

**Board of County Commissioners
Leon County, Florida**

Workshop on Infant Mortality Issues

**February 9, 2016
1:00 p.m. - 3 p.m.**

**Leon County Board of County Commissioners
Leon County Courthouse, 5th Floor**

**Leon County
Board of County Commissioners**

Notes for Workshop

Leon County Board of County Commissioners

Workshop

February 09, 2016

To: Honorable Chairman and Members of the Board

From: Vincent S. Long, County Administrator

Title: Workshop on Infant Mortality Issues

County Administrator Review and Approval:	Vincent S. Long, County Administrator
Department/ Division Review:	Alan Rosenzweig, Deputy County Administrator Ken Morris, Assistant County Administrator
Lead Staff/ Project Team:	Eryn D. Calabro, Director, Office of Human Services and Community Partnerships Tiffany Y. Harris, Healthcare Services Coordinator

Fiscal Impact:

This item has no direct fiscal impact, but supports a recommendation scheduled for consideration at the regular Board meeting on February 9, 2016 to increase the County’s contribution to the Community Human Services Partnership (CHSP) by \$200,000 for FY 2017, totaling \$1,200,000.

Staff Recommendation:

Option #1: Accept the staff report and findings presented herein on infant mortality issues along with the Recommendations 1-3 as follows:

- R1: Leon County Government should actively participate in the upcoming community events relating to infant mortality in order to bring additional attention to the issue in an effort to further reach more health professionals, engage Southside families, and improve the health outcomes of women and children.
- R2: County staff should continue to coordinate with DOH-Leon regarding the special funding anticipated to reduce infant mortality and report back to the Board on plans to utilize said funding.
- R3: Support increasing the County’s CHSP funding level for non-profit service agencies by \$200,000 for FY 2017 totaling \$1.2 million (on the Board’s February 9, 2016 regular agenda).

Report and Discussion

Background:

During Commission discussion at the November 17, 2015 meeting, the Board discussed its ongoing concern for local infant mortality rates, particularly among African American children, and directed staff to schedule a workshop prior to the start of the FY 2017 budget cycle. During the December 8, 2015 Commission meeting, the Board approved and scheduled a February Workshop on Infant Mortality to:

- Provide local, state, and national data on infant mortality rates, literature, best practices, etc.
- Identify ongoing efforts of the state, county, non-profits, and healthcare providers in addressing high infant mortality rates
- Invite several local services providers and experts to participate in the Board workshop.
- Explore opportunities with local stakeholders to further efforts in addressing infant mortality and early childhood preventative health services and invite them to present at the Board workshop.

These efforts align with the Board's Quality of Life Strategic Priority:

- (Q3) - Maintain and further develop programs and partnerships necessary to support and promote a healthier community, including: access to health care and community-based human services (rev. 2013).

Based on the Board's direction, staff invited the following local service providers and experts to participate in the workshop:

- Claudia Blackburn, MPH & RN, Administrator for Florida Department of Health in Leon County.
- Kristy Goldwire, MSW, Executive Director of Capital Area Healthy Start.
- Dr. Mimi Graham, PhD, Director of FSU Center for Prevention and Early Intervention Policy with a specialization in inclusion programs for infants and toddlers with disabilities, home visiting, and center-based interventions for infants and toddlers.
- Dr. Joedrecka Brown, MD, Associate Professor, Department of Family Medicine and Rural Health of FSU College of Medicine.

Analysis:

The death of a baby before his or her first birthday is defined as 'infant mortality.' The 'infant mortality rate' is an estimate of the number of infant deaths (before their first birthday) for every 1,000 live births. The leading causes of infant mortality are birth asphyxia, pneumonia, term birth complications, neonatal infection, diarrhea, malaria, measles and malnutrition. The loss of a baby remains a sad reality for many families and takes a serious toll on the health and well-being of families. Growing evidence suggests that higher infant mortality rates are linked to a population's overall health and development across the life course.

Infant mortality is an important indicator of the health of a community and the rates are used worldwide to gauge the health and well-being of a population. Thus the reason access to healthcare remains a strategic priority to make Leon County a place where people are healthy and safe by maintaining and developing programs and partnerships necessary to support and promote a healthier community. Access to health care and community-based human services programs will aid in the prevention of infant mortality. Based on the Board’s guidance, this workshop provides the following information on infant mortality:

- Infant Mortality Rates and Data
- Federal and State Efforts To Reduce Infant Mortality
- Local Efforts to Reduce Infant Mortality

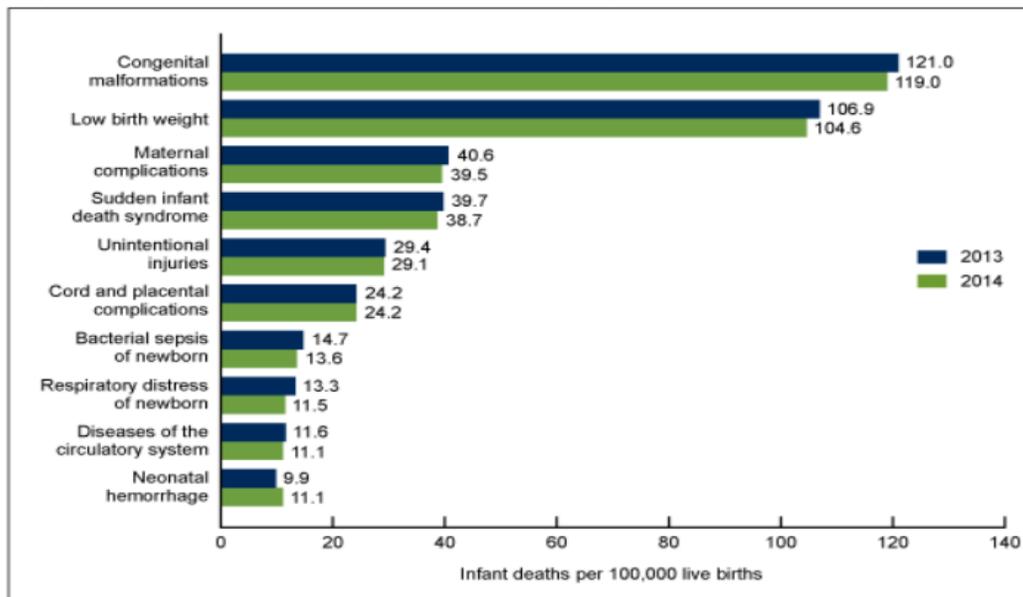
Infant Mortality Rates and Data

Pregnancy and childbirth are greatly impacted by the health of women and their families. Indicators or measures used to assess the health status of a community’s mothers and children include:

- The number of infant deaths
- The number of very low birth weight births
- The number of births to mothers ages 15-19
- Births to mothers who are overweight/obese
- Births with no prenatal care
- Maternal deaths

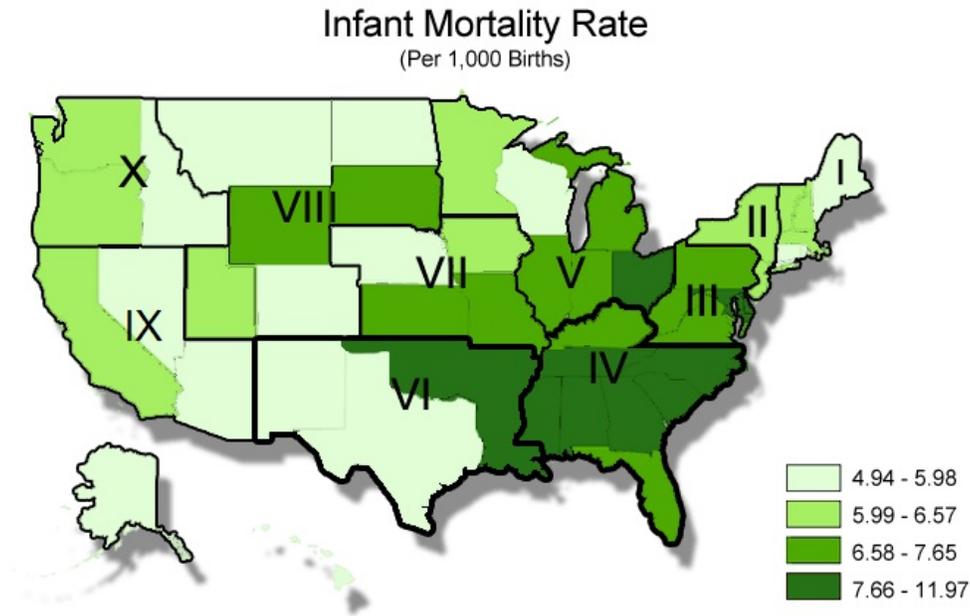
A total of 23,215 deaths occurred in children under one year of age in the U.S. in 2014 with 582.1 infant deaths per 100,000 live births, for a rate of 5.8. The 10 leading causes nationally in 2014 accounted for 69.1% of all infant deaths in the United States (Graph #1).

Graph #1: United States Infant Mortality, 10 Leading Cause of Infant Death, 2013 & 2014



In Florida, 1,327 families experienced infant deaths in 2014 resulting in a 6.0 infant mortality rate per 1,000 live births according to the Florida Community Health Assessment Resource Tool Set (CHARTS) which is maintained by the Florida Department of Health Office of Health Statistics and Assessment. Florida's rate is slightly better than neighboring states in the Southeast.

Graph #2: Infant Mortality Rates Across the U.S.



Of the 1,327 Florida infant deaths in 2014, 22 of them were resident families of Leon County. Leon County's 2014 infant mortality rate was 7.1 for every 1,000 live births, higher than the 6 rate statewide (Table #1). Compared to the state, Leon County has experienced significant annual fluctuations, both positive and negative, according to the 11 years of infant mortality data shown in Table #1. The earlier data shows Leon County's infant mortality rate as much as two to three percent higher than the state rate in some years (2004, 2007, and 2010). Since 2011, Leon County has twice experienced a lower rate than the state (2011 and 2013).

Table #1: Florida CHARTS Infant Deaths & Rates Per 1,000 Live Births

Years	Leon		Florida	
	Count	Rate	Count	Rate
2004	32	10.2	1,536	7
2005	26	8.4	1,626	7.2
2006	27	8.3	1,713	7.2
2007	30	9	1,689	7.1
2008	24	7.5	1,667	7.2
2009	24	7.7	1,525	6.9
2010	29	9.4	1,400	6.5
2011	18	5.9	1,372	6.4
2012	28	9.3	1,285	6
2013	16	5.3	1,318	6.1
2014	22	7.1	1,327	6

To better understand the fluctuation and trend of the local infant mortality rate, Graph #3 provides an illustration comparing the state and local rate from 1995 – 2014. Depicting 20 years of data in a line graph presents two findings:

Finding #1: An annual fluctuation of infant mortality rates in Leon County is not uncommon. This is due to the small sample size which greatly affects the rate.

Finding #2: Despite the annual fluctuation, Leon County’s infant mortality rate has trended downward over the last 20 years to closely align with the statewide rate.

Graph #3: Florida CHARTS Infant Death Rates, 1995-2014

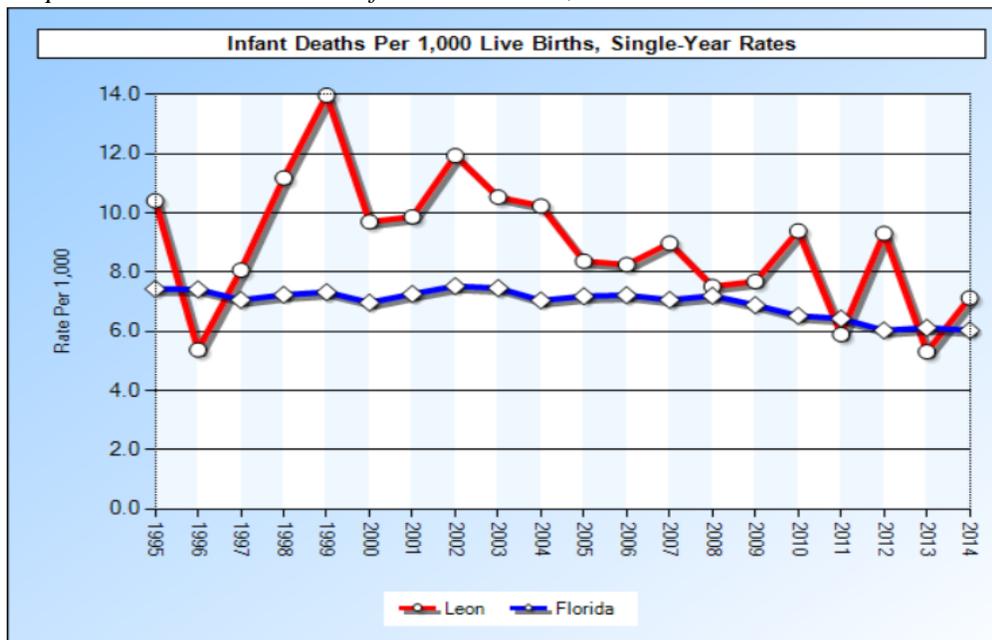


Table #2 shows the infant mortality rates for the region by county in 2014. This table reaffirms how the small sample sizes can greatly affect the rate. For example, both Jefferson and Wakulla Counties experienced one infant death in 2014 yet Jefferson’s rate is 7.9 while Wakulla’s is 3.0 for every 1,000 live births.

Table #2: Florida CHARTS Infant Death Rates in the Capital Region, 2014

County	Count	Rate
Leon	22	7.1
Gadsden	5	9.3
Jefferson	1	7.9
Wakulla	1	3
Florida	1,327	6

In addition to the community health conditions that contribute to infant mortality rates, pregnancy-related health outcomes are also influenced by socioeconomic factors such as race, ethnicity, age, and income. Locally, much attention has been given to the disparity between white and black infant mortality rates. Table #3 on the next page shows that while the infant mortality rate has declined across both races since 2004, the rate of black deaths is often more than three times the rate of white deaths in Leon County. Statewide, the rate of black infant deaths is more than two times the rate of white deaths.

Table #3 also sheds additional light on the fluctuation of the infant mortality rates, particularly the fluidity of the black infant mortality rate over the past 11 years. For example, the highest black infant mortality rate experienced over that time period was 18.3 in 2010 but it was flanked by single digit rates in 2009 (9.7) and 2011 (9.5), a feat not once realized statewide over the 11 year period. Another comparison with the rest of the state shows that white infant mortality rates in Leon County have exceeded the statewide rate for five of the 11 years measured in Table #3, while black infant mortality rates in Leon County have exceeded the statewide rate six times.

Table #3: Florida CHARTS Infant Death Rates Per 1,000 Live Births, by Race

Years	Leon				Florida			
	White		Black		White		Black	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate
2004	10	5.9	22	17.9	876	5.5	621	13.2
2005	6	3.6	18	14.7	882	5.3	652	13.6
2006	7	4	20	15	974	5.6	653	12.9
2007	10	5.7	17	12.7	906	5.2	689	13.4
2008	7	4.3	15	11.3	914	5.5	661	12.9
2009	10	6.3	13	9.7	780	4.9	667	13.2
2010	5	3.1	24	18.3	750	4.9	580	11.8
2011	5	3.1	12	9.5	698	4.6	584	12
2012	9	5.6	19	15.7	687	4.6	523	10.7
2013	8	5.1	6	4.8	707	4.6	517	10.6
2014	5	3.1	15	11.7	688	4.4	538	11

The racial disparity of mortality rates between white and black infants are without question and continue to be a local and statewide challenge. The disparity among infant mortality rates is often attributed to low-income households with lack of access to care which can lead to preterm births and other health risks. The remainder of this item focuses on the steps being taken to reduce the infant mortality rate, particularly in African American communities.

Finding #3: Much like the rest of the state, there is a significant disparity of mortality rates between white and black infants.

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Federal and State Efforts to Reduce Infant Mortality

The Federal Health Resources and Services Administration (HRSA) supports strategies and programs to prevent infant mortality and decrease disparities throughout communities. The Uniform Data System is an instrument used by HRSA to capture and report annually on certain data regarding care provided to patients, including those served in Leon County. This reporting instrument includes profiles of patients by zip code, age, race, and gender as well as reporting data on health outcomes and disparities. HRSA's efforts to help reduce infant mortalities include:

- The Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality is a public-private partnership that brings together infant mortality experts to share best practices and lessons learned.
- HRSA's Maternal and Child Health Bureau (MCHB) which is the only governmental program responsible for ensuring the health and well-being of the entire population of women, infants, and children plays a critical role in coordination, capacity building, and quality oversight at the community and state levels. For over 75 years, this program has provided a foundation for ensuring the health of the nation's mothers, women, children and youth, including children and youth with special healthcare needs, and their families by maximizing resources to enhance the quality and effectiveness of the following programs.
 - Maternal, Infant, and Early Childhood Home Visiting Grants to assist states that offer services to at-risk families in their homes and connect them with the assistance they need to raise healthy children. These services often begin during pregnancy and can help to improve birth outcomes.
 - Healthy Start Grants that help some of the nation's most at-risk communities to lower high rates of infant mortality and reduce disparities by improving the health of women, infants, and families.
 - The Association of Maternal and Child Health Programs (AMCHP) which is a national resource and advocate for state public health leaders that collects, reviews, and disseminates emerging, promising and best practices from public health programs across the country so that effective models can be shared and replicated to reduce infant deaths.

For best practices related to infant mortality, AMCHP suggests focus areas to include preconception care, mental health, data and assessment, financing, program and system integration, workforce development, injury prevention, emergency preparedness, family involvement, or other public health issues. AMCHP lists the following best practice programs in the State of Florida that address birth outcomes, infant health, and preconception health for women:

- The JJ Way Model of Maternity Care (Attachment #1) –The key tenet of the program is a patient-centered, woman-centered approach which has successfully reduced both maternal and infant morbidity and mortality in Central Florida. The key objectives for this practice are for pregnancies to reach a gestation of 37 weeks or greater and for newborns to have a birth weight of 5lbs. 8 ounces (2500 grams) or greater. The program

activities are built on the strengths of the Midwives Model of Care to reach populations that do not typically seek midwifery services. It is believed that increasing a woman's social capital increases the likelihood of a positive birth outcome. Gaps and barriers to the client's success are identified which begins the client's gap management triage. This includes educational messages and delivery approaches that are tailored to the clients through peer education and group learning. In Florida, the outreach clinic The Birth Place received a grant from the AMCHP to serve patients by targeting large African American communities in the Central Florida area.

- Florida Infant Risk Screening Tool (Attachment #2) – The objective is to screen every infant born in Florida for increased risk of post neonatal death (death at age 28 to 364 days) and refer the high risk infants for services that mitigate the risk of post neonatal death. The screening is currently offered to the parents of every newborn in Florida and about 95% of the parents choose to have the screen completed. The screening is based on data from the birth certificate and is performed before the infant leaves the hospital. Infants who screen as being at an increased risk of post neonatal death are referred to infant health care providers for enhanced services directed at reducing the risk.
- Florida Newborn Screening Results (FNSR) online access system – The goal of FNSR is to get newborn screening results into the hands of the primary care physician by providing easy online access to the screening results to ensure that each newborn is screened and proper follow-up is conducted to ensure that newborns receive a repeat screening for unsatisfactory and borderline results by their primary care physician.

Federal and state programs often provide important resources to combat infant mortality including best practices and grant funding, but these efforts are often delivered throughout communities through local governments, health care providers, and non-profit service agencies.

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Local Efforts to Reduce Infant Mortality

Ongoing efforts at the local level to address infant mortality include a coalition of government stakeholders, health care providers, non-profit service agencies, and university experts. This section of the analysis provides an overview of these partners and programs, several of whom will be participating in-person at the Board Workshop.

Leon County Government has been a leader in addressing infant mortality issues through the continued support of the County's Primary Healthcare Program, hosting the Year of the Healthy Infant Community Workshop in 2008, and securing a grant in 2011 that provided health education to African American women and girls of childbearing age in an effort to improve overall health and birth outcomes. Leon County was also awarded a grant in 2013 by the National Association of Counties (NACo) to host a Community Dialogue to Improve Health Initiative (Day of Dialogue) which also addressed local infant mortality issues.

Since 2001, the County's Primary Healthcare Program has provided funding for primary care, including care for women and children. \$1.2 million is annually dedicated for the provision of services for those who are uninsured, undeserved and lack access to care. The local CareNet partners, including the two Federally Qualified Health Centers – Bond Community Health Center, Inc., and Neighborhood Medical Center, Inc., provide a wide range of services and accept patients by appointment, walk-in and upon referral from hospital emergency departments.

Specific to infant mortality, Leon County was awarded a grant in 2011 through the Department of Health for \$130,000 for the "Reducing Racial and Ethnic Health Disparities: Closing the Gap" grant. The purpose of the program was to promote coordinated efforts to reduce and ultimately eliminate racial and ethnic health disparities. The County partnered with the Capital Area Healthy Start Coalition (CAHSC) and the Tallahassee-Greater Frenchtown Front Porch Community to establish awareness campaigns in order to convey the importance of safe infant sleep and good preconception health, the distribution of healthy women kits to promote well-women's care and health related prevention practices, and the establishment of health educators to provide preconception, inter-conception, prenatal health education, and information to African American women and girls of childbearing age.

More than 100 people, representing approximately 30 organizations consisting of citizen groups, health care providers, educators, researchers, public officials, and professional staff attended the County's Year of the Healthy Infant Community Workshop in 2008 to collectively discuss the issue of infant mortality and racial disparity in Leon County. This workshop led to the successful application for the Closing the Gap grant which was awarded from October 2011-June 2012. Subsequently, in 2013 Leon County applied for the National Association of Counties' (NACo) Community Dialogues to Improve Health Initiative (Day of Dialogue) to host a one-day community dialogue to strategize efforts in coordinating healthcare in the community. Leon County was selected as one of six counties to participate in the Community Dialogues to Improve Health.

The Day of Dialogue was hosted on April 3, 2014 and included community stakeholders including CareNet partners, local hospitals, and universities who were invited to discuss and identify opportunities to enhance the CareNet program through greater community collaboration and the establishment of formal partnerships. The overarching theme for the day was related to enhancing access to care in Leon County with the discussions focused on strengths and assets, gaps and barriers to collaboration, and removing barriers to collaboration for greater coordination of care (Attachment #3).

While the strengths of the community are in the fact that it is a capital community home to prestigious universities and innovative healthcare systems with quality healthcare providers, it was identified that more collaborative efforts are needed in shifting from a provider-centered model of care to a patient-centered model of care that includes a focus on creating an outcome-driven, shared vision for healthcare in the community. The need to promote health literacy and prevention was also emphasized as a way to educate the community as a whole to recognize the importance of being healthy.

The Florida Department of Health in Leon County (DOH-Leon) is a lead resource on all health care and policy matters including infant mortality. DOH-Leon was recently notified that it will receive special funding to reduce infant mortality disparities. Unable to provide details at the time of this writing, DOH-Leon anticipates updating the Board as part of its presentation at the February 9th workshop. Currently, DOH-Leon contracts with the Capital Area Healthy Start Coalition (Healthy Start Coalition) to provide the care coordination services to families.

Finding #4: The Florida Department of Health in Leon County was recently notified that it will receive special funding to reduce infant mortality disparities and will include information on this funding in its presentation to the Board at the February 9th workshop.

Capital Area Healthy Start Coalition:

The Healthy Start Coalition is the lead local agency in addressing infant mortality, preconception health, and healthy pregnancies. Healthy Start care coordinators, employed by DOH-Leon, provide free services to families who are expecting children and who have children from birth to three years of age. Healthy Start employs eight care coordinators with dedicated duties to aid in preventing infant mortality that include: home visits, pregnancy health education, nutrition education, childbirth education, parenting education, emotional support, mental health counseling, breastfeeding education and support, developmental screenings, smoking cessation counseling, safe sleep education and support, and linking clients to other needed resources. Following an in-depth assessment process, each Healthy Start client then receives services tailored to their specific needs as well as receiving core components of the Healthy Start program; these services are provided by their care coordinator. In 2014, Healthy Start provided services to 1,907 women and 850 children from birth to three years of age.

The Healthy Start Coalition's Fetal Infant Mortality Review Team (FIMR) reviews individual fetal and infant death records and provides recommendations and suggested interventions based on these case reviews. FIMR is composed of obstetricians, pediatricians, hospital representatives, the medical examiner, Florida Department of Children and Families personnel, and Healthy Start

Coalition representatives. It aims to address the social, economic, cultural, environmental, and health systems factors that affect infant mortality. Recommendations by FIMR that have been implemented locally include:

- The STRONGER Afterschool Program provides activities, discussions, and field trips that focus on individual, cultural and family views of health, exercise, nutrition, wellness, and personal hygiene. STRONGER participants are also provided with activities to promote positive character, increased self-esteem and goal setting. All with the hope of developing girls into Sisters who Trust, Respect and take every Opportunity to be Nice, Graceful, Encouraging, and Responsible. Healthy Start was awarded \$20,000 in FY 2016 for the STRONGER Program through the CHSP process.
- Who Will Be Your Baby's Doctor is a brochure created to assist pregnant women in Leon County with finding a pediatrician prior to delivery. The need for this brochure was identified by both area hospitals due to concerns over the number of women in the late pregnancy stage who have not conducted any research on local pediatricians for their unborn child (*Finding #5*).
- The Safe Sleep Campaign is a series of public service announcements (PSA) that were shown on high traffic television and radio stations advocating and demonstrating the importance of safe sleep and proper sleeping arrangements for infant children.

One of the interventions recommended by FIMR to the Healthy Start Coalition several years ago was to employ a full-time health educator to go out into the community and provide preconception health education. Preconception health literacy is an important component of family planning that requires reaching young women of childbearing age to teach them proper nutrition, self-care, and lifelong healthy habits that lead to healthy babies. A health educator can reach women and their partners at schools, churches, community centers, health fairs, and other community events. In recent years, Healthy Start was successful in securing funds for a health education position through the March of Dimes, the Florida Department of Health Closing the Gap Grant and the CHSP process. The health educator conducted 30-40 minute sessions covering all aspects of preconception health and was successful at reaching large sections of the community; however, Healthy Start was not awarded funding for this position during the FY 2016 CHSP cycle. Should the Board proceed with increasing the County's contribution to CHSP in FY 2017, it may benefit Healthy Start in its efforts to secure funding for this position. In addition, there may be an opportunity for Healthy Start to utilize the special funding anticipated by DOH-Leon given their ongoing contractual relationship.

The Healthy Start Coalition, in partnership with the Florida Area Health Education Centers Network, Florida Department of Health in Leon County, Whole Child Leon, and the FSU College of Medicine, organized two preconception health/maternal & child health conferences. The first conference, held on January 25, 2014 aimed at educating health professionals about preconception health and ways to encourage healthy behaviors in patients to improve pregnancy outcomes. The second conference held on April 18, 2015, focused on a comprehensive approach to improve the health of women, children, and families by addressing systems of inequality. Both events were attended by physicians, social workers, nurses, nutritionists, students, professors, and county, city, and state officials.

The Healthy Start Coalition plans to hold an event in July 2016 targeting families in the Southside area of Tallahassee. Speakers will conduct breakout sessions to discuss safe sleep and chronic diseases and how they affect pregnancy. Neighborhood Medical Center has agreed to participate and will provide blood glucose and blood pressure checks at the event. The partners mentioned above are also planning a third conference for late September to provide an opportunity for greater examination of maternal child health disparities entitled “Achieving Maternal Child Health Equity.” This conference will be led by Dr. Brown, MD, Associate Professor, Department of Family Medicine and Rural Health of FSU College of Medicine.

Finding #5: The local birthing facilities, including the hospitals, continue to express concerns over the number of women in the late pregnancy stage who have yet to identify a pediatrician for their unborn child.

Brehon Institute for Family Services, Inc:

The Brehon Institute for Family Services, Inc. (Brehon) is a CHSP funded local non-profit agency which serves families through its Healthy Families Program and the Brehon House, a transitional housing program for homeless pregnant women and their children. Healthy Families is an intensive home visiting program for families who have, or are expecting, a newborn and are at risk for poor childhood outcomes. Family support workers visit to offer support, education, problem solving skills, and linkages to health and support services. Services are offered to families for up to five years after the birth of the child.

The Brehon House provides homeless pregnant women and their children with a safe, stable, and nurturing environment in which to live during their pregnancy and the post-partum period. Residents are provided with parenting education, career counseling, assistance finding permanent housing, and case management services. For the FY 2016 CHSP cycle, the Brehon Institute was awarded \$59,811 for the Brehon House maternity home program.

Whole Child Leon:

Whole Child Leon receives direct funding from Leon County in the amount of \$38,000 to help raise awareness and improve the health of children up to five years of age by connecting families with community resources. Whole Child Leon is not eligible to apply through the CHSP process as they are not a direct service provider. Instead, it uses the Whole Child Connection web-based technology to:

- Assist families in identifying the needs of their young children.
- Connect families with appropriate service providers.
- Encourage and enable service providers to build collaborative networks.
- Enable communities to identify gaps in service and assess their progress in ensuring that all children thrive.

In 2009, the Whole Child Leon Physical and Mental Health Action Team created the Healthy Infant Partnership to engage agencies, organizations, civic groups, and individuals to implement strategies relating to increasing the number of babies healthy at age 1. FAMU, Bond, NMC, and the Tallahassee Housing Authority worked together to investigate why black women seek or

enter prenatal care later than their white counterparts. The Partnership adopted four priority strategies of pursuit:

- Service delivery practices that exhibit respect, empathy and compassion for women and families.
- Health education for women and men of reproductive age by involving institutions that influence cultural norms and behavior such as schools, churches social clubs, civic organizations and popular media.
- Comprehensive, holistic primary and prenatal care, which includes medical care plus attention to economic, social, cultural, emotional behavioral and nutritional conditions that influence the health of the mother before, during and after pregnancy.
- Comprehensive screening and health insurance for all children and all women of reproductive age utilizing all available options within the federal Medicaid program.

To implement these strategies, Whole Child partnered with local providers in 2009 and 2010 to conduct free community wide developmental screenings, workshops, surveys, and parenting classes. They also recommended new curriculum on family planning, reproductive health, and parenting for Leon County Schools.

Whole Child Leon produces a community report that captures local data on the six dimensions of the whole child. The six dimensions are: physical and mental health, quality early education and development, social-emotion development, spiritual foundation and strength, safe and nurturing environment, and economic stability. Whole Child Leon's latest Community Report takes a holistic view at the quality of care and community resources available that have a direct impact on the health and well-being of children and families in our community (Attachment #4). Throughout the report, key indicators are identified across the six dimensions that contribute to a child's well-being. In summary the report data showed that many children in Leon County face risks that are barriers to success in school and life. This report shows many children are able to thrive when they experience the following six conditions:

- Receive quality healthcare
- Live in an economically stable family
- Participate in quality early education and development activities from birth through age four
- Live in a safe and nurturing environment
- Develop positive social and emotional behavior
- Have a sense of hope, wonder and connectedness to others and the larger world that comes from a strong spiritual foundation

However, the report illustrates that too many children in our community do not experience one or more of these six conditions. Whole Child Leon views the quality of life of Leon County children and the economic health and stability of the community as interdependent. Whole Child Leon will use this report to engage the community to encourage ownership of early childhood success.

Florida State University's Center for Prevention and Early Intervention Policy:

The FSU Center for Prevention and Early Intervention Policy (Center) focuses on vulnerable infants and toddlers who can be positively affected through nurturing relationships, strong maternal and child health, and quality early childhood care and education. The FSU Center's work continues to contribute to major state initiatives for maternal and child health and development and was among the first Head Start programs in Florida to address infant mortality in 1994. Today this local model continues to demonstrate how quality community support and education empower vulnerable families to achieve greater stability and improve their child's health, development, and school readiness.

The Center specialization focuses on infants and toddlers in the areas of school readiness, infant mental health, quality childcare practices including the *Partners for a Healthy Baby* curriculum for home visiting (Attachment #5). *Partners for a Healthy Baby* is a nationally recognized evidence-informed curriculum used by many home visiting models to improve birth outcomes, reduce rates of child abuse, increase intervals between pregnancies, strengthen families, enhance child health and developmental outcomes and support family stability and economic sufficiency. This curriculum is designed to help the home visitor know what to look for in order to detect early signs of health or developmental problems and how to discuss concerns with the family and/or a health care provider. It also allows the home visitors to communicate effectively by using open-ended questions and other prompts that are provided, prepare parents with the knowledge and skills needed to care for their baby, support optimal bonding and attachment, encourage parents to engage in activities that support all aspects of their child's development, and promote changes toward healthier lifestyles for expectant and parenting families.

The FSU *Partners* curriculum is unique in that it addresses issues of child health and development within the context of the multifaceted needs of expectant and parenting families. The evidence-informed content in each book supports the home visitor's ability to systematically plan home visits and address key topics that are essential in achieving both family and program outcomes. More than 3,700 home visitation programs across the country use the curriculum as does the U.S. Department of Defense for its International New Parent Support Program.

The Center's purpose is to implement this vision by investigating what interventions are most effective, translating the related research findings into public policy and programs, and evaluating the impact on children, families and communities. The curriculum, FSU Partners for A Healthy Babies, is utilized internationally to promote a strong foundation for optimal child and family development. The Center's vision is that one day all children will be healthy, equipped to learn and nurtured to develop their full potential. To this end, the Center continually offers workshop and trainings. There four upcoming workshops scheduled in 2016 in Florida for home visitors to help them to support families and achieve program goals utilizing the Partners curriculum (Attachment #6).

Tallahassee Memorial Hospital Newborn Intensive Care Unit:

Tallahassee Memorial Hospital (TMH) offers the region's only neonatal intensive care unit or newborn ICU (NICU). The Women's Pavilion has two NICUs. The *Level-III* unit is for critical care babies and the *Level-II* unit is a step-down or intermediate care unit. TMH's NICU team cares for over 600 babies each year and has the only Level-III NICU within 150 miles.

The NICU offers a 19-bed Level-III unit and a 13-bed Level-II unit. A neonatal transport team of highly trained nurses and respiratory therapists is on-call 24 hours a day to bring premature and/or sick babies from area hospitals and centers to the Women's Pavilion. The NICU is also equipped with four nesting rooms to help with the transition before going home. For families located out of town or learning to use medical equipment or administer medication, the transition rooms allow families to be together overnight with the support of the TMH NICU team nearby.

TMH employs neonatologists, neonatal nurse practitioners, specially trained nurses, social workers, dietitians, respiratory, physical and music therapists and NICU staff are dedicated to providing babies with the highest level of specialized care.

In 2012, TMH NICU received a donation of a new Pacifier Activated Lullaby (PAL) medical device. PAL is a medical device invented by Jayne Standley, a researcher and Robert O. Lawton Distinguished Professor at the FSU College of Music. The innovative PAL device, which uses musical lullabies to help infants quickly learn the muscle movements needed to suck, and ultimately feed, helps premature babies overcome one of their greatest growth hurdles — learning how to suck and thereby take in food. Research studies have shown that PAL can reduce the length of a premature infant's hospital stay by an average of five days.

TMH recognizes that parents are a part of the healthcare team and are involved in the decisions made regarding the care of their baby. In every way possible, the hospital works to keep the family close to the infant if he or she must be in the hospital, including promoting skin-to-skin time or kangaroo care. This helps babies gain weight faster and respond better to early treatments so they can go home sooner.

With clinical expertise, advanced technology, and involving the parents and families in the care of the baby, premature or sick newborns have a better chance to survive and thrive after leaving the hospital.

Conclusion

Infant mortality is an important indicator of the health of a community and the infant mortality rates are used worldwide to gauge the health and well-being of a population. Growing evidence suggests that higher infant mortality rates are linked to a population's overall health and development across the life course. Thus the reason access to healthcare remains a strategic priority to make Leon County a place where people are healthy and safe by maintaining and developing programs and partnerships necessary to support a healthier community. Access to health care and community-based human services programs will aid in the prevention of infant mortality.

Leon County Government has been a leader in addressing infant mortality issues through the continued support of the County's Primary Healthcare Program, hosting the Year of the Healthy Infant Community Workshop in 2008, and securing a grant in 2011 that provided health education to African American women and girls of childbearing age in an effort to improve overall health and birth outcomes. Leon County was also awarded a grant in 2013 by the National Association of Counties (NACo) to host a Day of Dialogue for improving community health which specifically addressed local infant mortality issues.

As previously stated, a local panel of experts on infant mortality issues will join the Board for its workshop to provide an overview of the role their organization serves and how they coordinate to combat this important community health matter. The five findings presented in this workshop item are based on the available data collected from state and national sources, as well as information provided by the panelists that will participate in the Board workshop. The Board will also have an opportunity to engage the panel on the findings presented herein and additional opportunities to address infant mortality going forward. The findings are as follows:

- Finding #1: An annual fluctuation of infant mortality rates in Leon County is not uncommon. This is due to the small sample size which greatly affects the rate.*
- Finding #2: Despite the annual fluctuation, Leon County's infant mortality rate has trended downward over the last 20 years to closely align with the statewide rate.*
- Finding #3: Much like the rest of the state, there is a significant disparity of mortality rates between white and black infants.*
- Finding #4: The Florida Department of Health in Leon County was recently notified that it will receive special funding to reduce infant mortality disparities and will include information on this funding in its presentation to the Board at the February 9th workshop.*
- Finding #5: The local birthing facilities, including the hospitals, continue to express concerns over the number of women in the later pregnancy stage who have yet to identify a pediatrician for their unborn child.*

The racial disparity of mortality rates between white and black infants are without question and continue to be a local and statewide challenge. Given this racial disparity and the concern by local birthing facilities about the number of women in the later stage of pregnancy that have yet to have selected a pediatrician for their unborn child, staff offers the following recommendations consistent with the suggestions from the Day of Dialogue for collaborative efforts in health literacy and prevention:

Recommendation #1: Leon County Government should actively participate in the upcoming community events relating to infant mortality in order to bring additional attention to the issue in an effort to further reach more health professionals, engage Southside families, and improve the health outcomes of women and children.

Recommendation #2: County staff should continue to coordinate with DOH-Leon regarding the special funding anticipated to reduce infant mortality and report back to the Board on plans to utilize said funding.

Recommendation #3: Support increasing the County's CHSP funding level for non-profit service agencies by \$200,000 for FY 2017 totaling \$1.2 million (on the Board's February 9, 2016 regular agenda).

While the causes for infant mortality deaths vary, best practices point in the direction of education along with pre-pregnancy and pre-delivery intervention as the most effective tools in decreasing the number of infant mortalities in the community. Local providers and educators have historically demonstrated their commitment to addressing infant mortality and with the County's continued financial support through programs such as CHSP and collaboration on grants, the local infant mortality rate should continue to closely reflect the statewide rate.

Options:

1. Accept the staff report and findings presented herein on infant mortality issues along with the Recommendations 1-3 as follows:
 - R1: Leon County Government should actively participate in the upcoming community events relating to infant mortality in order to bring additional attention to the issue in an effort to further reach more health professionals, engage Southside families, and improve the health outcomes of women and children.
 - R2: County staff should continue to coordinate with DOH-Leon regarding the special funding anticipated to reduce infant mortality and report back to the Board on plans to utilize said funding.
 - R3: Support increasing the County's CHSP funding level for non-profit service agencies by \$200,000 for FY 2017 totaling \$1.2 million (on the Board's February 9, 2016 regular agenda).
2. Accept the staff report on infant mortality issues and take no further action.
3. Do not accept the staff report on infant mortality issues.
4. Board direction.

Recommendation:

Option #1.

Attachments:

1. Exploring the JJ Way ® Model of Maternity Care
2. Florida Infant Risk Screening Tool
3. NACo Day of Dialogue Summary Report
4. Whole Child Leon 2013 Report on the Status of Our Children
5. Florida State University *Partners for a Healthy Baby* Curriculum
6. Florida State University *Partners for a Healthy Baby* 2016 Workshops



Innovation Station

Sharing Best Practices in Maternal & Child Health

The JJ Way™ Model of Maternity Care

Location: Florida
Date Submitted: 6/2009
Category: **Emerging Practice**

BACKGROUND

Florida is currently struggling with significant racial and socio-economic disparities in birth outcomes. In 2005, 18.5% of black infants compared to 13.8% of all infants were preterm; 13.6% of black infants compared to 8.7% of all infants were low birth-weight. Statistics on birth outcomes are more readily available by race than by class. However, studies indicate that all low-income women, regardless of race or ethnicity, are at higher risk of poor birth outcomes. For instance, in one national longitudinal study, the risk of low birth weight among births to black women and white women who were poor was at similarly high levels.

The goal of The JJ Way™ is to eliminate racial and class disparities in perinatal health and improve birth outcomes for all infants. Realizing that the midwifery model could help improve birth outcomes for all babies, midwife Jennie Joseph (JJ), and her birth center team worked to create a midwifery-based model that was culturally relevant and accessible to women of color and low-income women.

PROGRAM OBJECTIVES

The key objectives for this practice are for pregnancies to reach a gestation of 37 weeks or greater and for newborns to have a birthweight of 5 lbs. 8 ounces (2500 grams) or greater.

TARGET POPULATION SERVED

JJ Way™ patients come from a tri-county area in Florida, which have an increasingly large African American population. The program currently serves approximately 400 women per year for prenatal, birth and postpartum services.

PROGRAM ACTIVITIES

The JJ Way™ is built on the strengths of the Midwives Model of Care to reach populations that do not typically seek midwifery services. The first adaptation of this model is the use of a team approach. JJ Way™ staff believes that increasing a woman's social capital increases the likelihood

TITLE V/MCH BLOCK GRANT MEASURES ADDRESSED

#11: The percent of mothers who breastfeed their infants at 6 months of age.
#15: Percentage of women who smoke in the last three months of pregnancy.
#18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

of positive birth outcomes. Every staff member has a role, from the receptionist who greets each woman, to the office manager who knows each client's name. The team includes the baby's father, friends and family. All members share the explicit goal of helping the mother achieve a healthy, full-term pregnancy. Consistent health messages are delivered by all staff.

Another enhancement is the emphasis on easy access. No one is turned away, and this reputation in the community facilitates that first step of entering the clinic. Another difference is a focus on gap management. The team works together to identify any gaps or barriers to the client's success and begins gap management triage.

Lastly, there is an enhanced approach to education. Clients receive information from peer educators as well as group learning processes. Educational messages and delivery approaches are tailored to the clients, and they focus strongly on post-partum education. Knowing that short inter-pregnancy intervals are associated with low birth-weight and prematurity, women are taught the importance of child spacing and various types of birth control.

The final difference between this model and the typical midwifery model is that the labor and delivery can take place in any location the woman feels most comfortable. If she prefers to birth at the hospital with an OB, program staff works with physician partners to ensure a smooth transition of care.

PROGRAM OUTCOMES/EVALUATION DATA

In 2007, The Health Council of East Central Florida analyzed outcome data for 100 low-income clients of the practice. Results showed 4.8% of babies were low-birth weight, and

4.7% were preterm, while the Orange County-wide rate was 9.1% and 15.4% respectively for the years 2005-2007. Data were also analyzed relating to the percentage of preterm (less than 37 weeks gestation), and low birth weight (under 2500 grams) babies born to JJ Way™ clients. The results showed 4.8% of babies in the program were born with low-birth weight, well below the Orange County rate of 9.1% during the years 2005-2007. The study also found 4.7% of JJ Way™ babies were preterm compared to 15.4% of babies born in Orange County from 2005-2007.

PROGRAM COST

The operational budget for FY2008 was approximately \$515,000. During that year 345 clients were served at an average cost of \$1,410 per client.

ASSETS & CHALLENGES

Assets

- There is existing infrastructure and capacity to address this problem.

Challenges

- The major challenge is that capacity to provide services has not increased with demand.

Overcoming Challenges

- Staff is currently working on a more effective business and development plan to respond to the increase in demand.

LESSONS LEARNED

Having each staff member involved at some level of patient care/case management helps to ensure continuity of care and promotes consistent health messages to the clients.

FUTURE STEPS

Two satellite sites operate in nearby counties. One site has a larger Hispanic population while the other a larger African-American population. Additionally, there are two volunteer consultants who are helping staff craft a more effective business and development plan to respond to the increase in demand.

COLLABORATIONS

This project involved collaborations with the local health department, WIC program, and Healthy Start as well as midwifery organizations and local hospitals. The Health Council of East Central Florida conducted a program evaluation of this project.

PEER REVIEW & REPLICATION

No peer review was included in the original submission.

Two satellite sites operate in neighboring counties. One site has a larger Hispanic population while the other a larger African-American population.

RESOURCES PROVIDED

For more information about this program, visit:

The non-profit organization that oversees the program:
<http://www.commonsechilbirth.org/>

The birth center, the original JJ Way™ Model site:
www.thebirthplace.org/

Key words: Access to Health Care, Birth Outcomes Family/Consumer Involvement, Health Inequity/Disparities, Prenatal Care, Reproductive Health, Infant health, Infant Mortality, Male Involvement

****For more information about programs included in AMCHP's Innovation Station database, contact bp@amchp.org. Please be sure to include the title of the program in the subject heading of your email** ***





The JJ Way®: Reducing Perinatal Outcome Disparities

A Retrospective Matched Comparison Group Study on Birth Outcomes in At-Risk Populations

Sarah J. Day, MSM, Wendy Gordon, LM, CPM, MPH, Tyan Parker Dominguez, Ph.D., MPH, MSW

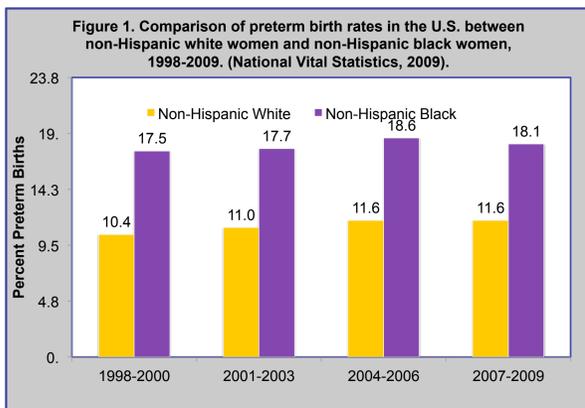
Mark Martzen, Ph.D., CIP, Jennie Joseph, LM, CPM



Introduction

Preterm birth (PTB), defined as birth prior to 37 weeks gestation, is the world's leading cause of infant mortality (Sowards, 1999).

The United States ranks 131st out of 184 countries in preterm birth (March of Dimes, 2011), placing it behind Canada, the UK, and France, as well as Afghanistan, Mali, and the Democratic Republic of the Congo.



Extreme racial disparities exist in birth outcomes in the U.S. African American women have higher rates of PTB and LBW infants than any other racial group in the U.S.

“The JJ Way®” is a model of prenatal care designed by midwife Jennie Joseph to reduce health disparities and adverse birth outcomes, such as preterm births and low birth weight infants.

Specific Aims

- To analyze and compare the birth outcomes of patients who participated in The JJ Way® with a matched comparison group of women with the same zip codes, age, and race, who received standard prenatal care.
- The birth outcomes that were measured were gestational age at birth and birth weight of the infant.
- The researcher hypothesized that The JJ Way® is a more effective model of care than traditional prenatal services for reducing adverse birth outcomes in at-risk populations such as African American women and low-income women.

Methods

The design was a retrospective matched comparison group study. Institutional Review Board approval at Bastyr University was granted in October of 2012. Data from The JJ Way® initial evaluation was applied for and received.

A historical comparison group was created from the Florida Vital Statistics live birth records for the same time period (2006-2007). The records with unknown prenatal care status were removed from the analysis in order to attenuate potential bias in comparing some prenatal care with no prenatal care. With the remaining records, a matched comparison group of 67 cases was created by randomly selecting records that matched The JJ Way® subjects on age, race/ethnicity and zip code.

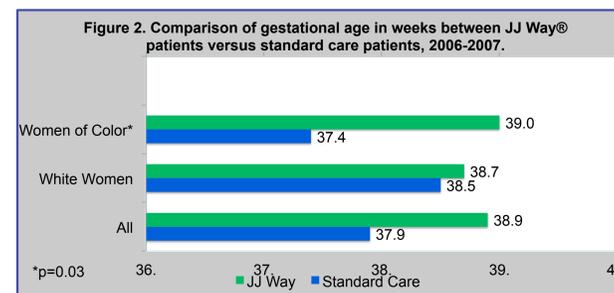
A first round analysis was done by coding subjects in each cohort as either “White,” which included women who self-identified as White and non-Hispanic, or as “Women of Color,” which included women who self-identified as African American, Haitian, and/or Hispanic.

A secondary analysis was performed comparing only the outcomes of non-Hispanic White women with non-Hispanic African American women. The sample size for this secondary analysis was small (n=104, 52 matched cases) and did not produce statistically meaningful results, but is discussed in the paper.

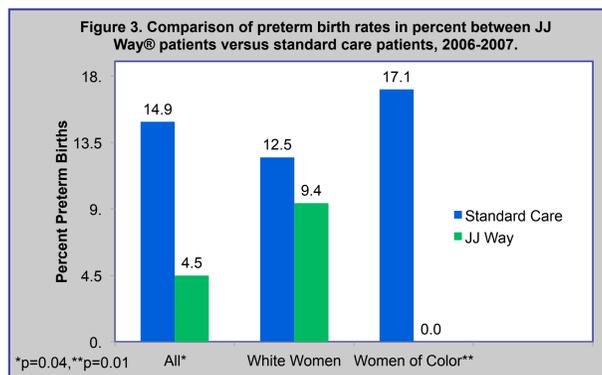
The two primary outcomes examined and compared across the two groups were gestational age at birth and birth weight. Both outcomes were analyzed as continuous variables (in weeks and in grams, respectively) and as categorical variables [preterm gestation (<37 weeks) versus full term; and low birth weight (<2500 grams) versus normal birth weight]. Differences in continuously measured gestational age and birth weights were tested for significance with T-tests. Differences in categories of preterm and low birth weight infants were examined using Fisher’s exact two-sided tests. All tests of statistical significance were calculated using SPSS.

Outcomes were compared by prenatal care group using the entire sample. Potential racial disparities in the outcome variables within each group were also examined [non-Hispanic White versus Women of Color (in the primary analysis) or African American (in the secondary analysis)].

Results



As a whole, The JJ Way® prenatal care group showed a trend toward higher gestational age at birth that did not quite reach statistical significance (38.9 weeks versus 37.9 weeks, p=0.07) and a non-statistically significant higher birth weight (3359.4 grams versus 3265.9 grams, p=0.41) than the standard care group. When comparing by race, there were no statistically significant differences between White women in the two groups in gestational age or birth weight. However, for Women of Color in the two groups there was a statistically significant difference in mean gestational age. As a group, Women of Color in The JJ Way® model gave birth to babies at higher gestational age than Women of Color in the standard care group (39.0 weeks versus 37.4 weeks, p=0.03; see Figure 2). The JJ Way® Women of Color had higher average birth weight than the standard care group, but the difference was not statistically significant (3348.1 grams in The JJ Way® group versus 3129.9 grams in the standard care group, p=0.30).



The outcome measures were also analyzed as dichotomous variables instead of continuous, i.e., preterm (<37 weeks) versus full term, and low birth weight (<2500g) versus normal birth weight. The overall preterm birth rates were 4.5% and 14.9% for patients of The JJ Way® and the standard care group, respectively (p=0.04). The overall rates of low birth weight in each group were the same: 4.5%. When comparing by race, the difference in preterm birth rates for the Women of Color between groups was prominent. The JJ Way® group had no preterm births (0%) among Women of Color, whereas Women of Color in the standard care group had a preterm birth rate of 17.1% (p=0.01). See Figure 3.

Conclusions

The findings of this study, which matched women from The JJ Way® with those of the same age, race, and zip code from the Florida Vital Statistics data base, revealed statistically significant longer gestational periods and lower preterm birth rates for Women of Color who were cared for within The JJ Way® model.

Given the decades of unsuccessful progress on reducing rates of preterm birth, low birth weight, and infant mortality in the U.S., The JJ Way® model’s success is noteworthy. It should be supported, funded, and larger studies should be conducted.

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Complete reference list available in thesis paper.



INFANT RISK SCREEN

Use ink. Be certain to check the appropriate boxes at the top of the birth certificate.



Pursuant to § 383.14(1)(b) and 383.011(1)(e), F.S., this form must be completed for each infant and submitted to the local County Health Department, Office of Vital Statistics.

MOTHER

Mother's Name: First		Last				Maiden	
Mother's Date of Birth				Mother's Social Security Number			

INFANT

Infant's Name: First		Last				Infant's Date of Birth		Boy	Girl
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Name of Infant's Doctor/ HMO or Group: _____ Name of birth hospital/ facility: _____

Was the infant transferred? No Yes If Yes, enter name of facility transferred to: _____

Was the infant admitted to neonatal intensive care unit for more than 24 hours? No Yes Unknown

SECTION 1: COMPLETED BY PATIENT

Yes _____ **No** _____ (please initial) I am interested in having my infant screened for risks that could affect his/her health or development in the first year of life.

Yes _____ **No** _____ (please initial) If my infant is referred, Healthy Start may contact me.

I can be reached at (home phone): _____ or (work or contact phone): _____

Street Address: _____
(Give either street address with bldg.#, apt.# or lot# or directions to baby's home)

Mailing Address: _____
(if different from street address)

Yes _____ **No** _____ (please initial) By initialing yes, I am giving my written permission on behalf of my infant for release of the confidential information on this form and any information provided during his/her evaluation for service by Healthy Start to Healthy Start care coordination providers, Healthy Start Coalitions, Healthy Families Florida, WIC, and my health care providers for the following purposes: care coordination, payment of claims for services, quality improvement of services, or screening for program eligibility. This includes any medical, mental health, alcohol/drug abuse, sexually transmitted disease, tuberculosis, HIV/AIDS, and adult or child abuse information. This authorization shall remain in effect unless withdrawn in writing.

Signature of parent or guardian

Date (mo/day/yr)

SECTION 2: BY PROVIDER

Item numbers correspond to the numbers on the Birth Certificate. Write the point(s) on the appropriate lines, and add for the total score.

Item 54 ④ _____ Abnormal conditions include one or more of the following: Assisted Ventilation (30 min. or more), Assisted Ventilation (6 hrs. or more), NICU admission, newborn given Surfactant Replacement Therapy, Hyaline Membrane Disease/RDS, or seizure or serious neurological dysfunction.

Item 4 ④ _____ Birthweight less than 2000 grams or less than 4 pounds, 7 ounces

Item 28b ④ _____ Infant transferred within 24 hours of delivery

Item 15 ① _____ Mother unmarried

Item 26 ① _____ Principal source of payment Medicaid

Item 30 ① _____ Maternal race black

Item 19 ① _____ Father's name not present or unknown

Item 40 ① _____ Mother used tobacco in one or more trimesters

Item 36d ① _____ Prenatal visits less than 2 or unknown

Item 16 ① _____ Maternal age less than 18 or unknown

Infant's Healthy Start Screening Score

CHECK ONE Referred to Healthy Start
If score less than 4 specify reason for referral: _____
 Not referred to Healthy Start

BE CERTAIN TO CHECK THE APPROPRIATE BOXES AT THE TOP OF THE BIRTH CERTIFICATE.

I have explained the Healthy Start program, and if screened, the patient's screening score.

Provider's/Interviewer's Signature and Title

Date (mo/day/yr)

NO ATTACHMENTS MAY BE ADDED TO THIS FORM.



Leon County Community Dialogue

IMPROVING COUNTY HEALTH • APRIL 3 2014

THE NATIONAL ASSOCIATION OF COUNTIES

The National Association of Counties (NACo) assists America's counties in pursuing excellence in public service by advancing sound public policies, promoting peer learning and accountability, fostering intergovernmental and public-private collaboration and providing value-added services to save counties and taxpayers money. The National Association of Counties (NACo) is the only national organization that represents county governments in the United States. Founded in 1935, NACo provides the elected and appointed leaders from the nation's 3,069 counties with the knowledge, skills and tools necessary to advance fiscally responsible, quality-driven and results-oriented policies and services to build healthy, vibrant, safe and fiscally resilient counties.

WHAT ARE THE COMMUNITY DIALOGUES?

The National Association of Counties (NACo), in partnership with the Robert Wood Johnson Foundation (RWJF) and the University of Wisconsin Population Health Institute (UWPHI) is conducting community dialogues in six counties across the country. The NACo Community Dialogue to Improve County Health sessions are intended to assist counties in assessing, planning, and strategizing current efforts toward coordinating health initiatives to improve the overall health of residents in these counties. These sessions are a part of NACo's Elected County Officials' Guide to County Health Rankings & Roadmaps project which aims to bring together public and private partners to share innovative ideas and strategize about how to resolve various challenges counties face.



LEON COUNTY COMMUNITY DIALOGUE

Community healthcare leaders in Leon County gathered together to discuss access to care in the county. Participants included members of the County Commission, the County Administrator and staff, the Florida Department of Health in Leon County Interim Administrator, and representatives from the Florida State University (FSU) College of Medicine, Big Bend Cares, Neighborhood Medical Center, Apalachee Center, Bond Community Health Center, Capital Medical Society Foundation, North Florida Medical Centers, Tallahassee Memorial HealthCare, Florida A&M University (FAMU) College of Pharmacy and Pharmaceutical Sciences, and the United Way of the Big Bend.

Leon County staff led participants in identifying the strengths and assets of the current healthcare system, the gaps and barriers to collaboration, ideas and solutions to addressing those gaps and barriers, and next steps to achieving the goals.

County Commission Chair Kristin Dozier opened the Community Dialogue by noting the main outcome for the discussion would focus on how to improve access to care in Leon County through greater collaboration and increased partnerships. She stated the county wants to be the catalyst that drives these types of partnerships forward. County Administrator Vincent Long highlighted the goals of the discussion, including a conversation on where the county and its partners should go next in improving access to care. Leon County staff emphasized the dialogue was intended to provide a forum for an honest look at where the community is and how the strengths can be enhanced and the gaps can be filled to improve access to care.

This report provides a narrative summarization of the Community Dialogue. The report is organized by area of discussion and not the exact order of conversation as it occurred on April 3, 2014. The report does not include every comment made throughout the day, but serves to highlight the ideas discussed in their respective sections.



IDENTIFYING STRENGTHS AND ASSETS

WHAT ARE THE STRENGTHS AND ASSETS OF THE HEALTHCARE SYSTEM IN LEON COUNTY AND HOW CAN THE COMMUNITY BUILD ON WHAT IS WORKING WELL?

Participants spent a majority of the first session discussing the strengths of the healthcare system in Leon County. There were a number of comments that emphasized the strength and dedication of the safety net providers in the community, including the We Care Network coordinated by the Capital Medical Society Foundation, Bond Community Health Center, and Neighborhood Medical Center. This group of providers, known as the CareNet program, is supported by other healthcare partners such as the Florida State University (FSU) College of Medicine, the Florida A&M University (FAMU) College of Pharmacy, and Tallahassee Memorial HealthCare.

In Leon County, partners share in the mission to serve indigent populations, in particular both Bond Community Health Center and Neighborhood Medical Center have a long history and depth of experience serving the uninsured and underserved in Leon and surrounding counties. Others have

“One of the things that is more unique about Tallahassee than most communities is... the large majority of health concerns and health programs are managed and directed by this community and through people in this community... When you have healthcare decisions made from afar, there isn't a sense of ownership... I think the way that this community makes decisions around healthcare and the fact that a large majority are made locally is highly important.”

— Mark O'Bryant
President and Chief Executive Officer
Tallahassee Memorial HealthCare

also developed innovative methods of improving access for underserved populations. Tallahassee Memorial HealthCare, in collaboration with the FSU College of Medicine and Capital Health Plan, has established the Transition Center. The Center helps connect patients who are uninsured or underserved with safety net providers and primary care providers to ensure a continuity of care and lower readmissions to the hospitals.

Leon County is home to two major universities, Florida State University and Florida A&M University. The FSU College of Medicine and

the FAMU College of Pharmacy serve important roles by attracting students and faculty who are interested in serving the underserved, supporting TMH's residency programs, and embedding faculty in local healthcare organizations who serve the uninsured and underserved. As Florida's state capital, Tallahassee and Leon County are in a unique position to influence state policy.

The county has partnered with the City of Tallahassee and the United Way of the Big Bend to develop the Community Human Services Partnership, which invests over \$4 million in social services, including healthcare, to improve the quality of life for our local citizens. The Florida Department of Health in Leon County operates a pediatric dental program. In partnership with Leon County Schools, it is piloting a sealant program for second graders.

WHAT IS OR SHOULD BE THE COUNTY’S ROLE IN IMPROVING ACCESS TO CARE?

The final portion of the morning session centered on the role the county could play to improve access to care. A number of partners discussed the county moving toward operating in a more outcome-driven fashion, consistent with nationwide healthcare trends. . The county was identified as the most appropriate partner to facilitate a discussion on a healthcare system that is more heavily focused on achieving

improved outcomes. This would include facilitating discussions to establish certain health benchmarks and supporting providers to reach identified goals.

The county was also identified as having an important role in taking the lead on key health issues that impact the community. This includes pursuing innovative health technologies, such as telehealth and telemedicine, through policy development at the local and state level. Regarding mental health, initiatives to reduce stigmas associated with seeking mental health treatment were discussed and the county was identified as playing an important role in educating the public and promoting the importance of treatment for mental health and substance use disorders.

“One of the issues we have in general is a level of public prejudice and stigma, not only about severe and persistent mental health issues... but with mild mental health issues... A lot of that has to do with both a reluctance to seek treatment and a reluctance to admit that there are interventions needed, and with the unavailability... of milder or more moderate forms of treatment, and that takes not just providers, but it takes a change in the culture of the community... I think that is a place where the county, with the partnership of the current providers, can take the lead and say we want to make this the healthiest county we can, both in terms of physical, but also in terms of behavioral health.”

— Jay Reeve
President and Chief Executive Officer
Apalachee Center

PUBLIC COMMENT PERIOD

At the end of this section of the dialogue, citizens were given an opportunity to make comments. Public comments included concern that the failure to expand Medicaid in Florida would have a dramatic impact on the uninsured, particularly in the African American population. Concern was expressed over the health disparities within the community and that the need for care in the underserved population is not met by the current system of care. Concern was also mentioned regarding the difficulty that high need patients have in navigating the healthcare system.

GAPS AND CURRENT BARRIERS TO COLLABORATION

WHAT ARE THE GAPS IN SERVICES IN THE COMMUNITY?

As the dialogue shifted from discussion of strengths and assets of the healthcare system, partners talked about the gaps in services they see as barriers. Although many partners highlighted the high quality of care provided by physicians, it was noted that some specialties suffer from a shortage of providers and additional physicians are needed to match the health needs of the community.

There was a discussion about gaps in services for the chronically ill. The current CareNet system has provided a strong safety net, but the system does not address funding of chronic disease treatment. There is an acute need to improve chronic care management and services for “high utilizers” that cycle in and out of the hospital.

Many partners highlighted the need to put increased focus on prevention efforts, particularly among high need populations. Finally, there was discussion around a gap in acute ongoing behavioral health services, although this stems more from a statewide funding lapse. Conversation among the partners highlighted the quality of services delivered and focused most of the discussion on gaps in access to care.

WHAT ARE THE GAPS IN ACCESS TO CARE IN THE COMMUNITY?

The partners discussed a number of critical gaps in access to care. The county has high quality health-care services and well-trained physicians; however, the partners discussed the lack of a full continuum of services. It is difficult for uninsured and underinsured patients to connect to needed services in the system due to fragmented providers and a lack of follow-up services available to them. It was noted that many patients stop seeking services when confronted with the difficulty of navigating the system. In particular, investments need to be made to close gaps in preventive care, follow-up, and ongoing outpatient treatment for the chronically ill.

For those uninsured populations gaining access to health coverage through the Affordable Care Act, accessing a fragmented system of care will be particularly difficult as many of them are gaining insurance for the first time or after a long

gap in coverage. The partners expressed concerns about gaps in coverage for those purchasing high-deductible plans on the Federal Health Insurance Marketplace.

Some providers have found it difficult to share patient health information. As information sharing is a critical component to a system that provides a strong continuity and continuum of care, partners expressed concern and a desire to move forward on improving capacity for information and health

“Our system is still very provider-centered rather than patient-centered and we expect patients to know how to navigate so many different systems to get all of the pieces [of care] that they need.”

— Lauren Faison
Administrator for Population Health and Regional Development
Tallahassee Memorial HealthCare

record sharing. Multiple partners discussed the current status of health information exchanges, which offer significant potential for improving the community healthcare system, but are still in the development stage or have yet to be adopted universally. Part of the slow adoption of health information exchanges has to do with the complex issues surrounding the Health Insurance Portability and Accountability Act (HIPAA) and other privacy requirements and the cost-prohibitive nature of connecting medical records systems to health information exchanges.

Healthcare delivery is provider-centered, which is a contributing factor to the continuum of care gap discussed earlier in the dialogue. Many partners discussed the need to shift towards a patient-centered model of healthcare delivery.

At this point in the dialogue discussion shifted to an issue within the primary care provider system for the uninsured and underserved population. Due to the timing of federal funding decisions, the gathering of these key partners served as an important opportunity to address this critical community partnership.

PUBLIC COMMENT PERIOD

No members of the public offered comments for this section of the dialogue.

REMOVING BARRIERS TO COLLABORATION

WHAT ARE SOME OPPORTUNITIES TO ADDRESS GAPS IN THE COMMUNITY?

At the start of this session on how to address gaps in the healthcare system, partners were led in a short discussion of what gaps had been identified earlier in the day. They were also prompted to consider the healthcare system as a whole and where each of the partners fit into solving some of these key gaps in the community.

The Center for Health Equity at Florida A&M University (FAMU) will engage in an agreement with both community health centers to implement an outcome-driven model addressing diabetes. The pilot program will take a baseline assessment of patients and put them through a structured system of care that eliminates barriers such as transportation, mental health, substance abuse, and follow-up care. The baseline assessment measures will be monitored and outcomes reported on a quarterly basis to view improvement. This type of model would address continuum of care issues discussed in the earlier segment on gaps.

The partners discussed both the process and the types of community outcomes that should be addressed. There was discussion of anchoring any community shared vision on improving health to a national standard that is recognized by both leaders and the public (e.g. Healthy People 2020). There was broad agreement that any outcome data should be based on data already collected by providers, as they are all faced with a number of data collection requirements already.

Many partners weighed in on the process of filling community gaps with a broad census focused on developing a committee or community health council that would develop a shared community vision or community-based plan that addresses agreed upon priorities. The United Way of the Big Bend operates a community health council that spans across community sectors. The county currently has

Participants discussed additional partners that should be included in the development of a community-based plan that impacts health but were not included in the Community Dialogue. Suggestions included:

- » Law enforcement
- » Leon County School District
- » City of Tallahassee
- » County commissioners from surrounding counties
- » Faith-based organizations
- » Patients/clients
- » County and city planners
- » Leon County Emergency Medical Services (EMS)
- » Transportation leaders
- » Business leaders

a Community Health Coordinating Committee and it could be utilized as a vehicle for community partners and the county to move community health priorities forward. There was discussion of engaging county leaders from surrounding counties to gauge the utilization of healthcare services in Leon County from individuals residing in those counties. Other suggestions included the development of a multi-year strategic plan that includes an annual plan incorporating community health priorities.

Improving health literacy in the community was suggested as an opportunity to address access to care issues. One solution offered was to develop a focus group or survey of Leon County citizens to gauge their current understanding of health and then undertaking a public education effort to fill the needed gaps identified. Another suggestion was to provide services that would guide people through the healthcare system. There is a shortage of support staff throughout the healthcare system in the community that can provide those types of services to improve access and health literacy. Providing this type of support staff for patients ensures they receive needed care.

PUBLIC COMMENT PERIOD

Comments included concern over the high rates of infant mortality in Leon County. Income inequality and poverty were also identified as barriers to accessing care in the community, which also impacts low income citizens ability to provide or get transportation to gain access to healthcare. Some commenters agreed with ideas discussed by the partners such as consolidated medical records to provide for consistency of care across providers, the concept of case management, and a shift to patient-centered care. Community goals would be shared with the public to ensure transparency.

NEXT STEPS: WHAT WILL EACH PARTNER COMMIT TO MOVING FORWARD?

County Administrator Long opened this section of the dialogue by drawing on comments earlier in the day that focused on moving toward a more outcome-driven approach. He noted that county contracts have been focused on getting people into a primary care home, but this could be a pivot point to shift toward outcome-driven contracts with providers. This would allow the county to focus on moving the needle on specific health care needs in the community identified by partners. Multiple partners indicated that the community needs to first assess the health issues and develop a community-based plan to address them, and then potentially address how the county contracts with providers.

The United Way of the Big Bend expressed willingness to take the lead on being the catalyst for the community health council to pool resources and contribute to a discussion of a community-wide shared vision. Many other partners stated that they were willing to devote time and resources to a community health council.

A number of partners, including the FAMU College of Pharmacy and the Tallahassee Memorial Health-Care Transition Center said they would focus on sharing information and tools with all the partners to improve knowledge of the needs of the community. Dr. Thompson from FAMU offered to compile health statistics for the area, including in subgroups of the community, to help understand the health issues of the community. The Transition Center will share its patient-by-patient identifier and GIS mapping tools that provide data on the neediest populations in the community.



NACo COMMUNITY DIALOGUE SERIES

Leon County Community Dialogue

IMPROVING COUNTY HEALTH • APRIL 3 2014



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Whole Child Leon

THE FUTURE OF LEON COUNTY
A REPORT ON THE STATUS OF OUR CHILDREN
JUNE 2013

Working Together to Build a Community Where All Children Thrive



The Future of Leon County

A Report on the Status of Our Children 2011-12

The purpose of Whole Child Leon is to engage the entire community in doing whatever is necessary to ensure that all children in Leon County are healthy and thrive in supportive, nurturing and loving environments. The Whole Child philosophy is grounded in the notion that communities must address and nurture all 6 dimensions of a child's well-being in order to raise a healthy child. A growing body of research shows that the first 5 years of life are crucial to brain development, to acquiring social skills necessary to be good citizens, and to developing emotional, physical, and mental health. Embracing the idea that we must nurture the whole child is key to giving our children the best start in life. Whole Child Leon is committed to ensuring that mothers receive physical and mental health care before, during, and after pregnancy and that children:

- Receive quality healthcare
- Live in an economically stable family
- Participate in quality early education and development activities from birth through age four
- Live in a safe and nurturing environment

- Develop positive social and emotional behavior
- Have a sense of hope, wonder and connectedness to others and the larger world that comes from a strong spiritual foundation

Whole Child Leon focuses on children from birth to age 5 because of how incredibly important these years are for the development of a child's brain. Childhood brain development affects the ability to learn and participate constructively in society throughout life. The figure on the following page illustrates that the majority of neurological development for basic senses, language, and higher cognitive functions happens before a child turns five years old.



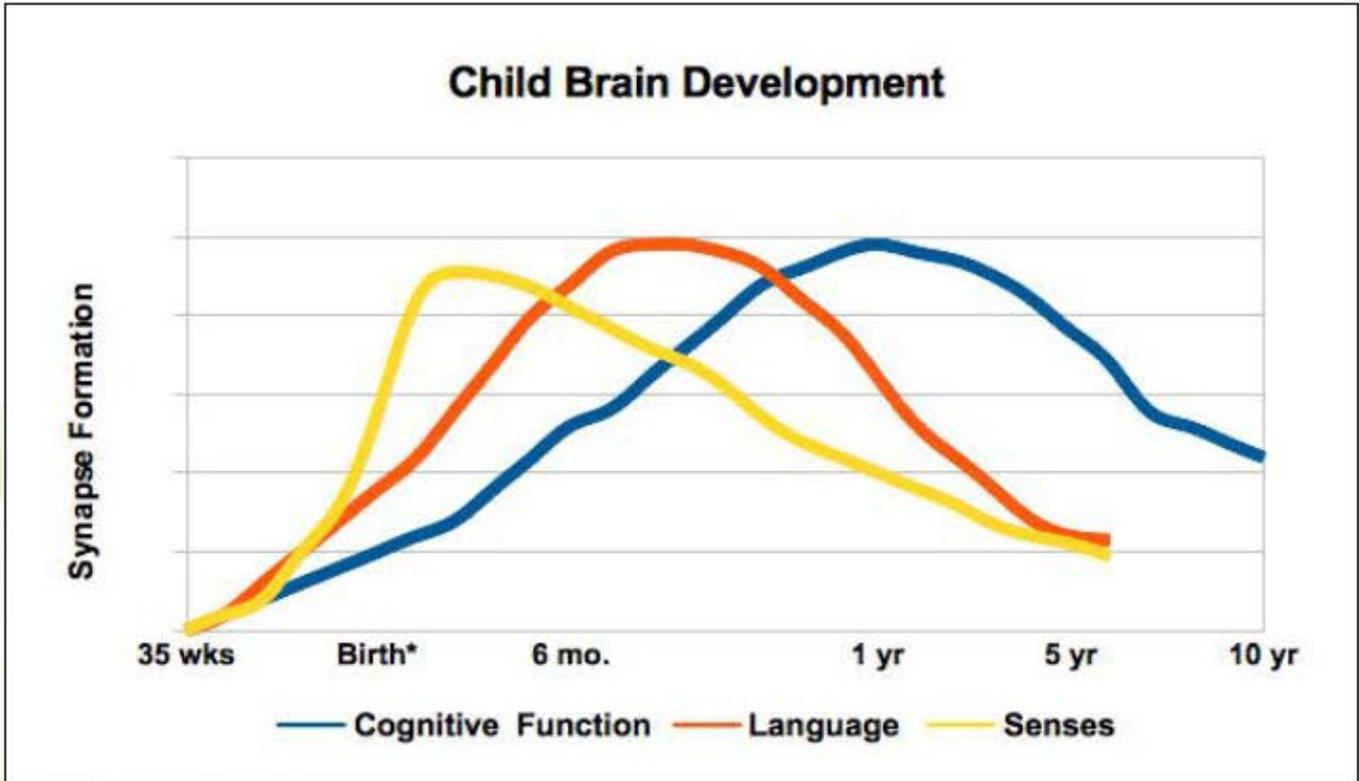


Figure 1 - Adapted from National Research Council and Institute of Medicine (2000 From Neurons to Neighborhoods: The Science of Early Childhood Development.

The Condition of Children in Leon County

This Status of the Child Report tracks the well-being of children in our community by highlighting key indicators of the condition of children 0-5 in Leon County. By providing high-quality data and trend analysis, Whole Child Leon seeks to enrich local and state discussions concerning ways to secure better futures for all children — and to raise the visibility of children’s issues through a nonpartisan, evidence-based lens. Data in the following pages show that many children in Leon County face risks that are barriers to success in school and life. This in turn means our community will be less able to compete and thrive.

This report shows many children are able to thrive when they experience the six conditions listed on the previous page. It also shows, however, that too many children in our community do not

experience one or more of these conditions. The quality of life of our children and the economic health and stability of our community are interdependent. Whole Child Leon will use this report to engage the community and encourage their ownership of early childhood success.

We selected indicators for this report that provide good markers of the health and well being of children in Leon County and for which quality data were available. We limited the number of indicators to keep the report manageable and easy to understand. Although data collection has improved, there are many indicators of child well-being that lack comparable, consistently collected county and state level data. We will continue to work with our community partners to increase the quality and amount of data available.

The 6 Dimensions of a Whole Child

Whole Child Leon unites the efforts of service providers, community leaders, child advocates and volunteers to provide a holistic service delivery network that enhances all 6 dimensions of a Whole Child:

1. quality health care for all children
2. safe and nurturing environments for children and families
3. economic stability for families with small children
4. quality early education
5. social-emotional development
6. spiritual foundation and strength

The Whole Child philosophy is grounded in the notion that communities must address and nurture all 6 dimensions of a child's well-being in order to raise a healthy child.

The following pages outline the data indicators and specific information about each of these 6 dimensions.





The 6 Dimensions of a Whole Child

Physical & Mental Health “Children Are Healthy at Age 1”



Data Indicators

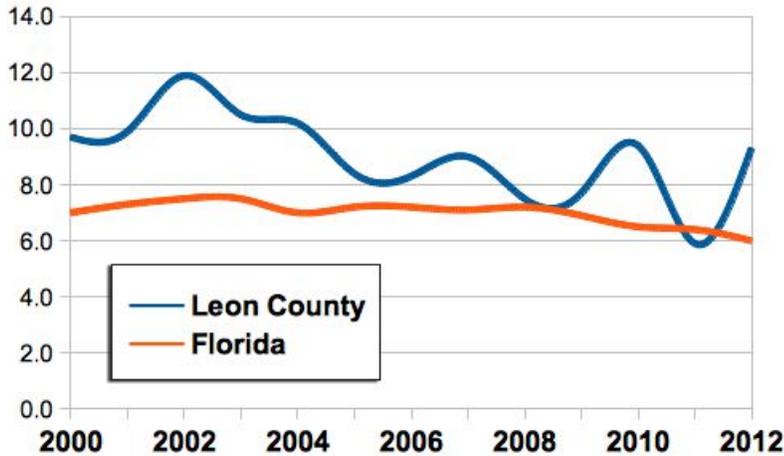
- Infant Mortality
- Immunizations
- Obesity measure
- Access to primary care

Children’s health is the foundation of their overall development and ensuring that they are born healthy is the first step toward increasing the well-being of all children. Poverty, poor nutrition, lack of preventive health care, substance abuse, maternal depression, and family violence put our children’s health at risk. Poor health in childhood impacts other critical aspects of a child’s life and can have irreversible consequences for their future health. Children whose physical and mental health needs are met in their early years are more likely to be ready to learn and succeed in school. Indicators such as infant mortality reflect the health and well-being of the mother and child during the prenatal period and first year of life. Other indicators such as low birth weight, immunizations, child obesity, and access to healthcare offer us a glimpse of the health status of Leon County’s youngest citizens.



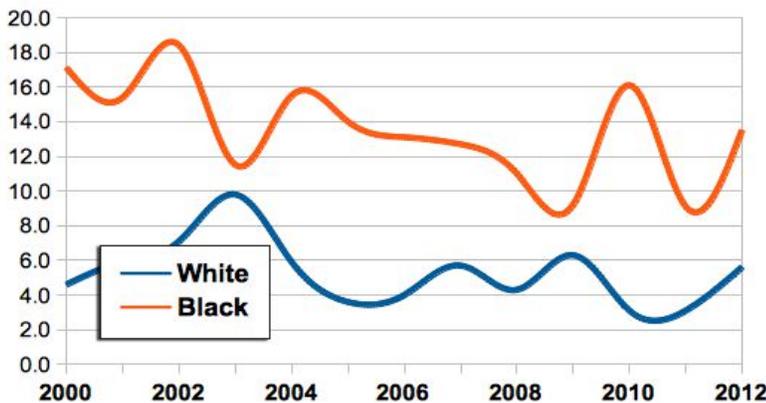
The 6 Dimensions of a Whole Child

Infant Mortality Rate



This figure shows the infant mortality rate (deaths per 1,000 live births) in Leon County and Florida for the last 12 years. Deaths to infants in the first year of life is an indicator for an area's general health, maternal health, quality and availability of pediatric care, and general public health practices. While Leon County's infant mortality rate has declined since 2000, the county's rate is still higher than the statewide average. Infant mortality is not experienced equally across races within Florida or Leon County. (Data from FloridaCHARTS.com, Florida Department of Health.)

Infant Mortality Rate by Race



This figure shows the disparity between white and black rates of infant mortality over the same time period. While the black rate has declined since 2000, the black rate is consistently higher than the white rate. (Data from FloridaCHARTS.com, Florida Department of Health.)

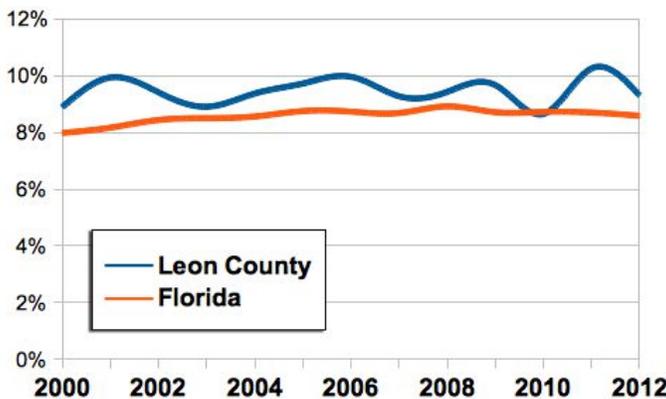


The 6 Dimensions of a Whole Child

Physical & Mental Health

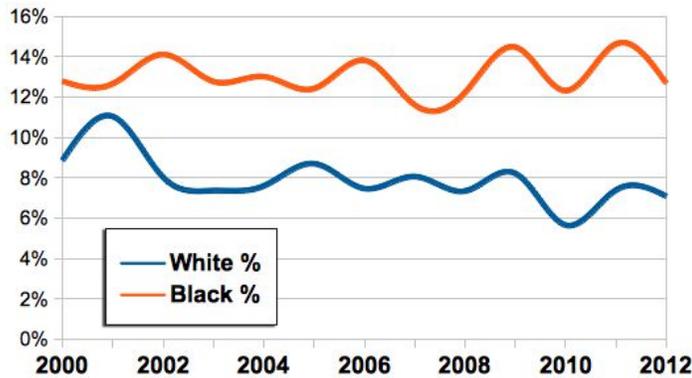


Low Birthweight Births



Birthweight can be an important indicator of health for the mother and the child. Low birthweight infants (less than about 5.5 pounds) have a high probability of experiencing developmental problems, short or long term disabilities, and are at greater risk of dying within the first year of life. For pregnant mothers, smoking, poor nutrition, poverty, stress, infections and violence can increase the risk of a baby being born with a low birthweight. The rate for low birthweight births has remained relatively stable since 2000. Roughly 9 out of every 100 babies in Leon County have a low birthweight, slightly higher than the state average. (Data from FloridaCHARTS.com, Florida Department of Health.)

Low Birthweight Births by Race



This figure shows the disparity between white and black low birthweight infants. The black rate is consistently higher than the white rate and the disparity has increased since 2000. The percentage is trending down for white births, but remaining steady for black births. (Data from FloridaCHARTS.com, Florida Department of Health.)

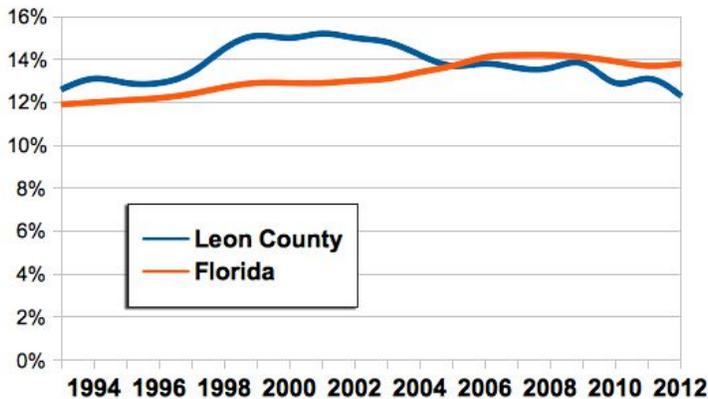


The 6 Dimensions of a Whole Child

Physical & Mental Health

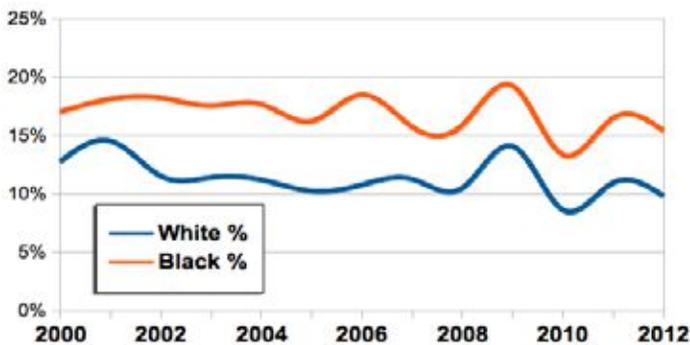


Preterm Births



Children who are born preterm are at greater risk for short and long term complications including disabilities and impediments to growth and mental development. Like low birthweight, this data can also be associated with poorer prenatal care or poor maternal health. The percentage of births that are preterm has declined since 2000 in Leon County and is lower than the state average. (Data from FloridaCHARTS.com, Florida Department of Health.)

Preterm Births By Race

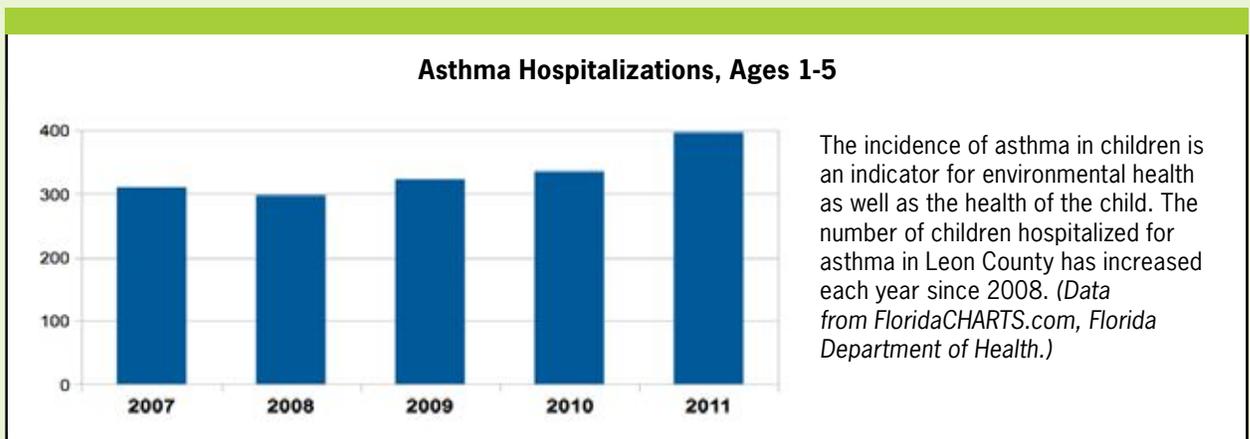
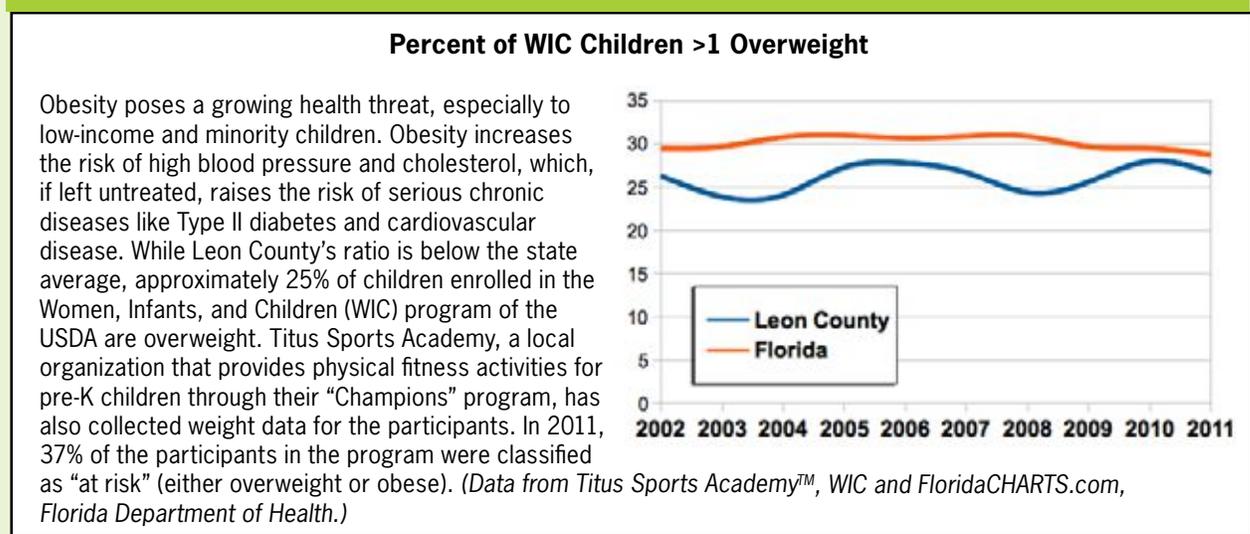
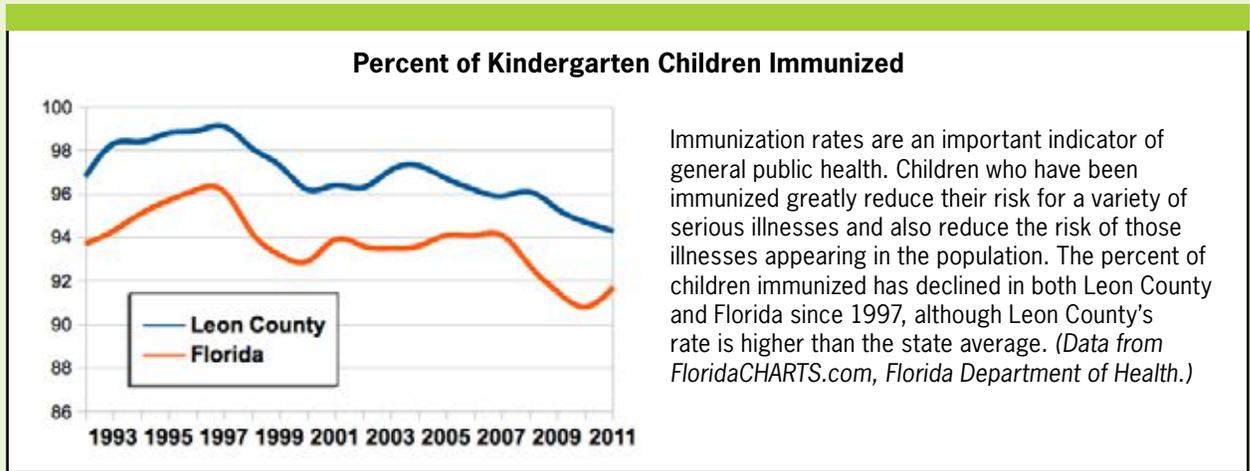


This figure shows the disparity between white and black preterm births. While both percentages have declined since 2000, the black rate is consistently higher than the white rate. (Data from FloridaCHARTS.com, Florida Department of Health.)



The 6 Dimensions of a Whole Child

Physical & Mental Health





The 6 Dimensions of a Whole Child

Social-Emotional Development



Social-emotional development refers to young children's behaviors, self-control, initiative, attachment and ability to form positive, trusting relationships with others. These skills are essential to a child's well-being and success in school and in life.

Many things contribute to a child's healthy social-emotional development, but none more than having a safe, stable and nurturing relationship with a caregiver. These relationships can be encouraged through breastfeeding initiation, reading and talking with your child, using positive discipline strategies, and seeking help when needed. While some of these behaviors are hard to quantify, others such as the number of young children in foster care can reveal discrepancies when they exist.

Data Indicators

- Children 0-5 with at least one developmental delay
- Children assessed as having one or more developmental delay, but not provided sufficient services.
- Children with social/emotional problems at entry to kindergarten

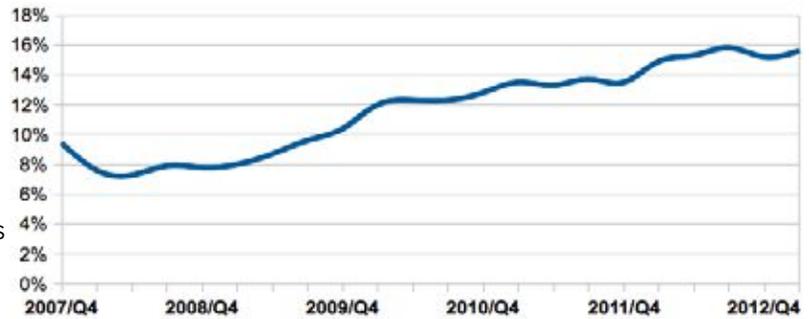


The 6 Dimensions of a Whole Child

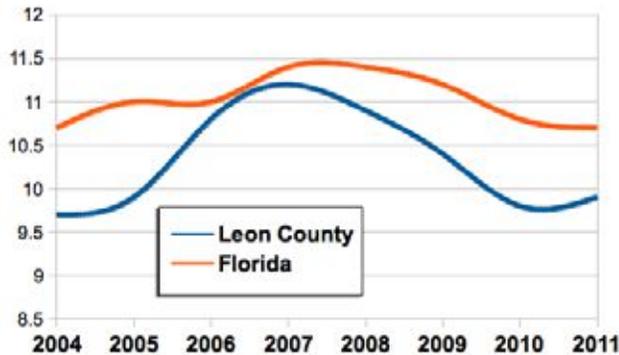
Social-Emotional Development

Percent of WIC Mothers Fully Breastfeeding (Infant at 26 weeks of age)

The initiation and maintenance of breastfeeding in the first year is associated with better health outcomes for the child. Although the percent of WIC mothers who breastfeed has increased since 2007, less than 16% surveyed were breastfeeding 26 weeks after giving birth. Considering the health benefits of breastfeeding, this percentage should be much higher. (Data from Leon County WIC.)

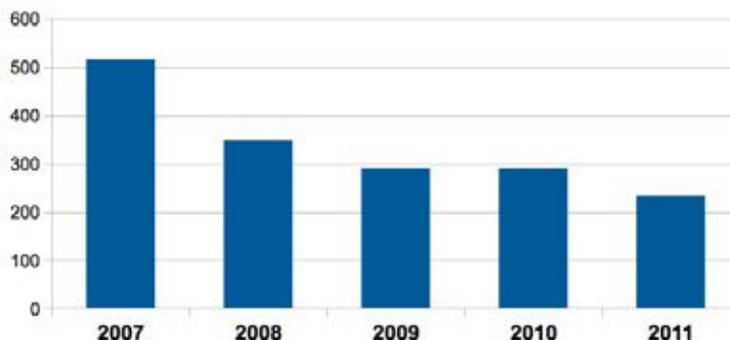


Infants in Foster Care (per 100,000)



Children in foster care often experience changes in caregivers that can be barriers to secure attachment with a primary caregiver and healthy emotional development. The number of infants in foster care has declined in Leon County over the past 7 years and is lower than the state average. (Data from FloridaCHARTS.com, Florida Department of Health.)

Children Ages 1-5 Receiving Mental Health Services



Children struggling with emotional or developmental difficulties can have increased difficulty with social relationships, education, and physical health. Mental health services assist children with these difficulties and prevent them from falling behind. The number of Leon County children receiving these services declined in the past 5 years. (Data from FloridaCHARTS.com, Florida Department of Health.)



The 6 Dimensions of a Whole Child

Safe & Nurturing Environment

The social-emotional development of children is also impacted by their environment. Just as children need safe and stable relationships, they also need safe and stable environments. Generally, all parents strive to be the best parents they can be, but many cannot afford or do not have access to all the necessary components for a child to thrive. Their environment could describe where they live, where they learn or where they play. Further, environment is impacted not only by physical conditions but also by the people and relationships that share the environment with the young child. Indicators on child homelessness, hunger and exposure to family violence begin to reveal the true condition of children in Leon County.



Data Indicators

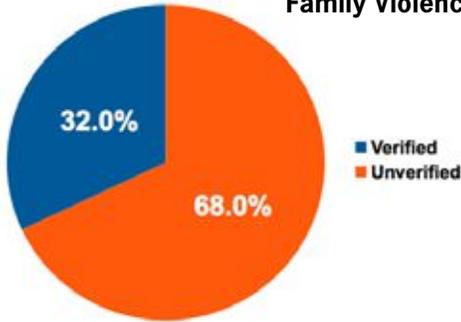
- Abused/neglected children 0-5
- Children in foster care 0-5
- Domestic violence involving children 0-5
- Food deserts
- Homeless children



The 6 Dimensions of a Whole Child

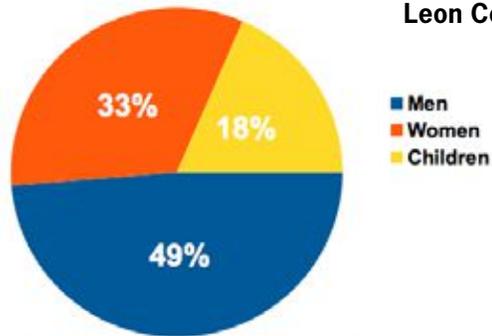
Safe & Nurturing Environment

Family Violence Cases Involving Children Ages 1-5



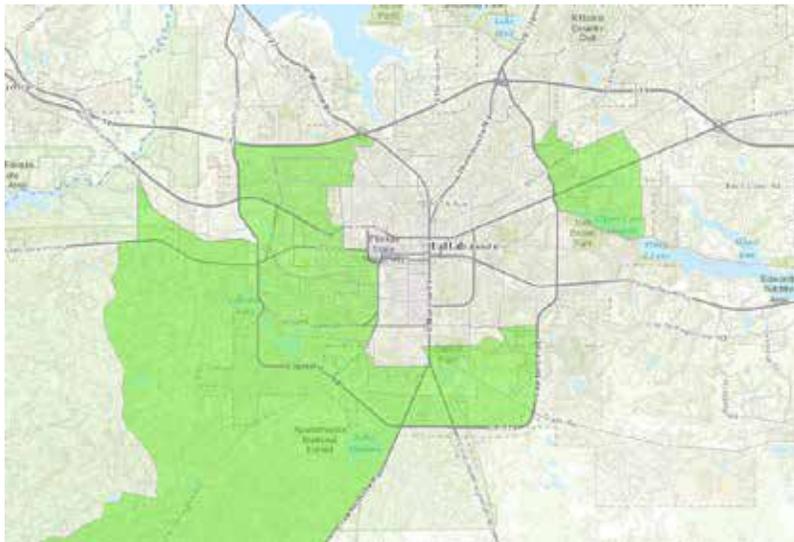
When young children live in unstable or hostile environments it can prevent them from achieving many of the Whole Child dimensions. Homes with family or domestic violence and abuse can cause long-standing mental health problems for young children and provide a poor model for social relationships. Of the total reported cases, 32% of reported cases in Leon County were verified. *(Data from Florida Department of Law Enforcement, UCR Domestic Violence Data.)*

Leon County Homeless — 2012



Any period of homelessness disrupts a child's life and the parents' ability to provide a safe and stable environment. As Figure 13 shows, young children make up almost 20% of the homeless population in Leon County. Of this 18% (approximately 500 children), 50 children were either pre-K or kindergarten age in the 2012 school year. *(Data provided by the Big Bend Homeless Coalition.)*

Food Deserts



Food deserts are areas where there is limited access to grocery stores or supermarkets. These stores have a wider variety of food items and healthier choices are readily available. Easy access to these stores (walking, biking, or short car trip) increases the chances that residents can make healthier food choices. The areas with higher percentages of low income households and lower access to healthier food stores in Leon County are shown in green in the map above. *(Data from the USDA Food Access Research Atlas.)*



The 6 Dimensions of a Whole Child

Quality Education

“All Children in Leon County Enter School Ready to Learn”



Often young children form relationships with caregivers outside the home and in child care centers. Therefore, it is imperative that efforts to ensure healthy child development also include early learning environments outside of the home. National research has shown that access to high quality early learning results in children more prepared for school, less third grade remediation and higher earnings later in life. Locally, we are in the process of collecting more data on this to show just how the impact of quality early learning affects the young children in Leon County.

Data Indicators

- Percent of children who attend pre-school
- Percent of children ready for kindergarten
- Percent of children in quality early learning centers (data unavailable at this time)

¹ Florida Department of Education, Florida Statewide Assessment Scores, <http://fcat.fldoe.org/mediapacket/2013/default.asp>



The 6 Dimensions of a Whole Child

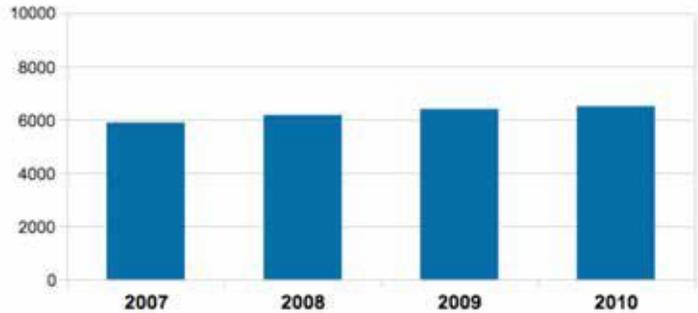
Quality Education “All Children in Leon County Enter School Ready to Learn”



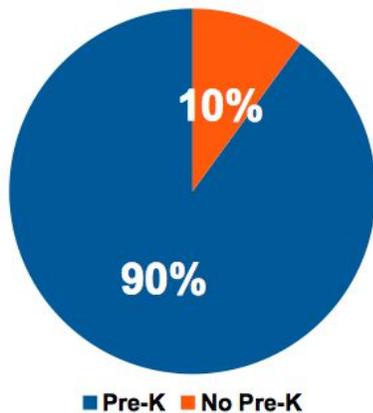
“Professionally trained early care providers create high-quality learning environments to stimulate children and support their readiness for kindergarten.”

Children Enrolled in Pre-K Programs

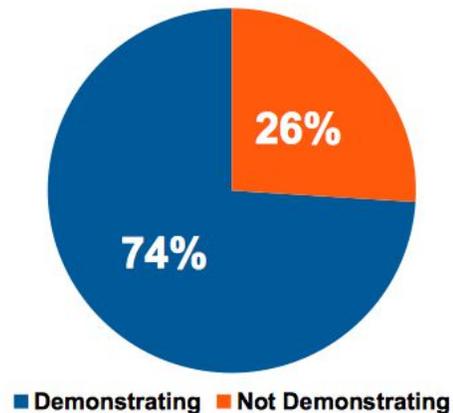
Pre-kindergarten programs are designed to give children a head start before primary school begins. The higher percentage of children enrolled in these programs, the earlier any issues that might prevent school readiness can be detected. The Leon County School District surveys incoming kindergarten students each year to determine pre-K attendance and school readiness. The most recent data shows while 90% of Leon County kindergarteners attended some form of pre-K (right), 26% of children are not consistently demonstrating the necessary skills (below).



Kindergarteners with Pre-K Experience



Kindergarteners Demonstrating Necessary Skills





The 6 Dimensions of a Whole Child

Economic Stability



Research shows that economically stable families have children who are better prepared for school, tend to stay in school and are more likely to go onto college. From 2000 to 2010, the number of children living in poverty in the United States jumped from 12.2 million to 15.7 million, an increase of nearly 30 percent.

Data Indicators

- Children 0-5 in poverty
- Unemployed parents with children 0-5
- Children 0-5 in single parent households



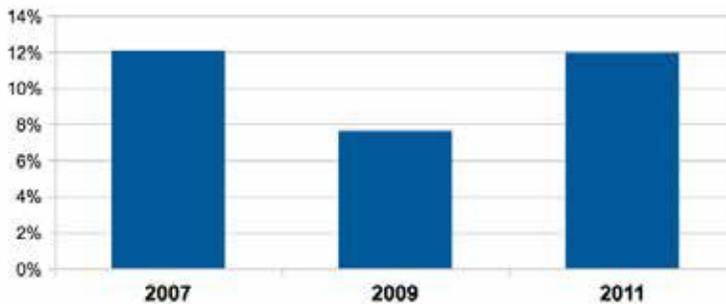
The 6 Dimensions of a Whole Child

Economical Stability

YEAR	FAMILIES IN POVERTY	INDIVIDUALS IN POVERTY
2007	9.9%	18.5%
2008	9.8%	18.9%
2009	10.7%	21.8%
2010	12.2%	23.3%
2011	13.6%	24.7%

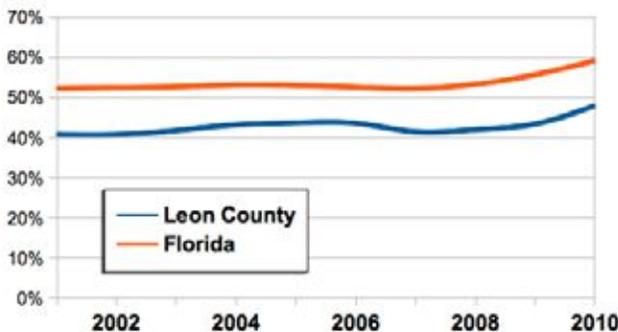
Information for individuals or families living in poverty (income below 100% of federal poverty level) can show the prevalence of barriers to economic stability. The more families or individuals living in poverty, the more challenges to healthy lifestyles, healthy diets, adequate medical care, and overall quality of life. The number of families and individuals in Leon County living in poverty has increased steadily since 2007 (Data from the 3-year American Community Survey).

Children Under 5 With Unemployed Parents
(American Community Survey, U.S. Census)



Any period of joblessness experienced by parents is a risk for the children. The ability to provide the same quality food, health care, and financial stability for children is challenged during unemployment. The latest American Community Survey estimates show that 12% of children under 5 in Leon County have unemployed parents, whether married or single. (Data from the 3-yr American Community Survey.)

Percent of Students Eligible For Free/Reduced Lunch
(Elementary School)



The percent of students eligible for free or reduced price lunches is another indicator of income instability or poverty. While Leon County's percentage of eligible students is below the state average, 50% of children are eligible for free and reduced lunches and this number has increased steadily since 2008.



The 6 Dimensions of a Whole Child

Spiritual Foundation and Strength



A whole child is a combination of body, mind, and spirit. Spiritual development is the focus of this dimension. Whole Child Leon does not endorse one approach to spiritual development over another, but rather encourages parents, families and our community to encourage children to pursue spiritual fulfillment. This can be done through participating in a faith based organization; experiencing the wonder of nature; understanding and appreciating the interdependence of all forms of life; nurturing a child's imagination and creative instincts through music, art, books and movement; and instilling a sense of hope.

“The best and most beautiful things in the world cannot be seen or even touched. They must be felt with the heart”.

—Helen Keller

Whole Child Leon Accomplishments in 2012-13



Connecting Children and Families to Services



WHOLE CHILD CONNECTION
Our web-based technology assists parents of young children and families in identifying their needs and connects them with appropriate service providers. In the last year, more than 11,000 families and providers accessed information from our websites and more than 2500 accessed our comprehensive resource guide. Whole Child Leon maintains a central community-wide calendar of children's meetings, events and activities that had more than 2100 visitors.



COMPUTER KIOSKS have been installed in over 26 key locations around town to provide families immediate access to the Whole Child Connection, including:

- 24 Elementary schools
- Early Learning Coalition of the Big Bend
- Leon County Courthouse



Photo: Heidi Compton

Creating Partnerships



PROFESSIONAL NETWORK—Whole Child Leon hosts a monthly meeting which provides a forum for more than 60 professionals from agencies and organizations to encourage and enable service providers to receive information on current best-practices, to build collaborative networks, and to create comprehensive systems of care for young children.

HEALTHY INFANT PARTNERSHIP is finding ways to address the high infant death rate and other poor birth outcomes in our area. The partnership is disseminating a survey, approved by the Institutional Review Board of FAMU to determine the health status of women of childbearing age in our community.

EARLY CHILDHOOD SYSTEM OF CARE—Whole Child Leon is the facilitating agency to engage more than 25 agencies in Leon and Gadsden County to share resources, information and best practices to produce meaningful improvements in the social-emotional health of young children. This collaboration of providers is committed to going beyond the coordination of services, to true integration of services for young children from infancy through eight years of age “at risk” of an identified early childhood social, emotional or behavioral disorder.





PARENT ADVOCACY COUNCIL—Whole Child Leon is in the process of organizing a council or forum where parents work in partnership with providers to improve early childhood services (availability, accessibility, and quality). We aim to empower parents to take ownership of the Whole Child philosophy and hold the community accountable to prioritizing the needs of young children.



95210: THE WHOLE PICTURE OF HEALTH (TWPH)—Whole Child Leon took the lead on this community-wide effort to address childhood obesity by promoting behavioral and policy change by creating a partnership that brought the 95210 healthy lifestyle for children campaign to our community. This initiative has evolved into the backbone for Tallahassee's efforts to change neighborhood food environments, increase physical activity and educate across all sectors on obesity prevention.



DENTAL SEALANT PROGRAM—Cavities, or dental caries, remains the most prevalent childhood disease and continues to take a heavy toll on children's health and well-being across certain socioeconomic, racial, and ethnic groups. From all available data it is clear that inadequate access to dental care is commonplace for children of families living in poverty despite tremendous advances in prevention. School-based sealant programs are especially important for reaching children from low-income families who are less likely to receive private dental care. Tooth decay may result in pain and other problems that affect learning in school-age children. Whole Child Leon has collaborated with the Leon County Health Department and Leon County Schools to implement a School-based dental sealant delivery program to provide sealants to children unlikely to receive them otherwise.

Call to Action

Our children are our future, and it is the responsibility of parents, lawmakers, business people, teachers and everyone in our community to work together to ensure that their needs are met. Unfortunately, many of the obstacles facing our children today are the same problems that are left unsolved year after year...

We need to work together as a community if we are to improve conditions for children and families. This should be a goal on which political partisans can agree, and we hope that our elected officials at the state and local levels will rise to the occasion. Over the next several months, Whole Child Leon will work with neighborhood groups on identifying their priorities for improving conditions of children 0-5 and then host a community-wide summit where we come together in a spirit of shared responsibility and shared sacrifice, and commit ourselves to investing in our youngest residents.



Whole Child Leon Steering Committee



Lorraine Ausley
(Founding Chair)



Kristin Dozier
Leon County Commissioner



Susan Ellis, LCSW
Infant/Early Childhood
Mental Health



Meade Grigg
Deputy Secretary for
Statewide Services
Florida Department of Health



Shonda Knight
Executive Producer/Anchor, WCTV



Angel Trejo, Chair



Laurie Dozier, III
President,
Mad Dog Construction



Ed Feaver
Lawton Chiles Foundation



Brooke Hallock
Chief Brand Officer,
Capital City Bank



Holly McPhail
Parent Representative



Tracey Cohen
President,
Target Copy



Vincent Edwards
Owner/General Manager,
Blessed Enterprise



Bob Gabordi
Executive Editor,
Tallahassee Democrat



Ed Holifield
President/CEO, Tallahassee Initiative
for Social Justice



Peggy Youngblood
Divisional Director,
Elementary Schools,
Leon County Schools

Not Pictured: Susan Dunlap, Vice-President of Collective Impact, UWBB



Bloxham Building • 725 South Calhoun Street, Tallahassee, FL 32301

Courtney Atkins, Whole Child Leon Executive Director

PARENTS: Get connected to community resources that can assist you and your family at the Whole Child Connection available at www.WholeChildLeon.org. Contact a Whole Child Leon Advisor today, at 850.487.7316



Strengthening Families with the FSU Partners for a Healthy Baby Curriculum

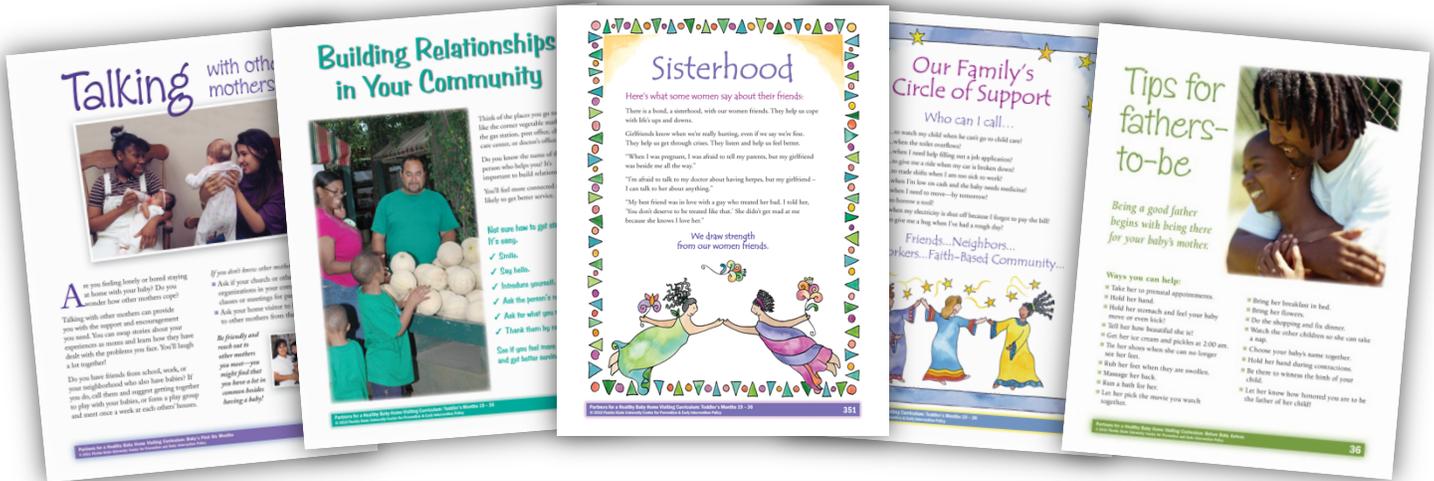


Parental Resilience

No one can eliminate stress from parenting, but a parent's capacity for resilience can affect how a parent deals with stress, solves problems, builds and sustains relationships, and asks for help.

Partners content supporting this protective factor	Partners handouts supporting this protective factor
<p>Before Baby Arrives (clear spiral)</p> <ul style="list-style-type: none"> Concerns about becoming a dad (p16, 18, 60, 96, 123, 185, 211) Family's mental health history and any use of medication (p43) Relieve and manage stress during pregnancy (p39, 41, 76, 106, 107, 134, 136, 166, 167, 199, 223, 224, 225) The power of positive thinking (p53) Nourishing the mind, body & spirit (p77) <p>Baby's First Six Months (lavender spiral)</p> <ul style="list-style-type: none"> Baby blues and postpartum depression (p43, 86, 129) Stress of parenting new baby (p4, 202, 210, 223, 258, 289, 339) Reducing stress (p122, 175, 176, 223, 224) <p>Baby's Months 7-12 (blue spiral)</p> <ul style="list-style-type: none"> Improve mother's self-image and weight (p10, 38, 102) Cope with mood swings (p71, 104) Getting enough sleep (p105) <p>Baby's Months 13-18 (white spiral)</p> <ul style="list-style-type: none"> Reducing stress (p14, 18, 23, 55, 136, 155) Understanding and managing emotions (p24, 75, 159, 225) Signs of depression (p27) <p>Toddler's Months 19-36 (pink spiral)</p> <ul style="list-style-type: none"> Turning powerlessness into empowerment (p68) Change negative words to positive self-talk (p129) Informed decisions to achieve best year goals (p130) Being organized can be empowering (p191) Seeing opportunities in mistakes (p253) 	<p>Before Baby Arrives</p> <p>26: 10 Ways to Relieve Stress 49: Nourishing Yourself from Within 69: Releasing Worries by Breathing Deeply 70: Loving and Mothering Yourself 81: Never Give Up! 104: You Are a Powerful Woman 111: Baby Blues</p> <p>Baby's First Six Months</p> <p>46: Calming Yourself When Baby's Upset 48: Brighten Your Day with Plenty of Sunshine 69: How to Get out of the Dumps 70: Making Time for Me 91: Believing In Yourself 101: You Can Make It Happen!</p> <p>Baby's Months 7-12</p> <p>90: How Were You Raised? 95: Your Depression Can Hurt Your Baby 130: Mothering Yourself 141: Learning from Mistakes 144: An Effective Father...</p> <p>Baby's Months 13-18</p> <p>7: Don't Cry over Spilled Milk 8: Is This Depression I'm Feeling? 19: Exercise with Your One-Year-Old</p> <p>Toddler's Months 19-36</p> <p>257: Action Plan for Creating Your Best Year 294: Smoothing out Issues with Your Child's Mom 331: How Do You Handle Difficult Feelings? 347: What's Good In Your Life?</p>

Strengthening Families with the FSU Partners for a Healthy Baby Curriculum



Social Connections

Parents with an extensive network of family, friends, and neighbors have better support in times of need and find opportunities to help others, which benefits self-esteem and grows communities.

Partners content supporting this protective factor

Before Baby Arrives (clear spiral)

- Support for mother-to-be at work/school/home (p13, 55, 56, 57, 91, 148)
- Support from partner/father-to-be (p16, 58, 59, 92)
- Sources of support & emergency contacts (p93)
- Support after baby comes home (p212)

Baby's First Six Months (lavender spiral)

- Support for mother (p9, 11, 13, 68, 107, 115, 131, 158)
- Father or partner's help with baby (p14, 73, 117, 161)
- Coping with mother's return to work/school (p207)
- Friendships with other mothers (p325)

Baby's Months 7-12 (blue spiral)

- Mom's relationship with partner (p33)
- Reach out to support network (p64)
- Build trusting relationships (p123)

Baby's Months 13-18 (white spiral)

- Finding a mentor (p8)
- Building a network of support (p102, 103)
- When families live apart (p13, 59, 142, 215)
- Special challenges of single parents (p59)
- Military families stay connected (p60, 140)
- Blended family concerns (p139)
- Support from father's friends and family (p184)

Toddler's Months 19-36 (pink spiral)

- Build a network of support (p11, 12, 16)
- Get to know people in the community (p70)
- Coping with deployment (p192)
- The value of close friendships (p194)
- Maintain special relationships (p317)

Partners handouts supporting this protective factor

Before Baby Arrives

- 6:** Circle of Support for My Baby & Me
- 8:** Advice for Expectant Fathers
- 33:** My Partner/Family Supports Me...
- 36:** Tips for Fathers-to-be
- 57:** The Importance of Female Friends
- 58:** Getting the Love You Deserve

Baby's First Six Months

- 2:** My Family Supports My Baby and Me by...
- 3:** Tips for New Dads
- 46:** Calming Yourself When Baby's Upset
- 102:** Talking with Other Mothers

Baby's Months 7-12

- 92:** Daddy's Not So Far Away
- 94:** Balancing Work & Baby
- 160:** Building Trusting Relationships

Baby's Months 13-18

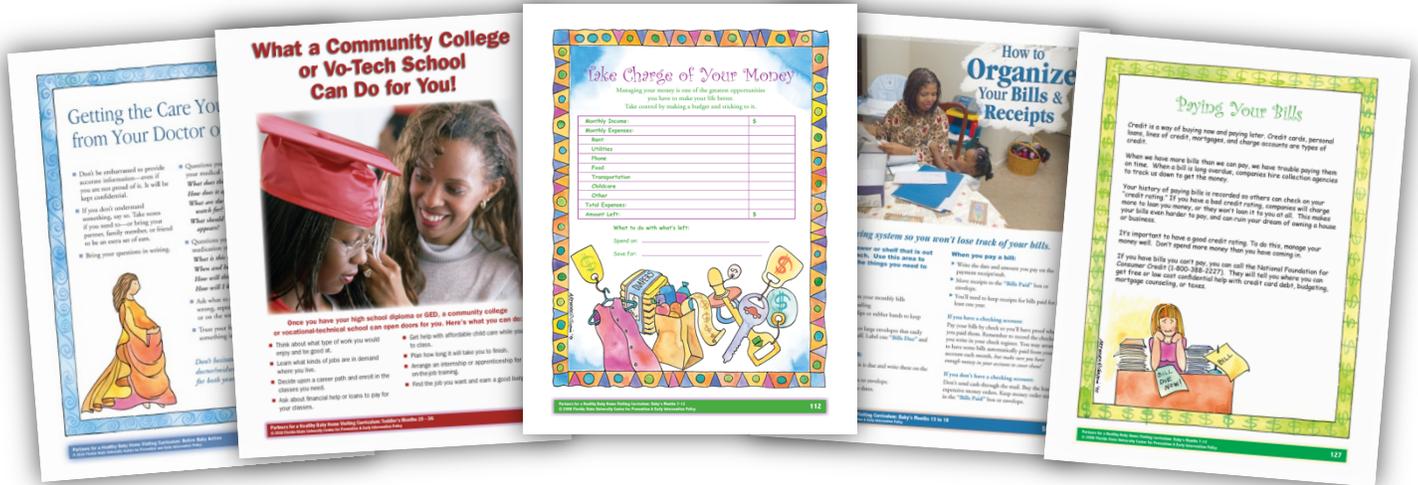
- 3:** For Single Dads: Advice about Contact with Your Child
- 17:** Staying Connected

Toddler's Months 19-36

- 258:** Our Family's Circle of Support
- 290:** Building Relationships In Your Community
- 350:** Helping Military Families Deal with Separation
- 351:** Sisterhood
- 404:** Ways to Nurture Relationships So They Last

Strengthening Families

with the FSU Partners for a Healthy Baby Curriculum



Concrete Support in Times of Need

Families thrive when they have access to food, shelter, clothing and health care. As times of crisis befall families, other concrete resources and services help them move forward to stability.

<i>Partners content supporting this protective factor</i>	<i>Partners handouts supporting this protective factor</i>
<p>Before Baby Arrives (clear spiral)</p> <ul style="list-style-type: none"> Addressing urgent family needs (p6, 50, 86, 116, 144, 178, 208) Budgeting (p20, 61) Sources of support & emergency contacts (p93) Choosing healthcare and insurance for baby (p228) <p>Baby's First Six Months (lavender spiral)</p> <ul style="list-style-type: none"> Well-baby visits (p98, 184, 309, 379) Addressing Urgent Family Needs (p7, 67, 113, 199, 283, 357) Money and time management (p20, 76, 120, 213, 183, 331, 332, 367) Returning to school/work (p75, 165) <p>Baby's Months 7-12 (blue spiral)</p> <ul style="list-style-type: none"> Life management skills (p7) Balancing work and school (p9) Money management (p37, 66, 67, 101, 149) Managing time (p65) Good work habits (p126) <p>Baby's Months 13-18 (white spiral)</p> <ul style="list-style-type: none"> Identifying changes to improve situations (p6) Ensure family's basic needs are met (p9) Managing time and good decisions (p54, 65, 99, 100) Monthly budget, managing finances (p63, 64) New job search, satisfaction, career steps (p108, 147) <p>Toddler's Months 19-36 (pink spiral)</p> <ul style="list-style-type: none"> Medical care and health coverage (p25, 84) Ensure basic needs are met (p10) Budgeting (p19, 79, 138, 200, 262, 263, 322, 324) Finishing school and seeking employment (p17, 21, 77, 78, 137, 198, 201) 	<p>Before Baby Arrives</p> <p>20: Getting the Care You Deserve from Your Doctor or Midwife</p> <p>37: Where Does Your Money Go?</p> <p>Baby's First Six Months</p> <p>26: Immunizations & Well-Baby Checkups</p> <p>32: Why It's Important to Finish School</p> <p>33: Child Support</p> <p>60: Emergency Contacts</p> <p>Baby's Months 7-12</p> <p>94: Balancing Work & Baby</p> <p>112: Take Charge of Your Money</p> <p>127: Paying Your Bills</p> <p>162: Where Can I Get Help?</p> <p>163: 10 Quick Tips to Success on the Job</p> <p>Baby's Months 13-18</p> <p>6: Options to Pay for Health Care</p> <p>48: Why Go Back to School?</p> <p>49: Keys to Success at Work</p> <p>58: How to Organize Your Bills & Receipts</p> <p>59: Owning Your Own Home</p> <p>Toddler's Months 19-36</p> <p>295: Ideas for Reducing Monthly Expenditures</p> <p>324: What a Community College or Vo-Tech School Can Do for You!</p> <p>325: Saving Just a Little Can Add up</p> <p>384: Borrowing Money is Risky Business</p>

Strengthening Families with the FSU Partners for a Healthy Baby Curriculum



Knowledge of Parenting and Child Development

Accurate information about child development helps parents adopt positive parenting patterns. When they learn what to look for at each age, they can help their children reach full potential.

Partners content supporting this protective factor

Baby's First Six Months (lavender spiral)

- Developmental screening for “red flags” (p229, 312, 383)
- Talk about how each baby develops at her own rate and what to expect baby to do this month (p186, 228, 268, 311, 344, 381)
- Explain why it’s important to talk, read, and sing with baby (p145, 188, 231, 346, 385)

Baby's Months 7-12 (blue spiral)

- Support baby’s emerging skills each month (p20, 21, 52, 85, 114, 138, 163)
- Developmental concerns or “red flags” (p23, 137)
- Explain how playful interactions help babies learn (p53)
- Expectations for baby to walk (p83, 164)
- Recognize baby’s important new skill of shaking head or saying no. Suggest ways to often say “yes” to baby (p112)
- Babies learn by copying and repetition (p113)

Baby's Months 13-18 (white spiral)

- Describe new skills of one-year-old to help family have realistic expectations (p36, 122, 201, 234)
- Developmental screening and special needs support (p39, 83, 165, 167, 237)
- Language development (p40, 85, 87, 124, 125, 170, 204)

Toddler's Months 19-36 (pink spiral)

- Typical behaviors and skills for a toddler (p98, 160, 224, 283, 346)
- “Red flags” and screening of development (p100, 102, 162, 225, 227, 285, 348, 350)
- Promote language (p163, 165, 166, 286-290, 351-353)

Partners handouts supporting this protective factor

Baby's First Six Months

- 53: Ways to Help Your Baby’s Brain Develop
- 73: Watch Me Grow: Baby’s Second Month
- 84: Watch Me Grow: Baby’s Third Month
- 87: Talking with Your Baby
- 97: Watch Me Grow: Baby’s Fourth Month
- 106: Babies Learn by Moving
- 108: Watch Me Grow: Baby’s Fifth Month
- 113: Watch Me Grow: Baby’s Sixth Month

Baby's Months 7-12

- 101: How Babies Develop
- 103: 7th Month Watch Me Grow!
- 122: 8th Month Watch Me Grow!
- 124: Babies Learn by Playing
- 139: 9th Month Watch Me Grow!
- 157: 10th Month Watch Me Grow!
- 172: 11th Month Watch Me Grow!
- 187: 12th Month Watch Me Grow!

Baby's Months 13-18

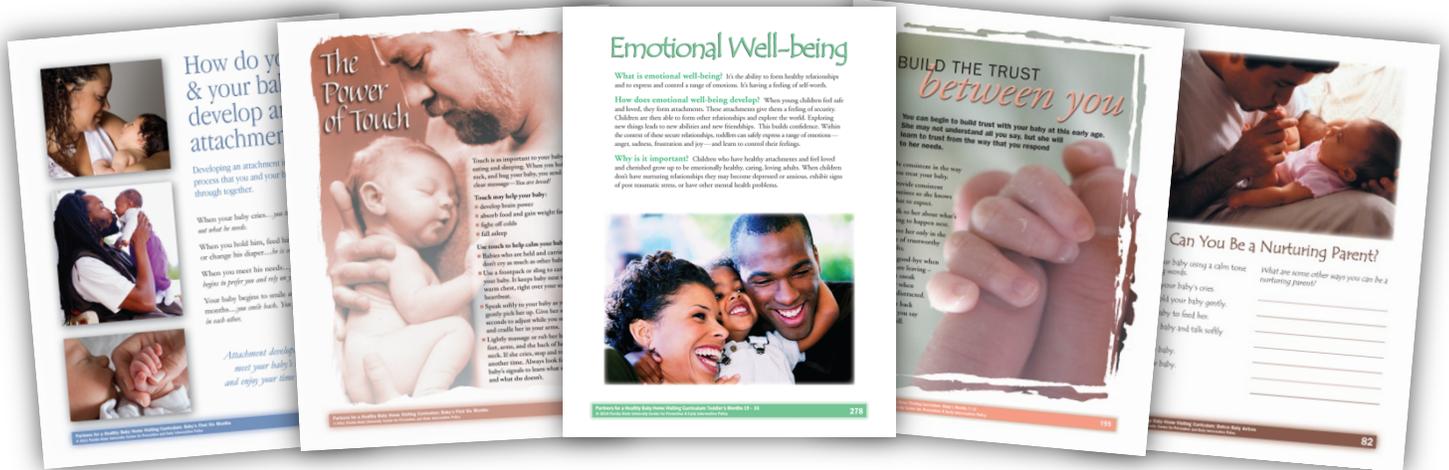
- 13: What to Expect from Your One-Year-Old
- 26: Encourage Toddler Talk
- 36: Help Me Grow
- 47: Knowing What to Expect from Your One-Year-Old
- 55: I Can Do It
- 65: 18 Months – Watch Me Grow

Toddler's Months 19-36

- 285: What Toddlers Learn by Playing
- 313: I Learn about My World by Exploring

Strengthening Families

with the FSU Partners for a Healthy Baby Curriculum



Social and Emotional Competence of Children

Building a close bond helps parents understand, respond to, protect, and communicate better with their children who, in turn, learn to self-regulate their behavior and have meaningful relationships with others.

Partners content supporting this protective factor

Before Baby Arrives (clear spiral)

- The importance of bonding and ways to bond with baby (p45, 81, 112, 139, 174, 229)
- Father-to-be/partner takes advantage of attachment moments during pregnancy (p123)
- Being a nurturing father/partner (p151, 185)

Baby's First Six Months (lavender spiral)

- Parent/child interaction (p16, 22, 83, 103, 104, 116, 119, 211, 233, 246, 251, 275, 364, 387)
- Recognize baby's signals or emotional cues and respond appropriately (p146, 193, 236, 275)
- Importance of touch for baby (p234)
- Bonding, if baby stays in the hospital (p61)

Baby's Months 7-12 (blue spiral)

- Responding to baby's needs (p19, 135, 161)
- Need to explore with parent in sight (p48, 133)
- Signs of attachment (p78)
- Trusting relationships and comforting (p79, 111)
- Unconditional love (p160)

Baby's Months 13-18 (white spiral)

- Supporting child's healthy social/emotional development (p44, 126, 171, 242)
- Reassure child when separating (p89)
- Provide a secure base for the child (p172)
- Give a child words to label their emotions (p206)

Toddler's Months 19-36 (pink spiral)

- Help parents understand social-emotional wellness (p46, 47, 53, 108, 109, 112, 169, 235, 356, 359)
- Encourage Dad's affectionate with his toddler (p14)
- Offer supports to keep parents connected with toddler during separations (p168, 192, 259, 261, 292, 316)

Partners handouts supporting this protective factor

Before Baby Arrives

- 9: Why Fathers Are So Important!
- 82: How Can You Be A Nurturing Parent?
- 113: Bonding with Your Baby

Baby's First Six Months

- 29: Help Your Partner Love Your Baby
- 39: Learning Your Baby's Signals
- 43: Bonding With Your Baby
- 75: How Do You & Your Baby Develop an Attachment?
- 76: The Power of Touch

Baby's Months 7-12

- 119: Keeping In Touch
- 155: Build the Trust Between You
- 184: Loving Your Baby No Matter What

Baby's Months 13-18

- 18: Why Doesn't My One-Year-Old Want Me?
- 25: A Precious Gift: Unhurried Time
- 27: Please, Don't Go
- 30: You Can Have A Loving Relationship with Your Child...And Still Teach Her to Behave
- 46: All Because of You...

Toddler's Months 19-36

- 259: Showing & Growing the Love between You
- 278: Emotional Well-Being
- 280: Easing Toddler's Separation Anxiety
- 286: Help Your Toddler Grow Socially & Emotionally
- 350: Helping Military Families Deal with Separation

Florida State University *Partners for a Healthy Baby* Workshops for Home Visitors

You'll leave these interactive workshops knowing how to use the *Partners* curriculum to:

- ★ Plan effective home visits.
- ★ Promote healthy birth outcomes.
- ★ Support parenting skills that promote optimal bonding, attachment, & responsive caregiving.
- ★ Teach parents ways to facilitate their child's development.
- ★ Detect early signs of health or developmental problems.
- ★ More easily address topics that may be difficult to discuss.

Learn how to support your families and achieve program goals using the research-based, practice-informed *Partners for a Healthy Baby* curriculum.

Register Online ★ www.cpeip.fsu.edu

February 2-4, 2016 Register by January 18

April 12-14, 2016 Register by March 21

June 14-16, 2016 Register by May 23

September 20-22, 2016 Register by August 26

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★ Training Info & Fees

\$500 per participant

Training fee does NOT include books. Workshop copies will be available for participants to use at the training.

Morning refreshments and an afternoon snack will be served each day.

Workshop cancellations received prior to registration deadline will be charged a \$50 processing fee (per person).

★ Hotel Reservations

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www.holidayinn.com/hotels/us/en/lake-buena-vista/dislb/hoteldetail

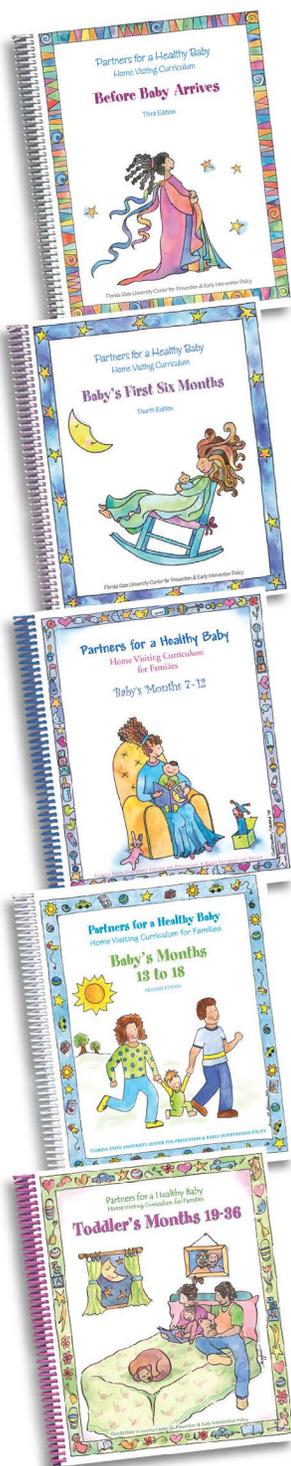
February Workshop: \$139 per night if reserved by 1/11/16. Code FFU

April Workshop: \$139 per night if reserved by 3/21/16. Code AFS

June Workshop: \$115 per night if reserved by 5/21/16. Code JSF

September Workshop: \$115 per night if reserved by 8/26/16. Code EPT

For more information contact Michelle Osorio ★ 850-922-1300 or mosorio@fsu.edu



On-site training is also available.

Can't bring your staff to our training?

Let us bring training to you!