2021-2026
Service Delivery Plan

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every mother. every family. every baby.

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A. Introduction

I. History of the Indian River County Healthy Start Coalition

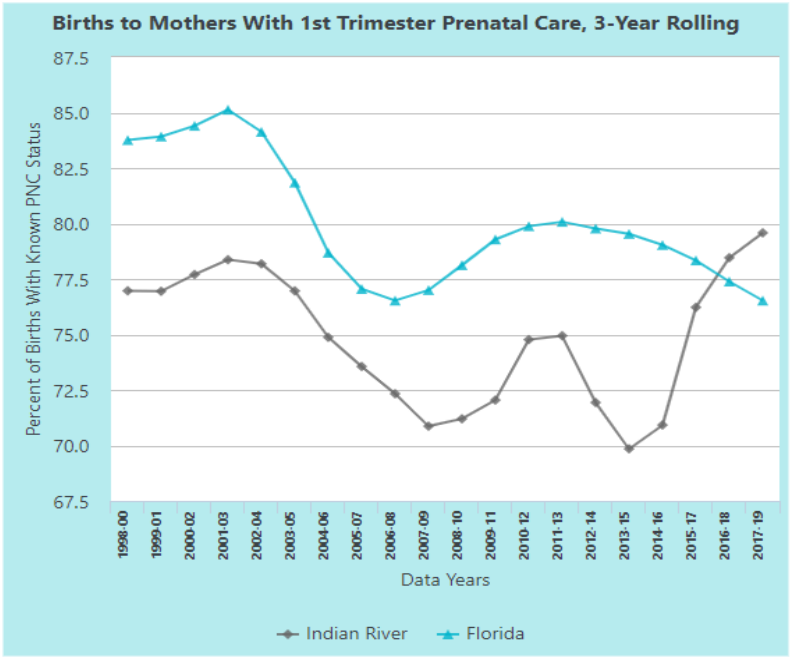
Healthy Start Coalitions were created through State statute to lead maternal child health efforts within each county across Florida. This initiative came to light by Florida's 41st Governor, Lawton Chiles. Governor Chiles created the Florida Healthy Start program to provide a comprehensive prenatal and infant care program to all pregnant women and infants across the state. By forming a Coalition within Indian River County, Maternal and Child Health advocates and key stakeholders were empowered to make local strategic decisions to improve overall maternal and child health, birth outcomes, and early infant development. Thirty years later, the Indian River County Healthy Start Coalition's (IRCHSC) mission is to establish and support a local system of care that optimizes the health of moms, babies, and their families. To help accomplish this mission, the IRCHSC team assesses data related to the Social Determinants of Health (SDOH), Infant Mortality, Maternal, and Child Health. IRCHSC then disseminates this data community-wide to providers, partners, funders, and families.

II. 2010-2014 Service Delivery Plan

In 2010, IRCHSC created a Service Delivery Plan which identified and addressed the following key health indicators as the following:

- The percent of women entering prenatal care in the first trimester
- The rate of women who smoke during pregnancy
- The rate of repeat births to teens

Indian River County Births to Mothers with 1st Trimester Prenatal Care, 3-Year
Source: FLHealthCHARTS, Florida Department of Health, Bureau of Vital Statistics

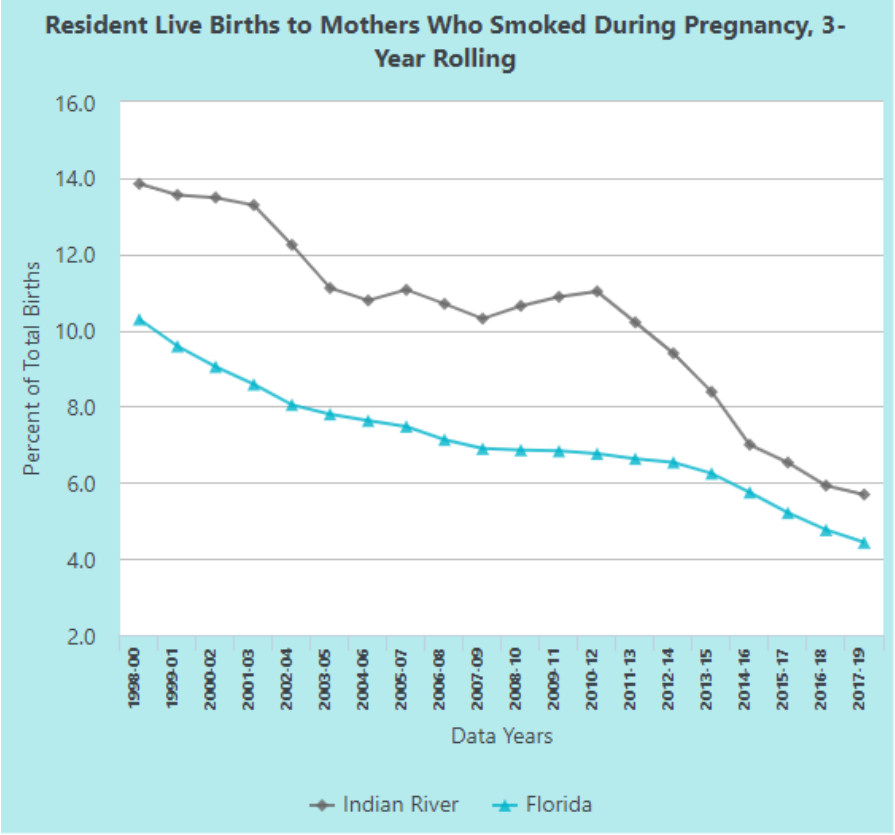


Since then, Indian River County has had a steady increase in women receiving entry into prenatal care within the first trimester. For 2017-2019, Indian River County was above the State's average at 79.6% compared to 76.5%. Measures have been put in place to keep this trend moving in the right direction. For

example, implementing the Coordinated Intake and Referral program has allowed IRCHSC to reach approximately 95% of all pregnant women within Indian River County. This type of success is made possible by the strong partnerships between IRCHSC, Cleveland Clinic Indian River Hospital, and Partners in Women's Health. Partners in Women's Health is one of the primary locations within Indian River County for women to receive pregnancy and childbirth services. IRCHSC can reach these women by having the Coordinated Intake and Referral/Maternity Navigation program housed within this location and having an additional Maternity Navigator housed within Cleveland Clinic Indian River Hospital.

Indian River County Resident Live Birth to Mothers Who Smoked During Pregnancy, 3-Year Rolling

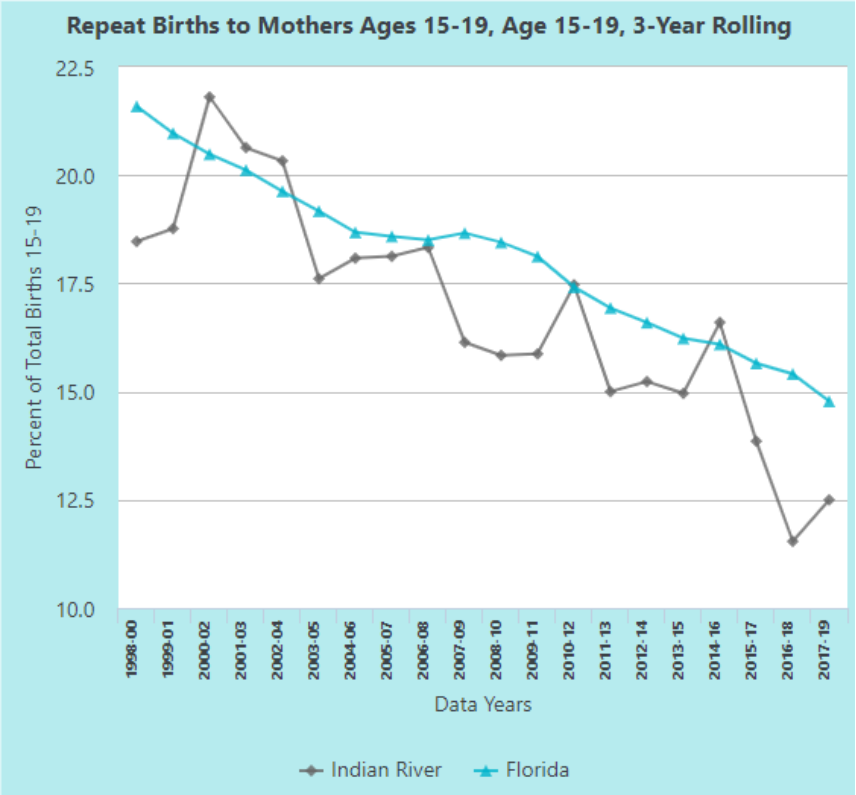
Source: FLHealthCHARTS, Florida Department of Health, Bureau of Vital Statistics



Indian River County has also had a steady decrease in the rate of women who have smoked during pregnancy. The rate for Indian River County remains higher than the State's average at 4.9% compared to 4.1%; however, smoking during pregnancy has continually declined since 2014-2015. IRCHSC will continue to monitor this birth indicator and will work closely with QuitDoc Foundation and Community Health Advocates to provide education and resources for pregnant women.

Indian River County Repeat Births to Mothers Ages 15-19, 3-Year Rolling

Source: FLHealthCHARTS, Florida Department of Health, Bureau of Vital Statistics



The rate for repeat births to teens continues to be a high priority for the IRCHSC. The rate of repeat births to mothers ages 15-19 (3-year rolling) for Indian River County is 12.5% compared to the State's average of 14.8%. Even with this birth indicator being below the State's average, Indian River County has a higher teen birth rate for ages 15-19 (20.5%), compared to surrounding counties and counties having a much larger population - such as Martin County (15.8%), Palm Beach (15.2%), Broward (11.8%) and Miami-Dade (12.6%). IRCHSC is currently working on developing and implementing the Preconception Prep Program (PPP) to address this priority area.

Continually analyzing key health indicators and data for Indian River County has altered IRCHSC's approach to addresses issues influencing maternal and child health. In the last Service Delivery Plan, the strategies were micro-focused. IRCHSC has seen more success by applying a macro approach to improving Maternal and Child Health and addressing the Social Determinant of Health. Therefore, this document approaches the Maternal and Child Health system of care on a larger scale and uses strategies and actions to derive change. Over the next five years, IRCHSC is focused on addressing the following goals:

1. Prevent infant mortality by focusing on the top causations: sleep-related death, preterm birth, and low birth weight.
2. Prevent material mortality focusing on the top causations: opioid overdose and hemorrhage.
3. Reduce racial disparities in maternal-child health outcomes.
4. Improve men and women's knowledge, attitudes, and behaviors related to preconception health and sexuality education.

5. Continue the process of Fetal and Infant Mortality Review (FIMR), educate the community as to the results, and begin to implement strategies recommended.

The implementation and achievement of these goals would not be possible without the relationships IRCHSC has built county-wide. For example, IRCHSC has secured a five-year contract with Cleveland Clinic Indian River Hospital to provide Healthy Start services to the Indian River County community in 2020. IRCHSC is also extremely fortunate to participate in multiple community initiatives, task forces, and committees to advocate for the health and needs of mothers and babies in the county. For example, IRCHSC recently participated in the completion of a Community Needs Assessment with the Indian River Community Foundation and conducted a Fetal and Infant Mortality Review funded by the Hospital District. These assessments have allowed IRCHSC to highlight Maternal and Child Health services during a global pandemic.

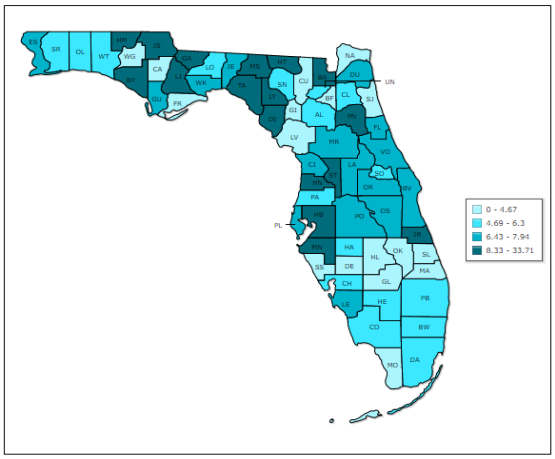
In addition to strong community partnerships, IRCHSC's Board of Directors initiated a strategic planning process in 2018. The process identified governance and fundraising as two significant areas of concern for organizational development. Since that time, the board has transformed into a well-rounded group comprised to achieve success programmatically and organizationally. Together, this group seeks to integrate data and research findings with community expertise to plan, implement, and evaluate Indian River County's Maternal and Child Health system of care. This immediate 2021-2025 Service Delivery Plan reflects this process and future initiatives related to the impact of Covid-19 and the long-term effects it will continue to have on Indian River County's mothers, babies, and families.

III. 2014-2020 Major Accomplishments

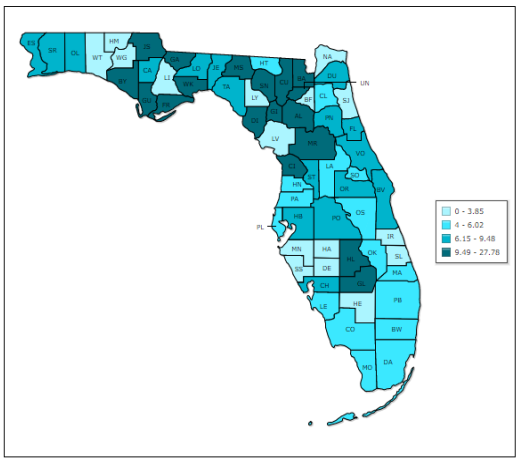
The Indian River County Healthy Start Coalition developed a Service Delivery Plan in 2010, extending through 2014. Since that time, IRCHSC has had an impact on decreasing infant mortality and increasing wraparound services for pregnant women. These efforts would not have been made possible without community partners such as Cleveland Clinic Indian River Hospital (Women's Health), Partners in Women's Health (Obstetrics, Midwifery, and Maternal-Fetal Medicine), and the Indian River County Hospital District.

In 2011, Indian River County witnessed a rise in infant mortality, most notably after the 2008-2009 crisis; IRCHSC saw the highest rate of infant mortality in Indian River County's history, 12.5 per 1,000. That year there were only four counties in the State with a higher infant mortality rate than Indian River County. The State's average at that time was 6.4 per 1,000. IRCHSC and the community took action by adding and expanding programs and pursued meaningful initiatives in lowering infant mortality. In 2015, in partnership with the Hospital District and Cleveland Clinic Indian River Hospital, Healthy Start became embedded within Partners in Women's Health. This partnership allowed for IRCHSC to expand its reach and an opportunity to educate pregnant women on services and resources available to them. In 2018, Indian River County celebrated the lowest infant mortality rate in recorded history, 1.5 per 1,000; only six counties in the State were lower than Indian River County. This was the lowest single-year infant mortality rate in accessible vital statistic records (1998-2020).

Infant Mortality (0-364 days from birth), Rate Per 1,000 Live Births, 2011



Infant Mortality (0-364 days from birth), Rate Per 1,000 Live Births, 2018



Indian River County Healthy Start is celebrating Indian River County's infant mortality rate.

The lowest in over 25 years!

We did it!

Community Collaboration

The health of the community relies on the innovation and collaboration that extends outside of the typical medical model of care and addresses the Social Determinants of Health. With the generous support from the community and community partners, IRCHSC was able to expand upon and add many programs to help serve the needs of Indian River community. Each enhancement was in response to an identified community needs.

Program or Initiative Implemented	Date	Need Identified
Parents as Teacher	2014- ongoing	Kindergarten Readiness levels of lower than 50%. **Partners:** Moonshot Community Action Network and Grand Harbor Community Outreach. **Model:** Parents as Teachers Affiliate; Evidence-based curriculum.
Community Doula Program	2017-ongoing	Women Giving birth alone in hospital and high cesarean rate. **Partners:** John's Island Community Service League. **Model:** Community-based model.

Nurse-Family Partnership	2018-ongoing	High rates of teen birth and poor inter-conception care (chronic health condition with moving into second pregnancies). **Partners:** Multicounty program including Brevard, Indian River, Martin, and St. Lucie Counties. The local Florida Department of Health in Indian River County is instrumental in coordinating services and providing support and assistance. **Model:** Nurse-Family Partnership Evidence-based curriculum.
Coordinated Intake and Referral/ Maternity Navigation	2018-ongoing	Statewide improvement to streamline services and reduce duplication of services. **Partners:** Indian River County Hospital District, Partners in Women's Health, and Cleveland Clinic Indian River Hospital. **Model:** Healthy Start Standards and Guidelines.
Health Education/Care Coordination Remodel	2018-ongoing	Statewide improvement system to be more centered around health education. **Partners:** Florida Department of Health **Model:** Healthy Start Standards and Guidelines
Babies and Beyond	2017-ongoing	Lower breastfeeding rates amongst Black women and lower postpartum hospital readmission rates. **Partners:** Cleveland Clinic Indian River Hospital.
Fetal and Infant Mortality Review (FIMR)	2019-ongoing	Collect and analyze data in real time and unify community around maternal and child health needs. **Partners:** Indian River County Hospital District. **Model:** A Guide for Communities: Fetal and Infant Mortality Review Manual 2nd Edition.

IV. IRCHSC Philanthropy

Philanthropic Community

The Community Needs Assessment (2019) says it best, "Indian River County is fortunate to have a community of both small and large donors, generous with their volunteer time and financial support. Included among them are some of the highest income residents in Florida, many of whom are committed to meeting the needs of vulnerable individuals and families through annual charitable gifts or improving the community through long-term philanthropic investments. Many of the community's best ideas and promising practices are the result of this generosity". IRCHSC has been fortunate to be on the receiving end of these generous donors. Many of IRCHSC's wraparound services and programs have been made possible by the generous support of the Indian River community. Having such a charitable community has allowed IRCHSC to implement innovative programs based on the community's needs.

An example of this is the Community Doula program. The Community Doula program was identified as a need within the Indian River community when it was discovered that approximately 100 women labor alone every year. As implementation plans expanded, it was identified that Doula programs also improve birth outcomes and family empowerment. Now, with the Community Doula program and its "on-call" service, women in Indian River County no longer have to labor alone. Additionally, within a short period of time, this program has been extremely successful and influential in improving birth outcomes in those who received this service, which includes prenatal visits, birth support, and postpartum support. The concept, creation, and execution of this program would not have been possible without the support from the John's Island Community Services innovation/strategic planning grant.

COMMUNITY IMPROVEMENT IN ACTION

In 2014, Indian River County conducted a Children's Needs Assessment. Through this process, the need for early childhood education and improved kindergarten readiness became a community priority. To assist in the increase of kindergarten readiness rates, IRCHSC, along with Moonshot Community Action Network, and various community leaders, assessed evidence-based programs, with their final selection being the Parents as Teachers program. Since then, the Parents as Teachers program has served 350 families. IRCHSC and the Moonshot Community Action Network strive to have 90% of children reading on grade level by third grade. Grand Harbor Community Outreach has also contributed to this goal by funding a book grant. This grant allows Parents as Teachers – Parent Educators to provide a book to every family, to build a library within the home. These libraries encourage literacy-based activities (reading, talking, and singing), which supports brain development.

Dancing with Vero's Stars

Dancing with Vero's Stars has made a mark on the Vero Beach Non-profit events scene ever since it first sashayed onto the stage of the Vero Beach Elks Hall on Saturday, March 14, 2009. At that time, less than 400 people made a full house, and less than $40,000 was raised for the

non-profit. The Indian River County Healthy Start Coalition recognized from that singular evening that Dancing with Vero's Stars would only grow and attain unlimited success as IRCHSC's signature fundraising event. In 2019, this event had over 655 attendees and raised more than $500,000.

Baby Talk Events

The IRCHSC Baby Talk events provide an opportunity for community members to discuss and develop a better understanding of maternal and child health within Indian River County. Each host picks a topic that is of interest to them. In 2019-2020, held four Baby Talks which covered the following:

Baby Talk #1 – Birth in Indian River County

Baby Talk #2 – The Fourth Trimester

COMMUNITY PARTNERS

Cleveland Clinic Indian River Hospital

Department of Children and Families

Florida Department of Health in Indian River County

Indian River County Sheriff's Office

Erin Grall, State of Florida House Representative

Midwife Love

National Association for the Advancement of Colored Peoples (NAACP)

School District of Indian River County

Substance Awareness Center of Indian River County

Indian River County Hospital District

Treasure Coast Community Health

Healthy Families

Nurse-Family Partnership

Health Council Southeast Florida

Tykes & Teens

Indian River County United Way

CareNet

Visiting Nursing Association

Whole Family Health Center

Mental Health Association

The Buggy Bunch

Women's Care Center

Communities Connected for Kids

IRC Children's Services Advisory Council

Women, Infants, and Children Indian River County

Baby Talk #3 – Indian River County Healthy Start

Baby Talk #4 – Maternal, Child, and Preconception Health

The Baby Talk events have provided IRCHSC insight, collaboration, and support from the community. So much so, IRCHSC has been able to pursue the development and implementation of a Preconception Health and Education program in Indian River County.

Website and Social Media

Before 2018, the social media presence for IRCHSC was minimal. Since that time, IRCHSC has steadily increased the posting frequency and follower growth. As of 2020, IRCHSC has implemented an entire social media strategy, including daily posting and community management. As a result, the audience continues to increase by at least 10% month over month.

In October 2020, IRCHSC hired a professional production company to create an entire library of informative videos in Spanish and English. These videos provide guidance and help clients register for prenatal, labor/delivery, and postpartum classes. This video library contains information covering the early stages of pregnancy, such as finding a provider, prenatal care, seeking medical attention, shared decision-making, Healthy Start Classes, infant CPR/infant safety, breastfeeding, babywearing, the first 24 hours, and many more. Additional content includes how to get enrolled in services and receive helpful information to start a healthy pregnancy by the Lead Maternity Navigator, as well as collaboration with community partners such as Christina Stamper with Madison's Miracles to discuss fetal loss and miscarriage. A total of twenty-three videos were filmed. These videos can be found on the Indian River County Healthy Start website. They are free and can be accessed at any time.

Mother's Day Garden of Love

The Mother's Day Garden of Love fundraiser is a beautiful metal art installation outside at Riverside Theatre. Anyone can purchase a flower to celebrate a mom that is "planted" in the garden on Mother's Day weekend. This is the first time IRCHSC has hosted this event, and it has already gained remarkable recognition.

In 2018, the Indian River County Healthy Start Coalition raised $5,000 in individual giving and capacity building. To develop a more enhanced level of fundraising, IRCHSC evaluated the strategies in place, which were more transactional or event-driven fundraising, to create a more diverse philanthropic action plan.

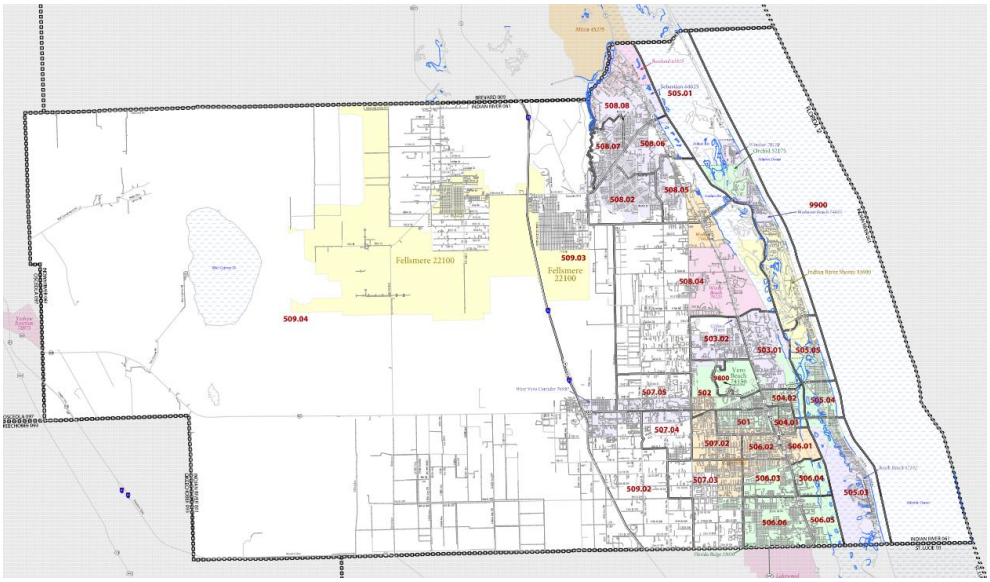
In 2020-2021, the Indian River County Healthy Start Coalition was able to raise $130,000. These activities included hosting "Baby Talk" events, the Mother's Day Garden of Love fundraiser, and two mailers. In addition, the Indian River County Healthy Start Coalition continues to prioritize Board development, annual appeals, and the cultivation of deeper donor relationships.

B. Indian River County Health Indicators

I. Community Profile

Indian River County is the 59th largest county in Florida as it encompasses 502.6 square miles of Florida's Treasure Coast. Indian River County, Florida, is bordered by Osceola County, St. Lucie County, Okeechobee County, and Brevard County.

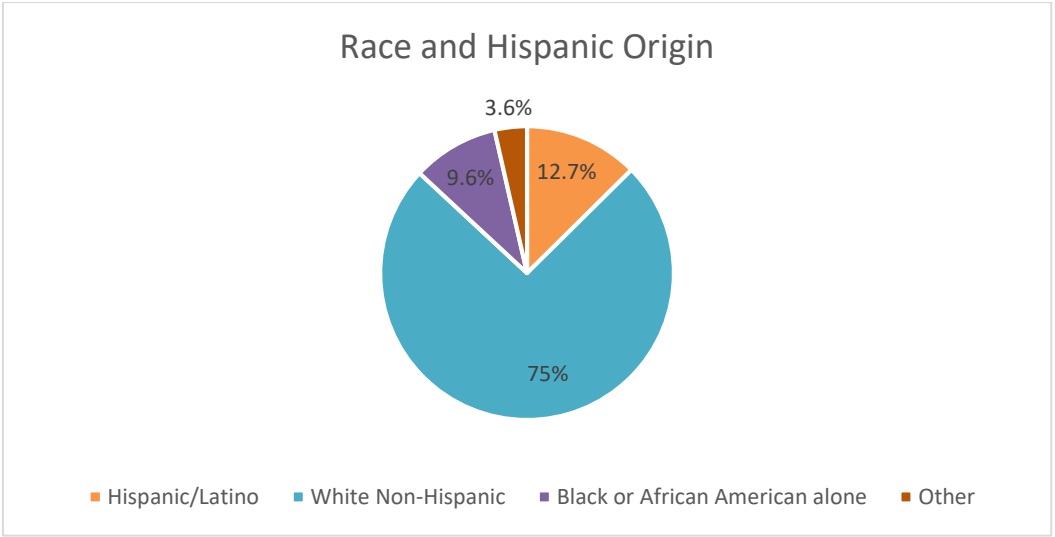
Indian River County Census Tract Map, 2020
Source: United States Census Bureau Map



In 2020, the United States Census Bureau recorded over 154,000 residents (the State of Florida, 21,477,737). The median age of the residents of Indian River County in 2019 was 53.5 years (the State of Florida, 42.4). Approximately 4% of the population is under the age of 5 (the State of Florida, 5.3%), while 15.6% are under 18 years of age (the State of Florida, 19.7%). The largest age group among this community is among the 65-plus age group at 33.8%, compared to the State of Florida at 21% (Census Bureau, 2021).

Indian River County's population is primarily White Non-Hispanic; approximately 75% of residents identify as White Non-Hispanic/Latino (the State of Florida, 53.2%). However, Hispanic/Latinos (of any race) represent the largest minority group (12.7%), compared to the State of Florida at 26.4%, followed by Black/African Americans/Other 13%, compared to the State of Florida at 22.7% (Census Bureau, 2021).

Indian River County Race and Hispanic Origin 2014-2019
Source: Census Bureau, 2021

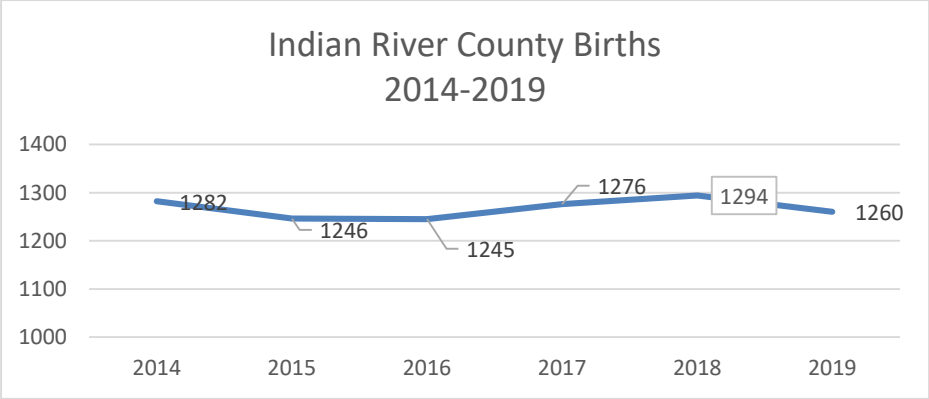


For educational attainment, 89.4% of persons' age 25 and older hold a high school diploma or higher. Twenty-nine percent (29%) of persons' age 25 years or older obtain a bachelor's degree or higher (Census Bureau, 2021).

Indian River County is one of the top ten wealthiest counties in Florida. With an average income per capita of $76,059, Indian River County exceeds the state average by more than $25,000. However, among all counties in the United States, Indian River County had the 10th largest income gap between the bottom 99% and top 1%. The top 1% earn over $2.9 million in average yearly income. In comparison, the bottom 99% earn an average of $43,373 -- the calculation for a living wage in Indian River County is $64,219 (Massachusetts Institute of Technology, Living Wage, 2020).

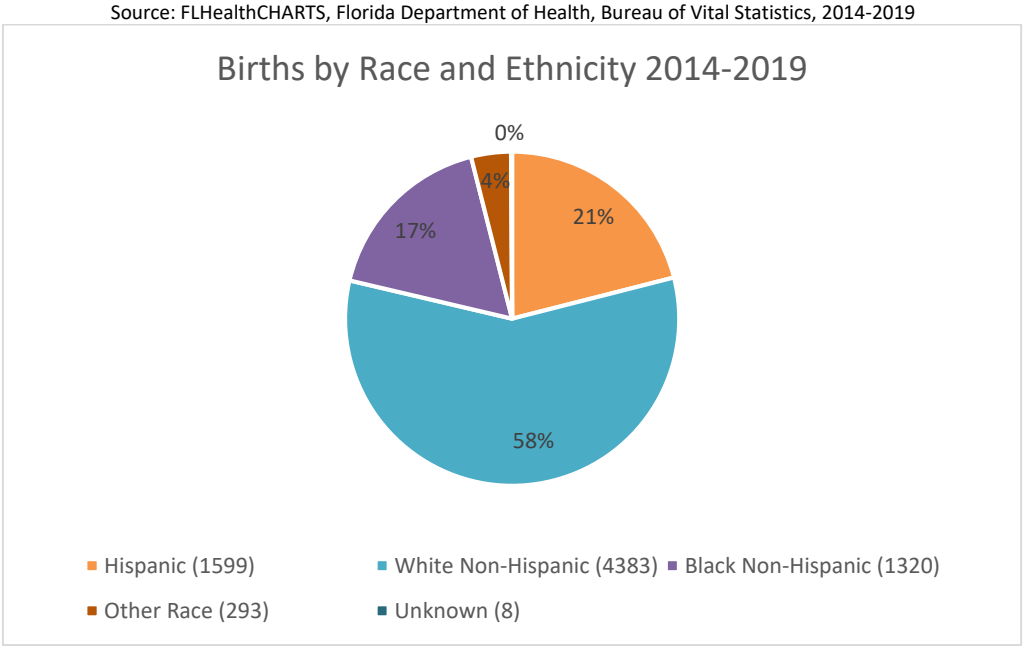
II. Maternal and Child Health Data

Indian River County Total Annual Births 2014-2019
Source: FLHealthCHARTS, Florida Department of Health, Bureau of Vital Statistics, 2014-2019



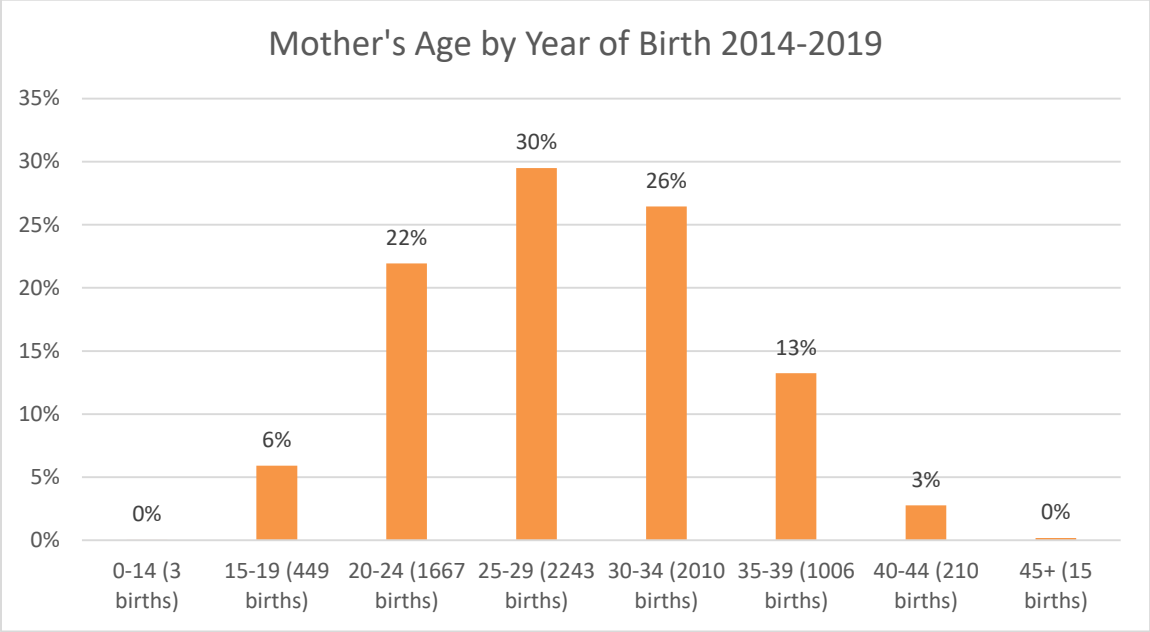
The birth rate for Indian River County from 2014 to 2019 is 9.6 per 1,000. From 2014 through 2019, there were a total of 7,603 births to Indian River County residents.

Indian River County Births by Race and Ethnicity 2014-2019
Source: FLHealthCHARTS, Florida Department of Health, Bureau of Vital Statistics, 2014-2019



It is typical for Race and Ethnicity to be recorded separately; however, this information has been combined to illustrate a fuller picture for Indian River County. Births by race and ethnicity for the time period of 2014-2019 was White Non-Hispanic 58%, Hispanic 21%, Black Non-Hispanic 17%, and other Race 4%.

Indian River County Births by Mother's Age by Year of Birth 2014-2019
Source: FLHealthCHARTS, Florida Department of Health, Bureau of Vital Statistics, 2014-2019



Indian River County births by mother's age for the combined birth years of 2014-2019, is 15-19 (6%), 20-24 (23%), 25-29 (30%), 30-34 (26%), 35-39 (12%), 40-44 (3%), and 45+ (.01%).

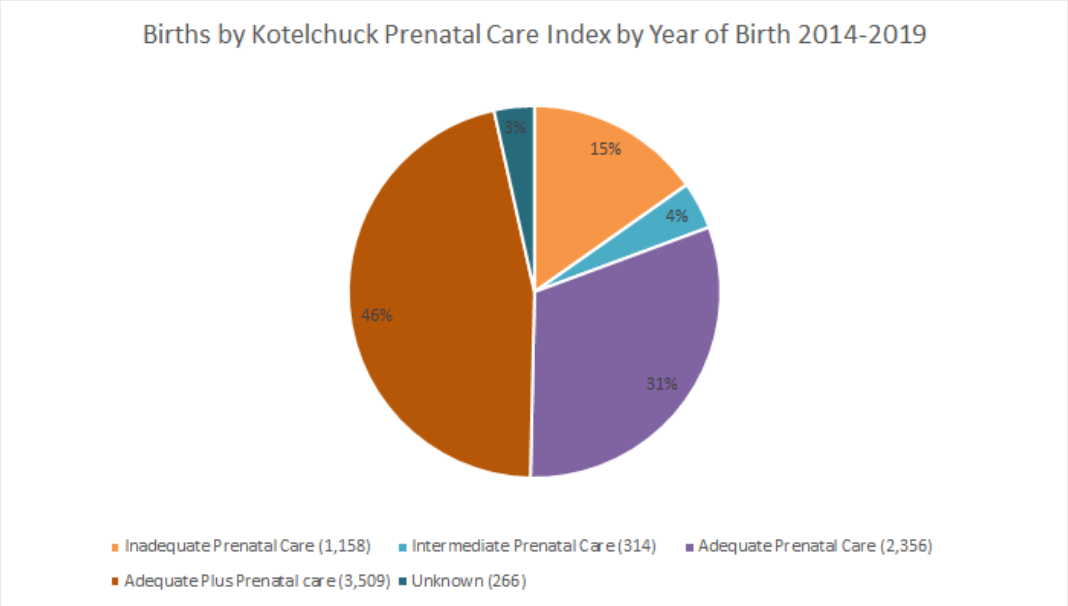
Indian River County 2014-2019 Births by Maternal Educational Attainment
Source: FLHealthCHARTS, Florida Department of Health, Bureau of Vital Statistics, 2014-2019

Indian River County Births 2014-2019		
Maternal Educational Attainment		
less than High School	**2585**	**34%**
HS Graduate or GED	**2705**	**36%**
College Degree	**1832**	**24%**
Master's Degree	**451**	**6%**
Unknown	**30**	**0%**
Total	**7,603**	**100**

The table above summarizes the mother's maternal education attainment for Indian River County births from 2014-2019.

Indian River County Births by Kotelchuck Prenatal Care Index by Year of Birth 2014-2019

Source: FLHealthCHARTS, Florida Department of Health, Bureau of Vital Statistics, 2014-2019



The Kotelchuck Index: Also called the Adequacy of Prenatal Care Utilization (APNCU) Index, uses two crucial elements obtained from birth certificate data: when prenatal care began (initiation) and the number of prenatal visits from when prenatal care began until delivery (received services). The Kotelchuck Index classifies the adequacy of initiation into four groups as follows:

- Pregnancy months 1 and 2
- Pregnancy months 3 and 4
- Pregnancy months 5 and 6
- Pregnancy months 7 to 9

With the underlying assumption that the earlier prenatal care begins, the better. To classify the adequacy of received services, the number of prenatal visits is compared to the expected number of visits for the period between when care began and the delivery date. The expected number of visits is based on the American College of Obstetricians and Gynecologists' prenatal care standards for uncomplicated pregnancies and is adjusted for the gestational age when care began and for the gestational age at delivery. A ratio of observed to expected visits is calculated and grouped into four categories:

- Inadequate (received less than 50% of expected visits)
- Intermediate (50%-79%)
- Adequate (80%-109%)
- Adequate Plus (110% or more)

Indian River County births by Kotelchuck Prenatal Care Index for the combined birth years of 2014-2019 is Inadequate Prenatal Care (15%), Intermediate Prenatal Care (4%), Adequate Prenatal Care (31%), Adequate Plus Prenatal Care (46%), and Unknown (3%).

Indian River County Births 2014-2019 by Gestational Age of Baby

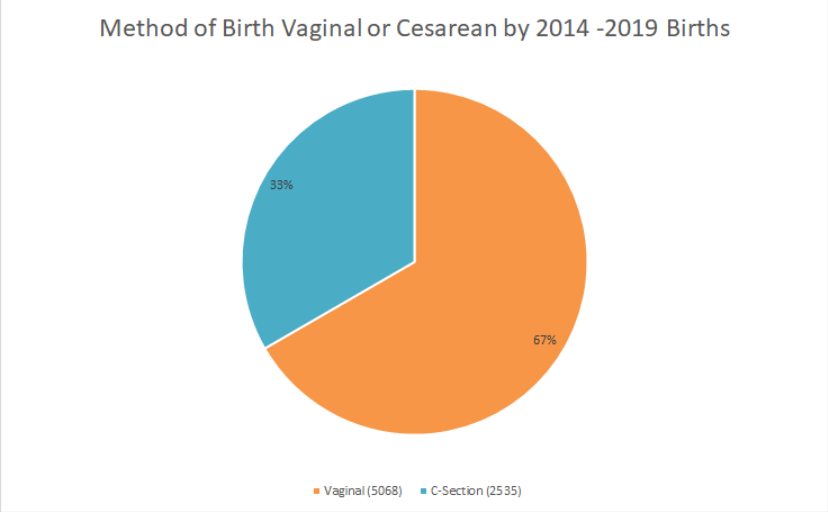
Source: FLHealthCHARTS, Florida Department of Health, Bureau of Vital Statistics, 2014-2019

Indian River County Birth 2014-2019		
Gestational Age of Baby		
Weeks	**Number of Births**	**Percentage**
<32	**123**	**2%**
32-36	**637**	**8%**
37+	**6,843**	**90%**
Total	**7,603**	**100%**

The table above provides the clinical obstetric estimate of the baby's age in weeks at birth. This is estimated by the provider.

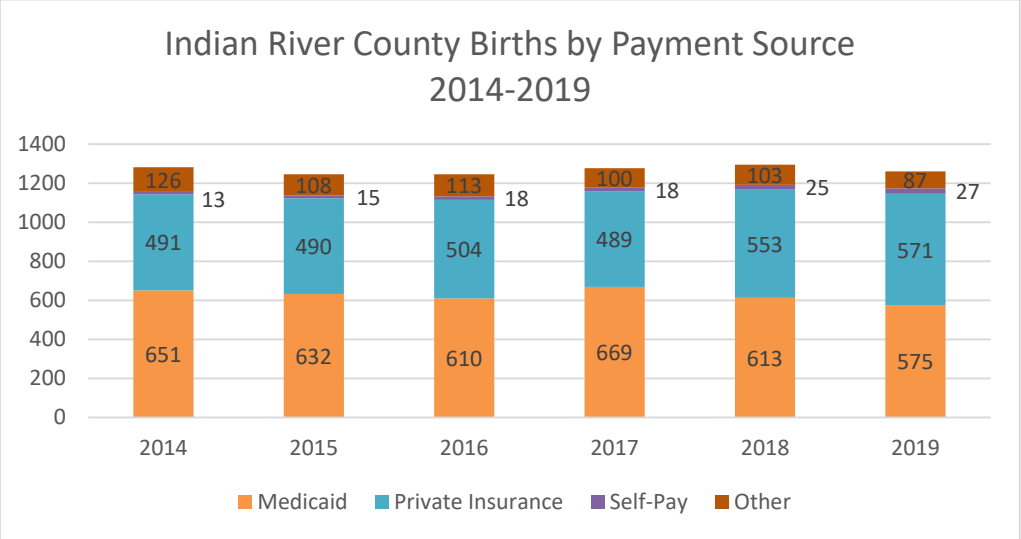
Indian River County Births by Delivery Method Year of Birth 2014-2019

Source: FLHealthCHARTS, Florida Department of Health, Bureau of Vital Statistics, 2014-2019



Cesareans are associated with impaired neonatal respiratory function, neonatal intensive care unit admission, and difficulty breastfeeding. For most low-risk pregnancies, cesarean birth increases the risk of hemorrhage, infection, uterine rupture, abnormal placentation, cardiac events, maternal psychological stress, extended hospital stays, increased pain, and increased maternal postpartum re-admissions (FPQC, 2019).

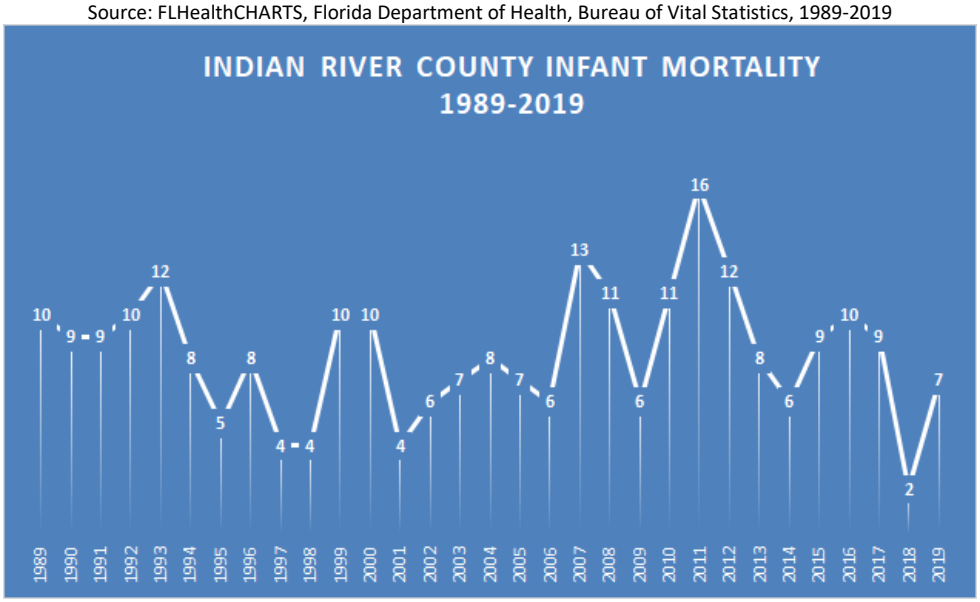
Indian River County Births by Delivery Payment Source by Year of Birth 2014-2019
Source: FLHealthCHARTS, Florida Department of Health, Bureau of Vital Statistics, 2014-2019



Half of all Indian River County families that gave birth from 2014-2019 were enrolled in Medicaid services. This means they made less than $28,888 based on data for a family of three; (Benefits.gov, 2020). Medicaid payment for births has remained steady; around 50% is a trend that will continue. Mothers whose payment source for birth/delivery was Medicaid was 3.9 per 1,000.

III. Priority Areas of Focus

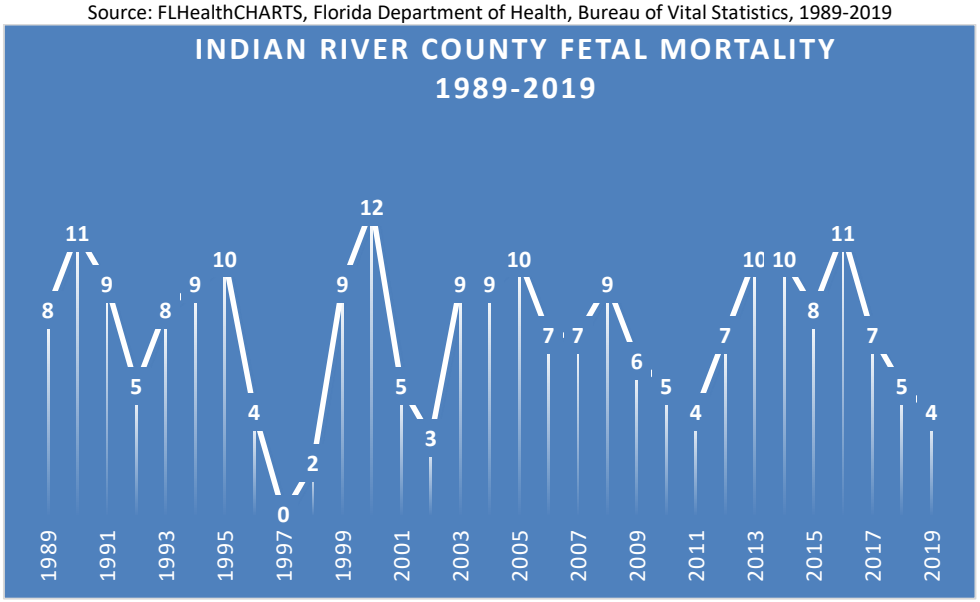
Indian River County Infant Death Count from 1989 – 2019
Source: FLHealthCHARTS, Florida Department of Health, Bureau of Vital Statistics, 1989-2019



In 2016, Indian River County saw the highest rate of infant mortality in Indian River County's history, 12.5 per 1,000. That year there were only four counties in the State with a higher infant mortality rate than Indian River County. The State average at that time was 6.4 per 1,000. In 2018 Indian River County celebrated the lowest infant mortality rate in recorded history, 1.5 per 1,000; only six counties in the State were lower than Indian River County.

Indian River County Fetal Death Count from 1989 – 2019

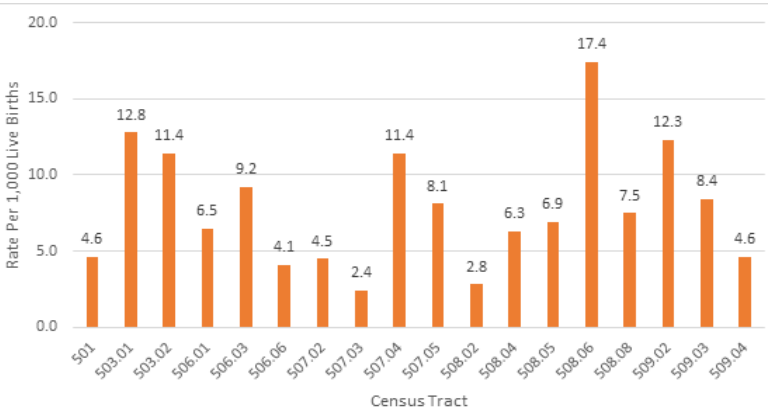
Source: FLHealthCHARTS, Florida Department of Health, Bureau of Vital Statistics, 1989-2019



Fetal death refers to the spontaneous intrauterine death of a fetus at any time during pregnancy. It's essential to review the fetal mortality rate and the infant mortality rate related to the Social Determinants of Health and how these determinants influence maternal health and affect pregnancy outcomes. When Indian River County saw the highest rate in history (2016), there was also an increase in fetal deaths, the largest increase since 2000. Since then, fetal deaths continue to decrease within Indian River County, even as there has been a slight rise in infant deaths. IRCHSC will continue monitoring these trends and reviewing these cases during the fetal and infant mortality review process.

Indian River County 2014-2019 Infant Deaths per 1,000 Live Births, by Residence Census Tract

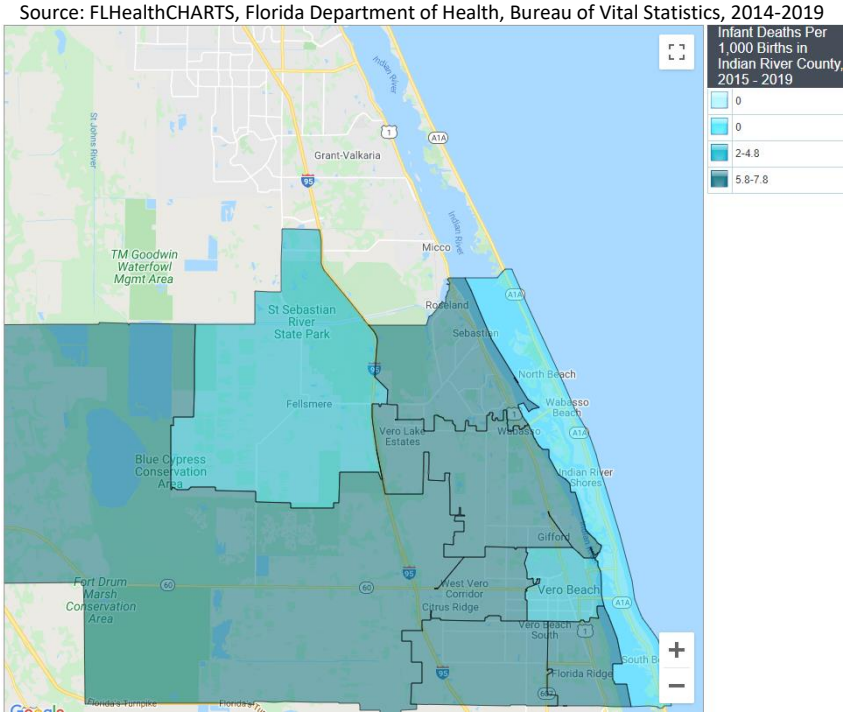
Source: FLHealthCHARTS, Florida Department of Health, Bureau of Vital Statistics, 2014-2019



Between 2014 and 2019, the areas with the highest infant death rates by census tract (CT) in Indian River County were CT 508.06 (Sebastian), CT 503.01, CT 503.02 (Gifford) and CTs 507.04 and 509.02 (unincorporated Indian River County).

Indian River County 2014-2019 Infant Deaths per 1,000 Births, by Residence Census Tract

Source: FLHealthCHARTS, Florida Department of Health, Bureau of Vital Statistics, 2014-2019



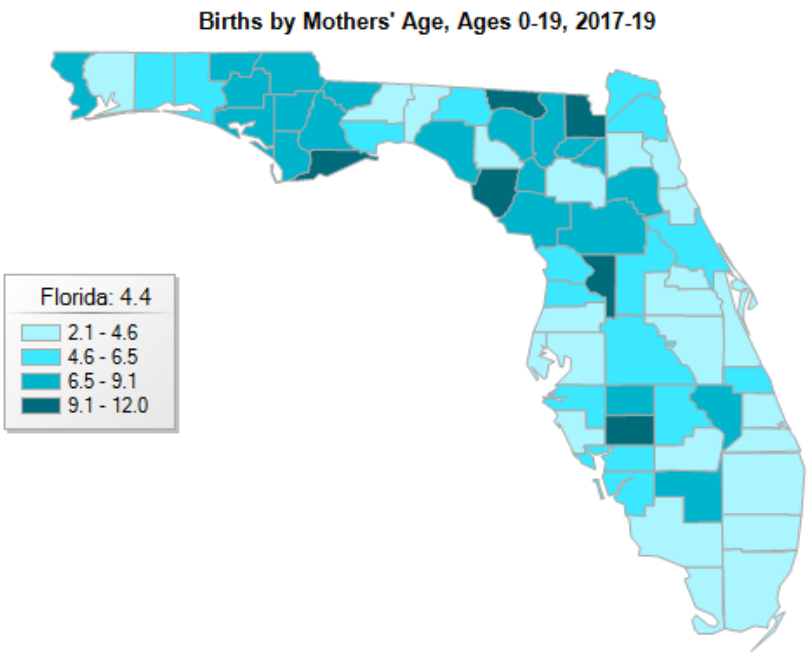
Dividing the data into zip code and census tract provides a more profound understanding of the existing disparities within Indian River County. For example, one zip code within Indian River County may represent various socioeconomic statuses and disparities related to the Social Determinants of Health.

Indian River County 2014-2019 Infant Mortality Rate by Race and Ethnicity

Source: FLHealthCHARTS, Florida Department of Health, Bureau of Vital Statistics, 2014-2019

Indian River County 2014-2019 Infant Mortality Rate by Race and Ethnicity		
Race and Ethnicity	Number of Deaths	Infant Mortality Rate per 1,000 Births
Hispanic	5	7.5
White Non-Hispanic	16	3.6
Black Non-Hispanic	17	12.1
Other	5	N/A
Total	43	5.6

During the 6-year time frame, there were a total of forty-three (43) infant deaths. Sixteen (16) White Non-Hispanic infants, five (5) Hispanic infants, and seventeen (17) Black Non-Hispanic infants. Black Non-Hispanic infants had the highest infant mortality rate (12.1 per 1,000).



The Teen Birth rate (5.19 per 1,000) for Indian River County remains higher than the State's average and higher than surrounding counties.

C. Community Needs Assessment

The Community Needs Assessment was the first process to complete the Indian River County Healthy Start Coalition Service Delivery Plan. Through this process, IRCHSC was able to identify areas of improvement, gaps in services, and overall needs related to maternal and child health within Indian River County. IRCHSC's goal was to determine priority groups at high risk of poor pregnancy outcomes due to socioeconomic/medical risk factors. The following objectives focus on:

1. Identify the prevalence of poor pregnancy outcomes, high-risk populations, economic costs, and trends.
2. Assess current social, psychosocial, economic, and environmental issues in the community that impacts perinatal health outcomes.

I. Objective 1 – Collect and Monitor Local Data

To identify the prevalence of poor pregnancy outcomes, high-risk population, economic costs, and trends, IRCHSC had to assess existing resources. From January 2019 to October 2020, the Indian River County Healthy Start Coalition lead a Fetal and Infant Mortality Review (FIMR). This project was made possible by The Indian River County Hospital District, The Department of Health Indian River County, The Health Council of Southeast Florida, and over 33 community members who dedicated hours of their time over the year to complete this project. The FIMR teams reviewed 18 infant deaths that occurred from 2014-2018. This included vital statistics, medical records (e.g., hospital and prenatal records), autopsy reports, social services, law enforcement case notes, and maternal interviews.

The medical causation does not vary from the medical causations typically seen locally, statewide, and nationally:

1. Congenital Anomaly
2. Prematurity Low or Very Low Birth Weight
3. Respiratory Distress
4. Infection/ Sepsis
5. Suffocation (sleep-related)

IRCHSC hosted a four-part "Baby Talk" series. This series provided an opportunity for community members to discuss and develop a better understanding of the strengths and weaknesses surrounding maternal and child health within Indian River County. The following topics included:

1. Baby Talk #1 – Birth in Indian River County
2. Baby Talk #2 – The Fourth Trimester
3. Baby Talk #3 – Indian River County Healthy Start
4. Baby Talk #4 – Maternal, Child, and Preconception Health

Implementing community surveys was vital in developing a better understanding of the current resources and what was essential to the community and key stakeholders. Surveys were provided during annual coalition meetings and one of IRCSHC's signature events, the Giving Closet. Based on survey results, IRCHSC developed an action item list for 2020-2021.

2020-2021 Action List:

Substance misuse in pregnant women and families	
Restart MORE initiative meetings	September 30, 2020
Explore postpartum doula combined with peer support workers	September 30, 2020
Education and Empowerment	
Check-in about birth doula training and postpartum doula training.	September 30 2020
Keep baby talk 2# ladies updated in progress of the postpartum doula projects	September 30 2020
Keep baby talk 1# ladies update on progress with birth	July 31 2020
Collect testimonials, photos, and client stories	On going
Create Facebook group for Pregnant During Covid-19	July 31 2020
Virtual Hospital Tour	July 31 2020
All classes accessible virtually	January 1, 2021

Health Disparities	
Explore Centering Pregnancy	January, 2020
Ask NAACP to be involved on the Community Action Team	September 30 2020
Look for a presenter for FIMR summit on centering	October 1 2020
Campaign about health disparities: No one ever told me that… Share info, solutions and data	January 1, 2021
Granny groups or church (baby talks) Meet with Tony, Cheryl and Julianne	September 30 2020 host one by end of Fiscal year
Access	
Create a highlight on a partner quarterly	January 1, 2020
Restart small classes 4 moms total 8 people total	August 30, 2020
All classes accessible virtually	January 1, 2021
Once a week COVID-19 update (social media)	August 30 2020
Collaboration	
Contact CCIRH about entrance into building for birthing women	July 2020
Check in with Healthy Families about Fatherhood initiative	September 30 2020
Request meeting with Partners' OB • Update on programs • Ask about improvements	September 30,2020
Meet with Dr. Presley's office	September 30, 2020
Meet with members of CSAC individually	July, 1 2020

The work that IRCHSC is able to accomplish would not be possible without the support from community partnerships that share a collective mission and vision. To achieve this, every year, the Indian River County Healthy Start Coalition holds its annual meeting. During this time, community members and residents are asked to participate in a reverse revisioning activity that helps guide the work of the IRCHSC each year. In addition to this meeting, IRCHSC and program staff participate in local community meetings. Participation includes Moonshot Community Action Network (MCAN), Visiting Nurse Association (VNA): Together for Health Collaborative, the Gifford Health Advisory Council, the

Gifford Community Meeting: 4-Pillars, the Hospital District Quarterly meetings, and the Cleveland Clinic Indian River Hospital Quarterly meetings.

The Indian River County Healthy Start Coalition also participated in an additional Community Needs Assessment hosted by the Indian River Community Foundation. IRCHSC assisted by hosting a maternal and child health focus group with Q-Q Research. The Indian River Community Foundation Community Needs Assessment found the following:

The primary issue that repeatedly materialized across all domains in this needs assessment was related to the economic barriers' lower incomes residents in Indian River County are facing. An ample income usually grants individuals access to resources that allow for a high-quality life for community residents — such as access to housing, health care, quality schools, secure neighborhoods, and time and money to enjoy recreational activities necessary for well-being. Throughout the needs assessment, residents expressed concerns with economic issues related to the affordability of basic needs like housing, health care, child care, and senior care. Creating opportunities for employment that allow residents to earn enough money to make ends meet, which is equal to (or even above) a living wage, is key to improving the lives of county residents. This will likely involve developing employment opportunities with salaries that allow residents to meet needs and enhancing training programs and educational opportunities that align with growth in higher-paying occupations. Below are several recommendations that can assist the stakeholders within the Indian River County community to address barriers and close gaps.

1. *Encourage collaboration to address complex, systemic problems, improve service quality, and balance competing priorities.*
2. *Increase housing stability and quality with policy, code enforcement, and resident empowerment.*
3. *Advocate for a living wage.*
4. *Assess barriers and improve access to community services.*
5. *Improve access to healthcare through expansion, integration, and innovation.*
6. *Use participatory approaches to build trust and transparency.*

The Indian River County Healthy Start Coalition also participated in the organization and planning of the 2020 Department of Health Community Health Improvement Plan (CHIP). CHIP planning remains ongoing. However, three priority areas have been identified.

1. Health (including but not limited to issues of Mental Health, Infectious Disease, Food Access, and Environment)
2. Economic Opportunity and Employment (including but not limited to issues of Poverty, Education, Food, and Shelter)
3. Housing (including but not limited to issues of Substandard, Affordable, and Homelessness)

The Indian River County Healthy Start Coalition will continue to serve on the CHIP working group come in 2021 –2022.

II. Objective 2 – The Social Determinants of Health and Birth Outcomes

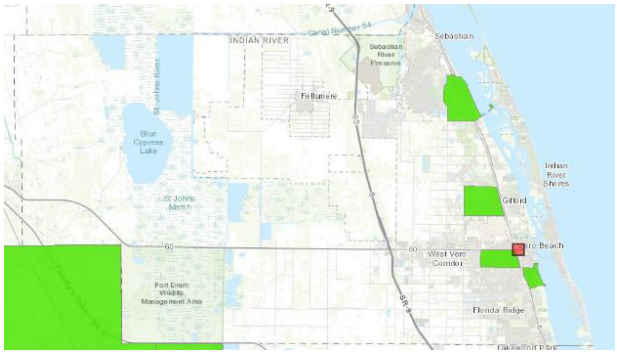
Economic Sustainability: Economic Sustainably is very remarkable in Indian River County. The disparities in wealth mirror Indian River County's health disparities. For example, in the census tract

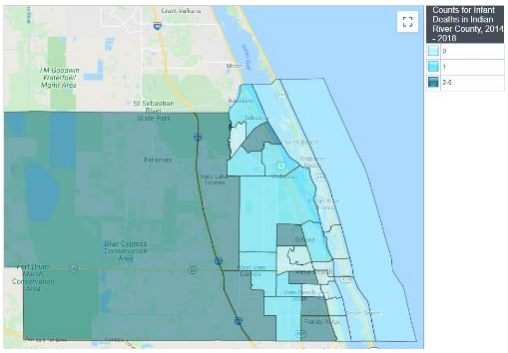
where Indian River County records the highest rate and number of infant deaths 503.02 (Gifford), IRCHSC also sees one of the lowest income per capita $17,288 (censusreport.org). Conversely, the census track with the lowest rate and number of infant deaths (505.01) has the highest per capita income, $117,286.

Neighborhood and Physical Environment: There are several ways in which the Social Determinants of Health impact birth outcomes. Transportation is the first. Indian River County has a large population of families that live in Fellsmere (per capita income: $14,489). This community does not have a prenatal care provider, and these mothers are forced to travel to get prenatal care. This is 30 min drive by car, but many do not have transportation. This means an over 2-hour bus ride with stops and bus changes.

Education: During the 2014-2018 FIMR, IRCHSC noted that 72.2% of the women who endured a loss had a high school diploma or less. In addition, Indian River County has been struggling with kindergarten readiness rates and low rates of children reading on grade level by third grade. The community has formed several groups to address these issues. The IRCHSC and program staff actively participate in these groups.

Food: The link between nutrition and maternal health is demonstrated when reviewing the maps provided below. Census Tracts which are considered food deserts according to the United States Department of Agriculture, Economic Research Service, mirrored those with high rates of infant mortality.





Community: Indian River County as a whole has a lower crime rate than the state's average. However, many families that live in pockets of poverty are constantly exposed to toxic stress and trauma. Abuse, crime, racism, and under-resourced systems plague these families and create barriers to health.

Health Care Systems: The most significant impediment to the maternal and child Health care system in Indian River County is access to Presumptive Eligibility for Pregnant Women (PEPW). IRCHSC has made considerable improvements to mothers' entry into prenatal care rates due to Coordinated Intake and Referral/Maternity Navigation. However, IRCHSC still receives concerns from clients and community members that the physical act of receiving PEPW is a barrier to care. IRCHSC is optimistic in regards to allowing the leading prenatal clinic to process PEPW and eliminate this obstacle.

III. Community Needs Assessment - Key Findings

The Community Needs Assessment identified areas of improvement, gaps in services, and overall needs related to maternal and child health within Indian River County. As a result, the Indian River County Healthy Start Coalition will continue to focus on the entire community, especially within the identified high priority areas:

1. Teen Births: For mothers younger than 19, Indian River County is higher than the State's average for teen births and higher than surrounding counties (5.2 per 1,000).
2. Racial Disparities: to continue to decrease disparities in infant mortality amongst Black Non-Hispanic women. Infant mortality among Black Non-Hispanic women remains more than double the rate of White Non-Hispanic women.
3. Geographic Focus: Census Tract (CT) 503.02 (Gifford), CT 508.06 (Sebastian), and CTs 507.4 and 509.02 (unincorporated Indian River County).

D. Fetal and Infant Mortality Review

The Fetal and Infant Mortality Review (FIMR) is a national model that was first introduced in 1990 as a collaborative effort between the American College of Obstetricians and Gynecologists (ACOG) and the Federal Maternal and Child Health Bureau. Florida adopted the FIMR model in 1992. Florida FIMR projects are organized under Florida Statutes 766.101. FIMR brings together key members of the community to examine the information from individual cases of fetal and infant death to identify the factors that contributed to those deaths, determine if those factors represent system problems that require change, develop recommendations for change, assist in the implementation of change, and determine community effects. The confidentiality of all information is strictly maintained. All cases brought before the review team are de-identified of the patient, provider, and institutional data. The goal of FIMR is to empower the community with information and improve systems. There are currently over 200 FIMR projects in the country.

I. Planning

An important first step in the implementation of a FIMR is the planning phase. This planning process takes approximately 6–8 months. The FIMR planning team was primarily comprised of staff from IRCHSC and DOH-IRC. The planning phase included the following objectives:

1. Identify potential members of the Case Review Team (CRT) and the Community Action Team (CAT).
2. Research the type of cases and the number of cases to be reviewed.
3. Explore methods of identifying cases to be reviewed and methods of analysis.
4. Contract with the DOH-IRC to provide nurse abstraction services to gather information from multiple sources, including medical records, social services agencies, law enforcement, and to interview women who have experienced a loss.
5. Contract with Health Council Southeast Florida (HCSF) to assist IRCHSC staff in coordinating and directing the project. Produce de-identified case summaries; present case summaries to the CRT; document CRT deliberations, findings, and recommendations; and assist in the development of the final report.
6. Develop policies and procedures, goals, and objectives.



The planning team set a goal of 18-20 cases between 2014-2018 for the Indian River County FIMR. This goal is consistent with recommendations for small cities or counties with few infant deaths from the Fetal and Infant Mortality Review Manual 2nd edition (2008). FIMR usually includes a review of fetal and infant deaths; however, this planning team chose to focus exclusively on infant mortality. Throughout the FIMR process, IRCHSC conferred with several leaders in the field of Maternal and Child Health, including William Sappenfield, MD, MPH, CPH of Florida Prenatal Quality Collaborative, Leisa Stanley, Ph.D. of Hillsborough Healthy Start, and Ms. Carol Brady of Florida Association of Healthy Start Coalitions and Florida Perinatal Quality Collaborative.

II. Implementation

IRCHSC contracted with the DOH-IRC to provide nurse abstraction services. Information was gathered from multiple available sources, including vital statistics, medical records (e.g., hospital and prenatal records), autopsy reports, social services, and law enforcement case notes, and maternal interviews. Eighteen cases were abstracted, de-identified, and reviewed. These cases were selected as they were the most instructive and detailed cases available. Through the data gathering process, inconsistent, unclear, or missing data in records across different organizations and departments were noted in six cases.

Two multidisciplinary groups completed the FIMR process, including clinicians and non-clinicians. These professionals represent the local health department, social service agencies, family planning services providers, drug treatment centers, hospitals, and law enforcement agencies. IRCHSC ensured that physicians experienced with OB/GYN, pediatric, and neonatology care participated as members of the CRT. The CRT carried a robust 33 members. The information derived from the CRT reviews was then used to identify fetal and infant death trends, as well as key factors in the deaths, and serves as a tool that helps the community implement changes to prevent future losses. The Indian River County CRT began meeting in November 2019 and continued through August 2020. The CAT was comprised of 28 professionals, philanthropists, and community members. The CAT used the findings and recommendations of the CRT to develop a strategic approach, including specific actions steps that, once implemented, aims to decrease infant mortality and improve pregnancy outcomes. The CAT met during October 2020.

III. FIMR – Key Findings

Through this process, the following priority areas were identified:

Maternal Age: Indian River County, teen birth rate from 2014-2018 was 5.4 per 1,000, above the State's average and higher than Indian River County's surrounding counties. Within the FIMR project, two (2) of the eighteen (18) mothers were teens. Advanced Maternal Age is defined as women over the age of 35 are typically at higher risk for poor birth outcomes. Mothers who were above the age of 35 made up 28% (5) of the infant deaths reviewed but represented only 16.2% of the births during the FIMR Project.

Type of Birth Cesarean or Vaginal: Indian River County's cesarean section rate from 2014-2018 was 33%. In 2019 this rate increased to 36%, meeting the State's average for the first time since 2011.

Findings notated the previous cesarean section in 22% (4) of the cases and cesarean section in current pregnancy in 38% (7) cases.

Wealth Disparities: Forty-four percent (44%) of households in Indian River County cannot afford the basic costs of living (United Way of Florida, 2020). Half of all Indian River County families that gave birth from 2014-2018 were enrolled in Medicaid services. This means that they made less than $28,888 based on data for a family of three; (Benefits.gov, 2020). Economic stability is a construct of the Social Determinants of Health that can impact the overall health of a family. In Indian River County, medical funding sources are the following: Medicaid 50%, Private Insurance 40%, Other and Self-Pay 10%. Access to insurance reflects overall access to quality health care. Of the FIMR cases reviewed, 78% (14) were enrolled in Medicaid services at some point in pregnancy or before infant death, while 22% (4) had private insurance. The overall birth data from 2014- 2018 shows Medicaid as a payment source for 50% of all births; that is a difference of 28% and may indicate that mothers who are "Medicaid recipients are more likely to have more risk factors for adverse birth outcomes, compared with women with private insurance" (Anum, Retchin, and Strauss, 2010).

Education: Higher educational attainment is associated with positive birth outcomes (Gage, Fang, O'Neill, DiRiezo, 2013). The birth data from 2014-2018 shows that 50% of mothers had a high school diploma or less. Indian River County is above the state's average for mothers who are over 19 and do not have a high school degree for 2019 (10.7% vs. 9.7%). In 73% of the cases reviewed in the FIMR project, the mother had a high school degree or less.

Geographic Area: One's neighborhood is one of the most insightful predictors of one's health outcomes than anything else, including health care. Identifying the geographic areas where infant mortality is most prevalent provides opportunities to understand more about residents living in those communities, challenges they face, and even issues they may have with access to services and supports. Between 2014 and 2018, the areas with the highest infant death rates by ZIP Code in Indian River County were in ZIP Codes 32967, 32966, and 32968 (Vero Beach), ZIP Code 32948 (Fellsmere), and ZIP Code 32958 (Sebastian). The areas with the highest infant death rates by census tract (CT) in Indian River were CT 503.02 (Gifford), CT 508.06 (Sebastian), and CTs 507.4 and 509.02 (unincorporated Indian River County). Dividing the data into zip code and census tracts provides a more profound understanding of the existing disparities within Indian River County.

Race and Ethnicity: The racial health disparities are reflected in the Indian River County infant mortality rate. During the five-year FIMR timeframe, there were a total of 36 infant deaths. Fourteen (14) White Non-Hispanic infants, five (5) Hispanic infants, and 12 Black Non-Hispanic infants. Black women represented 17% of Indian River County moms who gave birth during 2014-2018, yet accounted for 33% of the deaths. Black Non-Hispanic infants had the highest infant mortality rate (9.9 per 1,000), double the rate for White Non-Hispanic infants (3.8 per 1,000). The data in Indian River County mirrors that seen nationwide. Black mothers and babies suffer a higher rate of morbidity and mortality. Nationally, the Centers for Disease Control and Prevention (2020) state that the risk for Black Non-Hispanic women is more than double that of White Non-Hispanic women. Research shows this may be due, in part, to conventional risk factors for infant mortality such as mother's socioeconomic status, access and consumption of nutritious foods, and access to health care services. Still, the disparities are reflective of broader inequities. For example, Black mothers are more likely to be susceptible to

"weathering" or the premature aging of one's body due to social stresses. Related, the exposure to discrimination and racialized stress throughout the lifespan can negatively impact birth outcomes.

IV. FIMR – Next Steps

The Centers for Disease Control and Prevention (2021), recognizes preconception care as a critical component of health care for women of reproductive age. The main goal of preconception care is to provide health promotion, screening, and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies. Preconception care is part of a larger health-care model that results in healthier women, infants, and families. The Centers for Disease Control and Prevention states that Preconception Health Education can:

1. Prevent unintended pregnancies. Nearly half of all pregnancies are unintended. Risks associated with unintended pregnancy include low birth weight, postpartum depression, delays in receiving prenatal care, and family stress.
2. Prevent adolescent pregnancies. More than 400,000 teen girls age fifteen to nineteen give birth each year in the United States.
3. Detect and treat health conditions that may be associated with unhealthy pregnancies or infants. Prenatal care can detect gestational diabetes or preeclampsia before it causes problems with the developing fetus, and taking prenatal vitamins before critical fetal development periods can prevent congenital disabilities of the brain and spinal cord.

IRCHSC has identified the current preconception health strategy as increasing education and awareness of preconception health by implementing the following activities:

1. Form a community task force (non-profits, parents/caregivers, schools, medical providers, etc.) to plan a comprehensive county-wide preconception health program.
2. Implement action items and program initiatives identified by the community task force.

Awareness and education have been identified as a strategy to empower mothers and families to take control of their health. To address this priority area, IRCHSC, along with the Community Action Team, will develop a collaborative comprehensive, trusted, evidence-based source of information that addresses issues affecting families with children zero to three that can be shared community-wide using evidence-based public health strategies. The following activities will help achieve this goal:

1. Create task force/ focus groups comprised of maternal-child health, social services, health, and mental health agencies, and community members to identify emergent issues that impact families which children from zero to three (preconception health, prenatal care, resources in the community, postpartum support, breastfeeding, mental health support, safe care, and safe sleep).
2. Use the input to create comprehensive materials and messages culminating in the 'Nobody Told Me That' Campaign, including stories and testimonials from women in the community. Messaging should include information for mothers, fathers, and other caregivers.
3. Partner with trusted members of the community to distribute this information and advocate for behavioral changes that address the targeted modifiable risk factors (possibly using the IRCHSC Community Doula program)
4. Distribute revised messaging and materials to all task force members and other organizations (2-1-1, Visiting Nurse Association Mobile Clinic).

5. Create more awareness for Healthy Start and Cleveland Clinic's Maternity Navigator/ Coordinated Intake and Referral program as a central intake and information point.

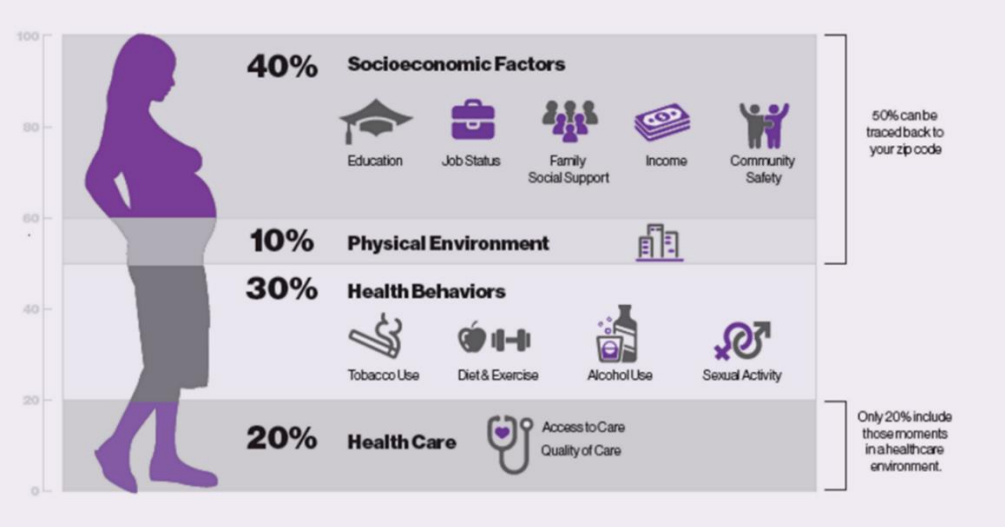
Lastly, Enhance Care for Women with High-Risk Pregnancies was identified as a top priority for the Indian River community. The first strategy identified to address this priority area is to increase support for women with high-risk pregnancies and those identified as having factors associated with poor birth outcomes using a risk screening tool. Strategy Two plans to enhance services for mothers who use substances. The following activities will help achieve this goals:

1. Sustain and expand effective programming currently being offered such as the Community Doula program, Nurse-Family Partnership, Parents as Teachers, Healthy Start, Healthy Families, and others.
2. Engage community partners such as churches and community-based organizations (2-1-1 and mobile clinic) to disseminate information related to the newly added high-risk maternity services (CCIRH Maternal-Fetal Medicine).
3. Create more awareness for Healthy Start and Cleveland Clinic's Maternity Navigator/ Coordinated Intake and Referral program as a central intake and information point.
4. Strategy Two: Continue the work of the MORE (Maternal Opioid Recovery Effort) Initiative group created to address the rise in substance-exposed newborns. Tasks may include identifying a provider for Medication-Assisted Treatment (MAT), conducting 5P screening on all pregnant women, providing naloxone kits to those at risk of overdose.

E. Implementation Cycle

I. Social Determinants of Health

The Social Determinants of Health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (CDC, 2020). The Community Needs Assessment and the Fetal and Infant Mortality report findings emphasized the huge impact that the Social Determinants of Health have on birth outcomes.



To continue to meet the needs of the Indian River County community as they relate to Maternal and Child Health, it was essential to confront and understand the social and structural determinants of

health to start identifying solutions and interventions that will protect every mother, baby, and family from poor health outcomes. Healthy behaviors are essential to healthy pregnancies – but they are not the most powerful predictors of a healthy pregnancy. The Social Determinants of Health play a more vital role in outcomes than do individual behaviors. The Community Needs Assessment and the Fetal and Infant Mortality Review allowed IRCHSC to collect the information needed to bridge the gaps in maternal-child health in Indian River County.

IRCHSC continues to create and improve a system of care that provides pregnant women and new mothers the resources, services, and programs needed to positively affect each of the constructs that address the Social Determinants of Health. Currently, IRCHSC has six programs available throughout the community. IRCHSC first entry into care is through the Coordinated Intake and Referral (CI&R) and Maternity Navigation service. This program is housed within Partners in Women's Health and Cleveland Clinic Indian River Hospital, where a Maternity Navigator informs all program participants about the various services for which they are eligible and makes referrals as appropriate. These referrals are then tracked. The Maternity Navigator follows up with program participants regarding services and overall satisfaction. The table provided below breakdowns each program along with the internal focus, program description, and eligibility.

IRCHSC Programs:

	Healthy Start	Babies and Beyond	Community Doula Services	Nurse-Family Partnership	Parents As Teachers
Internal Focus	Support and Health Education	Build Parent Capacity and Early Childhood Development	Add on to any service if a mother does not have anyone to support her during labor.	Mothers with Chronic Health Conditions	School Readiness
Coordinated Intake and Referral/ Maternity Navigation	*Helps with having a healthy pregnancy *Eating healthy * Stop Smoking *Breastfeeding *Caring for your baby *Childbirth, Breastfeeding, and infant parenting education *Friendly support *Mental health counseling *Community referrals	*Provides services to every mother, baby, and family *Childbirth education *Lactation support *Nurse Home Visits (Postpartum) *Increase health literacy *Development of strong parenting skills *Free "Beautiful" month-to-month pregnancy book *Mom groups for sharing support *Nutritional Support *Family planning and women care *Smoking cessation *Connection to community-wide services	*Growth and development *Teaches healthy ways of dealing with everyday stress *Assists in setting and achieving personal and family goals *Connections to community services your family may need	*Helps you have a healthy baby and pregnancy *Helps you be a better parent *Helps you make your home a safe place for your baby to live and play *Provides referrals for you and your family and build a strong network of support *Finds a way to continue your education and get a job training *Set goals for your family's future and find ways to reach them	*Personal visits and group meetings *Equip parents to prepare children from prenatal through kindergarten for stronger development and success in school Cultivate family well-being and healthy child development *Provide early detection of developmental delays *Prevent child abuse and neglect *Increase children's school readiness and success
Program Description	Telephone calls, information packets, home or face-to-face visits, support groups, and community education	Prenatal risk screen and prenatal education, lactation consultant at the hospital, registered nurse newborn home visit, phone calls at 8 weeks, certified lactation consultants	Home or Face-to-face Visits, Support Groups, Community Education	A nurse trained in taking care of moms and babies will visit you and your family during pregnancy and until your baby is 2 years old	A certified Parent Educator will provide visits on a weekly, bi-weekly or monthly basis. Services are provided throughout pregnancy until age 3. Can enroll anytime
Eligibility	Available to all pregnant women and families with babies less than a year old, lives in Indian River County	Available to all pregnant women and families who may be expecting, lives in Indian River County	Available to all pregnant with lack of support during labor Lives in Indian River County	First pregnancy, before 26 weeks gestation, on Medicaid, teen mothers, lives in Indian River County, Gifford Area – Priority Area	Pregnant or have a child up to age 3, lives in Indian River County

Healthy Start Health Education:

Healthy Start Health Education services aim to promote early prenatal care and address the needs of pregnant mothers. A healthy birth outcome is the ultimate goal. The IRCHSC acknowledges that there any many barriers preventing pregnant women from gaining adequate access to care. This home-visitation program aims to elevate those barriers by enrolling program participants during the early stages of pregnancy due to the Universal Prenatal Risk Screen. In addition, in-home education, assistance, and wraparound services are provided to improve health literacy and achieve positive birth outcomes. Services are provided to mitigate or eliminate these risk factors and address social determinants of health that contribute to adverse birth outcomes and developmental delay.

Babies and Beyond Program:

The Babies and Beyond program is a unique service. It provides education and wraparound services that address the true causations of infant mortality and the key determinants of health that impact infant mortality. This program casts the widest net and reaches the most families within the Indian River community to provide them with evidence-based education, support and referrals to additional programs deemed necessary. With this program having a four-tiered approach, IRCHSC is able to reach families at different stages of their pregnancy journey and provide them with the support and education they may need at a time where it is best received. Tier 2 and Tier 3 of this program also address the causations related to infant mortality as they provide lactation support and postpartum home visits from a registered nurse. The Nurse Home Visitation practice is an evidence-based approach recommended by the World Health Organization (WHO) to improve maternal mortality and infant mortality. The WHO recommends newborn home visits to identify and make appropriate interventions if needed right after the birth of a baby. The WHO describes breastfeeding as "one of the most effective ways to ensure child health and survival." Indian River County Healthy Start Coalition's Certified Lactation Counselors (CLCs) promote to all mothers who give birth at Cleveland Clinic Indian River Hospital to initiate breastfeeding within one hour of birth. The CLCs also promote exclusively breastfeeding the infant for the first six months of life to achieve optimal growth, development, and health; and breastfeeding up to two years with other complementary foods. Lastly, this program provides an opportunity for pregnant women, new mothers, and families to create a social support system, which is critical within the postpartum period, where many mothers may feel isolated or alone, especially in the time of Covid-19.

Community Doula Program:

The Community Doula Program provides an opportunity to engage and empower families, improve health outcomes, reduce disparities, and provide positive learning experiences in a practical and fiscally conservative way. Aligned with the mission and vision of the Indian River County Healthy Start Coalition, the Community Doula program complements Indian River County’s local system of care by optimizing the health of moms, babies, and families. The goal of the program is to improve the health literacy of participating women and families while addressing the causation of infant mortality and morbidity. The program provides a trained, non-medical professional to offer physical, emotional, and educational support to a mother before, during, and after childbirth. The Doula helps to ensure that a mother achieves the healthiest, most rewarding birth experience possible. This program is a result of strong community partners, ongoing collaborative efforts and local support. It is locally funded by the Indian River County Children’s Services Advisory Council, John’s Island Community Service League, and the Indian River County Hospital District. The Community Doula program addresses the Social

Determinants of Health by utilizing a community-based model. The program explicitly connects women in their communities specially trained as Doulas to provide support during critical times of pregnancy, birth, and postpartum. The program is based on the power of peer-to-peer support. This is made possible because the Doulas are of and from the same community as their clients. As a result, the Community Doula is able to understand their client's cultural needs while creating long-term links to support networks.

Nurse-Family Partnership:

The Nurse-Family Partnership (NFP) is an empowerment program for first-time moms. The program helps transform new mom's lives and create better futures for themselves and their babies. The program works by having a trained registered nurse (RN) regularly visit first-time moms-to-be, early in the first trimester, and continuing to the child's second birthday. Program completion constitutes three years of active participation in the NFP program. The Nurse-Family Partnership RN's provide assistance to mothers, babies, and families to attain a stable living environment and succeed in raising their child/children. The NFP program was brought to Indian River County three years ago to reach pregnant mothers from the Gifford Community and decrease the black infant mortality rate within Indian River County. The Fetal and Infant Mortality Review supports program implementation by revealing the racial disparities in health reflected within the Indian River County infant mortality rate. Black women represented only 17% of the moms that gave birth during 2014-2018, yet accounted for 33% of the deaths, resulting in an infant mortality rate double the rate for white infants. The NFP program has helped reduce the black infant mortality rate by providing a Registered Nurse to conduct home visits for high-need mothers starting at the very beginning of their pregnancy till the child is three years old. Currently, forty-three percent (43%) of the clients enrolled are black mothers and families within Indian River County. This program has grown tremendously and has been at capacity for most of 2020 and 2021.

Parents as Teachers:

As identified in the Indian River County Community Needs Assessment (2019), a persistent problem within the community is children are not ready for kindergarten and are not reading by the third grade. The Parents as Teachers program (PAT) provides at-risk mothers and fathers the knowledge and skills to maximize their child's cognitive, social and emotional development during the most crucial period of brain development (birth through age three). The areas of focus for this program include child development, parent/child interaction, play activities designed to target developmental domains, and overall family well-being. These families are served within their homes. One of the primary goals for Parents as Teachers is to increase parent-child literacy activities among parents living in poverty in Indian River County. Research shows that differences in socioeconomic status are strongly associated with variation in language outcomes. Children from disadvantaged backgrounds differ substantially from their more advantaged peers in verbal and other cognitive abilities by the time they enter kindergarten (Ramey & Ramey, 2004). The United States Department of Education (2013) states that in low-income neighborhoods, there is one book for every 300 children; in middle-income neighborhoods, there are 13 books per child. PAT provides a book at every PAT visit. As a result, families are able to build a library within the home. Having accessibility to books is the first step on the journey to kindergarten readiness and reading by third grade.

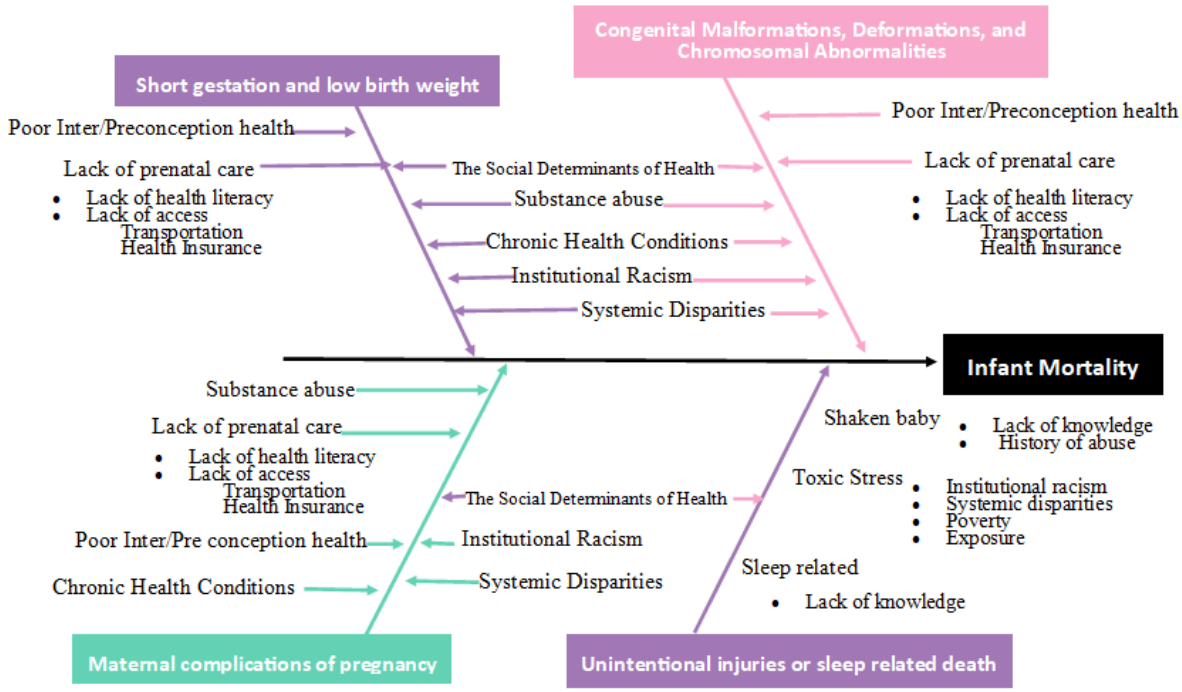


II. Fishbone Medical Causation

When developing and evaluating the system of care within Indian River County, IRCHSC considers present and contributing factors related to infant mortality. The Fishbone provided below identifies four direct contributing factors related to infant mortality within Indian River County:

1. Short gestation and low-birth weight
2. Maternal complication of pregnancy
3. Congenital malformations, deformations, and chromosomal abnormalities
4. Unintentional injuries or sleep related death

Indian River County Infant Mortality Causations



III. 2021-2022 Annual Action Plan

As identified in the Community Needs Assessment and Fetal and Infant Mortality Review, IRCHSC has multiple focus areas. To address each priority area, IRCHSC has implemented an annual action plan that identifies emergent goals and strategies to address these specific areas of focus. The Service Delivery Plan differs from the previous service delivery plan as it focuses on not just the behavior (i.e., smoking while pregnant) but also addresses the Social Determinants of Health that influence pregnant women and families within Indian River County.

2021-2022 Annual Action Plan will address the following goals:

1. Prevent infant mortality by focusing on the top causations: sleep-related death, preterm birth, and low birth weight.
2. Prevent material mortality focusing on the top causations: opioid overdose and hemorrhage.

3. Reduce racial disparities in maternal-child health outcomes.
4. Improve men and women's knowledge, attitudes, and behaviors related to preconception health and sexuality education.
5. Continue the process of Fetal and Infant Mortality Review (FIMR), educate the community as to the results, and begin to implement strategies recommended.

Goal 1	**To prevent infant mortality focusing on the top causations: sleep related death, preterm birth and low birth weight.**
Strategy 1.1	Continue to partner with subcontractors to provide quality evidence-based programs and services (Health Education Services, Coordinated Intake and Referral, Babies and Beyond, Parents as Teachers, Community Doula Program and Nurse Family Partnership). Action Steps: A. Meet quarterly with subcontractor leadership (CHD and CCIRH) to ensure communications and outcome measures and deliverables are satisfied. B. Continue to remain compliant with all state required trainings. C. Provide staff with opportunities for professional development training. Minimum of two additional trainings per year.
Strategy 1.2	Promote safe sleep behaviors among families and infant caregivers. Action Steps: A. Explore social media campaign "show me your baby sleeping safe" possible adding incentive. B. Continue to distribute “Gifts to inform” resources to educate on “this side up” to address SIDS and other sleep related safe sleep practices (goal of 1000 families). C. Tailor outreach and messaging of safe sleep practices to specific audiences and neighborhoods (review with Community Action Team of FIMR). D. Continue to collaborate with the IRC Healthy Department, Nurse Family Partnership and additional community partners regarding the Direct On Scene Education (DOSE) program about Safe to Sleep for all infants (Active by January 2022). E. Continue to purchase and distribute pack and plays to program participants (25 per year). F. Add discharge class at CC-IRH adding addition safety guidance. Explore adding a baby shower feel with incentive gifts.
Strategy 1.3	Promote effective preterm birth prevention strategies for women of reproductive age with an emphasis on disparate populations. Action Steps: A. Provide 200 women with doula services. B. Provide 25 families with Nurse Family Partnership. C. Provide 40 families with Health Education Services. D. Begin process of Preconception Health Program.
Strategy 1.4	Promote effective strategies to prevent babies being born with low birth weight (LBW) and very low birth weight (VLBW). Action Steps: A. Provide 200 women with doula services.

	B. Provide 25 families with Nurse Family Partnership. C. Provide 40 families with Health Education Services. D. Begin process of Preconception Health Program.
Strategy 1.5	Promote entry into prenatal care to first trimester. Action Steps: A. Continue collaboration with community MCH stakeholders consistent, early access to Medicaid coverage through community access points. B. Clarify prenatal care provider's policy on entry into prenatal care before Medicaid approval has occurred. Receive copy of policy. C. Add PEPW to expanded CI&R program.
Strategy 1.6	Increase health literacy, prenatal, inter-conception and postpartum education and care. To prevent and decrease conditions that place women and baby at risk. Action Steps: A. Continue to work with Cleveland Clinic Indian River hospital to monitor trends, risk factors, and causation of morbidity and mortality (quarterly meetings held with leadership). B. Engage Family Practice Providers, pediatricians and OBs and asses and identify what preconception health and sexuality education is currently being done. C. Review all materials and meet with coalition providers and partners to create cohesive messaging concerning women's health and wellness. D. Continue to offer two free Community Doula training per year.

Goal 2	**To prevent material mortality focusing on the top causations: Opioid overdose and hemorrhage.**
Strategy 2.1	Promote vaginal births among low-risk (full-term, singleton, and vertex presentation) women. Action Steps: A. Assist in continuing Cleveland Clinics efforts in implementing PROVIDE initiative. B. Provide 200 women with doula services. C. Continue to offer two free Community Doula training per year.
Strategy 2.2	Promote prevention of substance use in preconception and pregnant women. Action Steps: A. Assist in Cleveland Clinic efforts in implementing the MORE (Maternal Opioid Recovery Effort) initiative. B. Complete community mapping.

Goal 3	**To reduce racial disparities in maternal child health outcomes.**
Strategy 3.1	Continue to raise awareness in the community and the state of Florida concerning the multiple barriers that vulnerable pregnant women and families encounter regarding access to care. Action Steps: A. At each board meeting highlight, a program and educate all Board of Directors on the components of healthy start programs and screening so they can be advocates in the community.

	B. Meet quarterly with local providers (PIWH, FWC, Midwife Love) Educate and provide ongoing technical assistance to healthcare providers regarding components of the screen and services provided by Healthy Start. C. Attend local meetings that touch communities with elevated risks for poor birth outcomes. D. Monitor what emerges in Martin County as MCHSC implements the maternity care bus. E. Meet with community, local, or state representative and/or decisions makers to advocate and educate on the importance of decreasing barriers and increasing access to health care and healthy literacy.
Strategy 3.2	Target medical providers and community organization to increase knowledge and awareness of the Healthy Start programs and the importance of the Coordinated Intake and Referral system (CI&R). Action Step: A. Utilize the report developed to collect and analyze screening rates (total forms processed, number of consents, number of positives, number of referrals). B. Ongoing identification of screening concerns with Healthy Start Service Providers. C. Meet with a community organization or medical provider monthly.
Strategy 3.3	Target Coalition partners (hospital, pediatricians, community health departments and other community organizations) to create cohesive messaging regarding disparities in maternal child health outcomes. Action Steps: A. Educate the community by providing and distributing cohesive messaging for Indian River County mothers and babies (e.g. lunch and learn, monthly newsletter, social media platforms.) B. Attend community collaborative meetings and provide updated information and cohesive messaging regarding disparities in maternal child health outcomes.
Strategy 3.4	Target Cleveland Clinic Indian River Hospital regarding additional provider trainings including implicit bias and trauma informed care. Action Steps: A. Communicate the overall needs/results identified at the Annual Coalition meeting (e.g. Letter to CCIRH). B. Attend quarterly meetings with the Hospital District. C. Present/educate on peer-reviewed, evidence-based standard of care (quality, equity and dignity) and the importance it has on positive birth outcomes. (review at QA/QI). D. Host a free training that offers CEUs for providers.
Strategy 3.5	Promote entry into prenatal care to first trimester. Action Steps: A. Attendance at local family friendly events to engage the residents of Indian River County/targeted population on Healthy Start programs/services (3 - Touch A Truck, Sheriff's BBQ, MLK Parade, Buggy Bunch Event - tentative). B. Attendance at local meeting(s) with community partners or key stakeholders to discuss new ways to raise awareness of Healthy Start programs/services. C. Provide and disseminate social media posts of related content (15 per month).
Strategy 3.6	Continuously collaborate with Indian River County maternal and child health stakeholders, agencies, medical providers and clients to improve community conditions. Action Steps:

	A. Four (4) communication touch points (Office meeting, office Staff appreciation, personal email, speaking at Medical Society or dept. meeting) per year to OB, Pediatricians, midwives, other birth workers. B. Twelve (12) one on one meetings with C level (ask to bring someone who does not know about HS). C. Connect with Managed Care Organizations (6-Sunshine, Humana, Prestige, Stay Well, Florida Community Care, Miami Children's MMA).
Strategy 3.7	Build awareness of current statistic and trends in MCH of education and involvement with key MCH issues in Indian River County. Action Steps: A. Host focus groups two (2) a year. B. Healthy Start Family story – one (1) personal family story each quarter. C. Meet with two (2) social service agencies a month. D. Twenty-four (24) media prints per year E. Four (4) speaking engagements per year F. Four (4) e-newsletters G. FIMR information release H. Four (4) mailings to legislators per year personal stories I. Two (2) legislative visits per year J. Ensure that "A Program of IRCHSC" is included on all program materials

Goal 4	**To improve the knowledge, attitudes, and behaviors of men and women related to preconception health and sexuality education.**
Strategy 4.1	Gain community buy in for the importance of preconception health and sexuality education Action Steps: A. Form a diverse Preconception Health Workgroup comprised of funders, elected officials, community organization representatives, nonprofit leaders, medical professionals and public health professionals, school district personal, and private school leads. B. Assess Indian River County School District life course model highlighting of preconception health and sexuality education activities currently occurring in Indian River County and resources (funds, staff, technology, curriculum) being used. C. Complete SWOT analysis. D. Research evidence base preconception health models. E. Determine options for activity plan or curriculum. F. Compare current local data contrast with state and communities in which these activities are currently happening. G. Gain consensus around initiatives and curriculum or program to be used county wide.
Strategy 4.2	Implement Preconception Prep Program (PPP) Action steps: A. Based on recommendations from Preconception Health Workgroup, create action plan for launch of program.

Goal 5	**To continue the Indian River County Fetal and Infant Mortality Review (FIMR), educate community as to the results, and begin to implement strategies recommended.**
Strategy 5.1	Facilitate Indian River Counties 2019-2020 Fetal and Infant Mortality Review (FIMR) with Healthy Start Coalition and Community Partners Action Steps: A. Work with contractors, and other key stakeholders serving on the project steering committee, to address and resolve barriers experienced in project implementation. B. Meet/Attend Case Review team and Community Action Team Meetings. C. Continue informal quarterly FIMR with partners to review progress on goals set and review current cases.
Strategy 5.2	Publicize information found Action Steps: A. Conduct/Facilitate FIMR Summit. B. Disseminate and publish information found in FIMR findings.

IV. Community-Wide Initiatives

In addition to the 2021-2022 Annual Action Plan, IRCHSC addresses community needs by implementing other community-wide initiatives. Currently, IRCHSC is looking to implement the following programs:

Preconception Health Prep Program (PPP):

During the Fetal and Infant Mortality Review, the Community Action Team identified an area of need throughout the community to be preconception and sexuality health. The Indian River County Healthy Start Coalition is currently working with the Indian River County School and community partners to evaluate what is currently being implemented within our county, as well as developing new and innovative ideas to help fill this need among the community.

Maternal Opioid Recovery Effort (MORE):

This project's purpose is to work with providers, hospitals, and other stakeholders to improve identification, clinical care, and coordinated treatment/support for pregnant women with opioid use disorder and their infants.

"No One Told Me That":

Community Health Campaign was identified through the FIMR-Community Action Team with the intention of addressing Awareness and Education on Issues Affecting Newborns and New Moms. This campaign includes stories and testimonials from women in the community. Messaging should include information for mothers, fathers, and other caregivers.

Childbirth Education:

Partnership with the Daisy Hope Center to host group parental education classes. A recently released study found that Centering Pregnancy (group prenatal care):

1. Reduced early preterm delivery (before 32 weeks) to 1.3% compared to 3.1% for individual care.

2. Reduced preterm delivery (before 37 weeks) to 7.9% compared to 12.1% for individual care.
3. Virtually eliminated the racial disparity in preterm birth for Black women relative to white and Hispanic women (Retrieved from: https://www.centeringhealthcare.org/why-centering/research-and-resources).

Car Seat Program:

The Florida Department of Transportation Safety Office funds the purchase and distribution of car seats to trained/qualified Child Passenger Safety (CPS) instructors and technicians. Car seats, along with a demonstration of proper fitting and function, are available to individuals who meet and sign the Poverty Certification Form.

Direct On Scene Education (DOSE):

An innovative attempt at eliminating sleep-related infant death due to suffocation, strangulation, or positional asphyxia by using First Responders to identify and remove hazards while delivering education on scene. First Responders are trained to identify and remove hazards from an infant's sleep space while on the scene during an emergency and non-emergency 911 calls.

The Fatherhood Initiative:

The Indian River County Healthy Start Coalition recently introduced a Doula Dad class to the community. In an effort to engage more father and male caregivers, IRCHSC would like to create a new initiative to help support this target group and provide them with the education and resources that are needed to make them successful parents and caregivers.

F. Staffing Structure

I. Logic Model

Our Mission: To establish and support a local system of support services that optimizes the health of moms, babies, and their families living in Indian River County.

Our Values: Diversity, Integrity, Relationships, Excellence.

Our Vision: To see every infant has the opportunity for good health and positive early learning experiences that unfold within strong family relationships.

Our Goals:

Prevent infant mortality by focusing on the top causations: sleep-related death, preterm birth, and low birth weight.

Prevent material mortality focusing on the top causations: opioid overdose and hemorrhage.

Reduce racial disparities in maternal-child health outcomes.

Improve men and women's knowledge, attitudes, and behaviors related to preconception health and sexuality education.

Continue the process of Fetal and Infant Mortality Review (FIMR), educate the community as to the results, and begin to implement strategies recommended.

Inputs	Activities	Systems Outputs Short-term	Intermediate Outputs	Long Term Outputs

• Coalition Leadership
• Connection to community
• Diverse Healthy Start Staff
• Evidence based programs:
  ○ Parents as Teacher
  ○ Nurse-Family Partnership
• Innovative home grown programs:
  ○ Doula
  ○ Babies & Beyond
• State-wide System of Care
  ○ Health Education
  ○ Coordinated intake and Referral
• Cleveland Clinic Indian River Hospital
• Department of Health, Indian River County
• Other community partners (leaders, organizations, and stakeholders)
	• Empowerment based models
	• Safety net in place in referral system- 95% of families seen
	• Everything is built from relationships with community
	• Contract Management
	• Fundraising
	• Continuous community involvement
	• Continuous quality assessment and improvement (QA/QI) meetings
	• Analysis of assets, gaps
	• Strategic planning
	• Data tracking, reporting
	• Marketing and presentations about progress
		• Parent confidence and knowledge improves
		• Families connect with supports needed in community
		• Families connect with peer supports
		• Children receive regular developmental screening and a health review, including hearing and vision.
		• Most families are seen by Healthy Start (95%)
			• Community sees Healthy Start as the trusted resource for information on parenting 0-3
			• Stigma reduces for acceptance for services
			• Demand for programs grow
			• Funding from local sources increases
			• As programs expand, families are easily able to access care and support
				• Increase in healthy pregnancies and improved birth outcomes
				• Increased Kindergarten Readiness rates
				• Knowledge is embedded with people in community

II. Community Partners – Subcontracts

Florida Department of Health

IRCHSC contracts with the local Department of Health to ensure that the Healthy Start Prenatal Risk Screen data is entered into the Health Management System (HMS). The Health Department also houses the Registered Nurse for the Nurse-Family Partnership Program. The Health Department and IRCHSC work closely to monitor and track Maternal and Child Health data within Indian River County.

Cleveland Clinic Indian River Hospital

IRCHSC is fortunate to have a committed partnership with Cleveland Clinic Indian River Hospital (CC-IRH) with an aligned mission to provide the best system of care that serves Indian River County's maternal and child health community. In 2020, CC-IRH signed a five-year contract with Indian River County Healthy Start Coalition to provide the following services:

1. Lead Agency Designation: CC-IRH is designated as the Lead Agency for Healthy Start Health Education Services and related activities in Indian River County.

2. Healthy Start Screening: CC-IRH shall assist IRCHSC in promoting the use of the Healthy Start Prenatal and Infant (postnatal) Risk Screening instruments by community prenatal and infant care providers. Where applicable, CC-IRH will work with their prenatal staff to meet screen rate goals and will collaborate with IRCHSC staff to provide training and education as necessary.

3. Coordinated Intake and Referral/Maternity Navigation: Informs all program participants about the various services for which they are eligible and makes referrals as appropriate. Referrals are then tracked. Program activities include the completion of a universal risk screen, referral to Healthy Start programs, referral to community-wide agencies/organizations, connection to resources (essential items), and client/infant follow up.

4. Comprehensive Healthy Start Health Education: CC-IRH shall continue to offer Healthy Start's system of care, including the following: Coordinated Intake and Referral System, Mothers and Babies curriculum, the ICC's curriculum, and utilizing new screening tools processes such as ASQ's and Edinburgh, Tobacco screening, substance screening, and intimate partner violence screening.

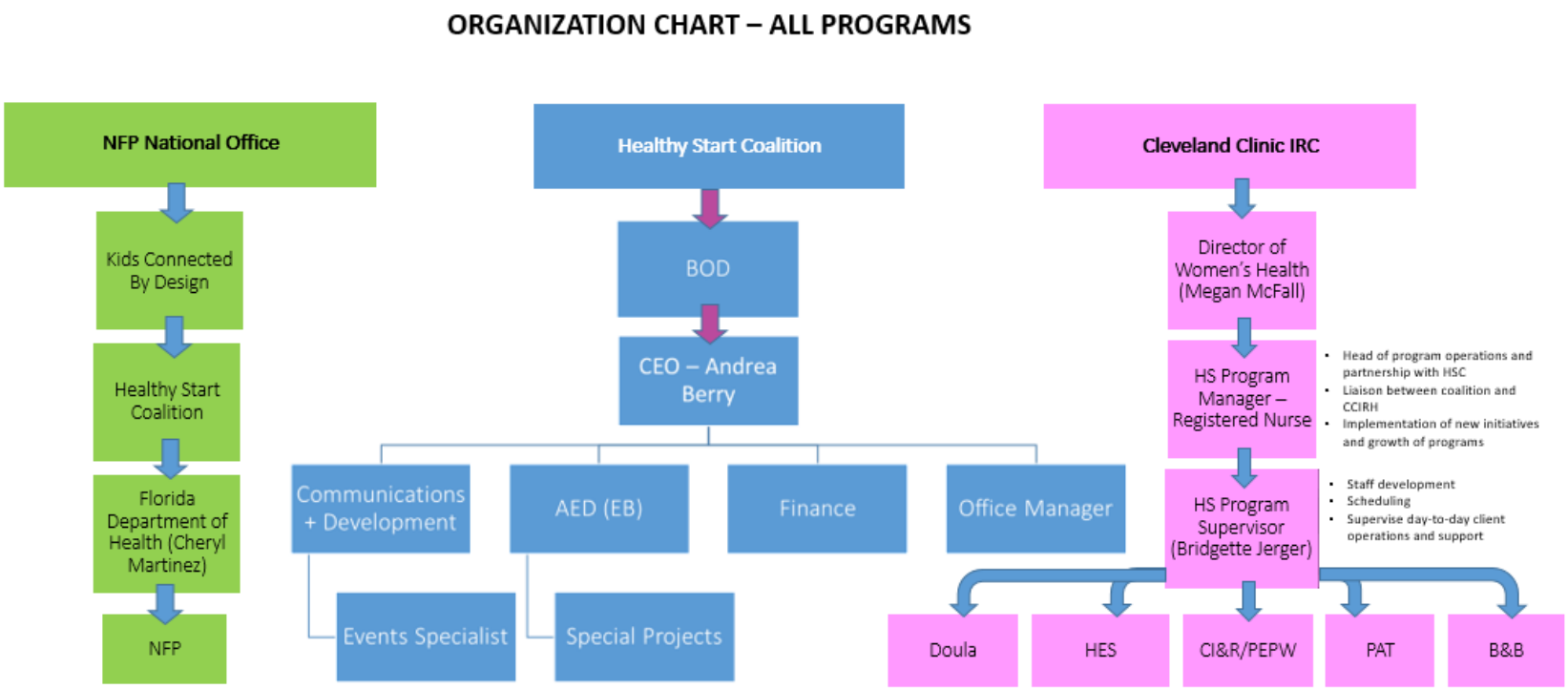
5. Babies and Beyond: Certified Lactation Counselors (CLC) housed at Cleveland Clinic Indian River Hospital will provide a visit to each mom that delivers at the hospital. Moms will receive guidance and support from a CLC for breastfeeding and safe sleep. Mom and baby will be offered a home visit by an RN after hospital discharge. During the visit RN will assess mom and baby and complete a home safety check, as well as referrals to community organization or medical home when needed. Mom will be referred to mom and developmentally appropriate baby playgroups for continued support and evidence-based parent education. This program is designed to increase health literacy, strengthening parenting skills, and ensure that each baby in Indian River County gets the healthy start they deserve.

6. Parents as Teachers - Expanded Healthy Start (Ages 0-3) and Training: CC-IRH shall provide services to selected families with children age 0-3 years old. The Parents as Teachers model has been selected for use in the parenting education standards for Health Coordinators. Appropriate staff will attend Parents as Teachers regular training. Health Education and other Healthy Start services shall be provided to each family as needed. Compliance with well-child appointments, immunization schedules and participation in other programs such as WIC (when applicable) will be emphasized. Doula services will be provided to those in need of more support and education on pregnancy health literacy.

7. Community Doula Program: CC-IRH shall assist with all activities related to the management of the Community Doula program. Responsibilities include, but are not limited to the planning, preparation, and the facilitation of trainings, contract management (new contract and renewals), Doula assignment, reporting, funder requirements, and QA/QI meetings.

8. Healthy Start Training: CC-IRH, subject to available funding, shall attend specific Healthy Start training models in order to move Healthy Start towards research-informed and/or evidence-based service delivery. CC-IRH will be notified of which trainings are deemed necessary.

III. Organization Chart – All Programs



IV. Long-Term Planning

To meet the growing needs of Indian River County, identified through the ongoing Fetal Infant Mortality Review and community appeals, IRCHSC has proposed several areas of expansion throughout current programs, to allow for IRCHSC to serve more clients (contingent on funding).

Presumptive Eligibility for Pregnant Women (PEPW):

PEPW assists eligible pregnant women to immediately receive prenatal care through Medicaid for up to 45 days while their eligibility for full Medicaid benefits is determined. Early access to prenatal care has been identified by the Health Improvement Planning, Infant Mortality Workgroup as a critical component in helping to reduce infant mortality. The PEPW program is designed to improve pregnant women's early access to outpatient prenatal services. PEPW is currently offered only at the County Health Department, adding an additional step for mothers who do not have insurance to enter into prenatal care. However, the addition of this service to our coordinated intake and referral program located in the prenatal care provider offices, county hospital, or other accessible locations will enable our highest risk mothers to become connected with prenatal care sooner, which is our greatest defense against infant and fetal mortality once pregnant. The PEPW program merged with coordinated intake and referral/maternity navigators within Partners in Women's Health medical office will enhance early prenatal care, which leads to better birth outcomes, healthier babies, and, consequently, lower medical costs.

Postpartum Doula Expansion:

The Postpartum Doula program would be an expansion of the existing Community Doula program. The program will be offered to any qualifying pregnant women who reside in Indian River County. The potential clients are identified through the Universal Healthy Start prenatal risk screen of pregnant women with all local providers. Clients will be introduced to the Maternity Navigator through the Coordinated Intake and Referral process and will be informed of the Postpartum Doula program and the benefits associated with program participation. All Healthy Start programs inform clients about doula services and make referrals, as appropriate. Doulas will connect with their families at the bedside at Cleveland Clinic Indian River Hospital after the birth of their baby. Each family will be given up to fifteen hours of in-home support. The doula will work with the family to find the times, days that work best for them. This may mean that the doula is coming in to help from 6am-9am or 11pm-1am. The needs of each family will be different. Regardless each family will have a check-in at four weeks, eight weeks, and twelve weeks. Screenings will be given during these times to check progress and education and provide support.

As the services provided by a postpartum doula differ from those of a birth doula, an additional annual training will be held at no cost to those who apply to become a Postpartum Doula and are approved by IRCHSC. The trainings will cover the following topics: Becoming a Mother, Newborn and infant care, Breastfeeding, Family Building, Sleep, Perinatal Mood and Anxiety Disorders, Birth, Multiples, and The Mother's Changing Body. This training will ensure the postpartum doulas are prepared to meet the client where they are in terms of their fourth-trimester challenges and obstacles, as well as help them celebrate their successes. As the program grows, IRCHSC would like to add a volunteer component. IRCHSC often gets volunteers wanting to help families directly with babies and family support. Till now, that has not been possible due to the nature of the programs. However, this program would allow trained postpartum doula volunteers to help families hands-on.

Programmatic Growth and Sustainability:

Babies & Beyond, RN- 1 FTE: As the Babies and Beyond program continues to grow and serve more of the community, this results in the need to hire additional staff. Currently, this program has (1) Registered Nurse (RN) who conducts nurse home visits. Only having one registered nurse to serve all of the Babies and Beyond clients becomes problematic when availability becomes restricted. If a second nurse is added to the Indian River County Healthy Start Coalition (IRCHSC) and Cleveland Clinic Indian River team, this will result in an expansion of home visits, as well as having this nurse complete CPR training/instruction within the home while completing beneficial assessments such as weight check (on baby), physical assessments and vital signs (on mother and baby), additionally adding a discharge class each day to educate every family about safety (CPR & Safe Sleep), breastfeeding, and resources in the community.

Nurse-Family Partnership, RN- .5 FTE: The NFP program provides valuable services to mothers, babies, and families by addressing and influencing the reduction in the number of babies not reaching their first birthday. This is made possible because clients/participants are provided with the opportunity to create a stable living environment, being successful in raising their children while building long-term changes. As the NFP program continues to gain momentum and serve more of the community, this results in the need to hire additional staff. Currently, this program has (1) Registered Nurse (RN) who conducts nurse home visits. Only having one registered nurse to serve all of the NFP clients becomes problematic when availability becomes restricted. The second halftime nurse helps elevate the waitlist for clients and allows IRCHSC to serve a higher rate of high-need families within Indian River community.

Doula Program Supervisor-1 FTE: The Fetal and Infant Mortality Review (FIMR) addressed the need for this expansion. The FIMR project reviewed eighteen infant deaths. Fourteen of the eighteen of these infant deaths happened in the fourth trimester. This time is when mothers and babies are most vulnerable and when they need the most support. However, it is often when they are the most isolated. COVID-19 has enhanced that isolation. IRCHSC wants to bridge that gap and ensure each family has the support that they need. As the Community Doula program continues to grow and expand into the fourth trimester, this will result in the need to hire additional staff, a Program Supervisor. The postpartum expansion also allows Healthy Start to create a postpartum doula volunteer opportunity. This kind of increase will require a Program Supervisor to ensure that this program, along with the expansion, remains successful and serves the community as intended.

Program Data and Sustainability Coordinator- 1 FTE: The Program Data and Sustainability Coordinator would be responsible for data collection, data management, and reporting. This role would elevate administration tasks currently completed by the Associate Executive Director and Chief Executive Officer. This would allow IRCHSC to address outcomes associated with COVID-19 and create innovative services/programs to meet the needs of the Indian River community and to continue to expand deeper levels of philanthropy.

Parents as Teachers-.5 FTE: In 2014, when the Children's Needs Assessment was conducted, the need for early childhood education and improved kindergarten readiness became a community priority. In order to assist in the increase of kindergarten readiness rates, IRCHSC, along with community leaders, assessed many evidence-based programs, with their final selection being the Parents as Teacher program. Since implementation, PAT has been partially funded (60%) through local grants (Children's Services Advisory Committee, John's Island Community Service League, and United Way). The remaining (40%) was funded through IRCHSC's biggest fundraising event, Dancing with Vero's Stars. As a result of

Covid-19, IRCHSC has been unable to host this event for the last two years, which has resulted in this program operating at a loss for the unforeseeable future. This program continues to expand to meet the needs of this community. This program will need to add an additional .5 part-time Parent Educator.

G. Allocation Plan for Healthy Start Direct Service Funds

I. 2021-2022 Allocation Plan

Projected Subcontracted Services Costs									
Funding Sources	Coalition Operating Funds	Up to 10% Total DOH funds-Indirect Costs	Coordinated Intake and Referral Funds	Subcontracted Provider Funds	Total DOH Funds	Medicaid	Other Funding (FUNDRAISING & GRANTS)	Other Funding (Other Programs)	**GRAND TOTAL**
Cleveland Clinic Indian River Hospital	$0.00	$0.00	$0.00	$166,651.46	$166,651.46		$2,000.00		**$168,651.46**
Indian River County Health Department									**$0.00**
Subcontracted Service Cost Total	$0.00	$0.00	$0.00	$166,651.46	$166,651.46	$0.00	$2,000.00	$0.00	$168,651.46
Percentage	0%	0%	0%	100%	99%	0%	1%	0%	100%
TOTAL	**$95,817.86**	**$83,172.45**	**$28,954.96**	**$166,651.46**	**$374,596.74**	**$55,277.66**	**$62,287.54**	**$0.00**	**$492,161.94**

H. Quality Assurance and Quality Improvement Plan

Improving the quality of the programs funded by the Healthy Start Coalition requires a coordinated effort by the organization. It is the IRCHSC's responsibility to guarantee that all pregnant women and children birth to age three who are determined to be eligible continue to receive quality Healthy Start services. To monitor effectiveness, both internally and externally, quality assurance and quality improvement (QA/QI) measures have been put in place. Healthy Start programs and services must adhere to the Healthy Start Standards and Guidelines so that services are provided in a manner that meets the needs of the participants. QA/QI also monitors contract performance expectations within the allocated contract amount and offers technical assistance as needed to assist in defining an overall funding strategy to accomplish these aims. A systematic approach is used by the IRCHSC to monitor all aspects of Healthy Start, both internally and externally. The plan will be data-driven and focus on continuous improvement. The goals of the Quality Assurance and Quality Improvement Plan are as follows:

1. To ensure that the established levels of quality care are maintained and continuously improved by all providers through:
    a. The monitoring and evaluation of the care, services, and processes provided to Healthy Start participants in order to identify areas for improvement and deficit trends;
    b. The implementation of corrective actions when deficit trends and opportunities for improvement are identified; and
    c. Monitoring and evaluating the resolution of the problem or opportunity for improvement to ensure the corrective action has been effective.
2. To ensure appropriate utilization of services, timeliness of service provision, and accessibility to services through:
    a. Ongoing review of state and local reports to examine the status of process indicators, performance measures, and outcomes;
    b. Establish performance improvement projects when expected target goals are not being met; and
    c. Re-evaluate processes implemented for continuous quality assurance.
3. To ensure IRCHSC's operations are in compliance with state statutes, contract requirements, and internal quality standards through:
    a. Self-monitoring of compliance on an annual basis with internal monitoring tool by Board and staff.
    b. Accomplishment of goals and objectives in the Service Delivery Plan.
    c. Clear Impact
4. To ensure the effectiveness of the Quality Assurance and Quality Improvement Plan through:
    a. The integration of information from all quality assurance and improvement activities;
    b. The assessment of the monitoring and evaluation process to determine its effectiveness; and
    c. Appropriate revisions to the program and/or service delivery plan as identified through the annual evaluation.

I. Organization

The QA & QI Improvement Plan is designed to encourage participation by Healthy Start staff, Coalition members and contracted providers to provide usable data to assess service performance in relation to the Service Delivery Plan for Indian River County, Healthy Start Standards and Guidelines, and



IRCHSC's adherence to contract requirements and State statutes. Other indicators of quality and appropriateness may be assessed based on the specific needs of Indian River County for future planning or special projects.

QA/QI Improvement Measures:

Responsibilities: In order to ensure quality assurance and improvement, a QA/QI improvement Committee is needed. The QA/QI Improvement Committee shall be responsible for ensuring the monitoring and evaluation of contracted services based on the most current Healthy Start Standards and Guidelines. The committee will also review quality improvement activities of IRCHSC relative to internal standards and utilization of services for input into the revision of the QA/QI Improvement Plan annually.

Participation: The membership of the QA/QI Improvement Committee will include Healthy Start Coalition staff, coalition members, or other qualified individuals in the community deemed to have the requisite knowledge that would benefit the quality improvement program. The Chief Executive Officer will staff the committee. The committee will include a diverse group of professionals who have experience or background in nursing, social services, counseling, program management, contract management, and/or quality improvement. Committee members are advised to discuss any conflict of interest that may arise. A conflict of interest, as well as a confidentiality document, must be signed.

Meetings: The QA/QI Improvement Committee will meet bi-monthly. These meetings will address a review of monitoring tools and procedures for each contract year and an annual review of the QA/QI Improvement Plan with recommendations for revisions. The minutes will be sent to committee members within 30 business days after the date of the meeting. Minutes will be kept and maintained by IRCHSC Staff. All committee meeting minutes will be forwarded to the Chief Executive Officer prior to them being sent to the QA/QI Improvement Committee.

Trainings: Healthy Start staff, Coalition members, and contracted providers will attend applicable trainings related to improving the quality and appropriateness of care and services being provided to Healthy Start families/participants and the residents of Indian River County.

Complaints and Grievances Procedures: A complaint is defined as any expression of dissatisfaction by a client, including dissatisfaction with the administration or provision of services, which relates to the quality of care provided.

Clients are advised, through written information provided by the Healthy Start Coalition, how to obtain help with a problem or concern related to their services. Information is given on how to file a complaint or grievance if the problem or concern cannot be resolved.

II. Quality Performance Standards – Department of Health Contract 2019-2020

Seventy-five percent (75%) of Healthy Start clients enrolled in Prenatal or Infant Child Pathway shall be screened for depression using the Edinburgh Post-Natal Depression Screen according to the schedule outlined in the Perinatal Depression Screening Intervention Pathway.
Seventy-five percent (75%) of Healthy Start clients who were screened for depression and had a positive score shall be referred to available services for depression based on the recommended Perinatal Depression Screening & Intervention Pathway.

Seventy-five percent (75%) of Healthy Start infants enrolled on the Infant Pathway will receive the required ASQ-3 or ASQ-SE developmental screenings based on the schedule outlined in the Development Screening & Intervention Pathway.
Seventy-five percent (75%) of infants who score below the cut-off value on the ASQ-3 or ASQ-SE shall be referred to the available service Screening & Intervention Pathway.
Seventy-five percent (75%) of post-partum women enrolled in the Interconception Care Pathway shall receive education on the Florida Family Planning Waiver.
Seventy-five percent (75%) of completed initial intakes will be referred to home visiting program.
Forty-eight percent (48%) of home visitation participants will complete the pathways.

Remediation Strategy: The Indian River County Healthy Start Coalition and/or contract providers are in jeopardy of not meeting contractual requirements; the Network must be notified within five (5) business days of discovery.

Performance Improvement Plan (PIP): Indian River County Healthy Start Coalition shall ensure that a PIP is developed and approved by the HSMN, in the event that quality performance standards are not being met. Indian River County Healthy Start Coalition shall ensure that each quality performance standard includes baseline data (when available), and specific goal measurements to be achieved and maintained. Indian River County Healthy Start Coalition shall ensure that the PIP is updated quarterly and submitted to the Network for approval or further revisions. At minimum, Indian River County Healthy Start Coalition shall ensure the PIP contains:

1. Identification of the quality performance standard that was not met;
2. Current performance on the quality performance standard and the goal to be achieved (with milestones for completion clearly delineated);
3. Delineation of services and processes that should be maintained and those that need improvement;
4. Identification of strategies and process changes designed to directly improve the performance outcomes and those that will be discontinued because they have been determined to be ineffective; and
5. The status of progress towards full implementation of strategies and their impact on the performance outcome.

III. Service Delivery Monitoring of Contracted Providers and Program Outcomes

The purpose of service monitoring is to ensure important aspects of care are being provided as outlined in the most current edition of the Healthy Start Standards and Guidelines. Procedures and protocols are reviewed to ensure compliance with the contract, including adequate staffing, reporting, coding, quality improvement activities, and data entry. Documentation of service provision is reviewed to ensure risk-appropriate services are being offered at the intensity indicated per the system of care established, as well as the needs of the mothers and babies are being met. The effectiveness of programs and services in relation to established performance and outcome measures is evaluated as established in the provider's contract.

Activities: • Administrative Review of Contract Requirements • Annual Record Evaluation of Performance and Outcome Measure Goal Attainment (Per Provider)



- Annual Data Reports
- Satisfaction Survey Results

Process:

- At the beginning of each contract year, a schedule of reporting deadlines and monitoring's will be completed by the Associate Executive Director. Each provider will be monitored annually during the contract year. The contract for each provider includes data reporting forms, monitoring tools and performance measure reports. No monitoring tool will be used that has not been negotiated with providers prior to the monitoring.
- Prior to each administrative monitoring, the provider will receive written notification confirming the date, time, location, and staff that will participate in the monitoring.
- Each administrative monitoring will include an entrance and exit conference; unless specified otherwise. The Chief Executive Officer will lead these reviews. The purpose of the entrance review is to go over the purpose of the monitoring, schedule for the review, and answer any questions. The exit review will provide a brief synopsis of the findings. A written report summarizing the findings and identifying any corrective action requirements will be mailed to the provider within 60 working days of the monitoring visit. The monitoring report is to be completed by the Associate Executive Director and approved by the Chief Executive Officer. If a corrective action plan is required, the provider will be given 30 working days to submit the plan to IRCHSC.
- The record review reports from service providers will be reviewed by the Associate Executive Director to assess documentation quality and status of performance measure attainment. Special attention will be given to provider's adherence to any corrective action or quality improvement plans.

IV. Client Care Monitoring of Coordinated Intake and Referral

The purpose of client care monitoring is to ensure that the program is meeting contract requirements in service provision, documentation standards, performance measure goal attainment, and participant satisfaction with the program, and that the participant's needs are being met.

Activities:

1. Quarterly Record Review of Service Tasks and Outcome Measure Achievement
2. Quarterly Data Reports
3. Annual Administrative and Service Provision Monitoring

Process:

1. At the end of every quarter the Associate Executive Director will facilitate a record review from the WFS database.
2. Monthly data reports pertaining to service delivery will be conducted utilizing WFS.
3. Resource Utilization Review/Utilization Management

V. Healthy Start Universal Risk Screen

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

Activities: 1. Review of prenatal and postnatal screening rates from Florida CHARTS/ Department of Health – Indian River County 2. Review of the reports in Well Family System (WFS) 3. Prenatal and Postnatal Screens to Care Coordination
Process: 1. Every Quarter, the Associate Executive Director and the Connections Specialist will review prenatal and postnatal screening rates. The Connections Specialist reports will be used to assess individual health care provider screening rates and examine any inconsistencies with the WFS reports. The Connections Specialist will target improvement plans with health care providers demonstrating negative trends in screening rates. The number of prenatal and postnatal screens referred to care coordination will be tracked to establish referral trends and impact on care coordination resources.

VI. Quality Management of IRCHSC Operations

The purpose of quality management in the operations of IRCHSC is to ensure maintenance of contract requirements, adherence to written policies and procedures, to monitor internal standards and to ensure the community/client's needs are being met.

Activities: 1. Monitoring of contract requirements and tasks required in statute
Process: 1. Coalition staff has established general qualities and internal standards related to professionalism, working environment, knowledge base and accuracy of communication, and timeliness in responding to the community and providers. 2. Coalition staff will meet on at least twice per year to conduct a self-review.

I. Resource Inventory

I. Local Provider and Community Resources

In an effort to continue to move the needle, the Indian River County Healthy Start Coalition continuously reviews past community plans and evaluates local resources to ensure that Indian River County residents are receiving the best care available. Resource inventory provided below.

Delivery System: Both Indian River Memorial Hospital (IRMH) and Sebastian River Medical Center (SRMC) delivered babies in the 1990s, with IRMH providing delivery services for unfunded women. In 2000, Sebastian River Medical Center, located in the northern part of the county, stopped delivering babies and discontinued maternity services. In 2019, Indian River Medical Center transitioned to Cleveland Clinic Indian River Hospital (CCIRH). CCIRH is the only hospital in the county providing maternity care services. Indian River County residents also deliver at birthing centers located in neighboring counties: Brevard to the north and St Lucie to the south. High-risk deliveries are usually performed at Arnold Palmer Hospital in Orlando, which has a high-risk neonatal unit.

Provision for Unfunded Care: In the early 1990s the Indian River County Health Department provided prenatal care for Medicaid recipients and unfunded (Indigent) patients delivering at Indian River Memorial Hospital. Prenatal care and delivery for unfunded women was supported through indigent health care funds from the Indian River County Hospital District, an independent taxing authority. In 1995 the Hospital District and Indian River County Health Department transferred prenatal and postpartum care to a practice formed by the District and Indian River Memorial Hospital, Partners in Women's Health (Partners). The Indian River County Health Department continues to be the entry point for Partners by conducting pregnancy testing, determining PEPW eligibility, offering HIV testing, facilitating entry into WIC, distributing prenatal vitamins, and obtaining the initial prenatal care appointment at Partners.

Pregnancy Testing Sites: Indian River County Health Department provides low-cost medical pregnancy testing. Cost is determined by a sliding fee scale. Women's Care Center offers pregnancy testing at no cost; if the test comes back positive, a free ultrasound is also provided. CareNet Pregnancy Center of Indian River County also provides a self-administered pregnancy test at no charge.

Prenatal Care Providers: Indian River County obstetricians include (Dr. Felix Bugay, Dr. George Fyffe, Dr. Alfonsina Garcia-Bracero, Dr. Deni Malave-Huertas, Dr. Cristina McClure, Dr. James Presley, Dr. Rosana Salama Bello, and Dr. Jeff Chapa. Treasure Coast Community Health Center provides affordable gynecologic health services such as Special population services, Gynecologic surgery, Pap testing, Colposcopy and Cryotherapy, Evaluation and treatment of gynecologic and breast conditions, Evaluation of endocrine dysfunction and infertility, Menopause diagnosis and management, sexually transmitted infection testing and treatment and Detection and management of sexual and psychosocial issues.

Maternal-Fetal Medicine: In 2020, Cleveland Clinic Indian River Hospital started offering Maternal-Fetal Medicine services. Their unique team-based approach gives women who seek care for pregnancy-related complications many advantages. Patients will have immediate access to experts in the care of high risk pregnancy. The maternal-fetal medicine specialists or perinatologists primarily provide consultative services to obstetricians throughout the Treasure Coast to manage a wide variety of problems that can arise during pregnancy.

Infant Care and Child Services: Currently, Indian River County has eight locations that provide pediatric care. Indian River County Health Department also provides Dental services at reduced rates. Clients may apply for an indigent care program for financial assistance. Indian River County Department of Health provides childhood immunizations for residents of Indian River County. They offer free vaccines for children ages 2 months through 18 years who qualify for the Vaccines for Children (VFC) Program.

List of Prenatal Care Provider Offices:	
Partners in Women's Health	1050 37th Place Suite 101-OB/Suite 103-GYN Vero Beach, FL 32960
Women's Care Center	1986 31st Avenue Vero Beach, FL 32960
Treasure Coast Community Health (Gynecology)	Locations in Vero, Sebastian, and Fellsmere
Florida Women Care of Indian River County with Dr. Presley	1000 37th Pl, Vero Beach, FL 32960
Midwife Love, with Angela Love	126 43rd Ave SW, Vero Beach, FL 32968

List of Indian River County Pediatricians Offices:	
Whole Family Health Center • Accepts (Prestige, Humana, Staywell/Wellcare, Miami Children's, CMS, Clear Health Alliance)	981 37th Place Vero Beach, FL 32960
Dr. Surani & Dr. Wijetilleke • Accepts Medicaid (Prestige, & Staywell/Wellcare)	787 37th Street, Suite E 170, Vero Beach, FL 32960
Penny Pediatrics • Accepts Medicaid (Humana, Staywell/Wellcare, Sunshine, Miami Children's, Aetna Better Health, Amerigroup)	800 S Bay Street, Suite 4 Sebastian, FL 32958
Pelican Pediatrics • Private Insurance, unless sibling is an existing Medicaid patient	1382 US Hwy 1, Sebastian, FL, 32958
Treasure Coast Community Health • Accepts Medicaid (Prestige, Sunshine, Staywell/Wellcare, CMS, Humana)	Locations in Vero, Sebastian and Fellsmere
Dr. Laura L. Johnson, MD & Dr. Karen R. Westberry, MD (Nemours Children Primary Care) • Accepts Medicaid (Aetna Better Health, Humana, Molina, Staywell, CMS, Sunshine)	1155 35th Lane Suite 201A Vero Beach, FL 32960
Primary Care of the Treasure Coast (Dr. Saver) • Accepts Medicaid • Not a pediatric specialist, but provides Pediatric Care	1265 36th Street, Vero Beach, FL 32960
Treasure Coast Pediatrics • Private Insurance	3745 11th Circle, Suite 108, Vero Beach, FL 32960

List of Indian River County Primary and Urgent Care Providers:	
Whole Family Health Center Treasure Coast Community Health	981 37th Place Vero Beach, FL 32960

• Accepts all Medicaid plans if PCP is listed on the card • Walk-ins and Appointments	
Dr. Surani & Dr. Wijetilleke • Accepts Medicaid (Prestige, & Staywell/Wellcare)	787 37th Street, Suite E 170, Vero Beach, FL 32960
Care Spot • Sunshine Medicaid only • Can only use as an Urgent Care, not a PCP	1820 58th Ave #110Vero Beach, FL 32966
Indian River Walk-In • Private Insurance only • Can only use as an Urgent Care, not a PCP	640 21st Street Vero Beach, FL 32960
Treasure Coast Community Health • Accepts all Medicaid Plans • Walk-ins and Appointments	Locations in Vero, Sebastian and Fellsmere
Primary Care of the Treasure Coast (Dr. Saver) • Medicaid for infant only • Appointment only	1265 36th Street, Vero Beach, FL 32960

List of Community Providers of Early Intervention:	
IRC Health Department & EasterSeals Florida – Early Steps • Early Steps is Florida's early intervention system that offers services to eligible infants and toddlers, age birth to 36 months, who have or are at-risk for developmental disabilities or delays. Early intervention supports families and caregivers to increase their child's participation in daily activities and routines that are important to the family.	1900 27th St, Vero Beach, FL 32960
ChildCare Resources of Indian River County • According to the 2014 Indian River County Children's Assessment, early childhood development is the most important area in which the county should focus. The County Assessment states that opportunities for early childhood education are lacking, with a shortage of infant/toddler slots. United Way's ALICE report indicates that substandard childcare/education or no childcare/education are consequences of insufficient household income.	2300 Fifth Ave Suite 149 Vero Beach, FL 32960 USA
Kindergarten Readiness Collaborative (Moonshot Moment) • As part of the Moonshot Moment, all children in Indian River County are prepared for kindergarten across the five critical domains: social/emotional, physical health and well-	1555 Indian River Blvd, Suite B245 Second Floor Vero Beach, FL 32960 2459 St. Lucie Avenue (14th Ave.) Vero Beach, FL 32960

being, cognitive, communication, and adaptive learning. Early Learning Coalition • Partnering with parents, providers, and communities to ensure quality early learning experiences through programmatic and financial support.	
Castle • CASTLE Safe Families Vision ○ Every parent will learn the skills necessary to raise, discipline, and positively communicate with their children in a safe and nurturing manner. • CASTLE High Hopes for Kids Vision ○ Every child experiencing parental divorce or separation will have access to a support group with peers that help them learn about and cope with the divorce or separation. • CASTLE Families in Between Vision ○ Parents will learn how to make the transition from marriage to divorce or separation with minimal trauma to their children. • CASTLE Positive Parenting Vision ○ Parents will learn new parenting skills, including positive discipline techniques, and ways to improve communication with their children.	148 sta Royale Blvd, Vero Beach, FL 32962
Healthy Start Services (information provided below) • Healthy Families • Tykes & Teens • Parents As Teachers	

II. Maternal and Child Health Programs

Indian River County Healthy Start Coalition for pregnant women, babies, and families includes six programs: Health Education, Community Doula Services, Babies & Beyond, Nurse-Family Partnership, and Parents as Teachers. The programs complement each other and together complete the system of care in Indian River County.

Coordinated Intake and Referral (CI&R)/ Maternity Navigation: The Healthy Start coalitions have been tasked with establishing and maintaining a CI&R system of care in every county of Florida. For anyone acting as a CI&R worker, it is important to think of CI&R as separate from the Healthy Start program. The CI&R worker does not represent Healthy Start but instead represents all programs participating in CI&R. It is through CI&R that participants are contacted, assessed, provided information, and referred to home visiting programs and other community services. Eligibility for CI&R begins when a pregnant woman, interconception woman, or an infant/child is referred to CI&R by a health care provider, a community service provider, or through self-referral. In October 2020, the CI&R program was revised to provide additional services at two different touchpoints. The new CI&R

program now has two Maternity Navigators, formally Connections Specialist. Both Maternity Navigators administer a universal risk screen under Florida Statute 383.14. One Maternity Navigator (housed at Partners) is able to reach new moms at the beginning of their pregnancy with a prenatal risk screen. In contrast, the second Maternity Navigator (housed at Cleveland Clinic Indian River Hospital) is able to reach both mom and infant after childbirth with an infant risk screen.

The Healthy Start Program: The intent of the Healthy Start initiative is to assure all pregnant women and all young children in Florida have access to prenatal and child health care and services necessary to reduce the risk for poor outcomes. Most pregnant women and children have normal risk and need for prenatal and child health care services; however, others may need support and services tailored to reduce risk factors. The Healthy Start model provides a mechanism to identify and address increased risk, whether medical, psychosocial, or environmental. Other programs, such as the Regional Perinatal Intensive Care Program, Part C of the Individuals with Disabilities Education Act (formerly Part H), and the Children's Medical Services Early Steps Program, also provide services to those at increased risk for poor outcomes.

Once in a system of health care, pregnant women and infants are to receive screening for risk factors that make them more likely to experience preterm delivery or delivery of a low-birth-weight baby, or infant mortality, respectively. Offering Healthy Start risk screening to all pregnant women and infants is required by Florida Statute and serves to “funnel” those most at risk into the care coordination system for additional intervention. In so doing, risk screening reduces the population in need of further assessment to approximately 33 percent of all pregnant women and 14 percent of all infants. Because in 1997 Healthy Start children’s services were funded to age 3 years, and because no screen can identify all of the population potentially at-risk, Healthy Start allows providers to refer individuals they believe are at-risk “based on other factors (than score on the risk screen)”. Women and children birth to 3 years of age referred into Healthy Start based for other factors add to the population “funneled” into additional services. Additionally, women and parents of children birth to age 3 years who feel they have a need for Healthy Start services may self-refer for assessment.

Women and children birth to age 3 years identified as at risk for undesirable outcomes by screening or referral are required by the Healthy Start legislation to receive notification of their risk status. At initial contact, assets available to the participant to offset their risk status may be discussed and a determination made as to whether the participant needs further intervention or simply needs information about community resources and the name of a Healthy Start contact in the event circumstances change. Participants in need of further intervention are “funneled” into additional Healthy Start services, depending on the nature of their need. Some will need “tracking” for follow-up, some will need a thorough assessment to determine the full extent of interventions needed to offset their risk, and others will need some other Healthy Start services (e.g., tobacco education and cessation, parenting education, psychosocial counseling). Once the Healthy Start participant is opened to care coordination, the provider will use professional judgment and assessment skills in collaboration with the participant/family to determine the level of services needed.

Parents as Teachers: Parents as Teachers (PAT) provides at risk parents with the knowledge and skills to maximize their child's cognitive, social and emotional development. This education happens during the most crucial period of brain development, which is birth through age three. Areas of focus include: child development, parent child interaction, play activities designed to target developmental domains, and family well-being. PAT provides services in the form of weekly home visits to program participants from birth to three years old. The homes visit initially are completed once a week. Families receive services that assist them with learning how to promote their child's brain development, how to interact with their children, age-appropriate developmental play activities, and

family well-being. This program is a voluntary program; parents may decide to end services before their child's third birthday.

Nurse-Family Partnership (NFP): Nurse Family Partnership is a community health program that helps vulnerable mothers in specific targeted communities achieve a healthy pregnancy. This is attained by helping mothers engage in preventative health practices through early prenatal care, improving their diets, reducing their use of cigarettes, alcohol, and illegal drugs. NFP helps improve child health and development by assisting parents with responsible, competent care and building a positive future for their children. Mothers enrolled in the program receive free in-home visits from a registered nurse from the prenatal period through the baby's second birthday.

Healthy Families: Healthy Families, Indian River County is a voluntary program that works with either pregnant women or families of newborns to promote bonding and positive parenting. It is funded by the Ounce of Prevention through a grant with the Department of Children & Families and operates in nearly all counties. Families can become eligible by completing the Healthy Start prenatal screening (there is a separate score for the Healthy Families program on Healthy Start's screen) or they can complete a separate Healthy Families screening. Healthy Families and Healthy Start may overlap services for a short time so that the pregnant woman is engaged with Healthy Families prior to the birth of her child, but each program provides and coordinates different services to benefit the family. Most families are served by one or the other program. Family Support Workers model and instruct parents on how to engage their child with appropriate developmental activities. It is an intensive and prescribed model with goals that must be met before the parent and child graduate the program. Families feeling overwhelmed by the stress of parenthood often benefit most from Healthy Families.

The Healthy Start Community Doula Program: The Healthy Start Community Doula program supports, educates, and empowers pregnant women to take control of their health. The program will achieve this by providing prenatal educational support and continuous labor support to the laboring woman at the hospital. The services will continue postnatal. Specialized services are provided by a trained Doula. The program aims to improve birth outcomes and health literacy for residents of Indian River County.

Babies and Beyond Program: The focus of the Babies and Beyond program is on touching every mom, baby, and family in Indian River County, the Babies and Beyond program provides childbirth education, lactation support within the hospital, nurse home visitation to postpartum moms, and developmentally appropriate peer-to-peer play groups. This program is designed to increase health literacy, strengthen parenting skills, and ensure that each baby in Indian River County gets the healthy start they deserve.

III. Service Strengths

In 2018, the Indian River County Healthy Start Coalition, in collaboration with the Hospital District and Partners in Women's Health, embedded a Connections Specialist within the Partner's office to complete the Coordinated Intake and Referral (CI&R) program. This partnership allowed this program and the Connections Specialist to reach 95% of all Indian River County mothers. In October 2020, the CI&R program was revised to provide additional services at two different touchpoints. The new CI&R program now has two Maternity Navigators, formally Connections Specialist. Both Maternity Navigators administer a universal risk screen under Florida Statute 383.14. One Maternity Navigator (housed at Partners) is able to reach new moms at the beginning of their pregnancy with a prenatal risk screen. In contrast, the second Maternity Navigator (housed at Cleveland Clinic Indian River Hospital) is able to reach both mom and infant after childbirth with an infant risk screen. Both

Maternity Navigators inform all new moms and families about the various services for which they are eligible and makes referrals as appropriate. Referrals are then tracked. The Maternity Navigators follow up with program participants regarding services and overall satisfaction. Through community collaboration, the IRCHSC has simplified navigating services and programs available in Indian River County.

There are two Maternity Navigators available to the community by phone or in-person to help answer questions or concerns related to the client or potential client. One bilingual Maternity Navigator is located within Cleveland Clinic Indian River Hospital and is available five days a week from 9:00 am - 5:00 pm. The second Maternity Navigator is housed within Partners in Women's Health, is available five days a week, from 9:00 am - 5:00 pm.

In 2020, Cleveland Clinic Indian River Hospital implemented Maternal Fetal Medicine services for the Treasure Coast. Dr. Jeff Chapa is now seeing high-risk patients at Partner's in Women's Health. The Maternal-fetal medicine services include the following:

1. Maternal-Fetal Medicine Subspecialists (Perinatologists)
2. Genetic counselors and medical geneticists
3. ObGyn Hospitalists
4. Neonatologists (experts in the care of newborns)
5. Licensed sonographers
6. Perinatal nurses

In collaboration with community partners, IRCHSC provides childbirth education classes. The prenatal education classes help expecting mothers to become an informed parent before their baby arrives. IRCHSC uses the centering approach classes. This means that the focus is on the mother's needs and encourages sharing of knowledge and experiences – which builds bonds between parents that can last a lifetime. IRCHSC covers a wide range of topics including pregnancy nutrition, childbirth, coping with stress, babywearing, breastfeeding, infant care, brain development and milestones, infant CPR and post-partum self-care.

These classes are designed to work in conjunction with the mother's prenatal care; one for each trimester and then one post-partum. The goal is to see the mother and family four times during their pregnancy and post-partum period. IRCHSC has also launched a video library which provides free evidence-based informational videos that can be accessed at any time.

IV. Service Gaps

Indian River County has two hospitals, Cleveland Clinic Indian River Hospital and Sebastian River Medical Center, with only Cleveland Clinic Indian River Hospital having a designated labor and delivery unit. Cleveland Clinic Indian River Hospital does not contain a neonatal intensive care unit (NICU) or a Pediatric wing. As a result, any babies that are premature in Indian River County has to be sent to either Holmes Regional Medical Center in Brevard County or Cleveland Clinic Tradition Hospital or Lawnwood Medical Center, both located in Martin County.

Indian River County has limited treatment providers and centers for pregnant women or new mothers. IRCHSC is currently working with the Florida Perinatal Quality Collaborative and Cleveland Clinic Indian River Hospital on the Maternal Opioid Recovery Effort (MORE) and an effort to address this need within the Indian River community.



J. COVID-19

I. Response and Protocols

As a result of Covid-19, IRCHSC services have expanded. Each program converted to telehealth immediately to serve and support families with no disruption. Program staff also provided essential resources by dropping items off safely to clients at their doorstep. Program staff also assisted Cleveland Clinic Indian River Hospital on the labor and delivery floor as essential employees. To reach pregnant women and families during quarantine, IRCHSC provided evidence-based information to local families navigating pregnancy and parenting during a pandemic. There was also an increase in social media presence. The Chief Executive Office provided videos on policy updates, pregnancy questions, and answers, as well as helpful videos such as how to make baby wipes with essential oils and paper towels.

In June 2020, IRCHSC began transitioning staff back to the office. To allow for sufficient social distancing, IRCHSC continues to monitor and update policy changes as needed. As of April 2021, home visitation programs are operating via telehealth. However, the hospital-based programs (Doula and Lactation) are back in the hospital and provide face-to-face visits. IRCHSC hopes to return to home visits by July 1, 2021, with proper protocol and procedures in place. Program staff and IRCHSC continue to monitor and develop new ways to meet the needs of clients and community. IRCHSC has updated its Emergency Management and Disaster Recovery Procedures to put appropriate measures in place to properly respond to a biological agent emergency. The addition of this new protocol was approved at the January 2021 Board of Directors meeting.

K. Conclusion

The Indian River County Healthy Start Coalition has developed this Service Delivery Plan with the support and consensus from the Board of Directors and community members. The Community Needs Assessment and the Fetal and Infant Mortality Review have allowed IRCHSC to better understand the strengths and weaknesses of maternal and child health within the Indian River Community. IRCHSC is unwavering on the mission to provide every baby a healthy start by continuing to sustain and expand current programs. These programs address the Social Determinants of Health, provide education and awareness for pregnant and new mothers, and empower and educate Indian River County moms and babies who are most vulnerable. As IRCHSC looks at the next five years, the mission and vision have never been so bright. The priority areas of focus that have been identified align with Healthy Start's stated purpose to reduce infant mortality and low birth weight and improve the health outcomes of babies. IRCHSC is excited to continually improve the maternal and child health system of care to benefit all families throughout Indian River County.



M. Appendix

I. Board of Directors

IRCHSC Board Directors
2020-2021

Board Member	Contact	Term
Karen Campbell President Attorney (retired) 11 Gem Island Dr Indian River Shores, FL 32963	(248) 321-8037 (C) kcampbell@stclaircompanies.com	Jan 2019 -Jan 2022 (1st term)
Audrey Richards, MD Vice President Physician, Obstetrics and Gynecology (retired) 8388 Calamandren Way, Vero Beach, FL 32963	(772) 559-5601 (C) audreyvero@gmail.com	Nov 2020 - Nov 2023 (2nd term)
Charlene Kaplan Treasurer Audit Manager, Morgan, Jacoby, Thrum, Boyle 700 20th Street, Vero Beach, FL 32960	(312) 213-2121 (C) charlenekaplan@gmail.com	Nov 2020 - Nov 2023 (2nd term)
Karan Morein Secretary 191 Terrapin Point, Vero Beach, FL 32963	(772) 473-3503 (C) karancm2003@yahoo.com	April 2020-April 2023 (1st term)
Alan Temple Business Owner, Investor 1241 Indian Mound Trail, Vero Beach, FL 32963	(772) 473-0036 (C) alan@templefamilyco.com	April 2020-April 2023 (1st term)
Allen Jones 200 Beachview Dr #3S Indian River Shores, FL 32963	(772) 713-6721 (C) allennjones3@gmail.com	October 2020-October 2023 (1st term)
Frida Randolfi 1345 45th Avenue Vero Beach, FL 32966	(239) 692-7316 (C) fridaflores114@gmail.com	October 2020-October 2023 (1st term)

I. Partnering Agencies

Agency for Health Care Administration (AHCA)

Children's Services Advisory Committee

Department of Children and Families

Florida Department of Health

Exchange Club of Indian River

Grand Harbor Community Outreach

Indian River Community Foundation

Indian River County Hospital District

John's Island Community Service League

John's Island Foundation

Quail Valley Charities

United Way of Indian River County

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