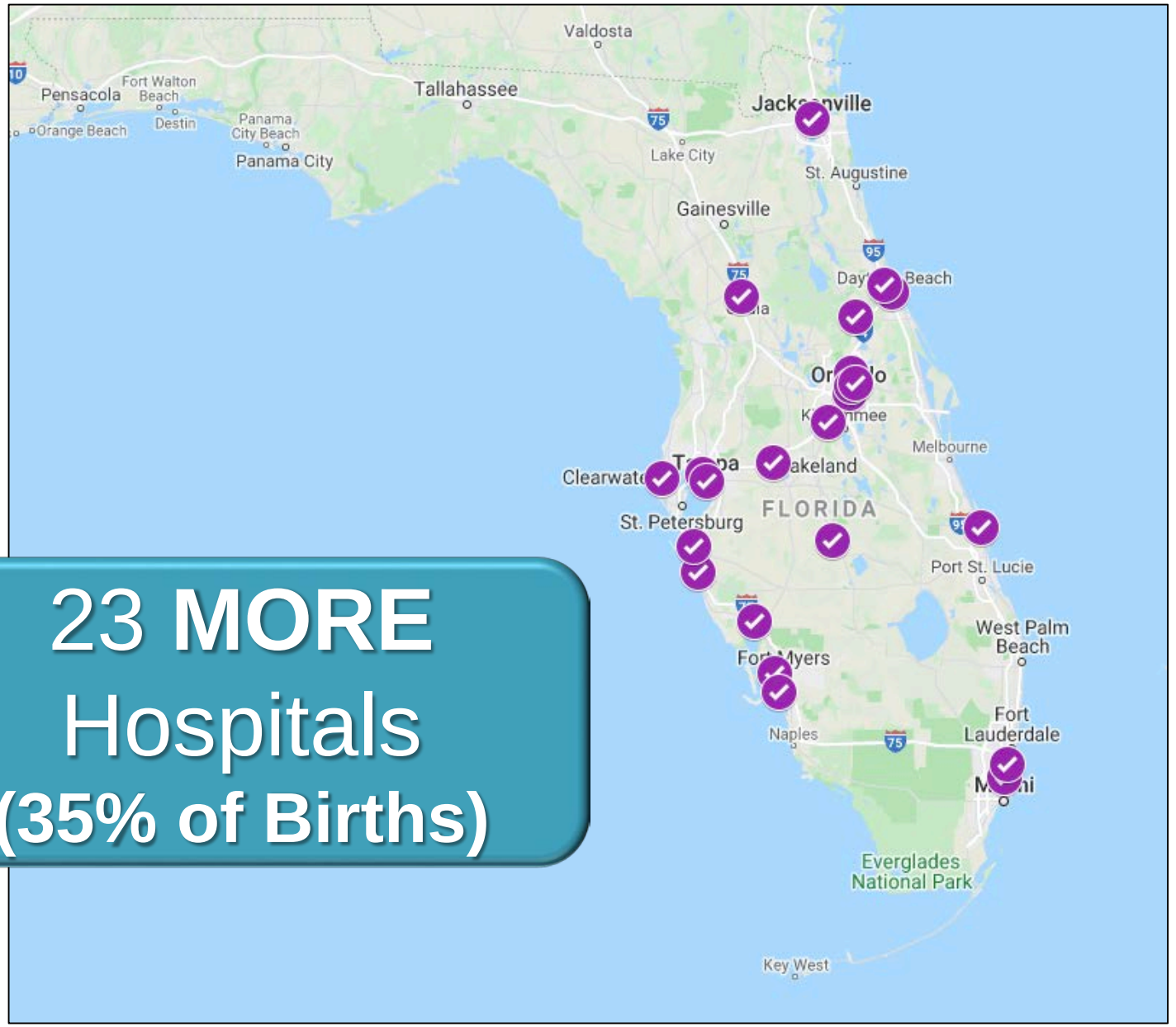


MORE: Maternal Opioid Recovery Effort



More:

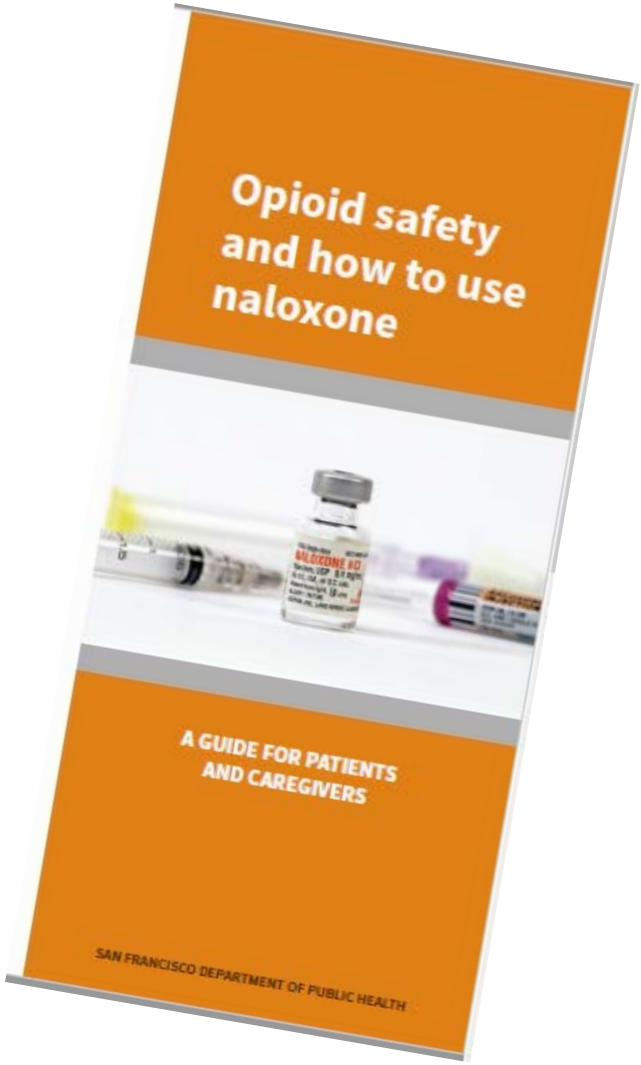
- ✓ Attention
- ✓ Support
- ✓ Services
- ✓ Follow up
- ✓ Compassion



23 MORE
Hospitals
(35% of Births)

MORE Patient Education Material





MORE 4-Part Video Series



From Judgment to Healing: *The Impact of Stigma*

Getting Real: *Taking the First Steps Toward Recovery*





Screening, Brief Intervention, and Referral to Treatment

Mothers & Babies to Services: *Plans of Safe Care*



MORE Folders & Huddles

- **MORE folders include:**
  - Patient care check list
  - Provider and patient education
- **Team huddles at admission to coordinate care**
- **Pilot in 4 hospitals**



When an OB patient screens + for Opioid Use Disorder (OUD) during an admission, a MORE Folder (stored on L&D/Triage/MBU) is obtained by the patient's nurse.
Folder contents are listed below:

(1) MORE *OUD Clinical Algorithm* for provider review
(2) *MORE Checklist/Workflow*
(3) Contraceptive Counseling materials
(4) Community Mapping Tool to use with community referrals
(5) *Save a Life Naloxone (Narcan ®) guide* to help providers complete Naloxone counseling / prescription
(6) *MORE patient education materials: MORE HOPE pamphlet & Naloxone tri-fold* for the patient

The patient's nurse works with the rest of the OB clinical team to make sure the OUD Clinical Algorithm is followed & MORE Checklist is completed prior to discharge. Reminding the clinical team that OUD is the leading cause of maternal death in Florida may help the team understand why these steps matter. Remind all members of the care team that reducing stigma. & treating patients with empathy & compassion improves outcomes for moms with OUD.

√	MORE Checklist/Workflow	Clinical Team Initials/Notes/Date
	Report + OUD screen to OB provider & give OB provider the **MORE Clinical Algorithm** to review	
	Request a neo/peds consult for positive OUD screen to counsel on NAS & how moms engage in opioid exposed newborn care when appropriate	
	Call Team Huddle-OB Provider, Neo/Peds, Social work, Charge Bedside RN during hospitalization	
	Confirm **Hep C, Hep B, HIV** and other recommended secondary screening completed	
	Confirm the provider has the **Save a Life Naloxone guide** (to assist with Naloxone counseling/prescription as a risk reduction strategy for all patients who use opioids regularly)	
	Handoff/Review **MORE folder & MORE Checklist/Workflow** with postpartum RN	

√	Prior to Discharge	Clinical Team initials/Notes/Date
	Review **MORE patient education materials (MORE folder** or http://fpqc.org/more Reinforce important role of mom/family in self-care & care of baby with NAS.	
	Confirm patient's readiness for Medication-Assisted Treatment (MAT) & plan is documented. Remind providers that help with clinical management of OUD / MAT is available through the *UCSF Substance Use Warmline*: 855-300-3595 with free addiction med phone consult.	
	Confirm the patient is linked to behavioral health services/recovery treatment program & has follow up **or** work with a social work consult to confirm a warm hand off & close follow up to establish linkage to services.	
	Work with Neo/Peds team to engage & support mom/family, providing non-pharmacologic care as appropriate: breastfeeding, skin to skin, rooming in, Eat Sleep Console (ESC).	
	Confirm Behavioral Health and/or MAT appointment made before discharge.	
	Confirm Naloxone (Narcan ®) counseling has been provided & prescription has been provided before discharge. If possible, encourage having the prescription filled prior to discharge.	
	Confirm all recommended secondary infectious disease screening completed, results provided to the patient, & follow up plan established by OB for all positive screens.	
	Confirm comprehensive contraception counseling has been provided and method of contraception has been identified/prescribed.	
	Review this Checklist with OB Provider. Determine next steps for ANY incomplete elements.	
	Confirm patient has early postpartum follow up visit with OB for 1-2 weeks PP scheduled.	
	Ensure the OB clinical team is in communication with Neo/Peds to confirm a coordinated Plan of Safe Care (POSC). Make sure the patient / family understands their POSC.	
	Ensure *Alternatives to Opioids* pamphlet has been provided if opioids prescribed.	

Florida Perinatal Quality Collaborative 7.20.20 *Adapted from ILPQC MNO Initiative*

Putting the Community Pieces Together for Opioid Exposed Mothers



Contracting with Florida Healthy Start for community resource directories and consultation

Statewide ad hoc committee on Plans of Safe Care: Common messages & reporting system

Action plans for maternity units to be able to distribute Naloxone free at discharge

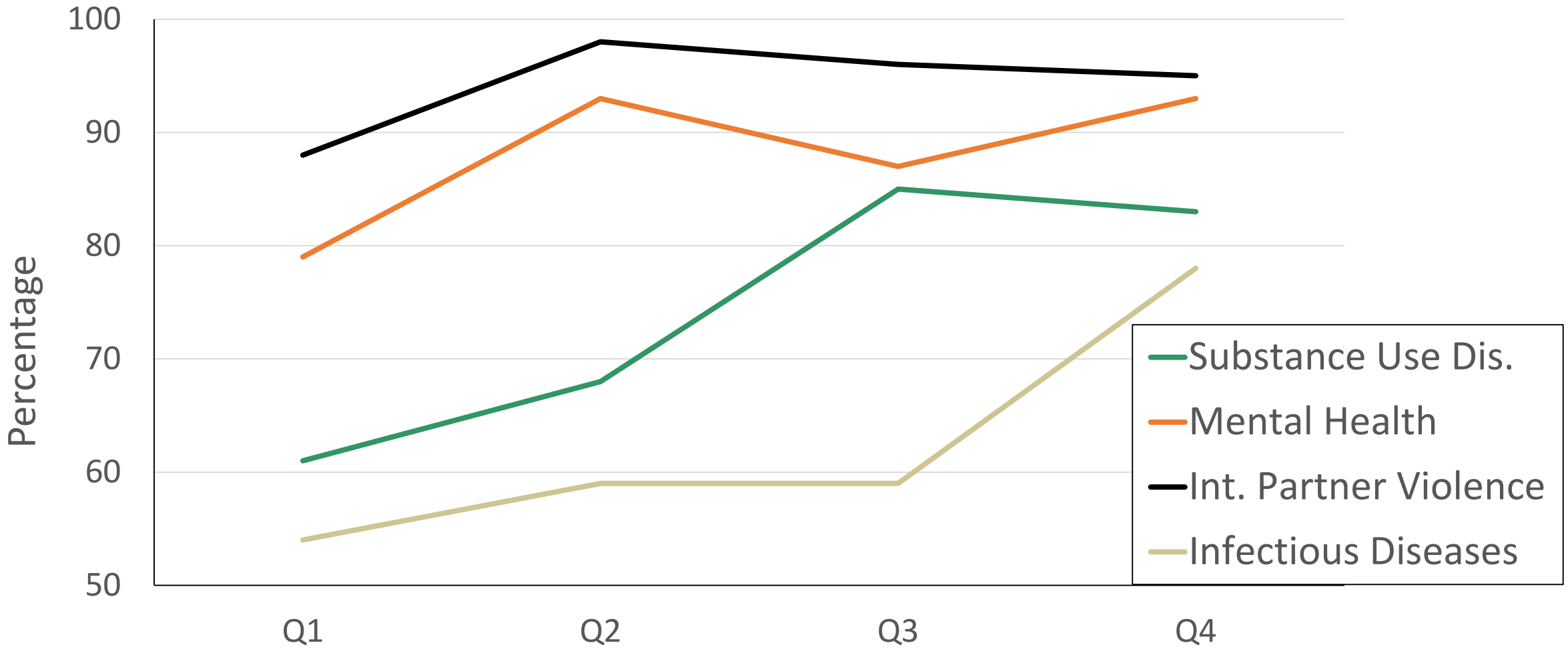
Statewide ad hoc committee to address community barriers to mothers receiving medication-assisted treatment

Monthly Coaching Calls

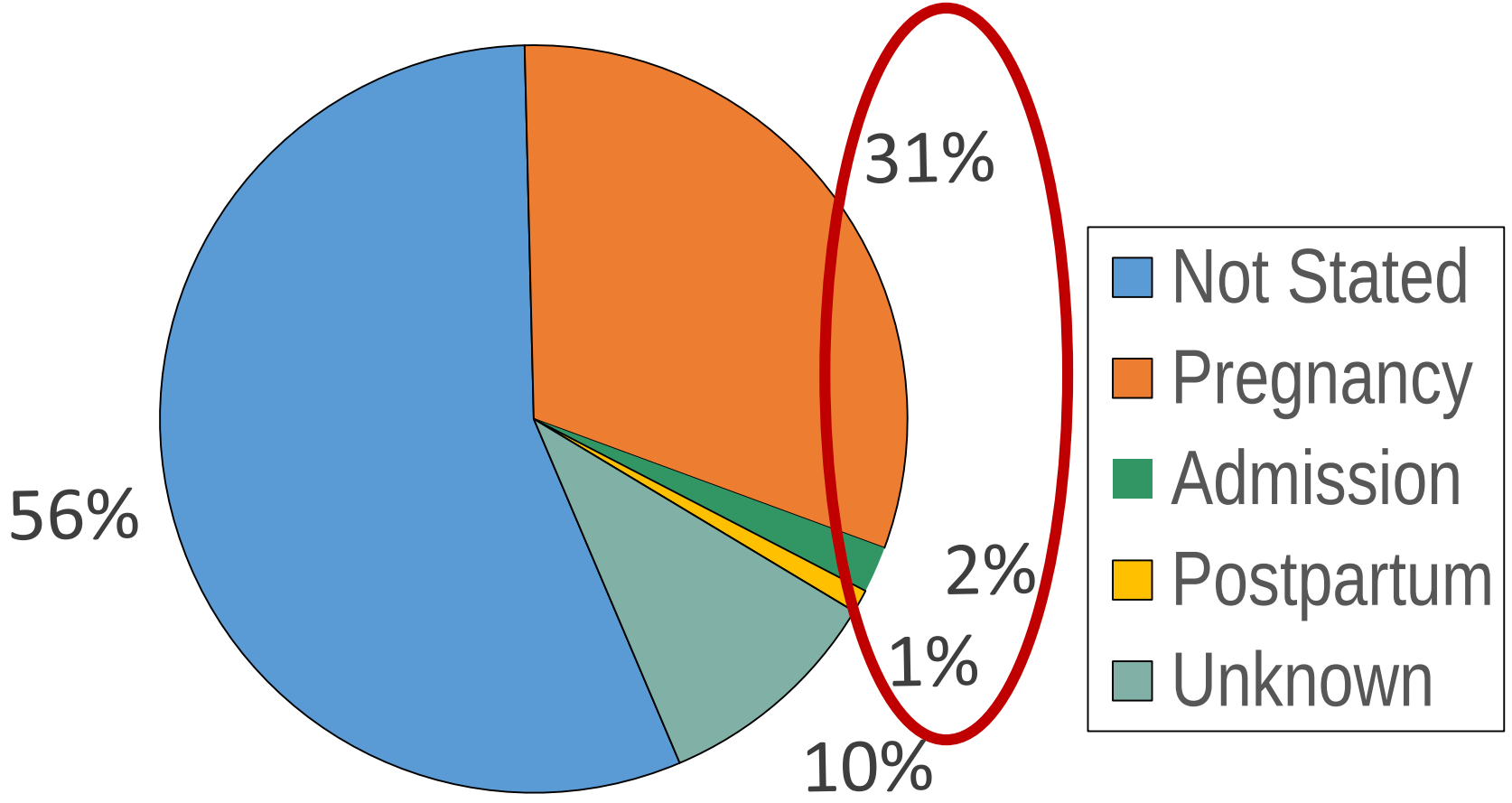


- Small hospital groups
- Physician & nursing leads
- Select one brief discussion topic
- Celebrate successes
- Discuss challenges
- Share 30-60-90 day plans

Maternal Screening in Hospital



Behavioral Health / Medication-Assisted Treatment



Comprehensive Discharge Planning

	Q1	Q2	Q3	Q4
Narcan education	21%	1%	5%	9%
Social work consultation	96%	94%	95%	96%
Contraceptive plan	56%	58%	52%	68%
OB postpartum visit	16%	23%	21%	13%
Pediatric consult	72%	78%	72%	92%
Behavioral/MAT referral	46%	48%	31%	28%
Healthy Start referral	85%	77%	75%	80%



Promoting Primary Vaginal Deliveries (PROVIDE 2.0)

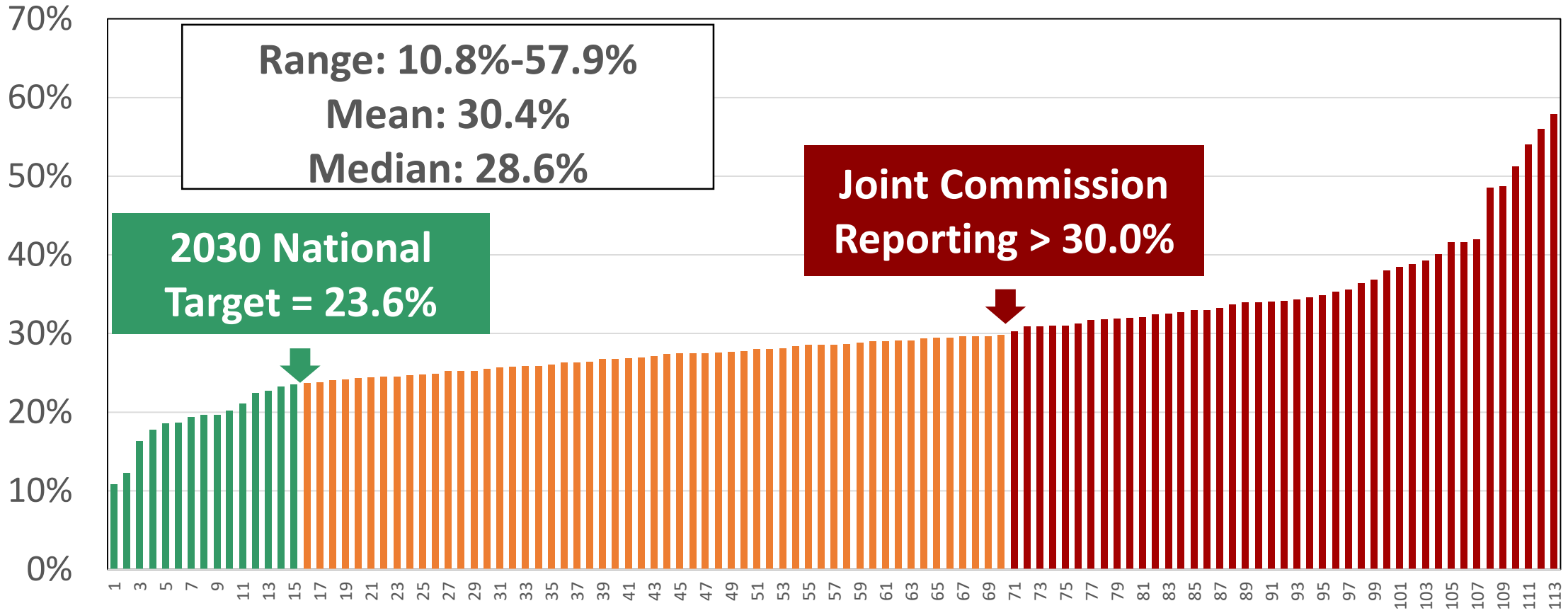
Promoting Safe Vaginal Birth &

Reducing Unnecessary Low Risk Cesareans (NTSV)

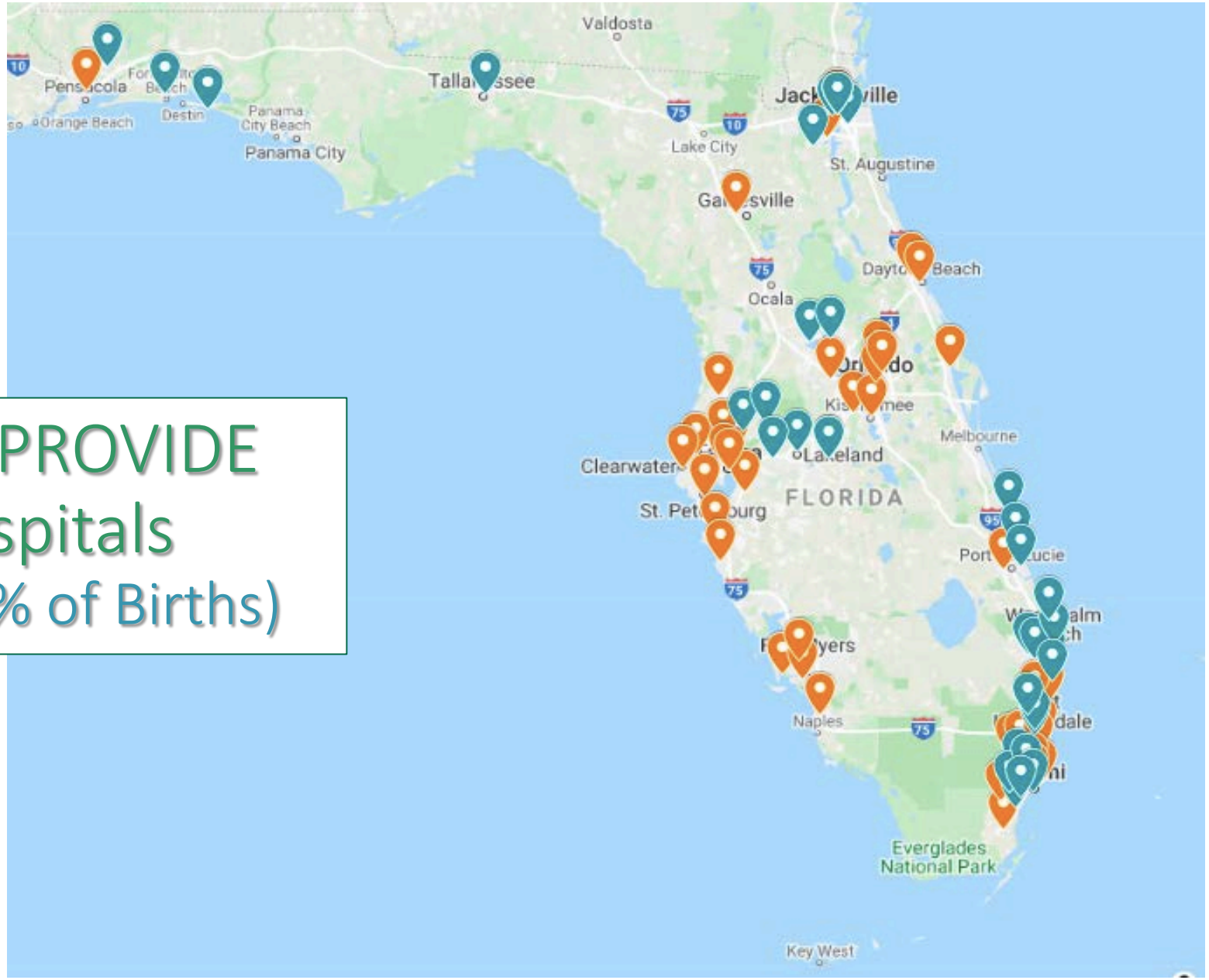
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH AIM

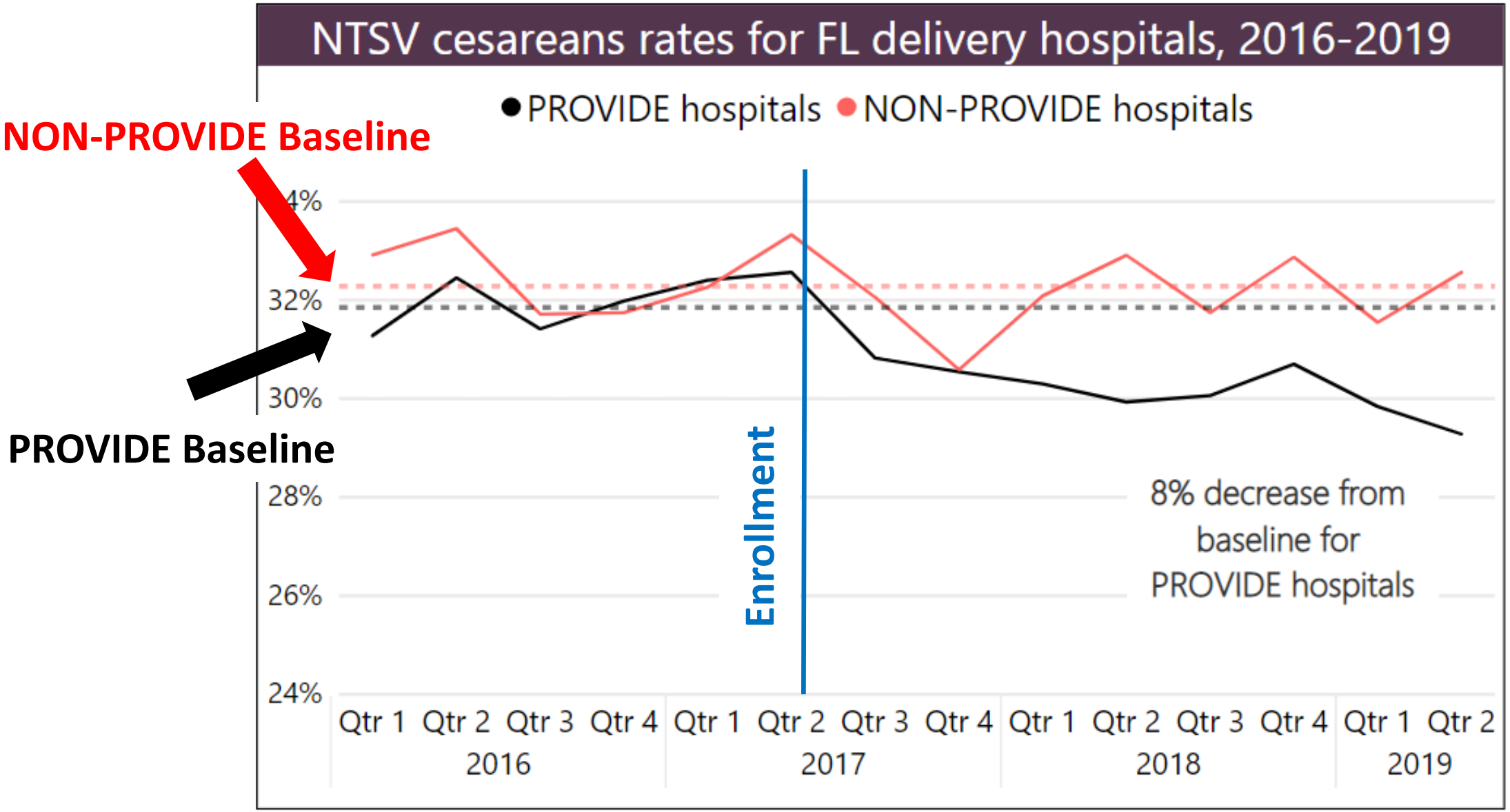
Florida HEALTH

2019 Low-Risk Nulliparous Term Singleton Vertex - NTSV Cesarean Rate, FL birthing hospitals



74 PROVIDE Hospitals (80% of Births)




NTSV cesareans rates for FL delivery hospitals, 2016-2019
PROVIDE hospitals
NON-PROVIDE hospitals
NON-PROVIDE Baseline
PROVIDE Baseline
4%
32%
30%
28%
26%
24%
Enrollment
8% decrease from baseline for PROVIDE hospitals
Qtr 1 Qtr 2 Qtr 3 Qtr 4 Qtr 1 Qtr 2 Qtr 3 Qtr 4 Qtr 1 Qtr 2 Qtr 3 Qtr 4 Qtr 1 Qtr 2
2016
2017
2018
2019

NTSV Cesarean Rates by Delivery Attendant

NTSV CESAREAN DELIVERY BY ATTENDANT REPORT-2018 (Q3)

Hospital Code	X	Year 2018(Jan-Oct)		2018 Q3(Aug, Sep, Oct)					
RandomID	Attendant Name	Running Yearly NTSV Ces	Running Yearly NTSV Births	Running Yearly Cesarean Rate	Quarterly NTSV Cesarean Total	Quarterly NTSV Births Total	Quarterly NTSV Cesarean Rate	Rank	Attendant Type
4231	Van De Waal	11	37	28.5%	16	17	**94.1%**	**1**	
4213	Latif Abdul	36	43	82.7%	20	23	**87.0%**	**2**	
3241	Vasha Patel	31	39	79.6%	19	25	**76.0%**	**3**	
3124	Li Mark	19	27	71.1%	13	18	**72.2%**	**4**	
2341	Shanice Four	17	23	71.9%	10	15	**66.7%**	**5**	
2143	Jose Miguel	13	27	47.4%	15	27	**55.6%**	**6**	
1234	John Smith	10	22	45.8%	10	20	**50.0%**	**7**	
2314	Jose Martinez	18	37	47.4%	12	24	**50.0%**	**8**	
1423	Rose Jones	29	56	51.9%	23	47	**48.9%**	**9**	
1432	Rosa Three	19	45	42.1%	11	23	**47.8%**	**10**	
3421	James Junior	10	23	45.1%	11	23	**47.8%**	**11**	
4132	Jane McJonas	14	34	42.5%	12	28	**42.9%**	**13**	
2431	John Peery	15	43	35.5%	10	27	**37.0%**	**14**	
3412	Alex Peters	10	30	34.5%	12	34	**35.3%**	**15**	
1342	Tom Jones	12	38	32.5%	10	30	**33.3%**	**16**	
4123	Alex III Mark	2	9	23.7%	6	18	**33.3%**	**17**	
2134	Pierre Thomas	1	7	14.0%	2	11	**18.2%**	**21**	
4321	Okoye Oba	2	18	13.0%	3	23	**13.0%**	**23**	
3214	Vasha Peters	1	10	8.5%	2	23	**8.7%**	**24**	
1324	Sam Three	0	3	5.2%	0	13	**0.0%**	**25**	

Labor Support Skills to Promote Vaginal Deliveries



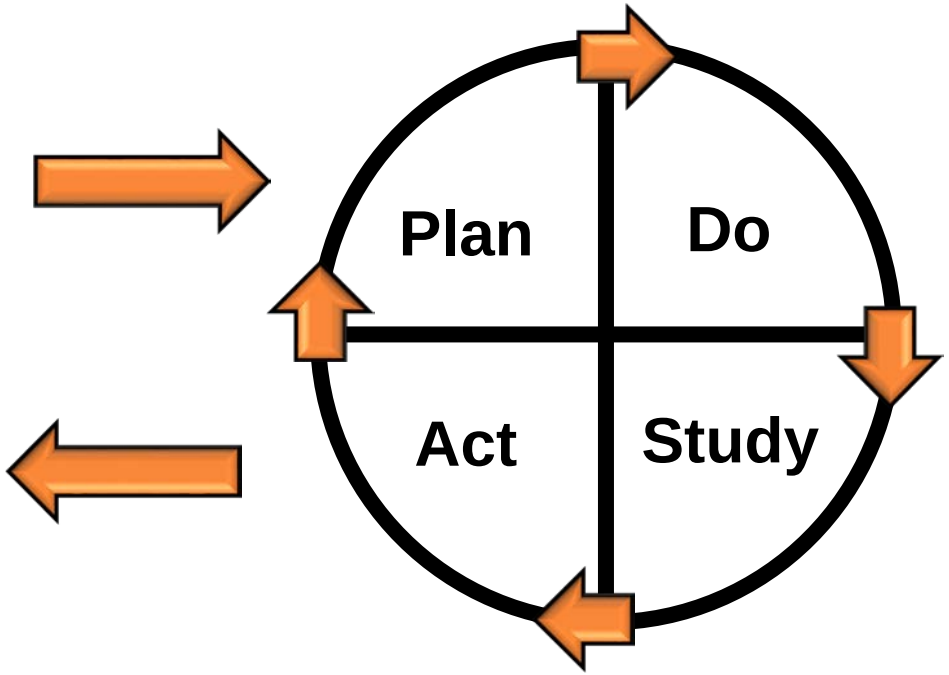
Quality Improvement

The Framework for QI

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?



Associates in Process Improvement: Model for Improvement

Questions?

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fpqc@usf.edu

www.fpqc.org

"To improve the health and health care of Florida's mothers and babies"

Cathy Timuta,
Florida Healthy Start

Bio: Cathy Timuta, MBA

(rev. 2-1-21)



Cathy Timuta is the Chief Executive Officer for the Florida Association of Healthy Start Coalitions (FAHSC) and the Healthy Start MomCare Network, Inc. which is the administrative services organization for FAHSC. She has been in these roles since October 2018. Prior to working at the state level, Cathy was the Executive Director for the Healthy Start Coalition of Southwest Florida for 19 years. She was a former Board President for FAHSC as well as former co-chairs for several committees including Legislative, Data, Contracts, and Managed Care Organizations committees. Cathy started her career in Minnesota where she received her MBA in health care administration. She was the Project Manager for the Minnesota Health Partnership, which was a collaboration of the state of Minnesota, the Buyer's Healthcare Action Group (Minnesota's largest employers), hospital systems, and health plans. Her passion is to ensure that families have access to needed healthcare and services to empower parents to give their every baby a healthy start in life.

Florida Association of
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EVERY BABY DESERVES A HEALTHY START

www.HealthyStartFlorida.com

Cathy Timuta, Chief Executive Officer



History

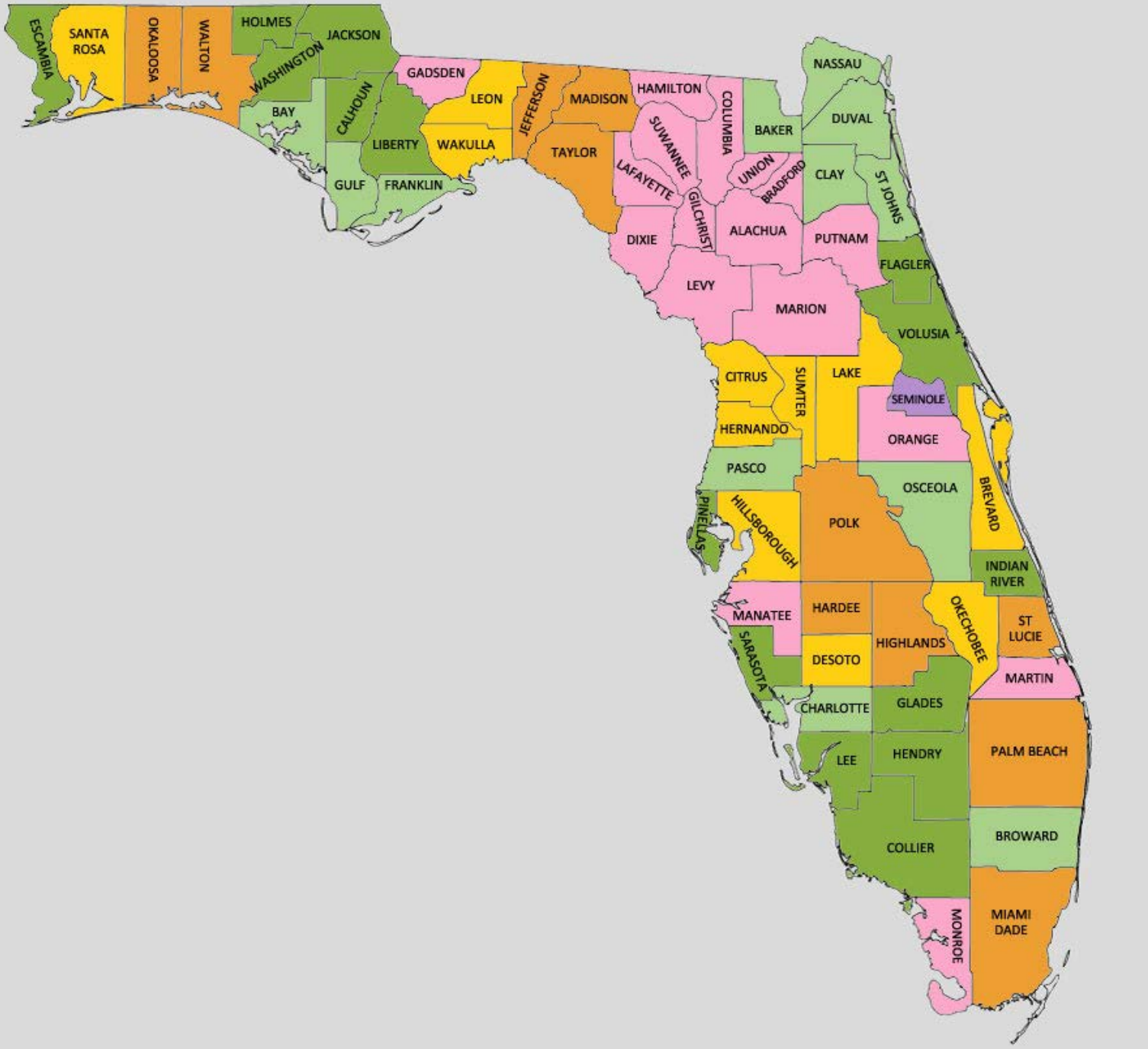
- In 1991, Healthy Start was signed into law with bi-partisan support. Goals:
  - Reduce infant mortality, low birthweight and support healthy child development;
  - Establish universal prenatal and infant risk screening by health care providers;
  - Establish community-based Healthy Start Coalitions;
  - Implement home visiting education and support for pregnant women and children 0 to 3 years of age.
- In 2001, implemented a Medicaid Waiver to provide Medicaid funding for Healthy Start services.
- In 2014, included in the Medicaid managed care statute for the health plans and Healthy Start to coordinate services.
- In 2019, launched a redesigned home visiting model.
- In 2021, **Healthy Start celebrates its 30th birthday!**

Florida Healthy Start
Florida Association of Healthy Start Coalitions

32 Healthy Start Coalitions

Administer $65 million from DOH and AHCA to support local maternal and child health systems of care.

Served more than 200,000 pregnant women, infants, and their families last year.

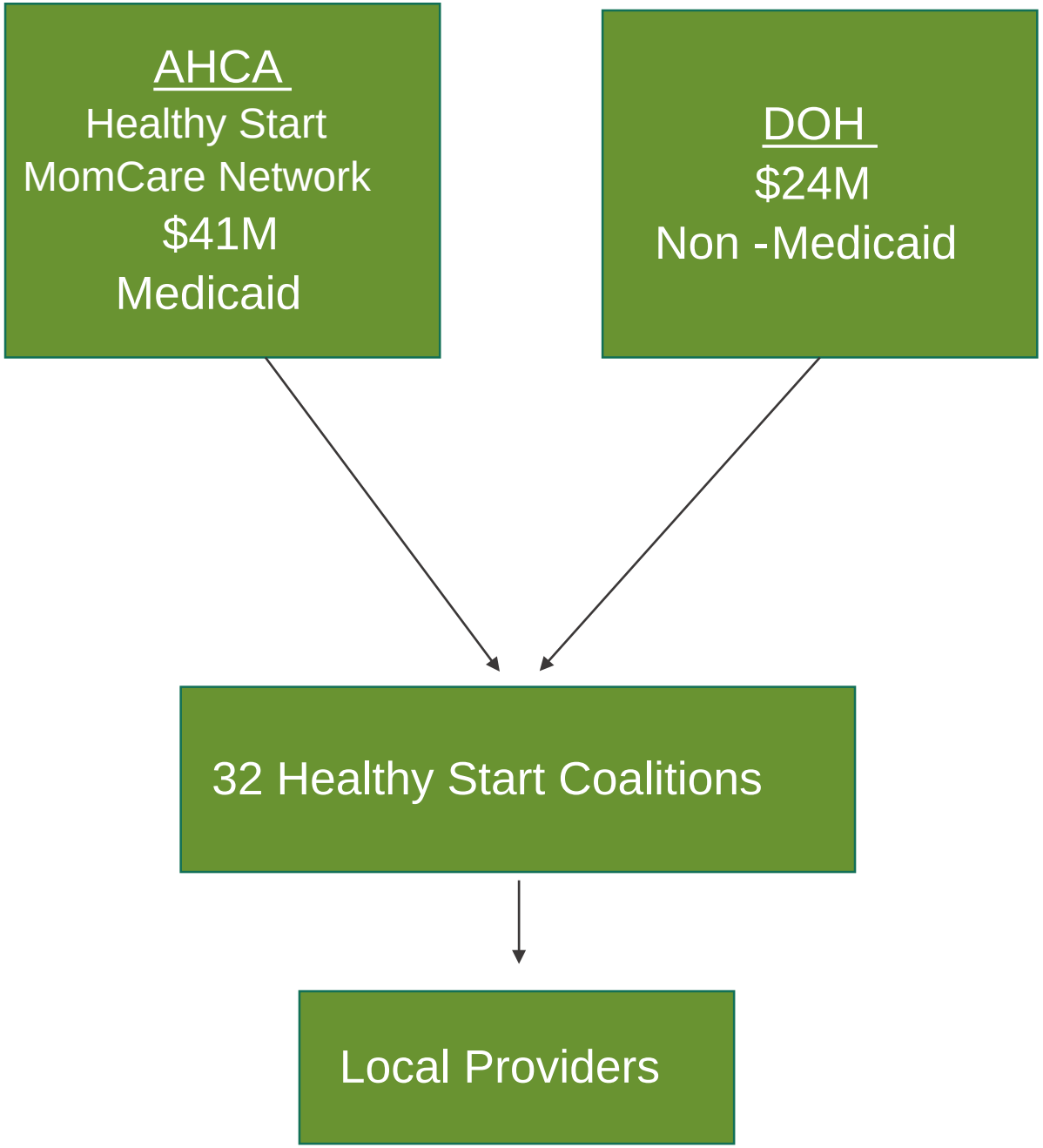




HEALTHY START COALITIONS

Collectively, we:

- **Mobilize** public and private partners on our common mission
- **Leverage** millions of dollars to improve programs and services for families
- **Align efforts** with the Florida legislature to keep them informed of the needs of its residents and the importance of our mission
- **Serve as a resource** for National maternal and child health initiatives for dissemination to our thousands of partners
- **Conduct assessments** of best practices and trends to **transfer knowledge** among our members and our constituents



Florida's HEALTHY START Funding Structure



Universal Prenatal and Infant Risk Screening

Voluntary, research based, brief questionnaire proven to identify pregnant women and infants at risk for poor birth outcomes.

- Florida Department of Health form
- First opportunity to identify families at-risk for poor outcomes.
- Last year, 144,952 pregnant women and 208,016 infants were screened.

Coordinated Intake and Referral (CI&R)

Reduces duplication between home visiting programs, provides family choice of home visiting program, and connection to additional community supports

Prenatal & Infant Risk Screens
Community & Health Plan Referrals

Coordinated Intake and Referral

HEALTHY FAMILIES FLORIDA
An affiliate of Healthy Families America®

Nurse-Family Partnership
Helping First-Time Parents Succeed®

Florida Healthy Start
Florida Association of Healthy Start Coalitions

Early Head Start

FLORIDA FEDERAL HEALTHY START PROGRAMS

Parents as Teachers®

HOME VISITING / FACE TO FACE SERVICES

- **RELATIONSHIP-BASED EDUCATION AND SUPPORT**
- Evidence based interventions:
  - Perinatal depression
  - Substance abuse
  - Intimate partner violence
  - Health and social emotional development
- At least 5 home visits prenatally; 8 in infant's first year
- Two-gen approach

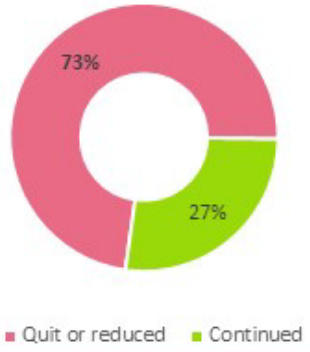




Early Outcomes for New Home Visiting Model (Medicaid clients)

Having a Healthy Pregnancy

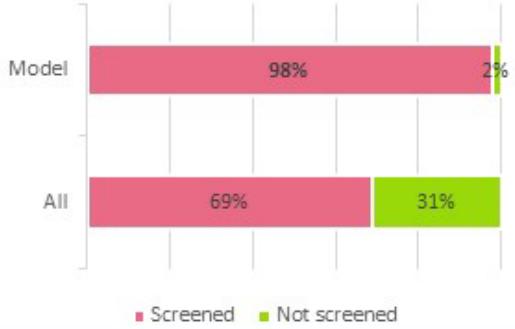
Moms quit or reduced tobacco use



Clean Start

131 of all clients were at risk of substance abuse. Of those, **95%** discontinued or reduced use.

Women were screened for depression



Delivering A Healthy Baby

Women delivered full term babies



Babies were a normal birthweight



Continuing Healthy Behaviors

81%
of all moms
initiated breastfeeding

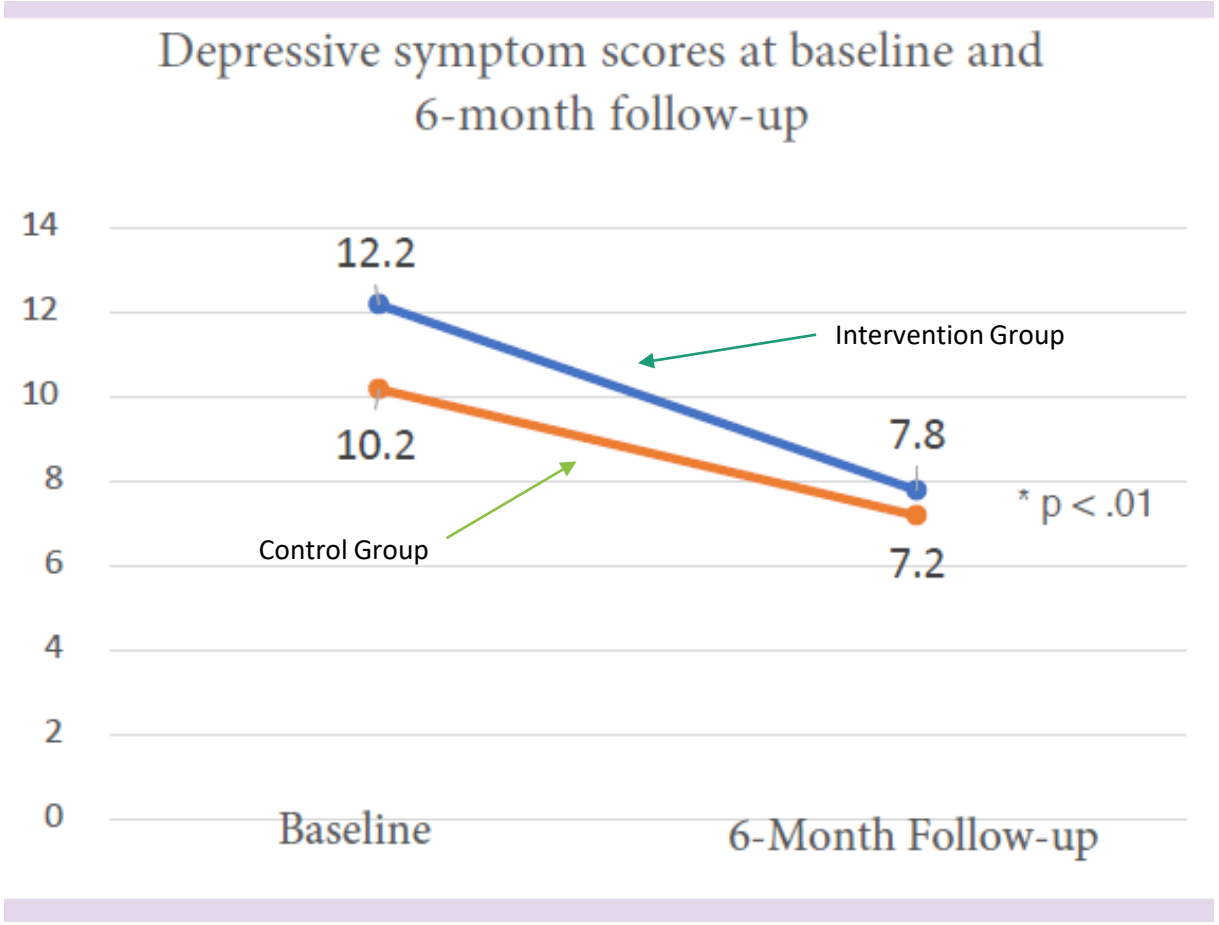


81% of all moms
went to their post partum appointment

FIRST RESULTS! Perinatal Depression Intervention: Statistically Significant Decrease in Depressive Symptoms

MOTHERS & BABIES





Working With Families

- Community outreach
- Coordinated intake and referral
- Home visitation / face to face services for individualized education and support
- Group education (community centers, clinics, churches)
- Community baby showers





Working With Health Care Providers

- Build relationships with prenatal providers, delivery hospitals, and pediatricians.
- Monitor universal risk screening rates by clinic and delivery hospital.
- Educate and support to health providers on screening, latest research, and client support.
- Provide educational materials for provider distribution.
- Partner with birthing hospitals/centers on intakes and discharges



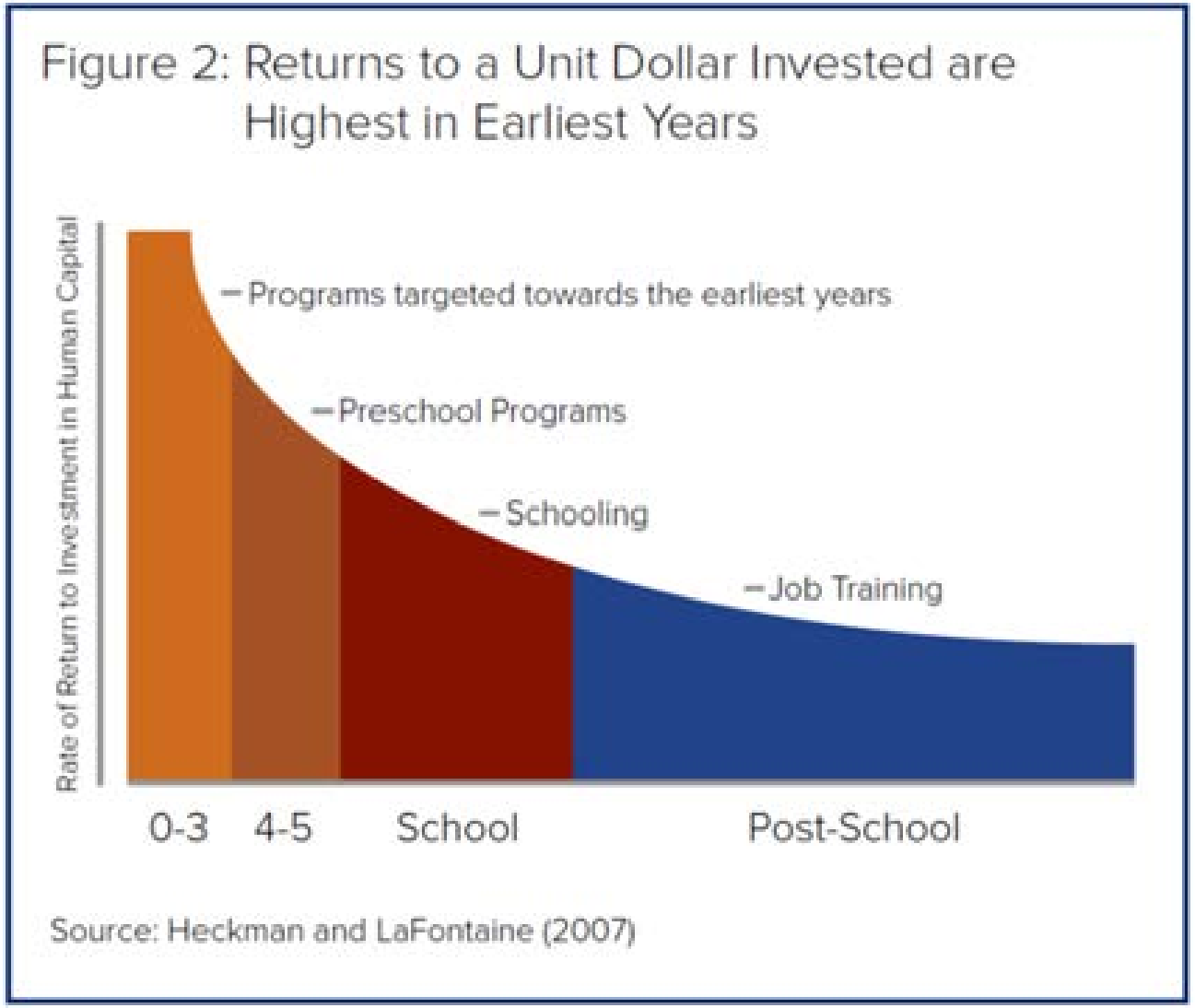
Working With Community Partners

- Community planning with foundations, Children's Services Councils, Health Planning Councils, County Health Departments, health care providers, and more;
- Leveraging local funding to support gaps and needs in the community;
- Engaging the community in collective impact initiatives such as local substance exposed newborn task forces, fetal and infant mortality reviews, pregnancy mortality reviews, safe sleep initiatives, etc.
- Coordination with health plans;
- Coordination with behavioral health and child welfare partners regarding high-risk clients.

Investing in Florida's Children

The highest rate of return on investment is during the earliest years

(ages 0-3)



Florida Association of
Healthy Start
COALITIONS, INC.



Thank you for your investment
in giving children a Healthy Start in life

www.HealthyStartFlorida.com