Indian River County Healthy Start Coalition, Inc.

Service Delivery Plan

2026–2031

Healthy Start

Indian River County
Healthy Start Coalition, Inc.

1555 Indian River Blvd., Suite B241

Vero Beach, Florida 32960

(772) 563-9118

www.irchealthystartcoalition.org

Megan McFall, B.Ed., RN - Chief Executive Officer

every mother. every father. every baby. every family.

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Regulatory and Contract Deliverable Crosswalk

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1. Executive Summary

The Indian River County Healthy Start Coalition, Inc. (IRCHSC) 2026–2031 Service Delivery Plan establishes a comprehensive framework to guide the delivery, coordination, evaluation, and continuous improvement of maternal, infant, fatherhood, and family support services throughout Indian River County over the next five years. Developed in response to the findings of the 2025 Community Needs Assessment, this plan reflects a community-informed and data-driven approach to improving outcomes for pregnant women, infants, fathers, caregivers, and families.

The 2025 Needs Assessment identified ongoing barriers that continue to impact the health, safety, and well-being of families in Indian River County, including limited access to affordable healthcare, transportation challenges, housing instability, childcare shortages, workforce limitations, language accessibility barriers, behavioral health concerns, and gaps in awareness of available community resources. The assessment also highlighted ongoing concerns related to maternal and infant health outcomes and the need for stronger coordination among community providers, earlier intervention opportunities, expanded family support services, and increased access to care and education.

In response, the 2026–2031 Service Delivery Plan outlines IRCHSC's strategic priorities, service delivery model, and measurable objectives designed to strengthen the local maternal and child health system. The plan supports a continuum of care that promotes healthy pregnancies, positive birth outcomes, safe infant development, engaged fatherhood, family stability, and improved access to services for families throughout Indian River County.

The Service Delivery Plan serves as a guiding document for:

- Program planning and implementation
- Quality assurance and performance improvement
- Subcontractor oversight and accountability
- Funding allocation and resource development
- Community outreach and engagement
- Data collection and outcome monitoring
- Annual action planning and strategic decision-making

Throughout the 2026–2031 planning cycle, IRCHSC will prioritize evidence-based and community-informed strategies that address both immediate service needs and barriers that affect family stability and access to care. Focus areas will include improving service coordination, reducing barriers to participation, strengthening partnerships among community providers, increasing awareness of available services, supporting family engagement, and ensuring services are responsive to the needs of the community.

The Coalition remains committed to ongoing evaluation, stakeholder input, and continuous quality improvement to ensure services remain responsive to emerging community trends and family needs. Annual implementation plans, performance measures, and community feedback mechanisms will support accountability and allow for adjustments throughout the life of the plan.

Guided by its mission and vision, IRCHSC will continue working collaboratively with healthcare

providers, community agencies, local leaders, families, and other stakeholders to strengthen a coordinated system of care that improves maternal and infant health outcomes and supports healthy families across Indian River County.

Mission

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

Vision

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

2. Introduction and History of IRCHSC

Indian River County Healthy Start Coalition (IRCHSC) was established in 1993 in response to Florida's Healthy Start Initiative, a statewide effort created to improve maternal and infant health outcomes through community-based planning, service coordination, and early intervention. Since its inception, IRCHSC has served as the local organization responsible for assessing community needs, coordinating maternal and child health services, identifying gaps in care, and supporting families throughout pregnancy, infancy, and early childhood.

Over the past three decades, the Coalition has evolved into a comprehensive system of care focused on improving the health and well-being of moms, babies, fathers, and families in Indian River County. IRCHSC serves as a convener, planner, evaluator, advocate, and system builder, working collaboratively with healthcare providers, community agencies, educators, government partners, and families to strengthen access to services and improve outcomes across the community.

Today, IRCHSC supports a broad continuum of maternal and child health initiatives and wrap-around family support services, including coordinated intake and referral, care coordination, health education, childbirth education, lactation support, doula services, fatherhood engagement, home visiting, preconception health education, bereavement support, fetal and infant mortality review (FIMR), nurse home visitation and navigation, and community outreach. Through these programs and partnerships, the Coalition works to address barriers that may impact healthy pregnancies, infant development, family stability, and access to care.

The Coalition's work is guided by ongoing community assessment, stakeholder engagement, performance monitoring, and continuous quality improvement activities to ensure services remain responsive to the changing needs of Indian River County families. IRCHSC places strong emphasis on collaboration, accountability, and evidence-informed practices that support healthy birth outcomes, safe infant sleep, breastfeeding support, engaged parenting, and early childhood well-being.

The 2026–2031 Service Delivery Plan builds upon the foundation established in the prior 2021–2026 Service Delivery Plan and the Coalition's annual action planning process. The previous planning cycle focused on maternal and infant mortality reduction, preconception health, fetal and infant mortality review activities, fatherhood engagement, governance, workforce development, and organizational sustainability. The 2026–2031 plan continues these core

priorities while aligning service delivery strategies with the findings of the 2025 Community Needs Assessment, current contract requirements, community feedback, and emerging local trends impacting families in Indian River County.

As the Coalition looks toward the future, IRCHSC remains committed to strengthening partnerships, expanding awareness of available services, supporting families through coordinated care, and improving maternal and infant health outcomes through a responsive and community-centered system of care.

Programs & Services

Program	Services Provided
Maternity Navigation/Coordinated Intake & Referral	Connects families to prenatal care, community resources, and support services to promote healthy pregnancies and positive birth outcomes.
Healthy Start Home Visiting/Health Education	Provides personalized support, education, and care coordination to pregnant women and families with young children in the comfort of their homes focusing on improving maternal and infant health, strengthening parenting skills, and connecting families to needed resources.
TEAM Dad/Fatherhood Initiative	Empowers fathers and father figures through education, support, and mentorship to promote responsible fatherhood, healthy relationships, and positive family engagement.
GROW Doula	Provides trained birth doulas who offer continuous emotional, physical, and informational support during pregnancy, labor, birth, and the postpartum period. The program helps families feel informed, supported, and empowered.
Babies & Beyond	Offers education, support services, and community connections that help families build a strong foundation. Services include childbirth education, lactation support, nurse home visitation and nurse case management, bereavement support, mental health referrals, and access to essential resources.
Parents as Teachers	Equips parents with the knowledge and tools they need to support their child's healthy development through pregnancy to age 3. Through home visits, developmental screenings, and parent education, families gain confidence in their role as their child's first and most important teacher.
Healthy Families	Program that supports expectant parents and families with young children through education, encouragement, and relationship-based services. The program promotes positive parenting, child well-being, family self-sufficiency, and healthy child development.
Fetal and Infant Mortality Review (FIMR)	Community-based process that reviews fetal and infant deaths to identify opportunities for improving systems of care and preventing future losses. Through multidisciplinary collaboration, the program develops recommendations that strengthen services and improve outcomes for mothers, babies, and families.

3. Needs Assessment Process and Findings

The 2025 Needs Assessment used quantitative and qualitative data to identify strengths, gaps, and emerging trends affecting maternal, infant, paternal, and family outcomes in Indian River County. Quantitative data included vital statistics, maternal and child health indicators, program data, FIMR data aggregation, and community health data. Qualitative data included consumer surveys in English, Spanish, and Creole, paternal surveys, community partner surveys, and community outreach feedback.

The Needs Assessment reflected input from more than 325 respondents, including families, fathers, and service providers. Across survey groups, respondents identified five primary unmet needs: affordable and accessible health care; safe and affordable housing; reliable transportation; childcare availability and workforce stability; and awareness of available services and language accessibility.

Needs Assessment Priority	Core Barrier	Service Delivery Response
Affordable and accessible health care	Cost, insurance coverage, provider shortages, limited access to dental and mental health care	Strengthen CI&R, PEPW support, provider partnerships, postpartum follow-up, perinatal behavioral health referrals, dental referral pathways, and Nurse Case Management.
Safe and affordable housing	Housing cost burden, limited availability, overcrowding, instability	Integrate housing screening, resource navigation, staff training, and referral partnerships into CI&R, Nuse Case Management, Healthy Families, PAT, and other programs.
Reliable transportation access	Lack of reliable or affordable transportation to prenatal care, pediatric care, education, employment, and program visits	Develop transportation partnerships, explore vouchers or ride-share support, and screen for transportation needs at intake and throughout service delivery.
Childcare availability and workforce stability	Childcare cost, limited availability, work schedule conflicts	Coordinate with early learning and childcare partners; integrate parenting education and early learning supports into programs; advocate for flexible childcare options.
Awareness of services and language accessibility	Limited knowledge of CONNECT/CI&R, language barriers, gaps in multilingual materials	Expand multilingual outreach, Healthy Start Ambassador training, provider education, public awareness campaigns, and cross-agency referral training.

Preconception health	Limited education and access to preventive care before pregnancy	Expand Healthier You / preconception health education, community education campaigns, school and youth-serving partnerships, and provider distribution of materials.
Dental care	Cost, lack of providers accepting Medicaid, limited awareness of oral health importance	Create referral network, community education campaign, and provider partnerships focused on oral health during pregnancy and interconception.
Sustainable maternal and child health services	Increasing cost of inpatient OB services and lower reimbursement threaten local comprehensive OB services	Collaborate with hospital leadership, funders, community partners, and local/state stakeholders to advocate for sustainable maternal health infrastructure.

4. Service Delivery Priorities 2026–2031

Priority 1: Improve access to affordable, culturally responsive, and timely health care.

Families will be connected earlier to prenatal, postpartum, infant, pediatric, dental, behavioral health, and supportive services through CI&R, provider partnerships, Nurse Case Management, PEPW, and multilingual outreach.

Priority 2: Address social drivers of health that affect maternal, infant, paternal, and family outcomes.

The Coalition will strengthen screening, referral, and community partnerships related to housing, transportation, childcare, food security, employment stability, and other family stability needs.

Priority 3: Prevent fetal and infant mortality and reduce poor birth outcomes.

IRCHSC will continue safe sleep education, preterm birth and low birth weight prevention, lactation support, childbirth education, doula services, nurse home visiting, FIMR, and data-informed outreach in high-need communities.

Priority 4: Prevent maternal morbidity and mortality.

The Coalition will use case management, post-birth warning signs education, doula support, care coordination, behavioral health referrals, chronic condition education, and postpartum follow-up to address maternal risk.

Priority 5: Reduce racial, ethnic, language, and geographic disparities in maternal-child health outcomes.

The Coalition will expand bilingual and bicultural outreach, targeted community engagement, provider education, fatherhood engagement, and community action strategies informed by FIMR and local data.

Priority 6: Strengthen preconception, interconception, fatherhood, and family-centered prevention.

IRCHSC will expand Healthier You, T.E.A.M. Dad, parenting education, healthy relationships and co-parenting supports, and reproductive life planning education.

Priority 7: Strengthen the local maternal-child health system through quality assurance, data, partnerships, and sustainable funding.

The Coalition will maintain dashboards, monitor subcontractor performance, review quality indicators, build partner capacity, and align funding with needs assessment priorities.

5. Implementation Framework and Annual Action Plan

The following five-year framework establishes stable priority areas and strategies for 2026–2031. Annual action steps, targets, responsible parties, and evaluation measures should be reviewed and updated each fiscal year based on funding, data trends, contract requirements, community feedback, and program performance.

Goal 1: Improve timely access to prenatal, postpartum, infant, dental, and behavioral health care.

Strategy / Action Step	Responsible Entity	Timeline	Evaluation Measure
1.1 Strengthen CI&R and CONNECT referral pathways	Maternity Navigators; Program Directors & Supervisors; Community Liaison; CEO	Annually	Number of screens/referrals; referral acceptance; closed-loop referral documentation; partner training logs
1.2 Expand PEPW and Medicaid navigation support at clinical and community access points	Maternity Navigators; Program Directors & Supervisors	Annually	Number of clients supported with PEPW/coverage navigation; referral outcomes
1.3 Build referral pathways for perinatal behavioral health and dental care	CEO; Directors & Supervisors; Community Liaison; Provider Partners	Annually	Referral network established; number of referrals; partner MOUs or referral protocols

1.4 Continue provider education on Healthy Start screening, CI&R, and available programs	Community Liaison; Program Directors & Supervisors, CEO	Quarterly	Provider touchpoint log; training attendance; screen rate trends

Goal 2: Address social drivers of health through coordinated screening, referral, and community partnerships.

Strategy / Action Step	Responsible Entity	Timeline	Evaluation Measure
2.1 Integrate housing, transportation, childcare, food, employment, and safety needs into intake and case review processes	Program Directors & Supervisors; Data Specialist	FY 2027 implementation; annual updates	Screening documentation; referral categories; dashboard reporting
2.2 Develop transportation partnerships and explore voucher or ride-share supports	CEO; Development Team; Community Liaison	FY 2027–2028	Partnership list; funding secured; number of rides/vouchers if implemented
2.3 Strengthen childcare and early learning partnerships	Program Directors & Supervisors; Community Liaison	Annually	Partner meetings; referral pathways; parent education sessions
2.4 Train staff on emergent vs. long-term housing resources and referral options	Program Directors & Supervisors; Community Liaison	Annually	Training completion; resource guide updates

Goal 3: Prevent fetal and infant mortality, preterm birth, low birth weight, and sleep-related deaths.

Strategy / Action Step	Responsible Entity	Timeline	Evaluation Measure
3.1 Continue targeted safe sleep education, safe sleep resource distribution, and Safe Baby trainings	Program Directors & Supervisors; Community Liaison; All Program Staff	Annually	Families educated; pack-n-play/equipment releases; training attendance
3.2 Provide doula, childbirth education, lactation, nurse home visiting, and health education services	Babies & Beyond/Doula Director & Supervisors; Subcontractors	Annually	Enrollment and service data; birth outcomes where available; class attendance
3.3 Use FIMR findings and dashboards to identify zip codes and populations for targeted outreach	CEO; FIMR Team; Data Specialist; CAG; Community Liaison	Quarterly/annually	FIMR recommendations; outreach locations; action plan updates

3.4 Continue Community Baby Showers and community-based education in high-need areas	Development Team; Community Liaison; Program Staff; CEO; Director of Operations; Director of Finance	At least annually	Attendance; referrals; services connected; partner participation

Goal 4: Prevent maternal morbidity and mortality by strengthening risk identification, clinical navigation, and postpartum support.

Strategy / Action Step	Responsible Entity	Timeline	Evaluation Measure
4.1 Expand and evaluate Nurse Case Management for high-risk pregnant and postpartum women	Babies & Beyond Nursing Supervisor; CEO; Nurse Case Managers; Data Specialist; Director of Finance; Director of Operations	Annually	Enrollment; risk factors; referrals; engagement; postpartum follow-up measures
4.2 Provide education on post-birth warning signs, hypertension, diabetes, hemorrhage, substance use, and when to seek urgent care	Nurses; Doulas; Health Educators; CLCs; CEO	Annually	Education documentation; materials distributed; staff training logs
4.3 Strengthen postpartum follow-up including lactation, mental health, and infant safety supports	Program Directors & Supervisors; Program Staff; CEO	Annually	Post-discharge contacts; postpartum visit referrals; lactation follow-up; mental health referrals
4.4 Continue advocacy for sustainable local inpatient OB services	CEO; Board; Directors; Community Partners	Ongoing	Meeting logs; community engagement; board updates

Goal 5: Reduce disparities through targeted outreach, language accessibility, and community engagement.

Strategy / Action Step	Responsible Entity	Timeline	Evaluation Measure
5.1 Expand multilingual materials and outreach in English, Spanish, and Creole	Development Team; Community Liaison; Program Staff	Annually	Materials created; distribution sites; social media and website analytics
5.2 Conduct Healthy Start Ambassador and CONNECT referral training for partner agencies	Community Liaison; Development Team; CEO	Semiannually or more often as needed	Number of trainings; partner agencies trained; referral increases

5.3 Target outreach in high-need zip codes and census tracts identified through data and FIMR	CEO; Directors; Community Liaison; CAG	Annually	Outreach calendar; referrals; community feedback
5.4 Continue community forums and summits that elevate FIMR, maternal health, fatherhood, preconception health, and family stability	CEO; Development Team; Program Directors	At least one major convening during the five-year period; annual education events	Attendance; evaluation results; action items generated

Goal 6: Strengthen preconception, interconception, fatherhood, and family-centered prevention.

Strategy / Action Step	Responsible Entity	Timeline	Evaluation Measure
6.1 Expand Healthier You preconception health education through youth-serving and community partners	CEO; Program Directors; Community Liaison; Community Partners	Annually	Cohorts delivered; participant evaluation; knowledge gain; partner feedback
6.2 Expand T.E.A.M. Dad and fatherhood engagement across programs	Fatherhood Coordinator; Program Directors; CI&R; Community Liaison	Annually	Fathers enrolled; group sessions; co-parenting and engagement indicators
6.3 Integrate reproductive life planning, chronic disease prevention, nutrition, mental health, and dental education into services	Program Directors; All Program Staff	Annually	Curriculum/materials used; client education documentation
6.4 Increase partner understanding of preconception health and its relationship to birth outcomes, literacy, and kindergarten readiness	CEO; Directors; Community Liaison	Annually	Presentations; partner trainings; materials distributed

Goal 7: Strengthen data, quality, governance, and financial sustainability.

Strategy / Action Step	Responsible Entity	Timeline	Evaluation Measure
7.1 Maintain Salesforce dashboards for programs and review data routinely in huddles and leadership meetings	CEO; Directors; Data Specialist	Monthly/quarterly	Dashboard review logs; action items; improvements tracked
7.2 Conduct routine subcontractor monitoring and technical assistance	Director of Finance & Operations; Program Directors	Quarterly/annually	Monitoring reports; corrective actions; performance indicators
7.3 Align grant proposals, donor engagement, and fundraising priorities with service delivery needs	CEO; Fund Development Team; Director of Finance & Operations; Grant Specialist, Board	Annually	Funding plan; proposals submitted; donor materials tied to priorities
7.4 Review and update policies, onboarding, performance expectations, and succession planning	CEO; Board; Directors	Annually	Policy updates; onboarding checklist; performance review completion; succession plan review

6. Number and Type of Subcontractors Necessary to Implement the Plan

The exact number of subcontractors will be determined annually based on available funding, contract requirements, community need, performance history, procurement requirements, and partner capacity. For planning purposes, IRCHSC anticipates needing the following subcontractor or formal partner categories during the 2026–2031 cycle:

Subcontractor / Partner Type	Purpose	Planning Notes
Clinical / hospital-based maternal and infant health service provider	Health education, screening support, maternity navigation, childbirth education, lactation support, doula coordination, postpartum support, and related services	Continue or competitively procure based on funding and contract requirements.
Home visiting / family support provider	Evidence-based or evidence-informed home visiting, parenting education, child development support, and family support	May include internal programs, contracted providers, or hybrid arrangements.
Behavioral health provider(s)	Perinatal mental health, substance use, grief and bereavement counseling, and referral pathways	May be implemented through MOUs, fee-for-service, or formal subcontracts.

Dental care referral partner(s)	Prenatal/interconception oral health referrals and education	Develop referral network.
Transportation partner(s)	Transportation supports for prenatal, postpartum, pediatric, education, and program appointments	Explore vouchers, ride-share, public transit, and health plan transportation connections.
Childcare / early learning partner(s)	Childcare navigation, parenting support, early learning referrals, and workforce stability supports	Use MOUs and collaborative referral pathways as appropriate.
Data / evaluation / quality improvement support	Data analysis, dashboards, evaluation, community reporting, or technical assistance	May be internal or contracted depending on complexity and funding.
Community outreach / translation / interpretation support	Multilingual outreach, materials, interpretation, and culturally responsive engagement	Prioritize Spanish and Creole accessibility.

7. Allocation Methodology

IRCHSC allocates funds using a transparent, needs-based, data-informed methodology. Annual subcontract allocations will be determined by the Board-approved budget, contract requirements, allowable costs, community priorities, anticipated number and type of clients served, geographic and demographic need, provider capacity, historical utilization, performance outcomes, quality monitoring results, and availability of other funding sources. .

Allocation Factor	How It Will Be Used
Needs Assessment Priorities	Funds will be prioritized for services that directly address health care access, housing navigation, transportation, childcare, language accessibility, preconception health, dental care, maternal health infrastructure, and other identified gaps.
Contract Requirements and Allowability	Allocations must comply with Department of Health, Healthy Start MomCare Network, Medicaid, local funder, and donor requirements.
Client Volume and Risk	Funding will consider projected number of pregnant women, infants, fathers, interconception women, postpartum clients, and high-risk families served.
Performance and Quality Data	Dashboard performance, monitoring outcomes, corrective action history, service completion, referral follow-through, and client satisfaction will inform future allocations.
Provider Capacity and Readiness	Staffing, training, language access, documentation quality, data capacity, and geographic reach will be considered.

Equity and Geographic Need	Priority will be given to strategies serving zip codes, census tracts, language groups, or populations with poorer outcomes or greater access barriers.
Sustainability and Leverage	Allocations will consider whether funds leverage hospital, county, donor, grant, Medicaid, or philanthropic resources.

8. Anticipated Number and Type of Clients to be Served

IRCHSC serves a county with approximately 1,200 births annually. The following planning targets are intended as initial annual service estimates for 2026–2031 and should be updated each year based on funding, staffing, contract requirements, demand, and actual service utilization.

Client / Service Population	Initial Annual Planning Target	Manner of Service
Pregnant women, infants, and postpartum women through CI&R / CONNECT / Maternity Navigation	Approximately 1500 intakes are completed annually for pregnant women, infants, and postpartum women.	Universal screening, intake, referral, PEPW support, follow-up, and connection to Healthy Start and community services.
Pregnant and postpartum women through Health Education / home visiting	Approximately 450 clients served annually or current contract target	Home/community visits, prenatal education, parenting education, risk screening, referrals, and follow-up.
High-risk pregnant/postpartum women through Nurse Case Management	Approximately 150+ individuals annually initially, adjusted by funding and demand	Nurse Case Management, chronic condition education, risk monitoring, referral coordination, and postpartum follow-up.
Doula clients	Approximately 250 births annually	Prenatal doula support, birth support, postpartum support, education, advocacy, and linkage to care.
Infants and families through Babies & Beyond / Nurse Home Visit / Lactation / Childbirth Education	Approximately 850 families annually	Postpartum nurse visits, lactation support, infant safety education, feeding support, and referrals.
Fathers / partners through T.E.A.M. Dad	Approximately 80 fathers/partners annually	Fatherhood education, mentoring, co-parenting support, group activities, and referrals.
Families through Healthy Families / evidence-based family support	Approximately 75 families annually	Longer-term family support, child development education, parenting support, and referrals.
Families through Parents as Teachers / early childhood support	Approximately 55 families annually	Home visiting, developmental screening, school readiness, parenting education, and resource

connection.

Participants in Healthier You / preconception health education	At least one cohort or partner-based offering annually, adjusted by demand	Preconception health, healthy relationships, chronic disease prevention, reproductive life planning, and self-advocacy education.
Community members through outreach, baby showers, summits, trainings, and Healthy Start Ambassador activities	Targets set annually by event calendar and outreach plan	Community education, resource distribution, referrals, multilingual materials, and partner engagement.

9. Community Outreach Activities

Community outreach will promote access to prenatal, interconception, infant, and fatherhood services across Indian River County. Outreach will be data-informed, culturally responsive, multilingual, and focused on communities and groups experiencing greater barriers or poorer outcomes.

Outreach Activity	Frequency / Timeline	Purpose / Audience	Evaluation Measure
Annual Community Meeting and Service Delivery Plan updates	Annually	Community feedback, transparency, priority setting, partner engagement	Attendance, feedback themes, action items
Community Baby Showers in targeted zip codes / communities	At least annually; more often as funding allows	Pregnant women, fathers, caregivers, families in high-need areas	Attendance, referrals, materials distributed, partner participation
Healthy Start Ambassador trainings	Semiannually or as requested	Frontline partner staff, faith leaders, childcare providers, healthcare partners, trusted community messengers	Number trained, agencies represented, referral changes
Provider outreach / office rounding	Quarterly or more often as needed	OB, pediatric, family practice, dental, behavioral health, and community providers	Touchpoint logs, screening/referral trends
Multilingual public awareness campaigns	Ongoing, with annual campaign calendar	English, Spanish, and Creole-speaking families	Materials produced, social media analytics, website traffic
Fatherhood outreach and family engagement events	Annually and through program calendar	Fathers, father figures, co-parents, families	Fathers enrolled, group participation, event feedback

FIMR-informed education / Maternal Summit / community forums	At least one major convening during plan cycle; annual education activities	Partners, providers, funders, community members	Attendance, evaluations, recommendations, CAG action items
Hospital, clinic, and community access point education	Ongoing	Pregnant and postpartum women, families, providers	Referrals, screen rates, materials distributed
Legislative, funder, and civic engagement	Ongoing	Decision-makers and funders influencing maternal-child health infrastructure	Meetings, presentations, advocacy updates

10. Quality Assurance and Quality Improvement Plan

IRCHSC will maintain a coordinated QA/QI system to monitor quality, contract compliance, service access, timeliness, documentation, client outcomes, subcontractor performance, and progress toward Service Delivery Plan priorities. The QA/QI system will be data-driven and will use monitoring, dashboards, corrective action, technical assistance, annual review, and community feedback to support continuous improvement.

QA/QI Activity	Timeline	Responsible Entity	Documentation / Measure
Review program dashboards and service indicators	Monthly through huddles; quarterly through leadership review	CEO, Directors, Data Specialist	Dashboard screenshots/reports, meeting notes, case reviews, action items
Monitor contract deliverables and fiscal compliance	Monthly/quarterly based on contract schedule	Director of Finance; Director of Operations; CEO	Deliverable calendar, invoices, monitoring logs, budget reports
Conduct subcontractor monitoring	At least annually; quarterly check-ins as needed	Director of Finance; Program Directors; QA/QI Committee	Monitoring tool, chart review, corrective action if needed
Review Healthy Start Standards and Guidelines compliance	Annually and during onboarding/training	Program Directors; Supervisors	Training logs, policy review, chart audits
Review client records / documentation quality	Quarterly sample review or as contract requires	Program Supervisors; QA/QI Committee	Chart audit summaries, case reviews, improvement plans
Review client complaints and grievances	As received; summary annually	CEO; Director of Operations; Program Directors	Complaint/grievance log, resolution documentation

Review referral follow-through processes	Quarterly	Program Directors; Community Liaison; Data Specialist	Referral dashboards, partner feedback
Evaluate community outreach and language accessibility	Semiannually	Development Team; Community Liaison; Program Directors	Materials inventory, outreach logs, feedback
Update Service Delivery Plan action steps	Annually	CEO; Directors; Board/Committees	Annual action plan update, Board approval/minutes
Initiate Performance Improvement Plan when targets are not met	As needed, with quarterly updates until resolved	CEO; Program Directors; Subcontractor leadership	PIP document, milestones, progress updates

11. Resource Inventory and Partnerships

IRCHSC will maintain and update a comprehensive resource inventory for pregnant women, postpartum women, infants, fathers, caregivers, and families. See Appendix A.

Community partnerships include maternal health providers, pediatric providers, dental providers, behavioral health providers, substance use treatment providers, housing agencies, transportation resources, childcare and early learning providers, food resources, legal and benefits resources, family support programs, and grief/bereavement supports.

Partner / Resource Category	Examples / Uses
Hospital and OB partners	Delivery care, inpatient OB sustainability, postpartum unit access, screening, lactation, education, and discharge referrals.
Pediatric and family practice partners	Infant care, well-child visits, developmental concerns, safe sleep education, family support referrals.
Behavioral health and substance use partners	Perinatal mental health, substance use support, grief and bereavement, trauma-informed care.
Dental partners	Prenatal and interconception oral health referrals and education.
Housing and basic needs partners	Housing navigation, emergency assistance, diapers, wipes, food, safety supplies.
Transportation partners	Transit support, health plan transportation, ride-share or voucher support.
Early learning and childcare partners	Childcare navigation, developmental screenings, school readiness, workforce stability.
Faith, civic, nonprofit, and community organizations	Trusted messengers, referral partners, outreach sites, donor and volunteer engagement.

FIMR CRT and CAG partners	Case review, system recommendations, community action, prevention strategies.

12. Annual Review, Evaluation, and Updates

This Service Delivery Plan should be reviewed at least annually. The annual review should include progress on goals and action steps, needs assessment updates, FIMR trends, dashboard performance, subcontractor monitoring results, client feedback, community partner feedback, financial and staffing capacity, and any changes in contract requirements. The Coalition may update annual action steps without changing the five-year priorities when emerging needs, funding changes, or performance data require a revised approach.

Annual Review Component	Suggested Timing
Review prior year action plan progress and dashboard data	July - August
Review subcontractor performance and contract deliverables	Quarterly and annually
Update community outreach calendar and provider engagement plan	Quarterly and annually
Update resource inventory and partner referral pathways	At least annually
Review allocation methodology and proposed subcontract budgets	During annual budgeting process
Review QA/QI Plan and monitoring tools	Annually
Present progress to Board and community as appropriate	At least annually

13. Telehealth Activities

On December 9, 2025, Indian River County Healthy Start Coalition CEO participated in a Zoom meeting with Dr. Kay Roussos-Ross, Professor and Chief, Division Academic Specialists in General Obstetrics and Gynecology with University of Florida. She is also the developer of a research-based mobile phone app called MOMitor ™ which is designed to supplement perinatal care from home. The app screens pregnant and postpartum patients in real time for symptoms of the leading causes of maternal morbidity and mortality.

During the discussion, participants reviewed community demographics, annual birth data, and maternal and infant health trends. Information was shared regarding Indian River County's sole hospital providing obstetrical services, including its leadership structure. IRCHSC also discussed its existing Nurse Navigation program within Babies & Beyond, which utilizes a hybrid model that incorporates telehealth services. As of June 2026, IRCHSC does not have a formal agreement with the UF MOMitor ™ program but will continue exploring opportunities to integrate components of the model into existing services.

Appendices

Appendix A: Resource Inventory

Appendix B: Organization Chart

Appendix C: Board of Directors

Appendix A: Resource Inventory

List of Prenatal Care Provider Offices	Address / Location
Cleveland Clinic Indian River Hospital Obstetrics and Gynecology	1050 37th Place Suite 101-OB/Suite 103-GYN Vero Beach, FL 32960
A Caring Center for Women *limited OB Care	1986 31st Avenue Vero Beach, FL 32960
Physician to Women	1000 37th Pl, Vero Beach, FL 32960
Midwife Love, with Angela Love	126 43rd Ave SW, Vero Beach, FL 32968

List of Birthing Hospitals and Centers	Address / Location
Cleveland Clinic Indian River Hospital	1000 36th St. Vero Beach, FL 32960

List of Pediatricians Offices	Accepted Plans	Address / Location
Whole Family Health Center	Medicaid, Insurance, Sliding Scale	981 37th Place Vero Beach, FL 32960
Vero Pediatrics	Accepts Medicaid, Insurance	959 37th Pl, Vero Beach, FL 32960
Nemours Pediatrics of Sebastian	Accepts Medicaid, Insurance	14430 US1 #101 Sebastian, FL 32958
Pelican Pediatrics	Accepts Medicaid if sibling is an existing patient	13832 US Hwy 1, Sebastian, FL, 32958
Treasure Coast Community Health (TCCH)	Accepts Medicaid, Insurance, Sliding Scale	Locations in Vero and Fellsmere
Nemours Children Primary Care	Accepts Medicaid, Insurance	1155 35th Lane Suite 201A Vero Beach, FL 32960
Treasure Coast Pediatrics	Private Insurance only	3745 11th Circle, Suite 108, Vero Beach, FL 32960

List of Indian River County Primary Care Providers	Accepted Plans	Address / Location
Whole Family Health Center	Accepts Medicaid, Insurance, Sliding Scale	981 37th Place Vero Beach, FL 32960
VNA Bus	Medicaid, Sliding Scale	Various locations within IRC - call daily to scheduled location at 772-494-6161
Indian River Primary Care	Accepts Insurance	1715 37th Place Vero Beach, FL 32960
Treasure Coast Community Health (TCCH)	Accepts Medicaid, Insurance, Sliding Scale	Locations in Vero and Fellsmere
Primary Care of the Treasure Coast	Accepts Medicaid, Insurance	1265 36th Street, Vero Beach, FL 32960

Parenting Support	Address / Contact
Treasure Coast Early Steps Program ● 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 561-881-2822
Buggy Bunch ● A faith-based nonprofit organization dedicated to building relationships and meeting the needs of moms and families in Indian River County through support, education, outreach, and community connection. Through playgroups, parenting programs, support groups, family resources, and practical assistance	1450 21st Street Vero Beach, FL 32960 772-226-0066

The Learning Alliance ● Focused on improving early literacy and kindergarten readiness in Indian River County through community-wide collaboration, evidence-based reading initiatives, and programs that support children, families, and educators to ensure all children learn to read at grade level.	2066 14th Avenue, Suite 102 Vero Beach, FL 32960
Early Learning Coalition ● Partnering with parents, providers, and communities to ensure quality early learning experiences through programmatic and financial support.	2459 St. Lucie Avenue (14th Ave.) Vero Beach, FL 32960
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 Vista Royale Blvd, Vero Beach, FL 32962
Healthy Start Services (information provided below) ● Healthy Families ● Health Education ● Coordinated Intake and Referral (CI&R) ● Parents As Teachers ● Babies & Beyond ● Doula ● Fatherhood	1555 Indian River Blvd, Suite B241 Second Floor Vero Beach, FL 32960

List of Childcare Centers	Address / Location
La Petite Academy of Vero Beach	1418 27th Ave, Vero Beach, FL 32960
Hope Montessori Academy	2715 Atlantic Blvd, Vero Beach, FL 32960
Kendall Academy Preschool	575 Royal Palm Blvd, Vero Beach, FL 32960
Childcare Resources	3200 5th Ave #149, Vero Beach, FL 32960
Kid City USA	760 20th Ave, Vero Beach, FL 32962
Bridges Early Learning Center	760 20th Ave, Vero Beach, FL 32962
Global Learning of Vero Beach	2044 16th St, Vero Beach, FL 32960
Vero Beach Preschool	2044 16th St. Vero Beach, FL 32960
Oxford Academy Preschool	1730 24th St. Vero Beach, FL 32960
Mrs. Lockwood's Home Childcare	1786 20th Ave SW, Vero Beach, FL 32962
Early Learning Coalition	2459 14th Ave, Vero Beach, FL 32960
For Kids Only of Vero Beach	2044 16th St, Vero Beach, FL 32960
First Impressions Daycare No. 2	935 9th CT SW, Vero Beach, FL 32962
Maitland Farm Preschool	5990 5th St. SW, Vero Beach, FL 32968
RCMA	7625 85th St, Vero Beach, FL 32967
Hibiscus Children's Village	1145 12th St, Bero Beach, FL 32960
Master's Academy Early Childhood Learning Center	2855 58th Ave, Vero Beach, FL 32966

Transportation	Contact
Medicaid Transportation	contact your Medicaid plan for further details
Go Line	772-569-0760
United Against Poverty The Going Up Bus	772-564-9365
Driving Success	772-646-8736
Whole Family Health for Appointments	772-257-5785

Therapies	Contact
All Aboard	772-567-0061
SOS Therapies	772-571-5594

A+ Therapy Pros	772-464-3303
Whiting Pediatric Therapy Services	772-584-3888
Coastal Behavior Analysis	772-774-8224

Financial Assistance	**Contact**
EOC	772-562-4177
Salvation Army	772-978-0265
A+ Therapy Pros	772-464-3303
Whiting Pediatric Therapy Services	772-584-3888
Coastal Behavior Analysis	772-774-8224

Dental Providers	**Contact**
Treasure Caost Community Health *adult & children	772-257-8224
Pelican Dental	772-569-9781
Seaside Smiles	772-562-6880
Nickel Pediatric Dentistry	772-494-6010
Indian River Dentistry	772-562-9025

Affordaable Housing	**Contact**
Habitat for Humanity	772-562-9860
Indian River County Housing Authority	772-567-6182
Treasure Coast Homeless Services	772-567-7790
Indian River County Housing Services	772-226-4360

Shelters	**Contact**
Samaritan Center	772-770-2900
Hope for Families	772-567-5537
Safe Space	772-288-7023
Camp Haven	772-999-3625
Women's Refuge of Vero Beach	772-770-4424

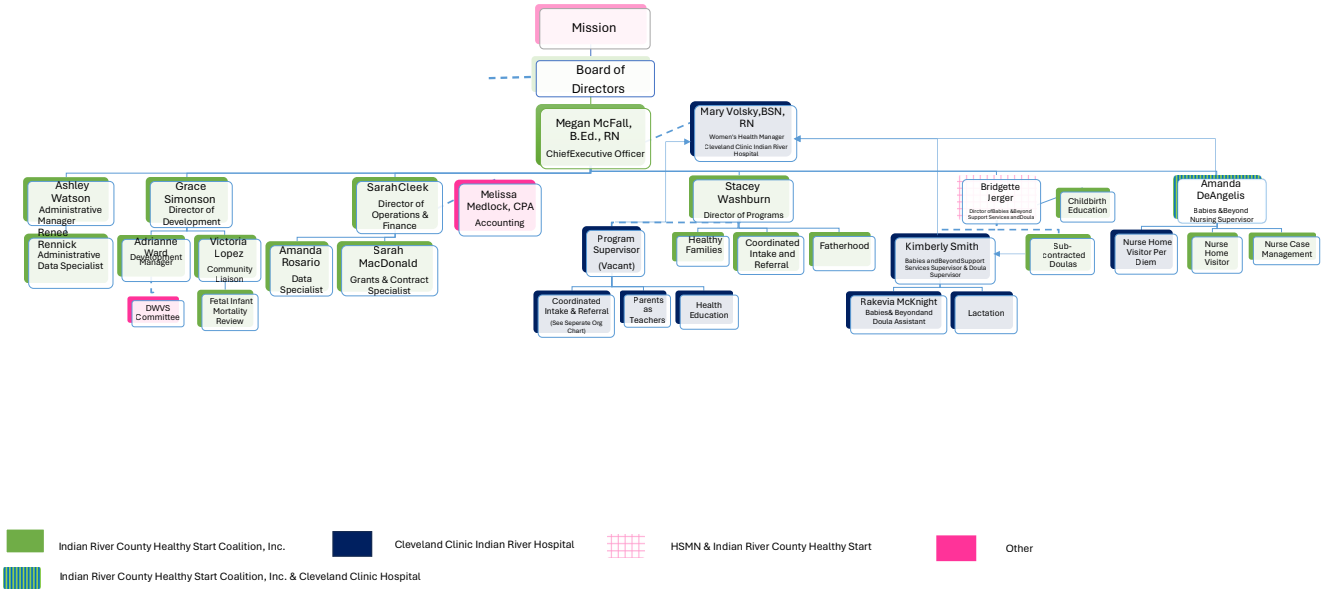
Mental Health	**Contact**

Legacy Behvioral Health	772-257-5264
Mental Health Collabortive	772-217-3663
New Horizons	772-672-8400
Treasure Coast Community Health	772-257-8224
Mental Health Association	772-569-9788
Tykes and Teens	772-220-3439
Whole Family Health	772-257-5785

Financial Assistance	**Contact**
EOC	772-562-4177
Salvation Army	772-978-0265
St Vincent	772-561-6774
IR Human Services	772-226-1423
Homeless Children's Foundation	772-532-1139

Appendix B: Organizational Chart

Indian River County Healthy Start Coalition, Inc. Organizational Chart



Appendix C: Board of Directors

IRCHSC Board of Directors:	Title
Karen Campbell	President
Allen Jones	Vice President
Frida Randolfi	Secretary
Kyle Thurn	Treasurer
Lee Curry	Director
Karen Morein	Director
Angie Radock	Director
Tiffany Abraham	Director
Susan Pierce	Director
Dr. Hal Brown	Director