

Real Story No. 6

Whole Child Leon Healthy Infant Partnership

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Project Highlights

Poor birth outcomes, especially for African-American mothers, have been a persistent problem in Leon County, Fla. In 2008, the Leon County Healthcare Advisory Board led community partners in the development of a plan to address this problem. In 2009, the Healthy Infant Partnership was formed to implement the plan. To date, more than 200 individuals representing 50 organizations have developed nearly 60 strategies to improve birth outcomes.

The partnership developed and prioritized community strategies based on a framework developed by the Lawton and Rhea Chiles Center for Healthy Mothers and Babies of the University of South Florida. The framework defines the four components of comprehensive perinatal care:

1. The system exhibits respect, empathy and compassion for women and families.
2. The system includes health education for women and men of reproductive age and their families.
3. The system provides comprehensive, holistic health care, including medical care plus attention to economic, social, cultural, emotional, behavioral and nutritional conditions that directly or indirectly influence the health of the mother before, during and after pregnancy.
4. The system provides comprehensive insurance benefits for all children and women of reproductive age.

Champions were recruited from community organizations to lead work teams that addressed one or more strategies that were identified and prioritized by the full partnership. Work teams met under the leadership of each champion to take actions designed to accomplish the strategy.

When the partnership had been in existence for two years, key informants were interviewed to determine what was working well and where improvements were needed. Key findings include:

- Whole Child Leon Healthy Infant Partnership efforts have had some initial success, but have a long road ahead.
- Generally, interviewees were positive about the process to identify strengths and weaknesses in their perinatal care system.
- Interviewees alluded to a tension between wanting to jump to solutions and the need to acknowledge and deal with the complexity of the issues.

Lessons learned include:

- Territoriality and competition among members was an obstacle that needed to be considered.
- Member attrition can derail implementation.
- Work groups often focused on narrowly defined actions that did not address root causes.

Background and Context

The Leon County Healthcare Advisory Board, in partnership with a broad range of community stakeholders, developed the “Year of the Healthy Infant” action plan in 2007 and 2008. This plan identified the major contributors to infant mortality and low birth weight and outlined strategies for improvement in Leon County, with emphasis on eliminating racial disparities in these rates. The Whole Child Leon Healthy Infant Partnership, formerly known as the Healthy Infant Coalition, was created to engage agencies, organizations, civic groups and individuals in a cooperative enterprise to implement the plan’s strategies. The partnership began its work on January 27, 2009, by convening individuals and organizations that were identified in the Health Care Advisory Board’s report to participate in the implementation process.

Low birth weight is a weight of less than 5 pounds, 8 ounces (2,500 grams) and affects about one in every 13 babies born each year in the United States. It is a factor in 65 percent of infant deaths. Low birth weight babies may face serious health problems as newborns, and are at increased risk of long-term disabilities. Infant mortality (deaths within the first year of life per 1,000 live births) and low birth weight rates have remained persistently high in Leon County between 2000 and 2008, especially for African-American births. Over this period, 265 infants died before their first birthday—87 white, 168 African-American and 10 other races or ethnicities. The infant mortality rate fluctuated for white infants from a high of 7.6 in 2001-2003 to a low of 4.5 in 2005-2007; for African-Americans, the infant mortality rate fluctuated from a high of 17.6 in 2000-2002 to a low of 13.0 in 2006-2008.

Over the same period, 2,645 infants were born with low birth weight—1,033 white, 1,502 African-American and 110 other. The low birth weight percentage for white infants fluctuated between a low of 6.0 percent in 2002-2004 and a high of 7.1 percent in 2005-2007. The African-American percent fluctuated from a high of 13.9 in 2004-2006 to a low of 13.5 in 2000-2002 and 2006-2008.

Florida’s Department of Health recommended using three-year rolling averages, which more accurately reflect trends in infant mortality and low birth weight by reducing the effect of small numbers on statistical calculations.

The Community

Leon County is located in Florida’s panhandle and encompasses the capital, Tallahassee, the 12th fastest-growing metropolitan area in the state. Its 12.4 percent growth rate is higher than both Miami and Tampa and half that of Cape Coral-Fort Myers and Naples-Marco Island. As of 2009, the population of Tallahassee recorded by the U.S. Census Bureau was 172,574. The population density was 1,573.8 people per square mile. There were 68,417 housing units at an average density of 714.8 per square mile. The racial makeup of the city was 60.42 percent white, 34.24 percent African-American 0.25 percent Native American, 2.40 percent Asian, 0.05 percent Pacific Islander, 0.97 percent from other races and 1.67 percent from two or more races. Hispanic or Latino of any race made up 4.19 percent of the city population, while non-Hispanic whites represented 57.79 percent.

Of the 63,217 households, 21.8 percent had children under 18 living in them. Married couples living together made up 30.1 percent, 13.2 percent had a female householder with no husband, and 53.4 percent were non-families. Individuals made up 34.7 percent of all households and 6.0 percent had someone living alone who was 65 years of age or older. The average household size was 2.17 and the average family size was 2.86.

In the city, the population was spread out, with 17.4 percent under the age of 18, 29.7 percent from 18 to 24, 27.9 percent from 25 to 44, 16.8 percent from 45 to 64, and 8.2 percent who were 65 years of age or older. The median age was 26 years. For every 100 females, there were 89.5 males. For every 100 females age 18 and over, there were 86.7 males.

The median income for a household in the city was \$30,571, and the median income for a family was \$49,359. Males had a median income of \$32,428 versus \$27,838 for females. The per capita income for the city was \$18,981. About 12.6 percent of families and 24.7 percent of the population were below the poverty line, including 21.6 percent of those under age 18 and 8.4 percent of those age 65 or older.

The population of Leon County is the most highly educated population in Florida with 49.9 percent of the residents with either a bachelor’s, master’s, professional or doctorate degree. The Florida average is 22.4 percent and the national average is 24.4 percent.

Key Tools and Processes

The first decision of the Whole Child Leon Healthy Infant Partnership was to integrate the goals and objectives of the Healthcare Advisory Board and the Whole Child Leon Health Action Team with the research findings from the Healthy Futures study. The qualitative study examined African-American women's experiences with perinatal care in Leon County. It was conducted by the Lawton and Rhea Chiles Center for Healthy Mothers and Babies at the University of South Florida. This decision was made to provide structure to the implementation plan and to ensure that the plan addressed as many of the issues as possible that were identified over the previous 18 months by the diverse community groups and individuals who contributed to this initiative.

Following the lead of the Healthcare Advisory Board, the partnership decided that making a significant impact on ensuring healthy birth outcomes for all infants in Leon County would require a comprehensive, multifaceted approach. The partnership also decided to adopt the comprehensive perinatal health care

framework that the Healthy Futures study produced, based on the experiences with primary and prenatal health care related by African-American women in Leon, Gadsden and Pinellas counties.

The Whole Child Leon Healthy Infant Partnership was formed by, and is comprised of, service agencies and organizations, medical and dental providers, advocacy groups, academicians, interested citizens, and local and state policy-makers who are dedicated to a collaborative, comprehensive approach to achieving healthy birth and infant outcomes. To date, more than 200 individuals representing 50 organizations have developed nearly 60 strategies to improve these outcomes.

These strategies are based on a comprehensive perinatal care framework developed by the Lawton and Rhea Chiles Center for Healthy Mothers and Babies of the University of South Florida and adopted by the Whole Child Leon Healthy Infant Partnership in 2009. This framework has four critical components, each with several goals, to create an optimal perinatal health system:

- 1. Service delivery practices that exhibit respect, empathy and compassion for women and families.**
 - Promoting continuity of care
 - Ensuring cultural competence by providers
 - Understanding the personal, emotional, social, economic and environmental concerns of patients
 - Addressing persistent barriers to care such as transportation and long waits
 - Including community-based organizations and social service agencies that bolster the mother's support system
- 2. 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.**
 - Parenting and sex education
 - Nutrition
 - Birth spacing
 - Healthy lifestyles and behaviors
 - Breastfeeding and bonding
 - Being an informed health consumer
- 3. 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.**
 - Primary care
 - Prenatal care
 - Infant/child health care
 - Dental care
 - Post-partum care
- 4. Comprehensive screening and health insurance for all children and all women of reproductive age utilizing all available options within the federal Medicaid program.**
 - Simplify the process for applying for and retaining Medicaid
 - Medicaid reimbursement rates for perinatal health care and dental providers need to be adequate to engage and keep providers in the system
 - Revise Medicaid policy to provide primary care coverage to women of reproductive age for at least two years post partum
 - Amend the Agency for Health Care Administration policy to provide Medicaid coverage for support

- services as an essential component of prenatal care
- Providers serving as medical homes for children, families and adults should be reimbursed fairly for providing case coordination services that identify needs and facilitate connections with appropriate community providers

A matrix was developed based on the components and goals of the comprehensive system as summarized by the Chiles Center team. During meetings held from January through May 2009, for each goal, the group used the matrix to identify gaps in the present perinatal care system and to suggest and prioritize strategies to address them. For each high-priority strategy, existing organizations that could play a role in implementing the strategy were listed and an individual to lead the effort was identified. Team leaders were selected based on their willingness to serve as a champion for one

or more strategies and for their ability to promote collaboration among community partners. Based on the prioritized strategies and the identified team leaders, 57 work teams were formed to implement one or more strategies. For instance, all the strategies related to breast feeding were addressed by a single team. Chiles Center staff developed a simple template so that team leaders could report progress quarterly.

Team leaders were asked to complete this template with the understanding that they could simply add information to the template for the previous quarter:

HEALTHY INFANT COALITION QUARTERLY TEAM REPORT
Submit to: Carla Caison at ccaision@health.usf.edu

Submitted by: _____ Date: _____

Component: _____

Goal: _____

Strategy: _____ Team leader(s): _____

What the team plans to do: _____

What the team accomplished in the past quarter: _____

Challenges experienced (if any): _____

How the team will measure its success: _____

Team Members:

Name	Affiliation	E-mail Address

Between June 1, 2008, and June 30, 2010, the full Whole Child Leon Healthy Infant Partnership met quarterly, but work teams met as needed to ensure progress. At the meetings of the full group, progress and achievements were reviewed, a steering committee was formed to help set the direction for the whole group, and members provided advice to assist work teams with strategy implementation. Indicators and metrics could continue to inform decision-making and enable project evaluation in the future and beyond the scope of this project.

One aspect of the quarterly reporting was to decide what each team would measure to determine if they were accomplishing their goals. The teams proposed ways to measure successes that included baseline values and targets and those measures were provided to the Chiles Center staff by June 2010.

The Whole Child Leon Healthy Infant Coalition has broadened community engagement through the active participation of an additional 175 community leaders in strategy implementation. As work teams and strategy champions developed the detailed plan to accomplish each strategy, they often identified key community members who could facilitate accomplishing one or more actions required for achieving the goal. When that happened, the community member was recruited and, if possible, added to the work group.

Barriers to Integration and Methods to Overcome Them

The partnership recognizes the difficulties in expecting changes in population outcomes when programs are only reaching a small percentage of that population. To provide information about what was working well in Whole Child Leon Healthy Infant Partnership efforts and what could be improved, a Chiles Center staff member interviewed key participants in the planning and implementation process. The results of the interviews are summarized below:

- Key informants paint a picture of the Whole Child Leon Healthy Infant Partnership effort as a work in progress that has had some initial success, but has a long road ahead.
- Interviewees spoke of recognizing the scope of the problem of infant mortality and adverse birth outcomes and the multifaceted nature of the response needed to address it as reflected in the strategies of their plan.

- Generally, interviewees were positive about the process they engaged in to identify strengths and weaknesses in their perinatal care system. They found the approach presented by the Healthy Futures Project (that is, components and goals of a comprehensive system and the matrix) helpful in prioritizing their actions and in revealing the complexity of the issues they face.

- At times, interviewees alluded to a tension between wanting to jump to solutions and the need to acknowledge and deal with the complexity of the issues. This tension played out in the views on the developed strategies and their implementation.

- Many acknowledged movement in the right direction, but recognized the need to reassess the plan over time. They also recognized the challenge of truly measuring the effectiveness of strategies when so many factors affect the end goal of eliminating infant mortality and adverse birth outcomes.

- The comprehensive approach, with additional meetings and workload, encumbered some. Opportunities to share the work and expand the partnership were identified, especially among larger state agencies and universities. Restrictions on time and funding are barriers one might expect to impinge on such an endeavor, but there was a recognition that the community is committed to success. Perhaps most important, interviewees seemed confident the work had begun to improve the perinatal care system and women and children’s health.

Documented Results:

To date, the Healthy Infant Partnership has established three mechanisms to measure results:

- Interviews with key partnership leaders
- Annual monitoring of performance indicators for each team
- Annual monitoring of county-wide outcomes

Assessing Progress

As the partnership plan is implemented, outcome and performance indicators may be refined, expanded or contracted. Any change to the indicators will be

included in the annual report to the community. In order to have a shared understanding of what these indicators mean, the following definitions apply:

- Outcome:** A change in condition or well-being for a specific population group.
- Outcome Indicator:** A measure of the extent to which an outcome has been accomplished.
- Strategy:** A policy, service or program intended to help accomplish an outcome. In most cases more than one strategy is necessary to improve an outcome.
- Performance Indicator:** A measure of the extent to which a strategy has been accomplished. A performance measure does not measure a change in the outcome.

It is expected that there will not be a one-to-one relationship between performance measures for each strategy and outcomes. With an outcome having a broad spectrum of contributing causes, such as birth outcomes, many strategies will have to be successfully implemented before one can expect to see a difference in outcomes.

Outcome Indicators

The partnership has developed a preliminary list of outcome indicators to measure Leon County’s progress in improving birth and infant health with special emphasis on reducing racial disparities in low birth weight and infant mortality. These indicators were derived from the “Year of the Healthy Infant” report produced by the Healthcare Advisory Board and from partnership discussions, and appear below.

1. Reduce low birth weight births

- By 2010-2012, the three-year rolling average for low birth weight births will decrease from 9.6 percent in 2006-2008 to 8.9 percent.
- By 2010-2012, the three-year rolling average for African-American low birth weight births will decrease from 13.5 percent in 2006-2008 to 12.6 percent.

Low Birth Weight Births

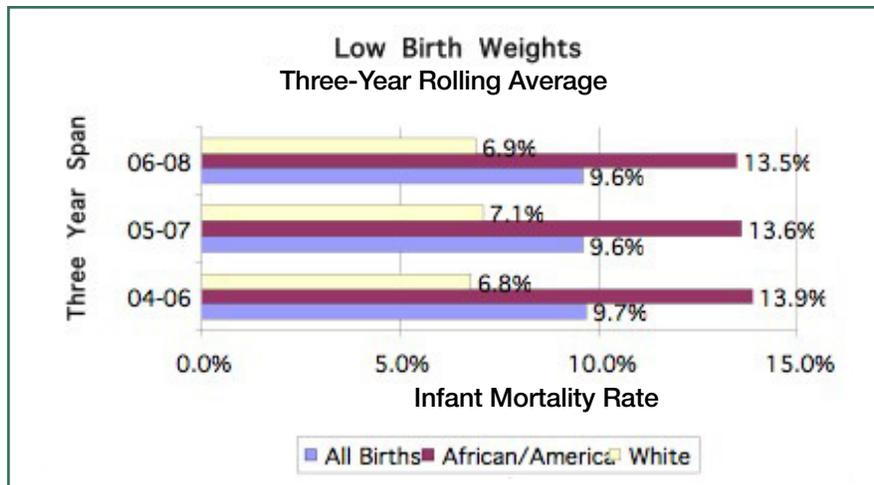


Figure 1. Low Birth Weights Three-Year Rolling Averages.
Source: Florida Charts, 2004 - 2008

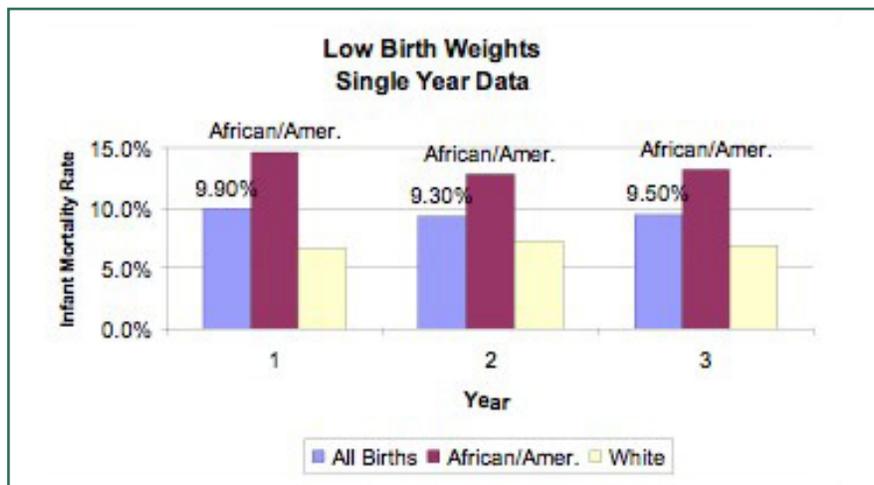


Figure 2. Low Birth Weights Single Year Data.
Source: Florida Charts, 2008

2. Reduce preterm births

- By 2010-2012, the three-year rolling average for preterm births will decrease from 13.6 percent in 2006-2008 to 11.6 percent.
- By 2010-2012, the three-year rolling average for African-American preterm births will decrease from 17.8 percent in 2004-2006 to 15.1 percent.

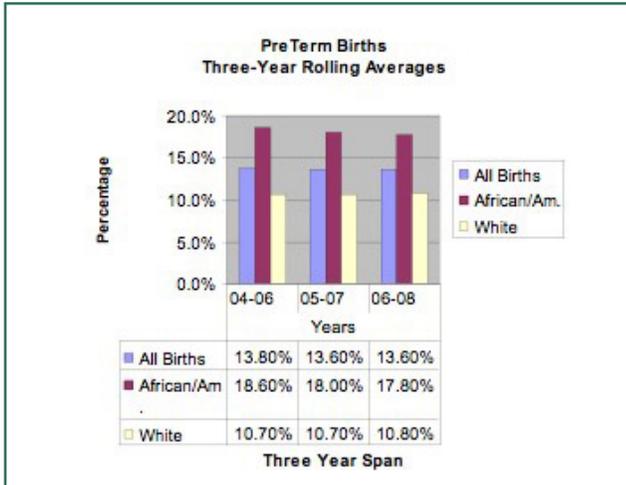


Figure 3. Pre Term Births Three-Year Rolling Averages.
Source: Florida Charts, 2004 - 2008

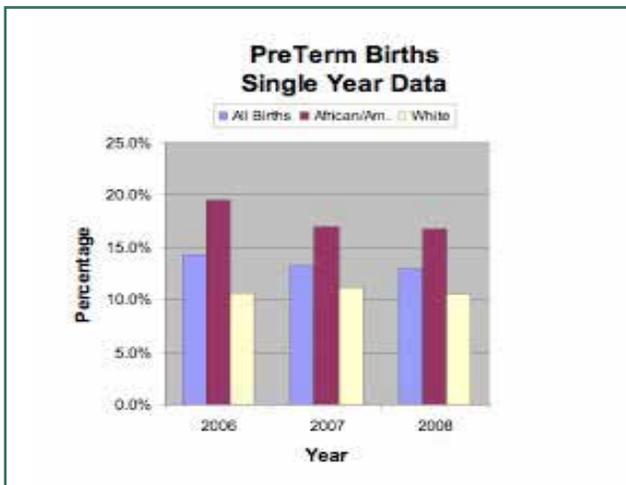


Figure 4. Pre Term Births Single Year Data.
Source: Florida Charts, 2006 - 2008

3. Reduce infant mortality (especially with respect to racial disparities)

- By 2010-2012, the three-year rolling average infant mortality rate will decrease from 8.3 percent in 2006-2008 to 7.1 percent.
- By 2010-2012, the three-year rolling average for African-American infant mortality rate will decrease from 13.0 percent in 2006-2008 to 11.0 percent.
- By 2018-2020 the three-year rolling average for African-American infant mortality will decrease from 13.0 percent in 2006-2008 to 4.5 percent.
- By 2010-2012, the three-year rolling average difference between white and African-American infant mortality rates will decrease from 8.3 points in 2006-2008 to 5.3 points.
- By 2018-2020, the three-year rolling average difference between white and African-American infant mortality rates will decrease from 8.3 points in 2006-2008 to 0.0 points.

Infant Mortality (rate per thousand live births)

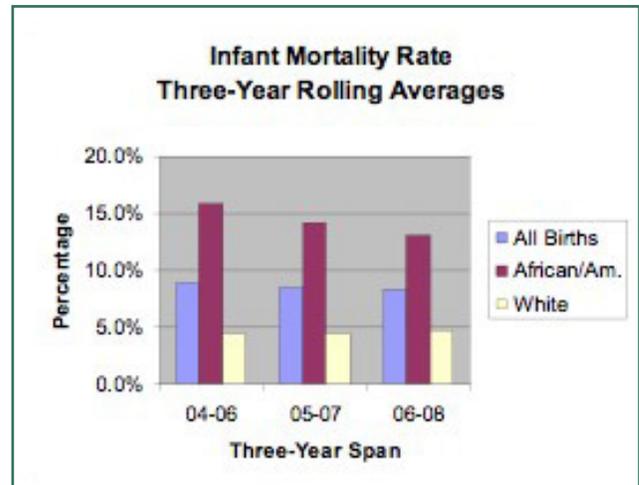


Figure 5. Infant Mortality Rate Three-Year Rolling Averages.
Source: Florida Charts, 2004 - 2008

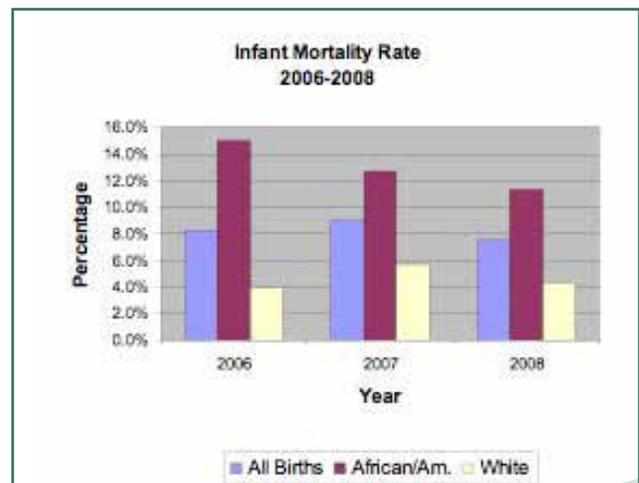


Figure 6. Infant Mortality Rate 2006-2008.
Source: Florida Charts, 2006 - 2008

4. Infants receive developmental screenings and appropriate services based on screening results

- By 2012, all infants enrolled in Early Steps will receive assessments within 45 days of referral.
- By 2012, all infants enrolled in Early Steps will begin receiving services within 30 days of plan completion.
- By 2012, all infants enrolled in Medicaid will receive a Child Health Care Checkup (procedure code: 99391).
- By 2010-2012, the three-year rolling average difference between white and African-American infant mortality rates will decrease from 8.3 points in 2006-2008 to 5.3 points.
- By 2012, all infants born in local hospitals will have their hearing tested before discharge.

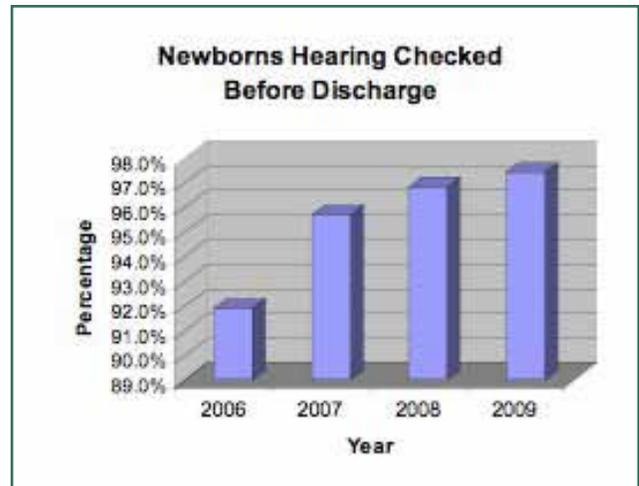


Figure 7. Newborns Hearing Checked Before Discharge. Source: Florida Department of Health. Children's Medical Services. Hospital hearing screening rates report. January 2012.

Documented Results

Summarized below is the partnership's progress on its priority strategies between May 2009 and May 2010.

Component 1. Service delivery practices that exhibit respect, empathy and compassion for women and families.

- Forty-two Leon County Schools and seven locations in the Leon County Parks and Recreation System participated in the Access Florida Community Partner Network allowing low-income families at 75 locations throughout the county to apply for food stamps. In addition, the Department of Children and Families facilitated applications for food stamps and medical insurance during 20 community events such as back-to-school programs, parades, festivals, health fairs and faith-based gatherings. As of March 2010, 12,803 Leon County children were receiving food stamps.
- A work team is collaborating with the Florida Department of Health, Office of Minority Health, to modify existing cultural competency training modules to educate different types of service providers who interact with women and children.
- The United Way of the Big Bend has implemented a new maternity and paternity leave policy.
- From mid-October through December 2009, 86 homeless women between 18 and 55 received services through the Homeless Prevention and Rapid Re-housing grant funded by the Department of Housing and Urban Development.
- The United Way of the Big Bend deployed community volunteers to provide assistance to 2,980 individuals and families resulting in \$908,667 in Earned Income Tax Credit refunds and provide financial education for 134 local residents between July 1, 2009 and April 30, 2010.
- To promote a "no-wrong-door" culture among service providers, a new software product, the Whole Child Connection Profile, was developed and distributed to service providers to help identify a family's needs and link them with providers who can help. Eighteen human service agencies have agreed to serve as Whole Child providers with at least one trained whole child advisor on their staff.

Component 2. 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.

- Much progress has been made toward improving family planning, reproductive health and parenting education in the Leon County schools.
 - Recommendations for curriculum changes were made to school administrators based on a thorough review of all elementary, middle and high school curricula.
 - The superintendent and assistant superintendent are supportive of appropriate curriculum changes.
 - A new health curriculum has been developed. It will be implemented and assessed using a standard evaluation tool developed by the Centers for Disease Control and Prevention.
- Children’s Medical Services held four parenting classes using the *Parenting Tools for Positive Behavior Change* curriculum.
- Florida A&M University’s Institute of Public Health has been asked to participate in a pilot testing of “A Healthy Baby Begins With You, Preconception Peer Educators (PPE) Program.” Aimed at the college-age population, the PPE Program enlists and trains college students as peer educators. The peer educators help disseminate essential preconception health messages to those who may not be actively seeking to start a family. Students from four universities will receive training as peer counselors in July 2010.
- The Whole Child Leon Healthy Infant Coalition has broadened community engagement through the active participation of an additional 175 community leaders in strategy implementation.
- Pregnancy Education Action Campaign Effort (PEACE), a partnership between North Florida Women’s Care and Tallahassee Memorial Hospital, has provided information about behavior choices associated with health before conception and free folic acid to Leon County women at health care events around the county.
- Leon County residents are more aware of the impact of social and environmental conditions on health and health outcomes through the efforts of the Health Equity Alliance of Tallahassee (HEAT), which engaged 14 community organizations to host screenings of *Unnatural Causes* allowing more than 250 residents to view and discuss the series.

Component 3. 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.

- To investigate why some black women obtain prenatal care later than white women, a survey has been developed and will be conducted at the Bond Community Health Clinic and at North Florida Women’s Care. The results of the survey will guide future strategies that will encourage earlier participation in prenatal care.
- The effort to expand the number of medical and ancillary providers who accept KidCare and Medicaid reimbursement rates succeeded in recruiting 17 medical providers, two dentists and 37 ancillary providers and early childhood specialists.
- The provision of medical care for children with special health care needs and their families has been enhanced through an agreement with the Bond Community Health Center to provide primary care, especially on weekends. This enhancement should increase involvement of women in ongoing primary health care and encourage early entry into prenatal care.
- The Florida Dental Association Foundation has provided \$5,000 to be used for prophylactic care for 25 children under age 5.
- The Capital Area Healthy Start Health Education Network in collaboration with Children’s Medical Services hosted a training session for local social service providers on the signs and symptoms of preterm labor.

- The Capital Area Healthy Start Coalition obtained funding from the Rotary Club to purchase and distribute more than 1,000 Healthy Women kits. Kits, designed to prevent periodontal disease, were distributed at health fairs and through community partners providing services to women.

Component 4. Comprehensive screening and health insurance for all children and all women of reproductive age utilizing all available options within the federal Medicaid program.

- Through collaboration between Whole Child Leon and the Leon County Schools, 375 children were newly enrolled in Medicaid or KidCare during fiscal year 2008-2009; 65 more were enrolled in fiscal year 2009-2010.
- During the 2010 legislative session, bills were filed in both the House and the Senate by Rep. Alan Williams and Sen. Al Lawson to extend Medicaid benefits for two years for women whose pregnancies were covered by Medicaid and who had poor birth outcomes.
- Twenty-nine collaborating partners engaged in two successful Early Childhood Developmental Screening Fairs. As a result of participating in these screening fairs, 95 percent of children with a detectable delay received a referral for full assessment and intervention services.

Lessons Learned

Perhaps the greatest challenge the coalition faced was a sustained commitment from the team leaders. The core members of the coalition were integral to the initial success. Important member characteristics included experience, commitment, diversity and lack of conflict. While an explicit goal of the coalition was to promote coordination, cooperation and collaboration, territoriality and competition among members arose as an obstacle. A primary lesson learned was the importance for coalition leaders to keep in mind that competition exists among health and human service agencies for clients and contracts, and to accept that self-interest is a motivator.

Strategies to minimize the impact of territoriality and competition could include focusing on communities and neighborhoods to appeal to a larger good and communicating to members that their organization’s identity will remain intact.

Member attrition posed challenges for the coalition as well. Team leaders and other coalition members change positions within their organization or get new jobs elsewhere and this can be disruptive to progress. Conducting strong recruitment and membership development efforts and getting agency buy-in early on may make it possible to retain more coalition members in the future.

Wrap-up

About the Author

Barbara Markiewicz, Ph.D., has been working at the Lawton and Rhea Chiles Center for Healthy Mothers and Babies at the University of South Florida since 2004. In that capacity, she has worked on several projects with the common theme of promoting health and well-being for Florida’s children and their families.

Her first project was to facilitate the activities of the Florida Interprogram Task Force, a multi-agency group charged with the development of a Statewide Five-Year Plan for Prevention of Child Abuse, Neglect and Abandonment. In June 2005, the task force published a comprehensive prevention plan requiring the state to take action in health, family and community safety, education and child care, substance abuse and mental health, housing and economic stability, collaboration, and funding and accountability. The statewide plan is now being implemented and revised by the Governor’s Office of Child Abuse Prevention and Permanency. Since 2007, Markiewicz participated in a project to first define the elements of a comprehensive perinatal care system and then to help Leon County, Fla., implement such a system. Her role was to facilitate the planning and implementation activities of a large, multidisciplinary community group focused on reducing infant mortality and to ensure the group’s sustainability. Currently, Markiewicz is collaborating with the Florida Department of Health on two projects. For several years, she has worked with the Refugee Program to evaluate and improve refugee utilization of health care. This project involves simultaneous analysis of health-related data for refugees from the Agency for Health Care Administration, the Centers for Disease Control and Prevention, the Department of Health, and the Department of Children and Families. Beginning in 2009, she has been working with the Division of Family Health Services to prepare needs assessments that will be instrumental in Florida obtaining federal funding for new and existing maternal and child health programs.

About the Series

Finding and documenting “Real Stories” of communities that have tried—successfully and not-so-successfully—to integrate community indicators and performance measures is vital to increasing knowledge of CI-PM integration. The Real Stories are intended to provide real-life examples of the advantages to both community indicator and organizational performance measurement projects as a result of integrating these two types of efforts:

- community indicators would have a greater influence on what governments and organizations do to improve a community and
- governments’ and organizations’ performance measures would be more relevant to the community conditions that are of the greatest concern to citizens and other key community stakeholders.

These Real Stories are also intended to provide practitioners’ tools and practices, which will allow other communities to learn from, and improve on, these efforts.

About the Community Indicators Consortium

CIC was organized in the belief that information sharing, collaboration and open dialogue—across geography and disciplines—are key to the advancement of people, the quality of community life and the sustainability of our shared environment. To that end, CIC seeks bridges that span the gap between community indicators use and performance measurement, providing ways for community groups and governments to coordinate efforts and jointly enhance knowledge about the use of indicators to leverage positive change.

Through these activities, CIC has become a major node in the expanding field of community measurement. The CIC website offers a place where community-based practitioners, academic experts, engaged community residents, public officials, students, civic leaders, planners, media professionals and other stakeholders can learn from one another and participate in an active global learning community.

Contact us

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