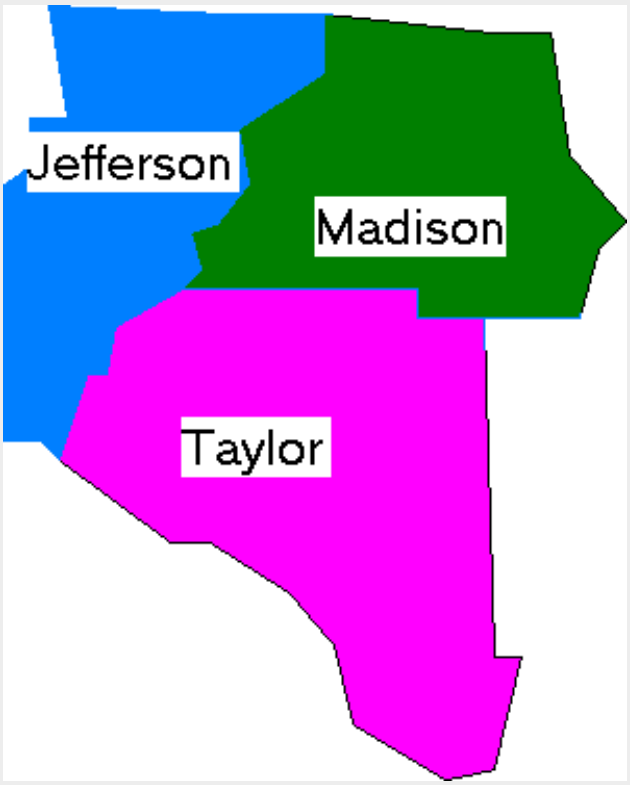
Healthy Start

Healthy Start Coalition of Jefferson, Madison and Taylor Counties



Healthy Start Coalition of Jefferson, Madison, & Taylor Counties, Inc.

Maternal and Child Health Service Delivery Plan 2026-2031

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Contents

Introduction

During the 1991 Florida Legislature Session, the Florida Healthy Start legislation was passed (Section 383.216 Florida Statutes). This legislation called for the establishment of prenatal and infant health care coalitions. The coalitions were to form public and private partnerships in developing and maintaining systems of care that ensure adequate and appropriate prenatal and infant care to all women and infants throughout Florida. In 1997, the Florida Legislature expanded the legislative mandate for Healthy Start from prenatal through age 1; to prenatal through age 3.

In 1992, local volunteers from the public and private sector began meeting on a regular basis to discuss ways to improve the overall health and social conditions of children and pregnant women in Jefferson, Madison and Taylor Counties. The three-county area had long been wrestling with the growing number of teen-age pregnancies, pervasive poverty and an infant mortality rate that had at times been two and three times the state infant mortality rate. With this foundation the Healthy Start Coalition of Jefferson, Madison and Taylor Counties was formed.

The Coalition is a non-profit 501 (c) (3) organization and is one of thirty-two prenatal and infant health care coalitions in the State of Florida. Primary planning staff consist of an Executive Director, Program Director, Provider Liaison, and a Certified Community Health Worker. There is a nine-member board consisting of three representatives from each county; Board of Directors meetings are held quarterly.

Primary funding for the Healthy Start Coalition of Jefferson, Madison and Taylor Counties, Inc. is provided through the Florida Department of Health, Infant, Maternal, and Reproductive Health Program. Funding is provided through state general revenue and federal funds from the Maternal and Child Health Block Grant. In 2001, the Agency for Health Care Administration, in collaboration with the Department of Health and the Association of Healthy Start Coalitions, developed a 1915(b) Medicaid waiver to provide additional funds for Healthy Start services in order to provide higher intensity of services. This waiver also included a component for the provision of case management services to SOBRA (Sixth Omnibus Budget Reconciliation Act) women eligible for Medicaid due to their pregnancy. In 2013, that Waiver was re-authorized with different parameters, including the deletion of SOBRA services, and for the first time the Agency of Health Care Administration (AHCA) began to contract directly with a representative of the Coalitions. The

Healthy Start MomCare Network, the Administrative Services Organization representing all Healthy Start Coalitions in Florida is the negotiator and contractor for all Healthy Start Medicaid Waiver in Florida.

The Coalition has also been successful, with the support of the advocacy of Coalition membership, to solicit funding and become the lead entity for Healthy Families services in the Coalition catchment area. The Coalition was a natural fit when new funding from the legislature in 2015 expanded Healthy Families to cover areas in Florida without these services. The Healthy Families Florida Program has received credentialling nationally from Healthy Families America to meet its rigorous standards of quality and our local program, Healthy Families Seven Rivers is part of that credentialing process.

Coalition Role

The role of the Coalition is centered on defining and improving systems of care for the maternal and child health population. The primary focus of the Coalition is to ensure that every pregnant woman has access to prenatal care and that every child has access to services that promote normal growth and development. The Coalition has the opportunity to affect positive changes in these systems through continuous quality improvement activities in the home visiting services for which it has oversight, and also through developing collaborative relationships with other agencies that serve the 0-3 population. The Coalition develops community-wide strategies, as well as Continuous Quality Improvement functions for programming. The Coalition's membership collectively understand that the health and well-being of a community are not determined solely by the availability of health care, but also by the availability of jobs, education opportunities, positive activities for the community's youth, and a sense of hope for the future.

The Coalition works in partnership with the Florida Department of Health and other private and public providers to ensure the needs of our communities are met. This partnership affords the citizens a much-needed voice in the decisions being made concerning our communities.

Responsibilities of the Coalition are to:

- Promote the health and well-being of all pregnant women and their children through public awareness and outreach

- Identify and address local health care needs for pregnant women and their families through designing systems of care
- Establish and provide oversight of the Healthy Start system of care
- Ensure quality assurance of Healthy Start services
- Ensure comprehensive prenatal and infant health care services are available and accessible
- Allocate public and private funds received by the Coalition for Healthy Start services
- Plan for new and expanded services that avoid duplication and promote partnerships and collaboration among existing service providers
- Develop partnerships to form a coordinated system of care for pregnant women and infants

In executing the tasks of identification of needs and gaps in services, the Coalition must be successful in partnering and collaboration. This design is the highest efficiency model of care that avoids duplication and encourages resource development. This also defines the strength of the Coalition, in terms of the capacity of its membership and whether their participation advances the mission of the Coalition. The Coalition membership is defined in Florida Statute Section 383.216(5) and in Florida Administrative Code, Chapter 64-F2. The membership of the Healthy Start Coalition of Jefferson, Madison, and Taylor Counties Inc. is identified as of May 2026 as follows:

Coalition Membership June 2026

Category	Member
Consumers of family planning, primary care or prenatal care services, at least two of whom are low-income or Medicaid eligible	Individual Consumers
County Health Department	• Jefferson County Health Department • Madison County Health Department • Taylor County Health Department

Migrant and community health centers, if their service area contains any part of the Coalition's service are represented by the Coalition	• Madison Medical Center (FQHC) • Taylor Medical Center (FQHC)
Hospitals, birthing centers and other providers of maternity and/or infant services to the population included in the Coalition's service area	• A Women's Pregnancy Center -Madison • A Women's pregnancy Center - Jefferson • Doctor's Memorial Hospital • Madison County Memorial Hospital • Little Pine Pediatrics LLC • Apalachee Mental Health • A New Dawn, a New Beginning • Taylor County Recovery Center • HCA Florida Capital Hospital • Tallahassee Memorial Hospital • Premier Medical Pediatrics • DMH Physician Partners Pediatrics
Local medical societies	• Big Bend Area Health Education Center • American Heart Association – Big Bend Chapter
Local health planning organizations	• Big Bend Rural Health Network • United Way of Big Bend • Big Bend Cares • FSU MPH Program • Madison Taylor Opioid Response Coalition
Local maternal and infant health advocacy interest groups and community organizations	• Kiwanis • March of Dimes • Healthy Families /Ounce of Prevention Fund of FL • Healthy Start • Florida CHAIN • 2-1-1 Help Me Grow
County and municipal governments	• City of Madison • City of Perry • Jefferson Board of County Commissioners • Jefferson County Extension Office • Madison County Extension Office • Madison County Board of County Commissioners • Madison County Sheriff • Madison County Recreation Association • Monticello Police Department • Madison County Supervisor of Elections • Taylor County Extension Agent • Taylor County Board of County Commissioners • Town of Greenville • Town of Lee • Madison County Emergency Management • Taylor County Emergency Management

Social services organizations	• 4-H (Jefferson, Madison and Taylor Counties) • Ability First • American Red Cross • Big Bend AHEC • Big Bend Hospice • Boys and Girls Club (Taylor) • Capital City Youth Services • Children's Home Society • Department of Children and Families (ESS, Protective Services, Child Support Enforcement) • Department of Juvenile Justice • Elder Care Services • FDLRS/Miccosukee (Taylor and Jefferson) • FDLRS/NEFEC (Madison) • Kids, Inc (Early Head Start Jefferson and Madison) • Madison Senior Center • Senior Center of Jefferson County • Suwannee River Economic Council • Taylor County Senior Citizens Center • Taylor County Early Head Start
Local education communities	• FSU School of Nursing • NFC Nursing/Allied Health • Early Learning Coalition of the Big Bend • Jefferson County Head Start • Jefferson County School District • Madison County School District • Taylor County School District • North Florida College • North Florida Child Development (Head Start, Madison) • Taylor County Head Start • Taylor County Pre-K • Vocational Rehab • Suwannee River Regional Library System
Community organizations who represent or serve the target population	• Big Bend Community Based Care • Brehon Institute • Capital Area Community Action Agency • Early Learning Coalition of the Big Bend • Catholic Charities • DISC Village • Guardian Ad litem • Legal Services of Northwest Florida • Lighthouse of the Big Bend • Three Rivers Legal Services • CareerSource/Workforce Innovation • Partnership for Strong Families • Madison Youth Ranch (a branch of FL Methodist Children's Home) • POPIN/FND

Representatives from minority organizations	• Big Bend Cares • HIV/AIDS Bureau • Ministerial Association • Sickle Cell Foundation
Local housing /shelter organizations	• Refuge House of Jefferson County • Refuge House of Madison County • Refuge House of Taylor County
Local homeless coalitions	• Big Bend Homeless Coalition
Corporations/private industry	• Big Bend Transit • Jefferson/Monticello Chamber of Commerce • Madison Chamber of Commerce • Taylor/Perry Chamber of Commerce • Madison County Community Bank
Insurance/managed care organizations	• Humana • Simply Healthcare • Sunshine Health • Florida Community Care • Florida KidCare
Churches /religious organizations	• Antioch Missionary Baptist Church, Perry • Christ Episcopal Church, Monticello • First Presbyterian Church, Perry • New Mt.Zion Missionary Baptist Church, Perry • Shiloh Missionary Baptist Church, Madison • Renewed Life Outreach Ministries • St. James Episcopal Church, Perry • Stewart Memorial AME, Perry • Architillery Missionary Baptist Church • Shiloh Missionary Baptist Church • Mount Zion AME • Harvest Center Ministries • Fellowship Missionary Baptist Church • Casa Bianca Missionary Baptist Church • New Brooklyn Missionary Baptist Church • Middle Florida Baptist Association
Community volunteers/Infant and Child advocates	• Greene Publishing • Monticello News • Perry Newspapers

Recap of Previous Service Delivery Plans

2021-2026

The most recent plan that closes June 30, 2026, can be defined as building a framework on a solid foundation. This time period of growth was not only in staff, but in reach to population and diversification of services. During this period the Coalition pivoted to grow the Continuous Quality Improvement Initiative (CQI) by focusing on the role of the Program Director. This position, created at the end of the previous cycle, developed new methods of systematically verifying the integrity of services, expanding training opportunities for new staff and constantly testing implementation of new CQI standards. The results are well-equipped home visitors, clear expectations in service delivery and a Quality Assurance Plan that is evolving and improving constantly.

Additional expansion in service delivery during this cycle includes TEAM Dad, Doulas, Moving Beyond Depression™, and Bi-Lingual Healthy Start services. The foundation of a dedicated Program Director in early 2021 allowed for the Coalition leadership to focus on other areas of program development and address significant gaps in service delivery. Fatherhood services were made available through a legislative mandate in 2022 with the first services provided in December 2022. The first few years of Fatherhood services were subcontracted to a local mental health provider to develop the foundation of these services. In July 2025, the Coalition hired in-house a TEAM Dad coach to gain more oversight over the program and develop strategies to outreach and expand capacity. Also, in 2022 the Coalition was allocated additional service dollars, used to expand Healthy Start services to the growing Spanish-speaking population in these counties. These bi-lingual services were not available before October 2022.

During the same period as Fatherhood expansion, the Coalition was awarded funding for local Fetal and Infant Mortality (FIMR) initiatives. This created a pathway to develop a systematic way of outreaching to prenatal providers and the Coalition's first Provider Liaison was on-boarded. This position started in October 2023 and created outreach plans to both prenatal providers in Leon County as well as local ancillary service providers in the catchment area. This position has expanded to include building Coalition membership, operations management for the Coalition, maintaining our resource directory, and expanding our outreach and education through our website. The timing of this staff addition coincides with the development of the Electronic

Prenatal Screening process and has been instrumental in onboarding our local CHDs onto the platform.

In 2024, the Coalition was able to secure grant funding to both develop a doula program as well as develop a maternal mental health program, namely Moving Beyond Depression™. Doulas were recruited and trained in March 2024 and doula services were first provided in May of 2024. The doula program most recently expanded to six additional doulas onboarded in April 2026. Mental health providers from three different agencies were trained in August 2024 and home visitors were initially trained in September 2024. Due to the need for services and attrition, a second round of counselors were trained in July 2025, and this cohort provides mental health services to all referred Healthy Start and Healthy Families participants.

Service Disruptions from the 2023-2024 Hurricane Seasons

The most significant barrier to expanding and delivering services during this period was the active hurricane seasons of 2023 and 2024. All were directly impacted by Hurricanes Idalia (August 2023) and Helene (September 2024), as well as Tropical Storm Debby (August 2024).

These events disrupted service delivery in several ways:

- Families were displaced, and some were lost to follow-up.
- Healthy Start staff who also serve on county health department emergency response teams were deployed, reducing program capacity.
- The launch of maternal mental health and fatherhood initiatives was delayed.

This period also accelerated the use of virtual services, which became popular among participants. However, some families were reluctant to return to in-home visits afterward, and capacity continues to be affected today.

2016-2021

The plan that closed June 30, 2021, is unique in the history of the Healthy Start Coalition of Jefferson, Madison and Taylor for a specific reason. It could succinctly be named the “plan that rebuilt the system”. Coalition leadership guided the development of this plan using those elements that were already underway in terms of Healthy Start programmatic changes, and also those that were inevitable at the time the plan was authored. The plan started with the visioning in December of 2015 where Board members conceived “By 2020, every pregnant woman residing

in Jefferson, Madison and Taylor Counties will have access to evidence-based home visiting services, ensuring the best start in life for her baby". The key here is evidence-based. At this juncture, the elements of the Healthy Start Redesign were quickly developing, and the Coalition had already become a pilot for the Coordinated Intake and Referral project under MIECHV. The Coalition had already just signed on to be the lead agency for the Healthy Families Seven Rivers program as well. Therefore, the convergence of all these programmatic changes and implementations resulted in a plan that focused almost solely on programming.

The results of those programmatic infrastructure activities resulted in developing a local Home Visiting Advisory Board from the CI&R activities and developing materials and other business agreements and charter documents that were modeled in the rest of the state from the pilot work. In addition, the Coalition was heavily involved in the rollout of the Healthy Start 2.0 program in early 2019, including serving as chair of the education and training team that developed the quality training pieces. The Coalition was also a pilot for the new program and was instrumental in developing the tweaks to the system in 2018 that were unique to implementing these large-scale changes in rural communities. The Coalition also chaired the committee on Healthy Start Standards and Guidelines that proposed standards to support the new program model. In addition, the Healthy Families program became a selected site in Florida for accreditation from Healthy Families America. The services that are now available in these counties to the 0-3 population are better coordinated, are delivered by highly trained professionals, and are held to a higher standard of rigorous quality as a result of the work over the last five years.

In addition to the primary goal of programmatic development, the Coalition also devoted its community work during these years to consumer education and preconception health messaging. The previous plans prior to 2016 were foundational in terms of developing women's health messaging and activities that could be replicated with success including neighborhood canvassing and education workshops. The Certified Community Health Educator single handedly maintained the efforts of health education to consumers of maternal and child health while the fledgling programs were being built during these formative years. The experiences gained from consumer education and programmatic achievements are the springboards for building the 2021-2026 Service Plan.

2008-2015

This plan was the longest in service for the Coalition, as the Florida Department of Health extended its due date two years in anticipation of the impact of the Healthy Start programming redesign. This planning phase of the Coalition focused on the Social Determinants of Health, in terms of allocating resources to the neediest families and creating greater resiliency for families in each of the counties. The Coalition invested in the Whole Child project, through its stakeholder planning activities as well as the Whole Child Connection, a web-based tool to link families to resources. Greater emphasis was made for consumer education, and the role of the Coalition Community Health Educator focused more on consumers than key stakeholders, combining a message of preconception health, and access to care. The Coalition's Community Health Worker became one of the first Certified Community Health Workers in Florida, a testament to the Coalition's focus on consumer education. The Affordable Care Act also molded this period for the Coalition; participating in local insurance navigation efforts as well as serving on the statewide KidCare Advisory Council became activities the Coalition associated with increasing its capacity for consumer education. The Coalition also focused on the black-white gap in birth outcomes, creating a pilot project through funding from the Closing the Gap project at Office of Minority Health. The evaluation from this preconception case-management model is used in the next planning phase of the Coalition (2016-2021) to create preconception workshops and further the mission of focusing on preconception health status.

2004-2007

This plan encompassed the most dynamic community input, evident from the action steps that included Coalition involvement in nearly every facet of the community. The plan was broad in scope, working towards permeating all areas of social service provision through creating new networks with different groups, being more visible in the community, and working with Healthy Start providers in a more technical and supportive way to increase "other" services. This plan was also the cornerstone leading the Coalition to focus on maternal care, opening up the foundation of preconception awareness. Through additional leveraged resources and a renewed focus on preconception health, the relationships forged as a result of this action plan allowed the Coalition to build a cadre of volunteers, focused on the message of women's health prior to pregnancy.

2000-2003

This Service Delivery Plan focused specifically on the systems of care for pregnant women and infants in the catchment area. During this time, the Coalition was challenged with implementing the Medicaid Waiver and addressing all systems of care in each county. Healthy Start Programs

and Services were targeted as first priority and were restructured and expanded to meet the needs in each county. The successful implementation of this plan moved the Coalition to a higher standard of accountability. Each Provider significantly increased their number of direct services by expanding their infrastructure. Together the Coalition and Providers have increased quality assurance/quality improvement activities. Fiscal accountability has also been reached through implementation of standardized procedures.

1995-2000

Five major health problems were identified in the 1995 Service Delivery Plan for Jefferson, Madison and Taylor Counties: Infant Mortality, Low Birth weight, Teen pregnancy, Trimester of entry into prenatal care, and Maternal Smoking. During the 1995 Service Delivery Plan the Coalition attempted to diminish barriers to increase access to care for pregnant women. Efforts included developing a child sitting program at each Health Unit. This program was successful in the early stage of the program but became difficult to maintain due to a lack of volunteers. Transportation barriers were also addressed. Flyer and business cards were developed with information on how to access public/private and Medicaid transportation. These were distributed to all social service agencies and providers of maternal and child health within each county. A special transportation fund was established in Madison County specifically for pregnant women. This was later defunded due to lack of utilization. During the 1995 Plan, efforts were also placed on teen pregnancy prevention in All. Taylor County was the only county to establish a program specifically for teens that addressed all issues facing teenagers, including teen pregnancy prevention. This program was called “Insider Television”. This program was very successful for two years. It was later cut due to funding and a lack of teen participation.

Major Accomplishments of the Last Five Years

Over the last five years, the Coalition has made several changes in the maternal and child health system in the three –county area by both expanding services and increasing the quality of services provided. At the beginning of the period, there was a significant amount of work devoted to state-level activities for Healthy Start redesign, and piloting Coordinated Intake and Referral. Healthy Families services were added as an additional resource for families in need of intensive home visiting services and parent education.

One of the most significant accomplishments is the system of care built as a result of the

collaborative process of the Home Visiting Advisory Board, a perpetual advisory council formed as a result of the Coordinated Intake and Referral project. The Board has developed agreements that succinctly describe their roles and dedication to avoid duplication of resources, as well as their ongoing commitment to ensuring evaluation of the system of care. This Board reviews data and marketing products that result in improvements to the system and increased identification of participants in Connect services. The Board participates in training to improve the quality of Connect services as well as responsiveness to referrals from providers in the coordinated system.

Another mammoth undertaking of the Coalition included adding Healthy Families services to the menu of available resources to families in these communities. The Healthy Families Seven Rivers project was funded in August 2015 and was selected for accreditation in January of 2019. At the conclusion of this planning cycle the project is fully staffed, including bi-lingual services, is fully accredited by Healthy Families America, and has a capacity to serve 65 families.

Towards the end of this planning cycle is the unprecedented COVID-19 pandemic and its impact on maternal and child health. The Coalition diversified its contracting unit to include an independent contractor in order to reach pregnant women that were becoming more difficult to identify through telephonic methods. In addition, other areas of deficit in the Healthy Start program were identified and many strategies are converging at the end of this planning cycle to ensure quality in perpetuity in Healthy Start. These include continued diversification of subcontractors, the addition of a breastfeeding peer support group, and the recent hire in February of 2021 of a full-time Program Director devoted to CQI processes. The next Service Plan will build upon this expansion of Healthy Start and include mechanisms for increasing skilled service providers, including a requirement for a Registered Nurse and Mental Health Services available within the staffing patterns of subcontracted providers. The programs have been built, and the quality is being measured; the next steps are to increase capacity for service provision.

Service Delivery Planning Process

Mobilizing for Action through Planning and Partnerships: A Community Approach to Health Improvement (MAPP)

The Coalition implemented a hybrid of the MAPP process, beginning in July 2025 with Board members and key stakeholders developing a timeline for activities and gaining consensus on needs assessment contents. The Coalition participated in a statewide MCH Needs Assessment, facilitated through a subcontract with the Florida Association of Healthy Start Coalitions (FAHSC). Throughout the summer of 2025, prepared maternal and paternal survey instruments were implemented, consumer focus groups were conducted and other needs assessment activities commenced. In December 2025, Coalition Board and planning committee reviewed the draft findings of the needs assessment and developed a timeframe for a community event and a facilitator subcontract. In February 2026, former Deputy Secretary of Health, Dr. Shamarial Roberson was engaged to facilitate a community meeting to set priorities as presented in the Needs Assessment.

Other Sources of Information

During the planning and assessment process, other sources of information and areas of community health were analyzed. Coalition staff attended various other community meetings (virtually) to solicit input and find solutions to our community's problems. These meetings consisted of both the Jefferson and Madison Disadvantaged Transportation Boards, the Home Visiting Advisory Council, the local FIMR Community Action Group, and Community Health Improvement Planning activities of the local hospital and health departments. Additionally, information was gathered from program staff through QI activities that result in additional administrative activities to be included in the Service Plan for 2026-2031.

Fetal and Infant Mortality Review (FIMR**)** data was also used during the Needs Assessment process. JMT is part of a regional committee that reviews a sample of Infant and Fetal Deaths for a five-county area, limited by resources. The Coalition's MCH Needs Assessment does, however, take a deep dive into the causes of infant death.

Resource Inventory and Gaps in Services

The three-county coalition area covers approximately 2,584 square miles and has limited health care resources available to its residents. Madison County Memorial Hospital and Doctor's Memorial Hospital (Taylor) are the two local hospitals serving county residents yet neither have Labor and

Delivery facilities. As of June 2026, there are no obstetric providers other than the county health departments and no birthing facilities within thirty minutes of the local health departments. Madison and Taylor County has increased the availability of various specialty services by partnering with hospitals and private providers in Leon County in an effort to bring specialists to the community on a part-time basis, including internal medicine, orthopedists, orthodontia, gynecology and optometry. The availability of these services is limited and is closely held with receiving care through hospital-contracted physicians. Most residents must seek specialty services in surrounding counties. Jefferson County residents continue to utilize neighboring counties for many of their service needs.

However, there has been additional momentum in the availability of Mental Health and Substance Abuse services in the counties. Disc Village continues to expand their focus on substance use and mental health under contract with the Managing Entity for these counties, namely the Northwest Florida Health Network. The Managing Entity covers Judicial Circuits 1 and 2 which includes Jefferson County but extends mental and behavioral health services to Madison and Taylor Counties which are in Circuit 3. This identity crisis and jurisdictional challenge along with an increased need documented in the prenatal screen is the impetus for the Coalition's undertaking of our own maternal mental health project in 2024.

Parenting resources are available through Healthy Families Seven Rivers; however, Circle of Parents™ opportunities have been discontinued in 2025 due a lack of commitment and appetite for the model fidelity.

Transportation remains an issue for the coalition area. With the implementation of Medicaid Managed Care, the local Disadvantaged Transportation Boards' role has significantly changed focus. Prior to 2015, the local Board had oversight over the designated Coordinated Transportation Provider, Big Bend Transit, as the sole Medicaid transportation provider for the area. Under MMA laws, Medicaid services can be "bid" to private providers based on the consumer-driven focus. The quality and dependability of that transportation is now outside the purview of the local Board, with the oversight being driven by the Agency for Health Care Administration. The effects locally are lack of communication, control, and optimization of resources as it relates to transportation in sparsely populated rural communities. However, Coalition leadership remains engaged in local transportation boards. A recent testament to that engagement is the local Board's coordination of transportation services to counteract the negative impacts of local grocery store closures resulting in the lack of WIC providers in the area.

Over the past five years, Jefferson, Madison and Taylor Counties have experienced additional changes in the provision of prenatal and pediatric services that are detailed below:

- Connect services, the front-line triage into all home visiting services originally launched in 2018 has expanded to include a dedicated home visit to those at highest risk who are unable to locate
- Connect services for infants have been expanded to include participation in a regional project to provide these services in the two local delivery hospitals in Leon County; this is a joint project of the Capital Area, Gadsden and JMT Coalition
- A Federally Qualified Rural Health Center, namely Madison Medical, has expanded its service capacity, built a larger building to increase specialty services including pharmacy and dental
- Doula services are now available in the area, under the Healthy Start umbrella with funding support from the Managed Care plans and FDOH
- Maternal mental health services have been established by the Healthy Start Coalition utilizing the Moving Beyond Depression™ framework
- Fatherhood services are now available effective December 2022 under the Healthy Start legislation, namely TEAM Dad
- The Jefferson Pregnancy Center opened in early 2025 to provide pregnancy testing and counseling and faith-based education to pregnant moms in Jefferson County
- HCA Florida Hospital, one of two delivery facilities in the region, changed their name and ownership from Capital Regional Medical and opened their 10-bed Level II Neonatal ICU in April 2022

Resource Inventory

The following resources are available and applicable for all counties in the Jefferson, Madison, and Taylor County catchment area. All share providers within and across county lines, as well as benefit from services from Leon County.

Florida Department of Health in Jefferson County

1225 W. Washington Street, Monticello, FL 32344

Offers Environmental Health Services, WIC Services, Family Planning, Healthy Start Services, Improved Pregnancy Outcome, School Health, STD and HIV testing, and Immunizations.

Prenatal Services

The Florida Department of Health in Jefferson County has the following:

- 1 Physician (contracted with Tallahassee Memorial Hospital) - 1/2 day, once/month
- 1 Nurse Mid-Wife – 1/2day/week (Tuesday pm)
- 1 Registered Nurses for Triage – 5 days/week

WIC

Women, Infant, & Children provide nutritional education and breastfeeding education, and support services are available one day a week. The WIC Program in this county is under the Leon County Health Department umbrella.

Healthy Start

Healthy Start services include targeted support services that address identified risks. The range of Healthy Start services available to pregnant women, infants and children up to age three include: Information and referral, Comprehensive assessment of service needs, Ongoing Care Coordination, Smoking Cessation Counseling, Childbirth Education, Breastfeeding and Parenting Support and Education, Well Woman Care Education, and Home visiting. The Healthy Start Program also provides PEPW Medicaid eligibility determinations, incentives and Group Prenatal Care classes. **Certified Lactation Counselors (CLC) are included in the staffing for Healthy Start services in Jefferson County.**

Family Planning

Family Planning is offered each Wednesday and every other Friday by a Certified Nurse Midwife.

Comprehensive School Health Program

This program includes nurses at all public schools in Jefferson County. The services provided by the school health program include, but is not limited to: vision screening, hearing screening, medication monitoring, and nutrition information. Referrals are also made to outside resources if necessary.

Florida Department of Health in Madison County

218 SW Third Avenue, Madison, FL 32340

Offers Environmental Health Services, WIC Services, Family Planning, Healthy Start Services, Improved Pregnancy Outcome, School Health, STD and HIV testing, and Immunizations.

Prenatal Care Services

The Florida Department of Health in Madison County has the following staff available to them:

- 1 Physician (contracted w/Tallahassee Memorial Hospital) - 1/2 day once/month
- 1 Nurse Mid-Wife/ARNP (for immediate perinatal care) – ½ day/week (Tues am)
- 1 Registered Nurses for Triage – 5 days/week

WIC

Women, Infant, Children nutritional education and support services are available at the Jefferson County Health Department two days a week. The WIC Program in this county is now under the Leon County Health Department umbrella.

Healthy Start

Healthy Start services include targeted support services that address identified risks. The range of Healthy Start services available to pregnant women, infants and children up to age three include: Information and referral, Comprehensive assessment of service needs, Ongoing Care Coordination, Smoking Cessation Counseling, Childbirth Education, Breastfeeding and Parenting Support and Education, Well Woman Care Education, and Home visiting. The Healthy Start Program also provides PEPW Medicaid eligibility determinations, incentives and Group Prenatal Care classes. **Certified Lactation Counselors (CLC) are included in the staffing for Healthy Start services in Madison County.**

Family Planning

Family Planning is offered two days a week by a Certified Nurse Midwife, who is also an ARNP, at the Madison County Health Department.

Comprehensive School Health Program

This program includes nurses at all public schools in the county. The services provided by the school health program include, but is not limited to: vision screening, hearing screening, medication monitoring, and nutrition information. Referrals are also made to outside resources if necessary.

Florida Department of Health in Taylor County

1215 N. Peacock Avenue, Perry, Florida 32347

Offers Environmental Health Services, WIC Services, Family Planning, Healthy Start Services, Improved Pregnancy Outcome, School Health, STD and HIV testing, and Immunizations.

Prenatal Care Services:

The Florida Department of Health in Taylor County has the following staff available to them:

- 1 Physician (associated with Tallahassee Memorial Hospital) - 1/2 day once/month
- 1 ARNP – 1/2 day every other except last week
- 1 Registered Nurse for Triage– 5 days/week

WIC

Women, Infant, & Children provide nutritional education and breastfeeding education and support services are available one day a week. The WIC Program in this county is now under the Leon County Health Department umbrella.

Connect Services

Using the prenatal and infant universal screening infrastructure, Connect services are a single point of entry for intake and referral for community services and supports that best support families' individual needs. Pregnant women and families with young

children are guided by a Connect worker to services such as education and support for childbirth, newborn care, parenting skills, child development, food and nutrition, mental health, and financial self-sufficiency. The Taylor County CHD provides Connect services for All in the Coalition catchment area.

Healthy Start

Healthy Start services include targeted support services that address identified risks. The range of Healthy Start services available to pregnant women, infants and children up to age three include: Information and referral, Comprehensive assessment of service needs, Ongoing Care Coordination, Smoking Cessation Counseling, Childbirth Education, Breastfeeding and Parenting Support and Education, Well Woman Care Education, and Home visiting. The Healthy Start Program also provides PEPW Medicaid eligibility determinations, incentives and Group Prenatal Care. **Certified Lactation Counselors (CLC) are included in the staffing for Healthy Start services in Madison County.**

Family Planning

Family Planning is offered two days a week by a Certified Nurse Midwife.

Comprehensive School Health Program

This program includes nurses at all public schools in the county. The services provided by the school health program include, but is not limited to: vision screening, hearing screening, medication monitoring, and nutrition information. Referrals are also made to outside resources if necessary.

Healthy Start Coalition of JMT

Healthy Families Seven Rivers

Comprehensive home visiting by paraprofessionals to prenatal or postpartum mothers to provide intensive parenting services as a child abuse prevention model. The target child can be served up to age 5.

Healthy Start Doulas

Lay women who provide home visits, coordinate referrals, develop birth plans and provide support and advocacy for moms in need during labor and postpartum.

TEAM Dad Services

Fatherhood education and support using the 24/74™ curriculum. Eligible fathers are those who are fathers of infants 0-3 residing in the catchment area.

Moving Beyond Depression™

Comprehensive maternal mental health services spanning 16 sessions, tailored to address the Edinburgh Depression Scale score and provide Cognitive Behavioral Therapy to establish appropriate copying strategies.

Domestic Violence

- **Refuge House**

1255 Washington Street, Monticello, FL 32344 | Madison, FL 32340 | Perry, FL 32348

Provides services to survivors of domestic violence, sexual assault and partner abuse and their families. Refuge House also offers support and "safe" places for women and children.

Mental Health

- **Apalachee Center for Human Services**

South Highway 19, Monticello, FL | 225 SW Sumatra Madison, FL | 301 Industrial Dr, Perry, FL 32348

Offers diagnosed psychiatric and social behavioral services for children and adults; no longer the catchment area's Medicaid provider for children's mental health services.

Substance Abuse

- **DISC Village Inc-** 1476 SW Main St, Greenville, FL Family Intervention Specialists & Case Management. Primary addiction services for at-risk prenatals are offered to referrals from Department of Children and Families, Healthy Start and Healthy Families.

- **Taylor County Recovery Center –** 215 N Washington St, Perry, FL. Outpatient Substance Abuse/Drug Treatment Programs, Certified Addiction Counselor.

Transportation

- **Big Bend Transit, Inc.**

  290 W. Dogwood Street, Monticello, FL 32344

  Provides transportation for Medicaid and non-Medicaid clients to and from medical services.

- **Private Medicaid Transportation provided under Managed Care Organizations**

Pediatric Services

- **Tallahassee Memorial Family Medicine (Monticello Family Medicine)**

  1549 S. Jefferson, Monticello, FL 32344

  Satellite of TMH, Tallahassee: 2 physicians and 1 PA on staff.

  Full-service family practice – medical care for all ages, female care, EKG and X-Rays.

- **Madison Medical Center (Federally Qualified Health Center under North Florida Medical Centers)**

  469 W Base St, Madison, FL

  General Primary Medical Care, Diagnostic Laboratory, Diagnostic X-Ray, Diagnostic Tests/Screens

- **Premier Medical Clinic**

  TMH Physician Partners 315 E Ash St Perry, FL 32347

  Full-service family practice including on-site services in Cardiology, Women's Health, Occupational, Internal, Diagnostic, Pediatric and Preventative Medicine.

- **Little Pine Pediatrics LLC**

  1702 S Jefferson St, Perry, FL 32348

  194 NE Hancock Ave, Madison, FL 32340

Services for Children with Special Needs

- **Kids Incorporated – Jefferson County Early Head Start Center**

  395 E. Washington St.

  Monticello, FL 32344

- **Kids Incorporated – Bright Days-Madison County Early Head Start Center**

  250 NW Haynes St.

  Madison, FL 32340

  The program provides comprehensive services to low-income pregnant women and children - birth through three years of age - and their families. Participants must meet income eligibility requirements and a minimum of 10% of the children served have special needs. Provides education and therapy (physical, occupational and speech). Education services and therapy are provided for children and their families who exhibit developmental delays.

- **Florida Diagnostic and Learning Resources System (FDLRS)/Miccosukee**

  3955 W. Pensacola St.

Tallahassee, FL 32304

Serves Jefferson and Taylor Counties. The various programs include Child-find, human resource development, parent services and technical assistance. This program also involves exceptional student education in counties served. Program headquarters is located in Tallahassee.

- **Children's Medical Services/Florida Department of Health**

  2390 Phillips Road

  Tallahassee, Fl 32308

  These services mostly located in Tallahassee are available to children in All. CMS provides services to children with special health needs (serious or chronic physical or developmental conditions that require extensive preventive and maintenance care) from birth to age 21 who meet medical and financial criteria. The program provides a continuum of services from prevention and early intervention programs to primary care with direct linkages to specialty and long-term care needs; www.cms-kids.com.

- **Children's Home Society – Early Steps (EIP)**

  1801 Miccosukee Commons Drive

  Tallahassee, FL 32308

  Serving children birth to age three who have, or are at risk for, developmental delay. A service plan is developed based on assessment, and services are coordinated and monitored through age 3.

- **Parents of the Panhandle Information Network (Family Network on Disabilities)** – 2196 Main St, Dunedin, FL; Funded by the U.S. Department of Education, Office of Special Education Programs (OSEP) provides parent training and information (PTI) services to the Panhandle of Florida. Services help to ensure that parents of children with the full range of disabilities have the training and information they need to prepare their children for not only school, but to be able to lead productive, independent lives to the fullest extent possible. http://fndusa.org/contact-us/programs/popin/

Childbirth Education (other than Healthy Start)

- **Brehon Institute for Family Services-Madison/Taylor County**

  S.A.F.E. (Safe and Family Education)

  P. O. Box 1382 P.O. Box 721

  Perry, FL 32348 Madison, FL 32341

  Home visiting program for young pregnant women and babies who are at risk. Childbirth education and parenting skills provided.

Parenting Education (other than Healthy Start)

- **Healthy Families Seven Rivers**

  1476 SW Main St

  Greenville, FL 32331

  Takes referrals for at-risk families of child abuse and neglect for intensive parenting services through home visiting venue.

- **Brehon Institute for Family Services-Madison/Taylor County**

  S.A.F.E. (Safe and Family Education)

  P. O. Box 1382 P.O. Box 721

  Perry, FL 32348 Madison, FL 32341

  Home visiting program for young pregnant women and babies who are at risk. Childbirth education and parenting skills provided.

Other Pregnancy Services

A Women's Pregnancy Center—345 NW Marion St, Madison, FL-for Taylor and Madison County clients. 1590 N Jefferson Hwy, Monticello, FL for Jefferson clients; Offering free pregnancy/ultrasound tests, counseling, abortion alternatives and post-abortion counseling, medical referrals, and supplies/clothing for mother and child; www.awpc.cc.

Local and Surrounding Hospitals

Jefferson County does not have a local hospital. All services requiring hospitalization must be received out of town. Depending on the illness, situation, or circumstance, people in Jefferson County usually receive services at Tallahassee Memorial Healthcare, Tallahassee Community Hospital, or Archbold Memorial Hospital (in Thomasville, Ga.). Each of these three facilities is at least 25 to 35 miles away. As with the other two surrounding counties, there are no obstetrical services available. Women must travel out of town for delivery.

Tallahassee Memorial HealthCare

1300 Miccosukee Road

Tallahassee, FL 32308

TMH offers a wide range of healthcare services. These services include Neonatal Intensive Care Unit and the women's specialty services at **A Woman's Place @ TMH**—include childbirth classes, infant-child CPR, classes for siblings and babysitting. Breast feeding support group and breastfeeding apparel, electric breast pumps (sales and rentals), accessories also available at Mommy Market. Counseling is available for post-partum depression. The Perinatal Bereavement Program at TMH offers counseling provided for anyone who has experienced a miscarriage, stillbirth, or death of a child during the first year of life. **TMH also provides Infant Intake services via a regionally funded Connect program.**

HCA Florida Capital Hospital

2626 Capital Medical Blvd.

Tallahassee, FL 32308

HCA offers labor and delivery services at the Family Center, as well as a variety of healthcare services including a surgery center, a cancer center, a heart and vascular center, and three satellite ER facilities in addition to the primary 24/7 emergency service unit. **HCA also provides Infant Intake services via a regionally funded Connect program.**

Shands Hospital

University of Florida ,Gainesville, Florida

Shands Hospital specializes in children's healthcare. There are numerous services and specialties offered by Shands. These include a Neonatal Intensive Care Unit, with Level I, II and III services offered, a burn unit with services offered and tailored to fit the patient/child's need and condition, a pediatric oncology unit specializing in children's cancer, a cancer center offering a wide range of services, including housing for patient's family, a bone marrow transplant unit, specializing in bone marrow transplants. There are also a number of other services offered which are especially for children. **Less than 12 births to women in the Taylor County area are delivered at Shands each year.**

Madison County Memorial Hospital

224 NW Crane Ave, Madison, Florida 32340

Madison County Memorial is a small rural hospital serving Madison and nearby counties. Emergency services are offered as well as inpatient and outpatient services. Home Health services are offered as well as physical, occupational, and speech therapy. Extremely critical patients would most likely be transferred to Tallahassee, or Valdosta, Georgia.

Doctor's Memorial Hospital

333 N. Byron Butler Parkway, Perry, Florida

DMH offers both inpatient and outpatient care to residents of Taylor and surrounding counties. Emergency room services are also available. X-rays, Lab services and various other healthcare options are available. ICU and Pediatric units are available. Home Health services are offered which include pediatric nursing, physical, occupational and speech therapy. Extremely critical patients would most likely be transferred to Tallahassee Memorial or Shands Gainesville.

Other hospitals which provide services to these counties are South Georgia Medical Center Valdosta, Georgia, and Archbold Memorial Hospital Thomasville, Georgia and North Florida Regional Medical Center Gainesville, Florida. These hospitals range from 35 to 125 miles away.

Additional service providers, based on proximity

Although there have been no substantial changes in the resource inventory for our communities in the last seven years, the area has benefitted from advancements in the maternal and child health sector of neighboring Leon County. The add-on resources that each county has availability to access are:

2-1-1 Big Bend, Family Health Line/Help Me Grow—PO Box 10950 Tallahassee, FL; Statewide hotline provides supportive counseling, information, and referrals on a variety of family planning, pregnancy, and young child issues. Help Me Grow provides developmental screening and appropriate referrals for developmental delays for children 0-8; www.211bigbend.org; (800) 451-2229

Big Bend La Leche League—2626 Care Dr. Ste. 109, Tallahassee, FL; League helps mothers breast feed by peer support, education, information, and encourages healthy development of babies; La Leche League International (www.llli.org); Florida (www.lllflorida.com)

Brehon House — Serves women 18 years and older who are homeless and pregnant; www.brehoninstitute.com.

Compassionate Friends Early Loss Program —Dealing with miscarriage, still birth, and infant death; tcfot@yahoo.com; www.tcftallahassee.com.

Children's Home Society Pregnancy Counseling—1801 Miccosukee Commons Dr; Counseling for birth parents with an unplanned pregnancy who are considering adoption for their child; or referring individuals in a crisis pregnancy to appropriate community resources; www.chsfl.org.

Early Learning Coalition of the Big Bend Region—3178 N Clark St, Perry, FL for Taylor residents, 702 E Base St, Madison FL for Madison residents. Jefferson residents are directed to use the Madison contact center. Child-care resource and referral; www.elcbigbend.org.

March of Dimes (Big Bend Division)1990 Village Green Way, Ste 3, Tallahassee, FL 32308; Resources to help ensure a healthy birth for every baby; www.marchofdimes.com.

Overview of the 2025 Maternal and Child Health Needs Assessment

The Healthy Start Coalition of Jefferson, Madison, and Taylor Counties participated in a statewide initiative aimed at collecting maternal and child health data for the 2025 MCH Needs Assessment. Nearly 20 Coalitions collaborated to engage WellFlorida Council, securing comprehensive and up-to-date data sets relevant to maternal and child health. In addition, coalition representatives contributed to committee efforts to ensure the successful completion of the project.

There are several pieces of the 2025 Needs Assessment that are written by Coalition, including the data summary, the priority areas of focus, and the insertion of summary data from localized qualitative tools.

Quantitative Data Summary

Jefferson, Madison and Taylor County residents have an average of 540 births per year (avg 2022-2024), small numbers for the purposes of statistical significance for Florida, but substantial in terms of the disparity in birth outcomes. These are impoverished, rural communities considered to be economically disadvantaged with poor prognosis for economic growth. It is important to note that while maternal and child health has improved significantly in Florida since the inception of the Healthy Start system of care in 1992, poor maternal and child health outcomes persist in these smaller communities. Perpetual poverty plays a key role in health outcomes, and these counties are some of the poorest in the state of Florida.

These three rural North Florida counties are uniquely different from the statewide population, in that these counties have little or no other races than black and white with some limited bi-racial makeup of the same two races. Taylor County has a higher white population than the state and Madison has nearly twice the state average of black population. Hispanic ethnicity is less than 3% for the entire area. All mirror the state in terms of percent of population by age group, with Jefferson having a slightly older population than the state.

For the Social Drivers of Health, these counties have significant barriers to optimal health. In Madison County, 19.4% of adults over the age of 25 do not have a high school diploma, compared to 10.4% for the state of Florida. In Madison and Taylor Counties, the median household income is concerning, at $48,176 and $44,985 respectively, compared to $71,711 for Florida. In Taylor County, 73% of families

with a female head of household with related children ages 0-4 are considered in poverty, compared to 34% statewide.

For Jefferson, Madison and Taylor Counties, mothers initiating prenatal care early are higher than the state average. An average of 80% of mothers of all races receive prenatal care early, compared to the state rate of 71.7%. These numbers may be attributed to the existence of prenatal care that is available at the local health departments in each county. The drastic shortage of obstetricians seen in the southern part of Florida is not as prevalent in the Big Bend Region. However, for the Hispanic population, there is a significant increase in late entry into prenatal care or no prenatal care at all, likely corelating with Pregnancy Medicaid requirements and immigration status, language barriers and transportation.

A woman's weight prior to pregnancy is directly correlated to birth outcomes. Obesity directly contributes to gestational diabetes, hypertension, and ultimately preterm birth. For these counties, there is not a significant difference between those that were underweight or overweight compared to the state. However, for obesity at the time of pregnancy, these counties are nearly double the state average. In Madison County, 42.6% of mothers were obese at the time of pregnancy, compared to 29.5% for Florida.

The shorter interval between the delivery of one baby and the conception of another has a strong correlation to LBW and VLBW outcomes. The accepted hypothesis is that nutritional depletion and stress on the mother's body from the labor and delivery process results in a higher-risk pregnancy and poor birth outcome for the subsequent infant due to lack of restoration. For births with an Inter-Pregnancy Interval less than 18 months, these counties mirror the state average of 36.3%.

For tobacco use, Jefferson County is below the state average at 2.1% of all live births to mothers who smoked during pregnancy. In Taylor County, this has declined dramatically over the last 5 years to closer to state averages. Smoking during pregnancy can lead to premature birth, low birth weight, and increased health risks for the infant.

In 2024 16.9% of mothers who participated in Healthy Start were reported with depression. In Jefferson and Madison County, those percentages were 24.5%. Of those mothers who consented to the Healthy Start screen in Florida in 2024 11.6% reported depression. In Madison County, that number was 20.7%. These statistics are a compelling motivation for the Coalition's maternal mental health initiatives. Jefferson and Madison County have high rates of systemic poverty, unemployment, scarce resources, and low education levels, which contribute to increased stress during pregnancy.

Birth outcomes are significantly less favorable than the state. 13.7% of births to mothers in Madison County are pre-term, compared to 10.7% for Florida. 13.5% of all births in Madison County are low birthweight infants, compared to 9.1% for Florida. For black mothers, 19.1% are born below a healthy weight. Births to teens in Taylor County are 14 births per 1,000 live births, compared to just 5.4 for Florida. In contrast, births to mothers over age 35 are lower than the state average. Evidence indicates that premature birth can negatively affect infant survival rates and is associated with increased risks for long-term developmental challenges.

Fetal death, or stillbirth is a significant concern in Taylor County, which has the highest fetal death rate in the state at 15.3 fetal deaths per 1,000 live births, compared to 6.9 for Florida. Potential contributors include elevated maternal stress from recent natural disasters, financial strain from an economic change in the community, and an overall increase in substance use amongst adults in the community. Taylor County suffered a major hurricane in August 2023, followed by the largest employer closing in October 2023 followed by another major hurricane in September 2024. This county consistently has high rates of child removal related to substance use as well.

An increase in Infant death is a concern for Madison and Jefferson Counties, whose infant death rate is 12.8 and 15.4 , twice the state average of 6.0. Pervasive poverty, inadequate housing, and maternal stress are all factors that impact the preconception health of the mother prior to pregnancy.

The causes of infant death in Madison County were primarily linked to unintentional injuries from unsafe sleep and disorders related to short gestation and low birth weight. Preconception care and counseling are primary interventions needed for the African American maternal population in Madison County. In Taylor and Jefferson County, primary causes of infant death were related to Congenital Malformations, Deformations and Chromosomal Abnormalities. Although premature birth is the leading cause of infant death, there are many contributing factors, most of which are associated with the preconception health status of the mother and her characteristics during pregnancy, which include nutritional status, pregnancy history, present pregnancy characteristics, psychological characteristics and adverse behaviors.

Qualitative Data Summary

The Healthy Start Coalition of Jefferson, Madison and Taylor Counties collected qualitative data from paternal surveys, three postnatal focus groups, a community stakeholder survey, and a maternal survey. Breastfeeding Support and Education: Positive attitudes toward breastfeeding and satisfaction with obstetric providers were observed. However, the need for intensified education on safe sleep practices among home visiting participants was identified.

Common themes across all data collection points include:

- Access to Prenatal Care: Longer waiting times for initial prenatal appointments may hinder early entry into care, suggesting a need to streamline scheduling processes.
- Home Visiting and Doula Services: Doula services were highly favored among home visiting options, indicating their importance in maternal support.
- Social Determinants of Health: Fair wages, housing, and childcare emerged as top needs across all groups, highlighting the necessity of addressing economic and social barriers to improve health outcomes.
- Food and Housing Assistance: A significant portion of respondents required food and housing support, emphasizing persistent gaps in basic needs.
- Trust and Safety in Healthcare: Most participants felt respected and safe in healthcare settings, with high levels of trust in clinic staff for health information.
- Community Awareness and Education: High awareness of community health programs like CONNECT, breastfeeding support, and family planning services demonstrates the effectiveness of ongoing health education efforts.

These themes suggest that improving maternal and child health requires a comprehensive approach involving enhanced education, improved access to care, support services, and addressing critical social determinants.

The highlights include no surprises in terms of men's health, where only 54.55% of men surveyed had a primary care provider and 36.36% receive no medical care at all. Although 100% of the paternal survey respondents reported living with the children they care for, this is not indicative of the population, where only 80% of fathers are acknowledged on the birth certificate.

The theme of the postnatal focus groups included positive attitudes and implementation of breastfeeding and overall satisfaction with obstetric providers. However, an emerging theme includes longer wait times for scheduling first prenatal appointments, which will affect early entry into care rates. Doula services were the most popular among home visiting services. Fair wages, housing and childcare was noted to be the top needs of all groups including the postnatal focus group women, maternal survey participants as well as paternal survey participants.

For maternal survey participants, 50.68% were enrolled in home visiting and only 48.61% utilized safe sleep practices for infants, indicating the need to intensify education amongst home visiting participants. 59.32% of respondents receive food assistance, and 68% need housing assistance, a recurrent theme for all instruments. Most of the respondents felt respected and safe in their healthcare settings, with 83% reporting trusting their health information with clinic staff.

Of the 39 key stakeholder respondents, 51.28% provide services to families with infants and children. Again, 56.41% highlighted affordable, safe housing as a top need. Regarding awareness of Healthy Start, 84.62% were aware of CONNECT, 82.05% were aware of breastfeeding support services, and 74.36% were aware of family planning services. These results are a testament to the Coalition's work as a facilitator of community health education.

Priority Areas of Focus

The Healthy Start Coalition maintains its commitment to improving maternal and child health outcomes through a strategic focus on several key priority areas. Priority areas of focus were chosen to address the concerning data of region's elevated obesity rates, high maternal depression prevalence, significant fetal and infant mortality disparities, and documented challenges in early prenatal appointment availability. Central to this approach is the emphasis on preconception and interconception care and education, which are critical strategies for reducing and eliminating infant and fetal mortality, and enhancing birth outcomes by addressing the health of mothers before, during, and between pregnancies.

Alongside these efforts, the Coalition recognizes the importance of expanding maternal mental health services and nutrition counseling. These services play a vital role in mitigating the negative effects of obesity and depression on birth outcomes, ensuring that mothers have access to the support and resources they need for healthier pregnancies and infants.

Behavioral health remains a significant area of focus, particularly in Taylor County, where ongoing strategies for prevention of substance abuse are essential. The Coalition is also committed to strengthening fatherhood services, with an expanded emphasis on men's health and co-parenting initiatives for female householders. These efforts aim to foster supportive family environments and improve outcomes for both parents and children.

Continued attention to Safe Sleep practices, family planning, and the availability of services at local county health departments is paramount. These initiatives ensure that families receive comprehensive education and access to essential services, supporting safer and healthier beginnings for infants.

While the tri-county area demonstrates strong identification rates of pregnant and postpartum women and consistent community referrals, there is a need to enhance the implementation of the Electronic Prenatal Screen. Focusing on this area will help ensure continuity of referrals from the screening process and facilitate provider education for seamless entry into care, ultimately strengthening the overall system of support for mothers and families.

Community Input Overview

A community meeting for Jefferson, Madison, and Taylor Counties was held February 26, 2026, to guide the development of the Coalition's 2026-2031 MCH Service Delivery Plan. The meeting involved the presentation of key maternal and infant health indicators, ongoing efforts in place to improve related outcomes, and facilitated discussion to gather community-informed recommendations. The strategic planning session included approximately 30 participants representing multiple sectors of the regional maternal and child health system**,** reflecting a cross-sector approach to improving maternal and infant health outcomes. This report presents a high-level summary of data shared during the community stakeholder meeting and key takeaways.

Across multiple indicators including infant mortality, fetal mortality, preterm birth, low birth weight, maternal obesity, and short interpregnancy intervals local rates exceed Florida state benchmarks. Jefferson and Madison Counties report infant mortality rates more than double the state average of 6.0 deaths per 1,000 live births. Preterm birth and low birth weight remain elevated in Madison and Taylor Counties. Maternal obesity and short interpregnancy intervals represent significant upstream risk factors contributing to adverse outcomes.

Although rural population size contributes to statistical variability, the sustained elevation across indicators and reporting periods reflects persistent maternal health risk and system-level access challenges. Programmatic data demonstrates measurable reductions in prematurity among Healthy Start participants relative to county population averages, indicating the benefit of structured screening, care coordination, and home visiting services. The following were identified by community stakeholders as recommended strategies to guide the 2026-2031 MCH Service Delivery Plan:

- Strengthening Care Navigation and Referral Systems
- Expanding Maternal Behavioral Health Support
- Strengthening Education on Birth Spacing and Maternal Health
- Expanding Community-Based Outreach and Engagement
- Community Health Workers and System Strengthening

Community Meeting Details

The Healthy Start Coalition of Jefferson, Madison, and Taylor Counties, in partnership with DSR Consulting and Management, LLC, convened a community engagement and strategic planning meeting on February 26, 2026, to inform the development of the Coalition's Maternal and Child Health Service Delivery Plan. This meeting was designed to translate the findings of the 2025 Maternal and Child Health Needs Assessment into a community-informed planning process focused on improving maternal and infant health outcomes across Jefferson, Madison, and Taylor Counties.

The session brought together stakeholders from local health departments, community-based organizations, and partner agencies to review key maternal and child health indicators, examine current Coalition strategies, and identify opportunities for improvement. Through presentation, discussion, and interactive polling, participants were asked to reflect on the drivers of poor birth outcomes, the effectiveness of existing interventions, and the strategies most likely to improve outcomes in the region. Polling and discussion findings showed strong concern around delayed prenatal care, challenges to insurance enrollment and follow-through, transportation and healthcare access, limited provider availability, and broader social and economic conditions affecting maternal and infant health. Participants also highlighted the importance of strengthening care coordination, expanding outreach and education efforts, and increasing access to supportive services that address maternal health before, during, and after pregnancy. Discussions emphasized the need for improved maternal mental health support, expanded family planning education and birth spacing resources, and stronger engagement of fathers and family support systems as protective factors for maternal and infant health.

This report summarizes the key indicators presented during the meeting and synthesizes community feedback gathered through facilitated discussion and interactive polling. It highlights the primary themes that emerged regarding current strategies, opportunities for improvement, and areas where new or expanded interventions may be warranted.

Regional Epidemiologic Overview

Infant Mortality

Infant mortality is defined as the number of deaths among infants under one year of age per 1,000 live births within a specified time period. According to the Florida Department of Health, Bureau of Vital Statistics and Florida Health CHARTS (2023–2024), Florida's infant mortality rate for 2021–2023 is 6.0 deaths per 1,000 live births. Rates in Jefferson, Madison, and Taylor Counties exceed the state benchmark:

- Jefferson County: 15.4 deaths per 1,000 live births
- Madison County: 12.8 deaths per 1,000 live births
- Taylor County: 7.8 deaths per 1,000 live births

Jefferson and Madison Counties report rates more than double the Florida average. Leading causes of infant death in the region include disorders related to short gestation and low birth weight, congenital anomalies, and sleep-related infant deaths, indicating the influence of both prenatal risk factors and postnatal environmental conditions. These patterns indicate strong associations with maternal chronic disease, obesity, hypertensive disorders, and delayed prenatal care (Centers for Disease Control and Prevention [CDC], 2023).

Fetal Mortality

Fetal mortality (≥20 weeks gestation per 1,000 live births plus fetal deaths) exceeds the state benchmark of approximately 6.0-7.0 deaths per 1,000 in Jefferson and Taylor Counties (FDOH, 2023–2024). Elevated fetal mortality reflects upstream maternal health risk, including chronic hypertension, diabetes, obesity, and insufficient risk management prior to and during pregnancy. These findings reinforce the need for strengthened interconception care and chronic disease stabilization.

Preterm Birth and Low Birth Weight

Preterm birth (<37 weeks gestation) remains elevated in Madison and Taylor Counties relative to Florida averages (FDOH, 2023–2024). Preterm birth is a primary contributor to infant mortality and neonatal morbidity, including respiratory distress and long-term developmental complications (CDC, 2023).

Low birth weight (< 2,500 grams (approximately 5 pounds 8 ounces)) trends parallel prematurity patterns. Data presented during the session indicate that Healthy Start participants experience lower prematurity rates compared with county population averages, consistent with national evidence supporting structured home visiting and coordinated prenatal intervention (U.S. Department of Health and Human Services [DHHS], 2022).

Maternal Health Risk Profile

Short Interpregnancy Intervals

Approximately one-third of births occur within 18 months of a prior birth (FDOH, 2023–2024). Short interpregnancy intervals are associated with increased risk of preterm birth, low birth weight, and fetal mortality (CDC, 2022). This represents an important preventable risk factor that can be addressed through strengthened postpartum contraception access, reproductive life planning education, and improved interconception care.

Maternal Obesity

Maternal obesity exceeds 35 percent of births in multiple reporting periods across Jefferson, Madison, and Taylor Counties (FDOH, 2023–2024). Pre-pregnancy obesity is associated with increased risk of hypertensive disorders of pregnancy, gestational diabetes, cesarean delivery, and adverse birth outcomes, including preterm birth. (CDC, 2023). Addressing maternal nutrition, chronic disease management, and healthy weight prior to and between pregnancies remains an important component of improving maternal and infant health outcomes.

Teen Births

Teen birth rates remain elevated in Taylor County relative to Florida benchmarks (FDOH, 2023–2024). Adolescent pregnancy is associated with increased risk of preterm birth, low birth weight, and

socioeconomic instability for both mother and child. Continued investment in comprehensive reproductive health education, youth engagement strategies, and access to family planning services remain essential for sustaining prevention efforts across the region.

Stakeholder Engagement Session

A multi-sector stakeholder session was convened to review key maternal and child health indicators, present existing Coalition strategies addressing these outcomes, and gather community-informed recommendations to guide the development of the Coalition's Maternal and Child Health Service Delivery Plan for Jefferson, Madison, and Taylor Counties. The strategic planning session included approximately 30 participants representing multiple sectors of the regional maternal and child health system**,** reflecting a cross-sector approach to improving maternal and infant health outcomes.

Participants engaged in facilitated discussion to reflect on the trends presented and identify factors contributing to maternal and infant health outcomes in Jefferson, Madison, and Taylor Counties. The conversation focused on both structural and community-level barriers influencing access to care, health behaviors, and service coordination across the region.

To encourage participation and assess baseline understanding of key indicators, an interactive polling activity was conducted. Participants responded anonymously to questions related to Florida's infant mortality rate, county-level mortality comparisons, short interpregnancy intervals, maternal obesity prevalence, and referral and linkage outcomes associated with the Healthy Start program.

Polling responses revealed several notable patterns. Many participants underestimated the magnitude of infant mortality in Jefferson and Madison Counties relative to the state benchmark. Awareness of the prevalence of short interpregnancy intervals and maternal obesity rates was also lower than anticipated among stakeholders, highlighting opportunities for increased education and shared understanding of key maternal health risk factors. Following review of the data, participants expressed strong support for expanded care navigation, behavioral health services, and improved coordination across healthcare and community-based service providers.

In conjunction with the facilitated discussion and written stakeholder feedback, the polling responses provided additional insight into stakeholder perceptions and priorities related to maternal and infant health outcomes. Detailed summaries of the pre-session and post-session polling results are included in the accompanying materials and provide additional context for the themes and strategic considerations identified during the engagement process.

Key Themes from Stakeholder Discussion

Following the review of regional maternal and child health indicators, stakeholders participated in facilitated discussion focused on identifying challenges affecting maternal and infant health outcomes and opportunities to strengthen existing efforts across Jefferson, Madison, and Taylor Counties. As participants reflected on the data and shared their experiences working with families across the region, several common themes emerged regarding access to care, service coordination, and awareness of maternal health risk factors.

Access to Prenatal Care and Early Engagement
During discussion of the regional data, several stakeholders noted that families may face challenges entering prenatal care early in pregnancy. Participants described challenges such as transportation limitations, difficulty navigating insurance enrollment processes, and limited availability of providers in rural communities. Stakeholders emphasized that delays in accessing prenatal care can limit opportunities to identify and manage maternal health conditions early in pregnancy, highlighting the importance of strengthening pathways that support earlier engagement with prenatal services.

Care Navigation and Service Coordination
As participants discussed the range of maternal and family support programs available across the region, stakeholders noted that families may struggle to understand what services exist or how programs connect to one another. Participants described situations in which referrals between healthcare providers and community-based programs may not always be completed or followed through, making it difficult for families to access needed support. These comments highlighted the importance of clearer referral pathways and improved coordination between organizations serving pregnant women and families.

Gaps in Access to Maternal Behavioral Health Services
Behavioral health needs during pregnancy and the postpartum period were also raised during discussion. Stakeholders noted that pregnant and postpartum women may face challenges accessing mental health services due to provider shortages in rural communities, stigma associated with seeking behavioral health care, and difficulties connecting families to appropriate providers. Participants emphasized that improving coordination between healthcare providers and behavioral health services could help ensure that mothers receive the support they need during pregnancy and after delivery.

Need for Greater Awareness of Maternal Health Risk Factors
The review of regional data prompted discussion about the level of awareness surrounding certain maternal health risk factors. Several participants noted that indicators such as short interpregnancy intervals and maternal obesity were not always widely recognized as contributors to adverse birth outcomes prior to the presentation. Stakeholders suggested that increasing awareness among both providers and families could help support healthier pregnancy planning and reinforce the importance of maternal health before and between pregnancies.

Community-Based Outreach and Education

Participants emphasized the importance of community-based outreach in connecting families with maternal and infant health services. Stakeholders highlighted the role of trusted community partners including home visiting programs, community health workers, and local organizations in sharing information with families and helping them access services. Several participants also noted the importance of engaging fathers and extended family members as part of broader family support systems that contribute to maternal and infant well-being.

Strategic Opportunities Identified by Stakeholders

Stakeholder discussion and polling results identified several strategic opportunities to strengthen maternal and infant health outcomes across Jefferson, Madison, and Taylor Counties. Participants emphasized that improving outcomes will require coordinated approaches that address both healthcare access and the broader system challenges affecting maternal health in rural communities. The opportunities outlined below reflect areas where stakeholders identified potential for measurable improvement.

Strengthening Care Navigation and Referral Systems

Stakeholders consistently highlighted the need for stronger care navigation to help families access services across the maternal and child health system. Participants noted that pregnant women often encounter challenges navigating insurance enrollment, scheduling prenatal appointments, and connecting with available community resources. In rural communities with limited providers, barriers such as incomplete applications, missed follow-up communication, or transportation limitations can delay entry into care.

Participants described situations in which families begin the Medicaid or pregnancy-related coverage process but have trouble completing required documentation or understanding eligibility determinations. These barriers can delay prenatal care or interrupt continuity of care. Expanding care navigation support through community-based staff or trained program personnel could improve follow-through and help families remain connected to services throughout pregnancy and the postpartum period.

Stakeholders also noted that referral pathways between healthcare providers, social service organizations, and maternal support programs could be strengthened. Families may receive referrals but lack the support needed to successfully complete the connection to services. Improving coordination and communication between organizations may help ensure that referrals result in completed service linkages and sustained engagement.

Expanding Maternal Behavioral Health Support

Limited access to maternal behavioral health services was identified as a significant challenge across the region. Stakeholders reported that pregnant and postpartum women may face long wait times, limited provider availability, and insurance barriers when attempting to access mental health services. In rural areas, shortages of behavioral health professionals further restrict access to counseling and treatment.

Participants emphasized that maternal mental health plays a key role in both maternal well-being and infant health outcomes. Untreated behavioral health conditions may contribute to delayed prenatal care, reduced engagement with healthcare services, and increased risk for complications during pregnancy and the postpartum period.

Expanding behavioral health integration within maternal health services and strengthening referral networks between healthcare providers and behavioral health professionals were identified as opportunities for improvement. Stakeholders also noted the importance of ensuring that behavioral health screening and referral processes are incorporated within existing maternal and child health programs.

Strengthening Education on Birth Spacing and Maternal Health

Review of regional maternal health indicators prompted discussion about the level of awareness surrounding certain risk factors, including short interpregnancy intervals and maternal obesity. Stakeholders noted that these indicators were not widely recognized as contributors to adverse birth outcomes prior to the data presentation.

Participants emphasized the importance of strengthening education related to postpartum family planning, reproductive life planning, and interconception health. Improving awareness of healthy birth spacing and expanding access to family planning services may help reduce preventable risks associated with closely spaced pregnancies.

Stakeholders also discussed the value of reinforcing maternal health education beyond clinical settings. Community-based education delivered through trusted local partners may help increase awareness of maternal health risks and encourage healthier pregnancy planning.

Expanding Community-Based Outreach and Engagement
Participants emphasized that trusted local relationships play a key role in connecting families with maternal and infant health services in rural communities. Stakeholders noted that families often rely on word-of-mouth communication, faith-based organizations, and community programs when seeking information about available services.

Expanding outreach strategies that leverage existing community networks may improve awareness of maternal health services and encourage earlier engagement with care. Stakeholders suggested that community workshops, peer support opportunities, and local partnerships could help strengthen connections between families and available services.

Participants also noted that some families may not currently be reached by existing programs, including youth, individuals who do not meet eligibility requirements for certain services, or families who may not initially appear to require assistance. Developing outreach strategies that increase awareness of available services and strengthen early engagement may help ensure that families receive support when it is needed.

Community Health Workers and System Strengthening

Community Health Workers (CHWs) represent a potential strategy for strengthening care coordination and addressing these system-level challenges. CHWs serve as trusted liaisons between communities and healthcare systems and can help bridge gaps between clinical providers and community-based services. Evidence demonstrates that CHW programs can improve appointment adherence, health literacy, chronic disease management, and care coordination, particularly in rural communities (Berini, Bonilha, & Simpson, 2022; Knowles et al., 2023). CHW programs have also been associated with improved maternal health engagement and reductions in preventable pregnancy complications.

Expanded integration of CHWs within the regional maternal and child health system could help address several challenges identified during stakeholder discussion. CHWs may support families by assisting with Medicaid and insurance navigation, helping schedule and follow up on prenatal appointments, reinforcing safe sleep and prenatal health education, and supporting management of maternal chronic health conditions. Through ongoing engagement with families, CHWs can also help strengthen communication between healthcare providers, community-based programs, and families receiving services.

Integrating CHWs into maternal and child health initiatives aligns with broader rural health system transformation models that emphasize embedded care coordination, continuity of care, and stronger connections between clinical services and community-based supports.

Given stakeholder-identified barriers including Medicaid navigation complexity, transportation challenges, and fragmented follow-up care, expanded CHW integration represents a strategic opportunity to improve maternal and infant outcomes. CHWs can support:

- Medicaid and insurance application assistance
- Appointment scheduling and follow-up
- Reinforcement of safe sleep and prenatal education
- Chronic disease management support

Integration of CHWs aligns with rural health transformation models emphasizing embedded care coordination and continuity.

Rural Health System Considerations

Rural communities face structural challenges including provider shortages, behavioral health workforce gaps, limited specialty access, and transportation barriers (HRSA, 2023). Improving maternal and infant outcomes requires:

- Integrated care coordination
- Behavioral health expansion
- CHW infrastructure
- Data-informed decision-making

- Cross-sector collaboration

Sustainable improvement depends on long-term system strengthening rather than short-term interventions.

Strategic Priorities

1. Reduce preterm birth in Madison and Taylor Counties.
2. Expand postpartum contraception and interconception care.
3. Increase perinatal behavioral health capacity.
4. Strengthen CHW integration to improve care navigation.
5. Enhance maternal obesity prevention and chronic disease screening.
6. Improve youth-focused prevention strategies.

2026-2031 Action Plan

Priority Area	Key Actions	Lead Staff	Support Staff / Partners	Timeline	Measures
SMART Goal 1: Improve preconception, prenatal, and maternal health risk reduction					
Preconception and interconception care; birth spacing and family planning	• Standardize reproductive life planning and postpartum contraception education. • Launch a tri-county interconception education campaign. • Strengthen referral pathways for family planning access.	Program Director	CCHW/Provider Liaison Home Visitors, County Health Departments, Prenatal Providers, CONNECT	2026-2027: develop protocols and materials. 2027-2029: implement and train staff. 2029-2031: monitor and refine.	More referrals, more education documented, fewer short interpregnancy intervals.
Maternal mental health and behavioral health access	• Expand maternal depression screening and follow-up. • Create a behavioral health resource directory and warm handoff process. • Strengthen local and telehealth referral options.	Executive Director Subcontracted MH Provider	CCHW/Provider Liaison Home Visitors, Community CHWs, Behavioral Health Providers, County Health Departments	2026-2027: map providers and train staff. 2027-2029: expand screening and linkage support. 2029-2031: evaluate access and	Higher screening and referral completion, stronger follow-up, improved access.

Priority Area	Key Actions	Lead Staff	Support Staff / Partners	Timeline	Measures
				sustain partnerships.	
Maternal obesity, nutrition counseling, and chronic disease risk reduction	• Expand nutrition and healthy weight counseling. • Strengthen referrals for chronic disease screening and management. • Integrate education on hypertension, diabetes, and stress.	Health Education Coordinator	CCHW/Provider Liaison Nutrition Staff, CHWs, County Health Departments, Providers, Home Visiting Staff	2026-2027: develop materials and partnerships. 2027-2029: implement counseling and referral support. 2029-2031: refine outreach based on trends.	More education delivered, stronger referrals, greater risk awareness.
SMART Goal 2: Increase timely access, service coordination, program capacity and system efficiency					
Care navigation, Medicaid support, and referral system strengthening	• Improve navigation for insurance, appointments, and follow-through. • Implement closed-loop referral tracking. • Educate providers on local maternal and infant	Program Director Provider Liaison	CCHW/Provider Liaison Home Visitors, Enrollment Staff, CHWs, Community Partners, Providers	2026-2027: assess gaps and build workflow. 2027-2029: implement tracking and outreach. 2029-2031: review data	Better referral completion, fewer delays in care, stronger continuity.

Priority Area	Key Actions	Lead Staff	Support Staff / Partners	Timeline	Measures
	health resources.			and improve continuity.	
Electronic Prenatal Screen implementation and provider engagement	• Increase provider use of the Electronic Prenatal Screen. • Provide training and technical assistance. • Review screening-to-enrollment data for missed opportunities.	Provider Liaison	CCHW/Provider Liaison Prenatal Providers, Clinic Staff, Home Visitors, Data Staff	2026-2027: baseline review and provider outreach. 2027-2029: expand training and monitoring. 2029-2031: sustain quality review.	More completed screens, stronger referral conversion, earlier entry into care.
Community Health Worker integration and rural system strengthening	• Expand CHW roles in navigation, follow-up, education, and chronic disease support. • Define CHW workflows across prenatal and postpartum care. • Strengthen cross-sector communication.	Executive Director	CCHW/Provider Liaison CHWs, Home Visitors, Providers, County Health Departments, Community Agencies	2026-2027: define scope and pilot activities. 2027-2029: expand integration. 2029-2031: sustain infrastructure and formalize partnerships.	Better appointment adherence, stronger coordination, improved system integration.

Priority Area	Key Actions	Lead Staff	Support Staff / Partners	Timeline	Measures
SMART Goal 3: Reduce infant mortality and improve family-centered support and prevention through programmatic saturation					
Infant and fetal mortality reduction; safe sleep education	• Intensify safe sleep education across prenatal and postpartum services. • Target prevention messaging in high-risk counties. • Review infant and fetal loss trends annually.	Program Director	CCHW/Provider Liaison Home Visiting Staff, Hospitals, County Health Departments, Pediatric Partners, CHWs	2026-2027: standardize education and review process. 2027-2029: expand county outreach. 2029-2031: adapt activities using annual data.	Greater education reach, better prevention alignment, improved caregiver awareness.
Fatherhood services, men's health, and co-parenting support	• Expand fatherhood engagement in outreach and referrals. • Offer men's health and co-parenting education. • Normalize father participation in maternal and infant health services.	Program Director	CCHW/Provider Liaison Fatherhood Program Staff, Community Organizations, Home Visiting Programs, CHWs	2026-2027: develop strategy and partnerships. 2027-2029: implement education and referral supports. 2029-2031: evaluate and expand	More father engagement, more referrals, stronger family supports.

Priority Area	Key Actions	Lead Staff	Support Staff / Partners	Timeline	Measures
				successful models.	
Community-based outreach, doula and home visiting awareness	• Expand awareness of doulas, home visiting, breastfeeding support, family planning, and CONNECT. • Use trusted community channels and local events. • Target underserved families, including youth.	Provider Liaison Doula Coordinator	CCHW/Provider Liaison Doulas, Home Visiting Staff, CHWs, Faith-Based Partners, Community Organizations	2026-2027: refresh materials and outreach calendar. 2027-2029: launch county campaigns. 2029-2031: maintain outreach and adjust to data.	Greater awareness, earlier engagement, broader reach.
Social drivers of health: housing, food, childcare, transportation, and economic needs	• Strengthen screening and referral for basic needs. • Maintain resource mapping and coordinated response planning. • Use social needs trends in planning and advocacy.	Executive Director Provider Liaison	CCHW/Provider Liaison Home Visitors, CHWs, Social Service Agencies, Housing and Food Partners, Coalition Leadership	2026-2027: update resources and screening process. 2027-2029: expand coordinated referrals and meetings. 2029-2031: monitor	More families connected to supports, better coordination, stronger use of data.

Priority Area	Key Actions	Lead Staff	Support Staff / Partners	Timeline	Measures
				trends and align advocacy.	
SMART Goal 4: Strengthen performance measurement, accountability, and continuous improvement					
Data, quality improvement, and stakeholder accountability	• Establish annual review of service and outcomes data. • Use stakeholder meetings to assess progress. • Track implementation and revise annually.	Executive Director and Program Director	Coalition Leadership, Data Staff, Program Managers, Community Stakeholders	2026-2027: establish dashboard and review calendar. 2027-2029: report progress and adjust implementation. 2029-2031: document outcomes and sustainability needs.	Annual progress review completed, stronger accountability, clearer alignment with priorities.

Quality Assurance and Monitoring

The Healthy Start Coalition of Jefferson, Madison & Taylor Counties employs both internal and external monitoring to assure quality in both program delivery and the core functions of the Coalition. The plan is included below:

I. Overview of Program

Purpose

The purpose of the Quality Assurance Program at the Healthy Start Coalition of Jefferson, Madison and Taylor Counties, Inc. (the Coalition) is to assess and improve the quality and appropriateness of care being provided to pregnant women, infants, and fathers by subcontracted providers. The purpose is also to ensure services are effective for the families receiving assistance from the Coordinated Intake and Referral team, Healthy Start, ~~or~~ T.E.A.M. Dad, or Healthy Start Doulas. The program ensures that any deficiencies identified through the monitoring and evaluation process that are not in compliance with established standards are targeted for corrective action.

Goals

The goals of the Quality Assurance Program are as follows:

A. To ensure that the established levels of quality care are maintained and continuously improved by all providers through

    1) The monitoring and evaluation of the care, service and processes provided to participants in order to identify areas for improvements and deficit trends;

    2) Identification of training needs based on the monitoring system;

    3) The implementation of corrective actions when deficit trends and opportunities for improvement are identified; and

    4) Monitoring and evaluating the resolution of the problem or opportunity for improvement to ensure the corrective action has been effective.

B. To ensure appropriate utilization of services, timeliness of service provision, and accessibility to services through

    1) Ongoing review of state and local reports to examine status of process indicators, performance measures and outcomes;

    2) Establish performance improvement projects when expected target goals are not being met; and

    3) Re-evaluate processes implemented for continuous quality assurance.

C. To ensure Coalition operations are in compliance with state statutes, contract requirements, and internal quality standards through

    1) Quarterly review and evaluation of the agency work plan by staff;

    2) Self-monitoring of compliance on an annual basis; accomplishment of goals and objectives in the Service Delivery Plan; and

    3) Community survey of Coalition’s responsiveness to the community's needs within the confines of statutes and our mission,

    4) Annual provider survey of Coalition's responsiveness to the providers needs within the confines of statutes and our mission.

D. To ensure the effectiveness of the Quality Assurance Program through

    1) The integration of information from all quality assurance activities;

    2) The annual assessment of the monitoring and evaluation process to determine its effectiveness; and

    3) Appropriate revisions to the program and/or service delivery plan as identified through the annual evaluation.

II. Organization

The Quality Assurance Program is designed to encourage participation by Healthy Start Coalition staff, Coalition members and subcontracted service providers to provide usable data to assess service performance in relation to the Healthy Start Standards and Guidelines, Intervention Pathways, and the Coalition's adherence to contract requirements and state statutes. Other indicators of quality and appropriateness may be assessed based on the specific needs of Jefferson, Madison, and Taylor Counties for future planning or special projects.

A. Quality Assurance Committee

Responsibilities

The quality Assurance 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 assurance activities of the Coalition relative to internal standards and utilization of services for input into revision of the Quality Assurance Plan annually.

Membership

Membership of the Quality Assurance Committee will include the Healthy Start Coalition Executive Director (ED) and Program Director (PD), board members and County Health Department (CHD) staff. The Board of Directors represents a diverse group of professionals who have experience or background in nursing, social services, counseling, program management, contract management, or quality assurance.

Meetings

The Quality Assurance Committee will meet annually. The meetings will address a review of monitoring tools and procedures for each contract year and a review of the Quality Assurance Plan with recommendations for revisions. The updated QA Plan will be sent to committee members within two weeks after the date of the meeting.

III. Quality Assurance Functions

A. Monitoring of the Healthy Start System of Care

Purpose

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 assurance activities, and data entry. Documentation of service provision is reviewed to ensure that risk appropriate services are being offered at the intensity indicated per the Healthy Start Standards and Guidelines (HSSG). The effectiveness of programs and services in relation to established performance and outcome measures is evaluated as established in the provider's contract.

Activities

- Quarterly Technical Assistance (TA)
- Annual Administrative Review of Services Provided as required by the Deliverables section of the Healthy Start Contract
- Annual Shadowing of direct services
- Monthly Record Review of Healthy Start Services
    1. Randomized, and
    2. Targeted – high-risk, by screen score
- Monthly Family Phone Survey
- Monthly Monitoring of the Program Tickler List
- Monthly Monitoring of Medicaid billing code by Provider for accuracy
- Quarterly Evaluation of the Birth Outcomes Report
- Quarterly Evaluation of the Health Plan Coordination Report
- Quarterly Evaluation of Performance and Outcome Measure goal attainment per provider
- Quarterly TA to Discuss Record Review Findings
- Quarterly monitoring of Medicaid Numbers

- Monthly monitoring of staff Training and Credentialling
- Annual Satisfaction Survey results
- Semi-Annual Fiscal Monitoring of Expenditures by Random Sample
- Annual Reconciliation of Budget vs Expenditures for Healthy Start funding
- Monthly Program Manager (PM) calls
- Monthly supervision of independent subcontracted provider
- Quarterly Random Record Review (1) per Enhanced Service

Process

1. Monthly, the Coalition PD will conduct a random record review for at least one participant per care coordination staff, and at least one Family Phone Survey per subcontracted provider. As part of the record review process, PD will be monitoring for adherence to the most recent HIPAA guidelines listed in the appendix. These results are then discussed contemporaneously with care coordination staff during the 1st, 2nd, 3rd Quarters TA meetings and the Semi-Annual/Annual Site Visits. A summary of the findings, along with an Action Plan for moving forward, will be sent to the appropriate Program Manager within two weeks of the meeting/visit.

2. Monthly, PD will monitor the Program Tickler List to ensure service provisions are happening at appropriate intervals as designated in the HSSG.

3. Monthly, the Coalition PD will monitor the Medicaid billing codes by Service Provider for accuracy. Any discrepancies will be appropriately staffed with Provider.

4. Monthly, the Coalition PD will monitor staff profiles in the Healthy Start Learning Management System (LMS) for any update to their training and credentials. All updates will be documented on the Training and Credentialing Log.

5. During the first quarter of the new fiscal year, the Coalition's Program Director (PD) will collaborate with the provider to schedule observation/shadowing of direct services, and observation of group education. All individual and group observations will be completed by the end of the second quarter. Observations will be reviewed based on the scale located on the Healthy Start Observation Tool and Healthy Start Group Observation Tool. Further observations will be scheduled as needed based on initial scores.

6. Each provider will have on-site monitoring by the Coalition at least twice during the contract year. This will include a site visit during the second quarter of the fiscal year, followed by the

Annual Administrative Monitoring in the fourth quarter of the fiscal year. The Service Provider will conduct peer reviews as part of their internal Quality Assurance plan.

7. Prior to each site visit, the provider will receive electronic notice confirming the date, time, and location of the visit. The initial site visit will include a cumulative report of record review findings, verification of appropriate resource inventory, review of supervision records, as well as an entrance and exit interview. The purpose of this preliminary site visit is to prepare sub-contracted providers for the Annual monitoring to be done during the fourth quarter. The Annual monitoring will include an administrative review of contract requirements, cumulative report of record review findings, verification of appropriate resource inventory, review of supervision records, and an evaluation of the provider's goal attainment of performance and outcome measures.

8. Annual monitoring visits will include an entrance and exit conference. 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. The provider will then receive a written report from the Coalition within two calendar weeks of the site visit summarizing the findings and identifying any corrective action requirements, if necessary. The monitoring report is to be completed by the Coalition Program Director.

9. During the 1st, 2nd, and 3rd Quarters, the Coalition will conduct virtual TA meetings to provide a plan of action to address record review findings. A summary of the findings, along with an Action Plan for moving forward, will be sent to the appropriate Program Manager within two calendar weeks of the meeting.

10. The Coalition will also conduct monthly Program Manager meetings every first Thursday of the month to discuss emerging system issues and programmatic review using the management reports of the Well Family System.

11. HS Provider Staff will participate in training offered by the Coalition on the core program components, documentation, and skill building.

12. Each Quarter along with the Record Reviews, the Coalition PD will review the Performance and Outcome Measures of each subcontracted provider. If subcontract provider falls below expectations (contract requirement: 80%) for two consecutive quarters on any performance measure, then a Quality Improvement Plan (QIP) will be established by the Coalition. Once the QIP is established, it will be sent to the subcontracted provider within two calendar weeks following the meeting/site visit. The subcontracted provider will return the initial QIP update

with at least 3 Action Steps for each QIP item within 30 calendar days from the receipt of the QIP. Quarterly updates should be sent to the Coalition by the due dates specified on the QIP.

13. Quarterly, the PD will also review the Birth Outcomes Report to ensure proper documentation of births.

14. Quarterly, the Coalition Program Director will review Healthy Start case records to identify any missing Medicaid numbers. Program Director will collaborate with County Health Department (CHD) staff to obtain and update any missing information accordingly.

15. On or before December 1st of each year, all subcontracted providers will provide a satisfaction survey to all open participants either by scanning a QR code with a link to the survey or by mailing it to them with a pre-addressed, stamped envelope for sealed mail to the Coalition. A list of all clients invited to complete the survey will be submitted to the Coalition on or before December 1st. All surveys should be received by the Coalition no later than January 1st. Participant satisfaction results will be tallied and shared with Providers no later than March 1st.

16. The subcontracted provider will conduct internal record reviews as part of ongoing clinical supervision with each Care Coordinator.

17. The subcontracted provider will submit at least one client for participation on the Interdisciplinary Care Team (ICT) call by the 15th day of the first month of each quarter. PD will review the Health Plan Coordination Report on the 16th day of the first month of the quarter to verify submissions. The subcontracted provider will confirm that the client has given the appropriate level of consent to share with the Managed Care Organization (MCO) prior to the date of the ICT call. For CI&R records, verbal consent is required (at a minimum) to share information with health plans. For Healthy Start records, written consent is required to share information with health plans (including on ICT calls). If the client has not provided written consent for sensitive information, then sensitive information may not be shared. This means that there may be some information that Coalitions are not able to share with health plans due to lack of client consent. If staff see that full consent was not given to Connect or Healthy Start for sharing information, Coalitions may outreach clients prior to the ICT call to see if consent can be obtained. **Regardless of the levels of consent that a client did or did not provide, all subcontracted providers will still be expected to attend the ICT call.**

18. Monthly, PD will conduct supervision with independent subcontracted provider using the Healthy Start Independent Subcontracted Provider Supervision form located in the appendix.

19. Quarterly, PD will review one random case record per enhanced services.

B. Monitoring of the Coordinated Intake and Referral System (CI&R)

Purpose

CI&R program is operated by Coalition subcontracted service providers. 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 service provision, adequate staffing, reporting, coding, quality assurance activities, data entry, performance measure goal attainment, and participant satisfaction with the program. Documentation of service provision is reviewed to ensure risk appropriate services are being offered at the intensity indicated per the Healthy Start Standards and Guidelines.

Activities

- Participation in the quarterly meeting of the Local Home Visiting Advisory Council
- Quarterly Monitoring of Well Family Data Reports for adherence to decision trees, and capacity concerns
- Quarterly monitoring of the contract requirements for Initial Intake completion
- Quarterly CIR collaboration with Capital Area Healthy Start Coalition (CAHSC) Program Manager
- Quarterly monitoring of Medicaid numbers
- Monthly Record Reviews
- Monthly monitoring of the CIR Action List and Referral Status Ticklers
- Annual Implementation Evaluation

Process

1. Record Reviews will be conducted on a random sample of Initial Intakes that were 1) referred to Healthy Start for an Initial Assessment, or 2) referred to another home visiting program, or 3) received education only. The criteria for record reviews are at least 10% of Connect referrals per CIR Staff per month Records will be reviewed for compliance with local decision trees and Chapter 4 of the HSSG. For any deficits in services, a Quality Improvement Plan (QIP) will be developed by the Coalition PD.
2. The Provider will perform record reviews during internal supervision sessions with CIR staff.
3. The subcontracted provider will maintain access to Florida's Medicaid System for adequate coding of Medicaid-billable services and ensuring documentation of Medicaid numbers in client records. Quarterly, PD will monitor CIR cases to ensure the documentation of Medicaid numbers is taking place. In the event of missing Medicaid numbers, PD will email list to CIR staff to correct documentation.
4. The Coalition will conduct an annual administrative and services monitoring of the program for maintenance of contract compliance using the Well Family System data reports and through direct observation of the Initial Intake. If corrective action is necessary, the Coalition will develop the Quality Improvement Plan, and designated HSC Staff will monitor the implementation and results.
5. Monthly, the Coalition PD will monitor staff training and credentials for any needed updates.
6. Each Quarter, the Coalition PD will collaborate with the CIR Program Manager (PM) at CAHSC to ensure that appropriate service provision is happening at Tallahassee Memorial Hospital (TMH) and Florida Capital Hospital (HCA).
7. Monthly, in concurrence with the Record Reviews, the Coalition PD will monitor the CIR Action List and Referral Status ticklers for outstanding cases of 30 calendar days or longer which have not transitioned to closure or enrollment in a Home Visiting (HV) program.

C. Monitoring of the 24/7 Dad® Fatherhood Services (T.E.A.M. Dad)

Purpose

24/7 Dad® is operated by a Coalition employee hired to provide Fatherhood services. 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 service provision, adequate staffing, reporting, coding, quality assurance activities, data entry, performance measure goal attainment, and participant satisfaction with the program. Documentation of service provision is reviewed to ensure risk appropriate services are being offered at the intensity indicated per the Healthy Start Standards and Guidelines.

Activities

- Monthly Record Reviews
- Monthly Supervision with Fatherhood Coach
- Monthly monitoring of training and credentials
- Annual Monthly Family Phone Survey
- Quarterly Monitoring of Outcome Measures
- Quarterly TA to Discuss Record Review Findings

Process

1. Monthly, the Coalition PD will conduct ~~a~~ random record review for each T.E.A.M. Dad participant until the subcontracted provider has a caseload of ten engaged participants. After minimal caseload is achieved a random sample of 20% will be reviewed.
2. Monthly, the Coalition PD will monitor staff training and credentials for any needed updates.
3. Monthly, the Coalition PD will conduct supervisions with Fatherhood Coach using the T.E.A.M. Dad Supervision form listed in the appendix.
4. Each Quarter, the Coalition will conduct TA meetings to provide a plan of action to address record review findings. A summary of the findings, along with an Action Plan for moving forward, will be reviewed with the Fatherhood Coach at the first supervision following the meeting.
5. ~~5.~~ Each Quarter along with the Record Reviews, the Coalition PD will review the Performance and Outcome Measures of the program. If Program expectations are not met for two consecutive quarters on any performance measure, then a Performance Improvement Plan (PIP) will be established by the Coalition. Once the PIP is established, it will be discussed with the Fatherhood Coach at the first supervision following the TA meeting
6. The Coalition PD and Fatherhood Coach will participate in monthly statewide TA calls.

D. Monitoring of the Healthy Start Doula Program

Purpose

The Healthy Start Doula Program is operated by Coalition individual subcontracted service providers. **The purpose of service monitoring is to ensure important aspects of care are being provided as outlined by guidance from the Healthy Start MomCare Network (HSMN).** Procedures and protocols are reviewed to ensure compliance with the contract, including service provision, adequate staffing, reporting, coding, quality assurance activities, data entry, and participant satisfaction with the program. Documentation of service provision is reviewed to ensure risk appropriate services are being offered at the intensity recommended by the Statewide Doula Coordinator.

Activities

- Monthly Monitoring of Doula Services
- Monthly Virtual Doula Coalition TA Call
- Monthly Virtual Doula Statewide Coordinator Meeting
- Monthly Monitoring of Health Plans
- Monthly Monitoring of Medicaid Billing
- Quarterly TA to Discuss Record Review Findings

Process

1. Monthly, the Doula Coordinator (DC) will review the client records for each subcontracted doula provider to ensure that outreach attempts and visits are documented in accordance with both state and localized guidance. This includes making sure that doulas are attempting an outreach within 72 hours of case assignment to perform introduction. Any discrepancies will be discussed with Coalition Doula Coordinator (DC) for additional TA opportunities during quarterly TA.
2. Monthly, the Coalition DC will conduct a virtual Coalition TA call with local doulas to discuss programmatic updates, case issues, and any additional concerns expressed by Provider or Coalition.
3. Monthly, the Coalition DC will attend the virtual Statewide Doula Coordinator Meeting to be informed of any update programmatic updates.
4. Monthly, the Coalition DC will monitor the Florida Medicaid System (FLMMIS) to monitor any changes in participant Health Plan/eligibility.
5. Monthly, the Coalition DC will assess the Medicaid billing report to ensure that it accurately reflects the services provided.
6. Quarterly, the PD will review a random record to assess for quality assurance.
7. Quarterly, PD will collaborate with DC to review record review findings.

E. Monitoring of the Moving Beyond Depression Program

Purpose

The Moving Beyond Depression (MBD) Program is operated by Coalition individual subcontracted service providers. **The purpose of service monitoring is to ensure services are provided as outlined by guidance from Every Child Succeeds®.** Procedures and protocols are reviewed to ensure compliance with the contract, including service provision, adequate staffing, reporting, coding, quality assurance activities, data entry, and participant satisfaction with the program. Documentation of service provision is reviewed to ensure risk appropriate services are being offered at the intensity recommended by the MBD facilitator.

Activities

- Weekly team meetings with the MBD facilitator
- Monthly clinical oversight with curriculum coordinator.
- Monthly Review of Referrals from Healthy Start Care Coordinators
- Monthly review of documentation of psychosocial services (insert code number)

Process

8. Monthly, the Coalition ED, Subcontracted Providers, and Curriculum Coordinator will meet virtually to discuss programmatic issues and updates.
9. Monthly, the Coalition PD will review Healthy Start cases to assess that appropriate MBD referrals/follow-ups are taking place.

F. Resource Utilization Review/Utilization Management

Purpose

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, Healthy Start Standards and Guidelines, and care coordination needs.

Activities

- Quarterly Review of prenatal and postnatal screening rates from the Department of Health
- Outcome of Regional Coalition Meetings
- Review of Screening Outreach Quarterly reports

Process

1. Quarterly, HS Coalition staff will review prenatal and postnatal screening rates and compare the state and local data. Deficiency in providers or birthing facilities falling below expected screening rates will be discussed with the Coalition Provider Liaison when the provider is located outside the Coalition catchment area.

2. Deficiency in provider screening rates at the local County Health Department will be addressed directly with the CHD Administrator.

3.The CI&R reports from Well Family System will be monitored monthly to ensure the appropriate screens are being transferred from the Health Management System. Any discrepancies in sharing all screens that consent will be directed to the Healthy Start MomCare Network.

G. Quality Management of Coalition Operations

Purpose

The purpose of the quality management in the operations of the Coalition is to ensure maintenance of contract requirements and adherence to Coalition written policies and procedures. All tools and surveys are listed in the Appendix.

Activities

- Quarterly monitoring of Service Delivery Plan goals and accomplishments
- Annual self-monitoring of contract requirements and tasks required in statute

- Annual provider satisfaction survey to evaluate responsiveness to providers and identified needs in their interactions with Coalition staff.
- A community survey of Coalition's responsiveness to the community's needs.
- Annual participant survey to be provided by subcontractors to assess the satisfaction of program participants.

Process

1. The Executive Director, in conjunction with the Board of Directors and Coalition's PD will develop action items for the Agency work plan and set dates for completion. This work plan will be reviewed with staff quarterly for updating staff on Coalition activities as well as monitoring completion of action items as targeted. The Executive Director will monitor timely completion at review. The Agency work plan is incorporated into the Coalition Service Delivery plan and reported to the State via the Coalition's Quarterly Action Plan Report.
2. Coalition staff have 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. Adherence to standards is measured through employee's annual performance evaluation, during staff meetings and by the responses obtained from the community survey and provider satisfaction survey. Survey results are shared with the Coalition's Service Delivery Planning Workgroup and deficiencies and strengths are incorporated into the Coalition's Needs Assessment.
3. A provider satisfaction survey will be disseminated to all subcontracted providers. The purpose of this survey is to elicit feedback on the Coalition's efficiency and effectiveness in helping providers maintain and improve services. The Program Director will compile the results and present the report to the Quality Assurance Committee.
4. A community survey will be disseminated in each county during the Service Delivery Planning phase. The purpose of this survey is to elicit feedback on the Coalition's efficiency and effectiveness in working with the Community. The Executive Director will work with the Program Director to compile the results and present the report to the Quality Assurance Committee.

IV. Program Evaluation

A. Assessment

1. Data collection is the foundation of quality assurance activities. The Coalition will collect data on processes and outcomes as well as utilization findings and participant satisfaction results to establish opportunities for improvement. Integration of information obtained will lead to an assessment of the quality assurance program.
2. Based on results, the Coalition may set priorities for quality assurance activities related to maternal and child health indicators that may be integrated into the service delivery plan and added to provider contracts.

B. Annual Review

The Quality Assurance Committee will review the QI plan annually for needed revisions, modifications, or enhancements.

Healthy Start Coalition of Jefferson, Madison & Taylor Counties, Inc.

Internal Quality Assurance Performance Standards

General Qualities	Standards	Measurement
Timeliness	Coalition staff will ensure that all requests for information by providers and the community via telephone or email are given a timely response and material for dissemination will b completed within negotiated timeframes.	1. Telephone calls and emails will be responded to within 24 hours of receipt as monitored by the community survey and provider satisfaction survey. 2. Board meeting materials will be to the Board members at least 10 days prior to the meeting as monitored by the Business Manager. 3. Reports and materials for dissemination will be completed by the due date or negotiated date as monitored by the community survey and provider satisfaction survey.
Presentation	Coalition staff will ensure that all presentations are comprehensive, accurate, and professiona	Material for presentation will be forwarded to designated staff for review prior to dissemination to community and providers as monitored by the

		community survey and provider satisfaction survey.
Professionalism	Coalition staff will maintain appropriate speech and attire for the working environment.	Appropriate speech and dress will be monitored by the community survey and provider satisfaction survey.
Loyalty	Coalition staff will support the mission and goa of the agency and refrain from negative commentary in a public setting.	Public support of the agency's goals and mission will be monitored by the community survey, provide satisfaction survey and supervisor observation.
Integrity	Coalition staff will demonstrate a commitment t follow through with tasks or requests.	Commitment to responsibilities will be monitored by the community survey and provider satisfaction survey.
Knowledgeable	Coalition staff will possess the knowledge to complete tasks requested or identify resourc where the information can be obtained.	Ability to access needed information for customers will be monitored by the community survey and provider satisfaction survey.
Accuracy	All work products and information disseminate will be accurate	Work products for dissemination will be forwarded t designated staff for review prior to dissemination as monitored by the community survey and provider satisfaction survey and supervisor observation.

Sharing	The Coalition will have a collaborative work environment as well as maintain a collaborative relationship with community and providers.	Collaborative relationships will be monitored by the community survey and provider satisfaction survey and supervisor observation.
Courteous	Coalition staff will be respectful and courteous in all interactions.	The courteousness of Coalition staff will be monitored by the staff self-assessment, community survey and provider satisfaction survey.
Ethical	The Coalition will comply with standard business practices and code of ethics.	The ethics of the Coalition staff will be monitored by responses obtained from the community survey and provider satisfaction survey.
Physical Environment	All equipment and furniture will be functional. The work environment will be clean and orderly	The physical environment will be monitored by the staff self-assessment.
Friendly Environment	The Coalition will provide a responsive and supportive environment for employees	Responsiveness and supportiveness of work environment will be monitored by the staff self-assessment.

Timeline and Monitoring of the Coalition's Quality Assurance Plan

Attachment 1: QA Monitoring Tool

Healthy Start – Quality Assurance Plan	**Year: FY 25/26**						
Internal	Who's Responsible?	Methods	Frequency/Due Dates	Due Dates	Outcomes/ Progress to date	Follow-up Strategies/Mechanisms for improvement	Progress
Provider Satisfaction Survey	PD/ED	ED will distribute surveys to providers for feedback.	Annual/ June 2025	July 2025	**Annual**		
Consumer Satisfaction Surveys	Providers	Providers will administer electronic consumer satisfaction surveys annually, by December 31st each year via online platform.	Annually	12/31	**Annual**		
External	Who's Responsible?	Methods	Frequency/Due Dates	Due Dates	Quarterly/Outcome Data	Follow-up Strategies for improvement	Progress to Date:
Quarterly Technical Assistance	PD	PD will collaborate with subcontractors to address needed TA based on record review findings	Quarterly	By: The last Friday of the last month of each quarter.			

Annual Administrative Review of Services Provided as required by the Deliverables section of the Healthy Start Contract	ED	Summarize feedback findings and develop strategies	Annually				
Annual observation/shadowing of services	PD	PD will schedule dates with Care Coordinators during the 1st and 2nd quarters to observe services including, but not limited to: IA's, FSPs, and IPCs.	Annually	12/12/25			
Monthly Record Review of Healthy Start Services 1.Randomized, and 2.Targeted – high-risk, by score	PD	PD will conduct a random case review for at least one participant per care coordination staff, and at least one Family Phone Survey per subcontracted provider.	Monthly				
Monthly Review of Healthy Start Program Tickler List	PD	PD will monitor the Program Tickler List to ensure service provisions are	Monthly				

		happening at appropriate intervals as designated in the HSSG.					
Quarterly Evaluation of Birth Outcomes Report	PD	PD will review Birth Outcomes Report to ensure timely and correct documentation of births and address any issues the report might highlight.	Quarterly				
Quarterly Evaluation of Health Plan Coordination Report	PD	PD will review Health Plan Coordination Report to monitor contract compliance of Provider submission of 1 client per quarter for ICT Collaboration.	On the 16th day of the first month of each quarter.				
Quarterly Monitoring of Medicaid Numbers	PD	PD will review all open cases for any missing Medicaid numbers. PD will collaborate with CIR staff to rectify any	Quarterly				

		missing information.					
Monthly monitoring of Medicaid Billing Code by Provider for accuracy	PD	PD will review Medicaid Billing Codes to ensure accuracy and staff any discrepancies with Provider.	Monthly				
Monthly Supervision of Independent Subcontracted Provider	PD	PD will conduct administrative, clinical, and reflective supervision monthly and document on supervision form.	Monthly				July: Complete August: Sept: Oct: Nov: Dec: Jan: Feb: March: April: May: June:
Monthly monitoring of staff training and credentialing	PD	PD will review staff profiles in the Healthy Start Learning Management System (LMS) for any updates to their training and credentials. Any updates will be documented on the Training and Credentialling Log.	Monthly				

Quarterly Evaluation of Performance and Outcome Measure goal attainment per provider	PD		Quarterly				
Quarterly Random Record Review (1) per enhanced services	PD	Quarterly, PD will review one random case record per enhanced services.	Quarterly				
Semi-Annual Fiscal Monitoring of Expenditures by Random Sample	ED						
Annual Reconciliation of Budget vs Expenditures for Healthy Start funding	ED						
Monthly Record Review of Coordinated Intake and Referral Services		PD will review at least 3 cases per month of the quarter selected at random or by targeted high-risk by screen score (if available) from the Well Family CIR System	Monthly				
Quarterly Collaboration with	PD	PD will hold quarterly	Quarterly				

CAHSC CIR Program Manager		collaborations with the CIR PM at CAHSC to ensure that CIR services are being provided as designated by the HSSG.					
Quarterly monitoring of Medicaid Numbers	PD	PD will review all CIR cases for the quarter to assess for missing Medicaid numbers. Any discrepancies will be staffed with CIR to rectify missing information.	Quarterly				
Monthly monitoring of the CIR Action List and Referral Status Ticklers	PD	PD will review the Action List and Referral Status ticklers for outstanding cases of 30 calendar days or longer which have not transitioned to closure or enrollment in a Home Visiting (HV) program.	Monthly				

Monthly T.E.A.M. Dad Record Reviews	PD	PD will review records for each client monthly until caseload reaches 10, then PD will review one case each month of the quarter.					
Monthly Supervision with Fatherhood Coach	PD	PD will conduct administrative, clinical, and reflective supervision with Coach monthly and document on T.E.A.M. Dad supervision form.					
Monthly Monitoring of Fatherhood Coach Training and Credentials	PD	PD will monitor LMS monthly for updates.					
Annual Family Phone Survey	PD	PD will conduct Family Phone Survey Annually to review participant satisfaction.					
Monthly Monitoring of Doula Services	Doula Coordinator	Doula Coordinator will monitor the records of each doula to ensure that	Monthly				

		documentation and service provision is occurring in accordance with both state and localized guidance.					
Monthly Virtual Doula Coalition TA Call	Doula Coordinator, ED, PD	Doula Coordinator will conduct a virtual Coalition TA call with local doulas to discuss programmatic updates, case issues, and any additional concerns expressed by Provider or Coalition	Monthly				
Monthly Virtual Doula Statewide Coordinator Meeting	Doula Coordinator	The Doula Coordinator will attend the virtual Statewide Doula Coordinator Meeting to be informed of any update programmatic updates.	Monthly				

Sub-Contracted Providers and Funding Allocation

The Healthy Start Coalition of Jefferson, Madison and Taylor Counties, Inc. does not engage in the competitive procurement process to select Healthy Start providers because the original contracts engaged in 1992 with each county health department has been a satisfactory relationship since inception. However, there has been a need to engage additional services not provided by the health departments, including bi-lingual services, Fatherhood services, maternal mental health, and doula services. These are separate from the county health department subcontracts. The total Healthy Start subcontracts needed for JMT are:

Counties Served	Provider	Services Provided	No. Subcontracts	Estimated No of Clients Served
Jefferson and Madison	Madison Co Health Dept	Healthy Start, including all enhanced services excluding psychosocial	1	270
Taylor	Taylor Co Health Dept	Healthy Start including all enhanced services excluding psychosocial and Connect Services for JMT	1	160
Jefferson, Madison & Taylor Counties	Azucena “Susie” Hernandez	Bi-lingual Healthy Start Services including all enhanced services excluding psychosocial	1	35
Jefferson, Madison & Taylor Counties	Battlefront Education & Wellness Inc	Psychosocial Services	1	25
Total Healthy Start Subcontracts			4	490

As a result of improved fiscal procedures linking funding to service deliverables beginning in 2012, the Coalition developed a mechanism of allocating funding that focused on service delivery. In 2014, the Coalition was able to maximize revenue for its providers through direct billing for Medicaid services through the Administrative Services Organization, namely the Healthy Start MomCare Network. The Coalition is a member of this ASO Network and bills directly for services that are eligible under the Healthy Start Waiver. This fee-for-service structure is passed down to subcontracts that will earn and receive their share of Medicaid earnings at a rate 13% lower than the Coalition's rate, for administrative purposes. Subcontractors receive their Medicaid funding, up to contract caps in addition to Base dollars allocated by the Florida Department of Health for Healthy Start services.

The Coalition disburses Base dollars by calculating the total number of births for the three-county area and applying the percentage of those births by county. The result is a distribution of funding related to proportions of the total births for the area. The funding that is allocated to the primary Healthy Start subcontractors (county health departments) is net of enhanced service contracts.

The most recent calculation:

Resident Births by County of Residence (Mother) by Year of Birth

	Resident Births				
	2023	2024	2025 (provisional)	Total	Avg
Jefferson	124	144	134	**402**	25%
Madison	199	223	165	**587**	37%
Taylor	199	194	212	**605**	38%
Total	**522**	**561**	**511**	**1594**	100%

Base Calculation 26/27

Projected Total Base Allocation	415,000.00
Bi-Lingual Individual	(50,000.00)
Psychosocial	(30,000.00)
Provider Liaision	(34,991.00)
To Allocate to HS Contracts	300,009.00
MCHD	186,141.09
TCHD	113,867.91
Total	300,009.00

Special Note:

Funds for provider liaison activities, a bi-lingual individual subcontractor and psychosocial services were subtracted first from the allocation before distributing by birth rate. The ability to serve Spanish speakers and provide maternal mental health services are new since the last service delivery cycle.

COST ALLOCATION PLAN July 01, 2026 – June 30, 2027

Total Allocation: $ 815,803

A. Clinical Services:

Healthy Start positions that support prenatal clinic.

Provider: N/A **Allocation:** N/A

B. Coalition Planning Dollars

These funds are allocated for the service planning and execution of community-wide strategies to improve birth outcomes in Jefferson, Madison and Taylor Counties.
$196,945

C. Connect Service

These services are intake and referral services provided by staff at the county health department who also have Healthy Start duties and Health Management System duties related to the logistics of the prenatal and infant universal screening instruments. $17,811 allocated to Taylor CHD and $5,236 maintained at the Coalition for bi-lingual intakes and high-risk locate services.

$23,047

D. Provider Liaison Activities

These costs for staff to regularly outreach to providers of prenatal and infant health services, promote and provide technical assistance on the electronic prenatal screen, and promote and provide technical assistance to local ancillary providers to make referrals into

the coordinated intake and referral system of care.

$35,055

E. Fatherhood Services

Cost of providing TEAM Dad fatherhood support and education services in Jefferson, Madison & Taylor Counties.

$124,665

F. FIMR Activities

Cost of developing and executing community strategies based on regional FIMR case review findings and recommendations. **$ 8,002**

G. Healthy Start Services:

These services include Healthy Start care coordination services, home visiting, smoking cessation, childbirth education, parenting support and education, breastfeeding support and education, interconception education and counseling, outreach to identify participants, outreach to community providers, CHD data entry, and lactation counseling services.

$380,009

Provider	CI&R Services (Connect)	Base Allocation	Allocation Methodology
Azucena Hernandez individual contract		$50,000	Calculated based on historical data for full caseload
Battlefront Education & Wellness Inc		$30,000	Fee for service psychosocial services subcontract

Madison County Health Department		$186,141	37% of births in Madison County, 25% of births for Jefferson County- 62% of CHD contract amounts
Taylor County Health Dept	$17,811	$113,868	38% of CHD Contract amounts
	$17,811	$380,009	

H. <u>Administration for All Healthy Start Funded Services:</u>

Services include Quality Assurance/Quality Improvement, contract management/fiscal accountability, Healthy Start program training, programmatic technical assistance to contracted providers and reporting. **Allocation:** $40,317 (10%) of total Base Direct Services allocation) **<u>total: $ 48,080</u>**

<u>Contract Time Frames:</u>

Healthy Start and Connect Services:

1. Madison County Health Department – July 01, 2026- June 30, 2027
2. Taylor County Health Department – July 01, 2026 -June 30, 2027
3. Azucena Hernandez – July 01, 2026- June 30, 2027
4. Battlefront Education & Wellness Inc - July 01, 2026- June 30, 2027

Outreach Plan for Maternal and Child Health Services in Jefferson, Madison & Taylor Counties, Florida

This outreach plan is designed to reach pregnant women, postpartum women, infants, fathers, and families in All with clear pathways to prenatal, interconception, infant, and fatherhood services. The plan emphasizes rural access, trusted community partnerships, and repeated touchpoints that connect families to Healthy Start, county health department services, home visiting, breastfeeding and safe sleep education, parenting support, and fatherhood programming.

Activity	Target Audience	County Focus	Key Message / Services Promoted	Outreach Channel / Partner	Timing / Frequency	Success Measure
Prenatal clinic referral outreach	Pregnant women in the first and second trimesters	All	Promote early prenatal care, Healthy Start screening, and care coordination	County health departments, obstetric providers, and family medicine clinics	Weekly	Number of referrals received and first prenatal visits completed
WIC and Healthy Start co-enrollment events	Pregnant women, postpartum women, and families with infants	All	Promote nutrition support, breastfeeding support, infant care, home visiting, and interconception services	WIC offices, Healthy Start staff, and county health departments	Monthly	Number of families screened and enrolled in services
Hospital and birthing discharge outreach	Postpartum women and families with newborns	All	Promote postpartum follow-up, safe sleep, home visiting, breastfeeding	Birthing hospitals, discharge planners, and	At discharge and within 72 hours	Number of postpartum contacts completed

			support, infant screening, and family planning	pediatric partners	after birth	and referrals accepted
Fatherhood engagement through T.E.A.M. Dad promotion	Fathers, expectant fathers, and male partners	All	Promote father involvement, parenting skills, co-parenting support, infant bonding, and healthy relationships	Healthy Start fatherhood program, barbershops, faith communities, and workforce programs	Monthly	Number of fathers enrolled and attending at least one session
Community baby showers (Baby Expo) and resource fairs	Pregnant women, new parents, fathers, and caregivers	Rotating across All	Promote prenatal care, breastfeeding, safe sleep, car seat education, and parenting resources	Libraries, schools, churches, civic groups, and local businesses	Quarterly	Number of attendees and on-site referrals made-at least 2 Baby Expos per year
Mobile and pop-up outreach in rural gathering sites	Families in rural and hard-to-reach communities	Priority rural areas across All	Promote free services, appointment scheduling, transportation support, and home visiting	Food pantries, churches, community centers, and housing sites	Twice monthly	Number of contacts made and appointments scheduled
Safe sleep and breastfeeding campaign	Pregnant women, postpartum families, grandparents, and caregivers	All	Promote ABC safe sleep practices, breastfeeding education, and infant wellness visits	Pediatric offices, childbirth classes, social media, billboards	Ongoing with seasonal campaigns	Number of materials distributed and referrals to education or lactation support

				and local radio		
Interconception outreach at well-child and immunization visits	Postpartum women with children ages 0 to 3	All	Promote birth spacing, reproductive life planning, maternal mental health, and chronic disease follow-up	Pediatric clinics, immunization events, and Healthy Start home visitors	Ongoing	Number of women receiving education and follow-up referrals
School and teen family support outreach	Pregnant and parenting teens and young fathers	All	Promote early prenatal care, parenting education, graduation support, father involvement, and infant care resources	School districts, school nurses, guidance counselors, and alternative education programs	Each semester	Number of school referrals and participants connected to services
Faith-based and community ambassador program	Families connected to trusted community organizations	All	Promote free maternal and child health services, reduce stigma, and normalize help-seeking	Pastors, church health ministries, community advocates, and civic leaders	Every other month	Number of ambassadors trained and referrals generated
Digital outreach and social media campaign	Women of reproductive age, pregnant women, fathers, and caregivers	All	Promote enrollment pathways, service locations, classes, appointments, and	Social media platforms and partner websites	Weekly	Number of engagements, inquiries, and appointment conversions

			fatherhood groups			
Cross-referral outreach with social service agencies	Families with housing, food, transportation, or behavioral health needs	All	Promote whole-family support, care coordination, mental health services, tobacco cessation, and parenting resources	Social service agencies, food assistance providers, domestic violence programs, and behavioral health partners	Monthly	Number of partner referrals and closed-loop follow-ups completed
Door-to-door canvassing	Families in targeted neighborhoods, including public housing, trailer parks, and low-income housing areas	All	Promote breastfeeding in August, safe sleep in October, and folic acid in January, along with available maternal and child health services	Coalition outreach staff and Shared Services members	Three times per year	Number of households reached with outreach materials
Women's health workshops	Women of reproductive age	All	Promote women's health education through curriculum-based workshops covering priority maternal and	Coalition community health workers and topic experts	Twice per year	Number of workshop participants and post-workshop survey responses

			reproductive health topics			
Referrals to maternal mental health services	Pregnant and postpartum women enrolled in home visiting with elevated depression screening scores	All	Promote telehealth and other maternal mental health services for women needing additional support	Home visitors and maternal mental health referral partners	As needed	Number of maternal mental health referrals completed
Referrals to doula services	First-time pregnant women and women with limited social support	All	Promote access to free doula services during pregnancy, birth, and the postpartum period	Connect staff, community health clinics, county health departments, obstetric providers, and pediatricians	Monthly	Number of new doula referrals
CCHW attends at least 7 local community events per month	MCH population	All	Promote all MCH services	Coalition member events	Monthly	Reach 25% of the maternal population ages 14-44 each year, for a total of 80 events per year

Provider Outreach Plan for Florida Prenatal and Infant Screening

This outreach plan is designed to promote the Florida Prenatal Screen and Florida Infant Screen to obstetricians in Leon County who serve residents of All, as well as three local health departments that provide obstetric care. The plan emphasizes provider education, screening compliance, referral pathways to Healthy Start and Connect, and ongoing technical support so pregnant women and infants are screened and linked to services in a timely manner.

Activity	Target Audience	Objective / Key Message	Outreach Method	Timeline / Frequency	Responsible Party	Success Measure
Provider introduction packet	11 Leon County obstetric practices and 3 local health departments that provide obstetric care	Promote the requirement to offer the Florida Prenatal Screen at the first or a subsequent prenatal visit and explain how screening connects families to Healthy Start and Connect services	Email and mailed packet with cover letter, screening overview, workflow guide, and provider support contacts	Month 1	Healthy Start provider liaison	Number of packets delivered and receipt confirmations obtained
One-on-one provider visits	Practice managers, lead obstetricians	Review screening requirements, referral	In-person or virtual visits with practice leadership	Months 1–3; then as needed	Provider liaison and coalition leadership	Number of sites visited and follow-

	, nurse managers, and health department clinical leaders	thresholds, consent procedures, and local service benefits for tri-county patients	and clinical staff			up actions completed
Staff in-service training	Front desk staff, nurses, medical assistants, providers, and referral coordinators	Standardize how staff explain the screen, obtain consent, complete forms correctly, and connect patients to services	Brief trainings during staff meetings or lunch-and-learn sessions	Quarterly	Healthy Start staff and clinical champions	Number of staff trained and knowledge checks completed
Workflow mapping and technical assistance	Obstetric practices and local health departments	Help each site implement a simple workflow for offering the prenatal screen, documenting consent, and submitting referrals consistently	Technical assistance session with workflow checklist and site-specific process map	Months 1–4	Provider liaison and quality improvement staff	Number of sites with a documented screening workflow
Electronic screening	Practice administrators and designated	Increase use of the electronic Florida	Registration support, login guidance, and troubleshooti	Months 1–2; ongoing	Provider liaison and system	Number of sites registered and actively

enrollment support	screening staff	Prenatal Screen system and reduce missed or delayed submissions	ng for electronic screening access	support thereafter	support contact	using the electronic screening system
Healthy Start and Connect referral education	Providers and referral staff	Reinforce that screening is the gateway to education, care coordination, home visiting, and other support services for pregnant women and infants	Referral pathway handout, quick-reference guide, and brief case examples	Monthly during rollout; quarterly thereafter	Healthy Start care coordination team	Number of sites using referral materials and referrals submitted
Provider champion engagement	High-volume obstetricians and health department leaders	Identify champions who can reinforce screening compliance and encourage peer participation	Recruitment calls, recognition, and peer-sharing opportunities	Months 2–6	Coalition leadership	Number of provider champions identified and engaged
Performance feedback reports	Practice leadership and health department	Provide regular feedback on screening volume,	Site-specific scorecards or summary reports shared by	Monthly or every other month	Quality improvement staff	Number of reports shared and improvements in

	administrators	referral completion, and opportunities for improvement	email or review meeting			screening completion rates
Reminder and re-engagement campaign	Sites with inconsistent screening activity	Reduce gaps in screening and encourage timely re-engagement with required workflows	Email reminders, phone follow-up, and brief check-in meetings	Monthly, as needed	Provider liaison	Number of inactive sites re-engaged and resumed screening activity
Provider support call promotion	All targeted providers and health departments	Encourage participation in provider support calls focused on registration, workflow, dashboards, and best practices	Email invitations and calendar reminders	Monthly	Provider liaison	Number of participants attending provider support calls
Printed materials for exam rooms and check-in areas	Pregnant patients in targeted provider sites	Help patients understand the purpose of the prenatal screen and encourage informed participation	Posters, flyers, and patient handouts in English and other needed languages	Month 1; refresh quarterly	Outreach staff and provider offices	Number of sites displaying materials and materials distributed

Recognition and retention strategy	Participating obstetric practices and health departments	Maintain provider participation by recognizing high-performing sites and reinforcing the value of screening for tri-county families	Certificates, thank-you messages, and recognition at coalition meetings or partner events	Semiannually	Coalition leadership and outreach staff	Number of participating sites retained and recognized

Outreach Plan for Coordinated Intake and Referral (CI&R) Services

This outreach plan is designed to promote Coordinated Intake and Referral (CI&R) services in All. CI&R is a telephonic triage and referral approach that helps pregnant women, caregivers, and families with young children connect to needed resources and enroll in the home visiting program that best fits their needs. The plan emphasizes a single-entry pathway to services, timely follow-up, and strong referral connections to Healthy Start, home visiting, education, and community supports.

Activity	Target Audience	County Focus	Key Message / Services Promoted	Outreach Channel / Partner	Timing / Frequency	Success Measure
Prenatal provider referral outreach	Pregnant women and families identified during prenatal care	All	Promote CI&R as the single-entry point for telephonic triage, resource connection, and home visiting enrollment during pregnancy	Obstetric providers, county health departments, and prenatal clinics	Monthly	Number of prenatal referrals received and completed CI&R contacts
Hospital and birth facility referral promotion	Postpartum women, caregivers, and newborn families	All	Promote CI&R as a connection to infant services, parenting support, safe sleep, ICC	Birth facilities, discharge planners, nursery staff, and pediatric partners	At discharge and within 72 hours after birth	Number of postpartum referrals submitted and completed CI&R follow-up calls

Activity	Target Audience	County Focus	Key Message / Services Promoted	Outreach Channel / Partner	Timing / Frequency	Success Measure
			services, education, and home visiting after delivery			
Community event and Baby Expo promotion	Pregnant women, families with infants and toddlers, fathers, and caregivers	Rotating across All	Promote CI&R as the easiest way to connect by phone to home visiting, parenting education, breastfeeding support, and community resources	Baby Expos, health fairs, libraries, schools, churches, and community events	Monthly	Number of event contacts made and CI&R referral forms completed
Door-to-door outreach with direct referral option	Families in targeted neighborhoods, including public housing, trailer parks, and rural communities	All	Promote a simple phone-based entry to services, including resource navigation, maternal support, and home visiting enrollment	Coalition outreach staff, community health workers, and local partners	Quarterly and during campaign months	Number of households reached and direct CI&R referrals initiated
WIC and Healthy Start co-referral outreach	Pregnant women, postpartum women, and families with	All	Promote CI&R as a referral bridge from nutrition and maternal-child health	WIC offices, Healthy Start staff, county health departments, and	Monthly	Number of co-referrals submitted and families connected to services

Activity	Target Audience	County Focus	Key Message / Services Promoted	Outreach Channel / Partner	Timing / Frequency	Success Measure
	children under age three		programs to home visiting and community support services	breastfeeding support staff		
Faith-based and trusted messenger campaign	Families connected to churches, civic groups, and trusted community leaders	All	Promote calling CI&R for help with pregnancy, infant care, parenting, transportation, food, and other family support needs	Churches, pastors, church health ministries, and community ambassadors	Every other month	Number of community messengers engaged and referrals generated
Digital and text message outreach	Pregnant women, postpartum women, caregivers, and fathers	All	Promote CI&R contact information, explain available resources, and encourage self-referral for home visiting and support services	Social media, text outreach, coalition website, partner websites, and digital flyers	Weekly	Number of digital engagements, inbound calls, and self-referrals received
School and teen parent outreach	Pregnant and parenting teens and young families	All	Promote confidential phone-based support for parenting education,	School districts, school nurses, guidance counselors,	Each semester	Number of school-based referrals submitted and families contacted

Activity	Target Audience	County Focus	Key Message / Services Promoted	Outreach Channel / Partner	Timing / Frequency	Success Measure
			infant care, home visiting, and connection to community resources	and teen parent programs		
Cross-referral coordination with social service agencies	Families with housing, food, transportation, mental health, or other social support needs	All	Promote CI&R as a coordination hub for connecting families to appropriate home visiting models and broader community resources	Food pantries, behavioral health providers, domestic violence programs, housing partners, and family support agencies	Monthly	Number of partner referrals received and closed-loop follow-up contacts completed
Printed materials with direct call-to-action	Pregnant women, caregivers, and families with children under age three	All	Promote the CI&R phone line and explain that one call can connect families to home visiting, parenting support, and community resources	Flyers, posters, rack cards, clinic handouts, and partner distribution sites	Quarterly	Number of materials distributed and inbound calls attributed to print outreach
Home visits for unlocatable	Women who score>6 on the prenatal screen	JMT	Home visit to engage in CI&R services	CCHW	As referred by the	Number of completed IIs for the CCHW

Activity	Target Audience	County Focus	Key Message / Services Promoted	Outreach Channel / Partner	Timing / Frequency	Success Measure
high-risk participant					Connect supervisor	
Referral feedback loop with home visiting programs	Home visiting providers, care coordinators, and coalition partners	All	Strengthen confidence in CI&R by showing that referrals are completed, families are reached, and enrollment pathways are working	Coalition meetings, partner huddles, and quality improvement reviews	Monthly	Number of referral outcomes reviewed and enrollment follow-ups completed

Community Education Plan for Maternal and Child Health Issues

This community education plan is designed to educate consumers of maternal and child health services in All on the full range of issues that affect maternal and child health. The plan uses a Certified Community Health Educator, social media, printed materials, and branded outreach items to deliver consistent, easy-to-understand messages about prenatal care, postpartum health, infant safety, breastfeeding, interconception health, maternal mental health, fatherhood, child development, and available community resources.

Activity	Target Audience	County Focus	Key Message / Topics Covered	Outreach Method / Channel	Timing / Frequency	Success Measure
Certified Community Health Educator presentations	Consumers of maternal and child health services, including pregnant women, postpartum women, fathers, and caregivers	All	Provide education on prenatal care, postpartum care, safe sleep, breastfeeding, infant development, maternal warning signs, and community resources	In-person sessions at community events, support groups, schools, churches, and partner sites	One Monthly opportunity	Number of education sessions delivered and participants reached
Topic-of-the-month social media campaign	Women of reproductive age, pregnant women, postpartum	All	Share monthly messages on prenatal care, folic acid, smoking	Social media posts, short videos, story graphics, and partner pages	Weekly with monthly topic rotation	Number of posts published, engagements, and

Activity	Target Audience	County Focus	Key Message / Topics Covered	Outreach Method / Channel	Timing / Frequency	Success Measure
	women, fathers, and caregivers		cessation, safe sleep, breastfeeding, postpartum warning signs, maternal mental health, father involvement, and child development			inquiries received
Printed educational materials distribution	Consumers receiving services in clinics, hospitals, WIC offices, and community sites	All	Provide easy-to-read materials on prenatal care, Healthy Start, CI&R, safe sleep, breastfeeding, interconception health, immunizations, and infant milestones	Flyers, brochures, posters, rack cards, and take-home handouts	Quarterly updates with ongoing distribution	Number of materials distributed and partner sites stocked
Branded item giveaway campaign	Families attending maternal and child health events and outreach activities	All	Reinforce key maternal and child health messages and increase visibility of local services through practical branded items with	Branded diaper bags, bibs, water bottles, magnets, pens, and tote bags	At major events and outreach touchpoints	Number of branded items distributed and event contacts made

Activity	Target Audience	County Focus	Key Message / Topics Covered	Outreach Method / Channel	Timing / Frequency	Success Measure
			contact information			
Safe sleep education campaign	Pregnant women, postpartum families, grandparents, and caregivers	All	Teach the ABCs of safe sleep, reduce unsafe sleep practices, and promote infant wellness visits	Educator talks, printed materials, social media graphics, and event demonstrations	Seasonal with year-round reinforcement	Number of caregivers reached and safe sleep materials distributed
Breastfeeding education outreach	Pregnant women, postpartum women, and support persons	All	Promote breastfeeding benefits, early initiation, common problem-solving, and available lactation support	Social media, brochures, support groups, and educator-led sessions	Monthly with an August focus	Number of participants reached and referrals to breastfeeding support
Maternal warning signs education	Pregnant women, postpartum women, family members, and support persons	All	Teach urgent maternal warning signs, encourage help-seeking, and reinforce the message to speak up if something feels wrong	Educator talks, social media posts, wallet cards, and partner distribution	Quarterly with maternal health observance tie-ins	Number of warning sign materials shared and participants educated
Interconception and women's	Postpartum women and women of	All	Teach birth spacing, reproductive life planning,	Workshops, clinic outreach, printed	Every other month	Number of women reached and follow-up

Activity	Target Audience	County Focus	Key Message / Topics Covered	Outreach Method / Channel	Timing / Frequency	Success Measure
health education	reproductive age		folic acid use, chronic disease management, and preventive care between pregnancies	handouts, and digital education		referrals made
Maternal mental health awareness outreach	Pregnant women, postpartum women, and family supports	All	Normalize conversations about stress, depression, and anxiety and promote screening and referral pathways for support	Community talks, social media, printed materials, and referral resource cards	Quarterly	Number of participants reached and mental health referrals provided
Fatherhood and family engagement messaging	Fathers, expectant fathers, male partners, and co-parents	All	Promote father involvement during pregnancy and infancy, parenting confidence, and available fatherhood supports such as T.E.A.M. Dad	Barbershops, community events, social media, printed materials, and branded items	Monthly	Number of fathers reached and referrals to fatherhood services
Infant development	Parents, caregivers, and families	All	Teach developmental milestones,	Parenting workshops, social media,	Monthly	Number of families reached and

Activity	Target Audience	County Focus	Key Message / Topics Covered	Outreach Method / Channel	Timing / Frequency	Success Measure
and parenting education	with infants and toddlers		responsive parenting, immunizations, well-child visits, and early learning supports	handouts, and community events		developmental resource referrals made
Community resource awareness campaign	All consumers of maternal and child health services	All	Increase awareness of Healthy Start, home visiting, CI&R, WIC, county health departments, transportation assistance, breastfeeding support, and parenting resources	Resource guides, event tables, social media, and partner distribution channels	Ongoing with quarterly refreshes	Number of resource guides shared and consumer referrals generated

Medicaid Eligibility Verification Process

The Healthy Start Coalition of Jefferson, Madison & Taylor verifies Medicaid eligibility for clients served through the Healthy Start and Connect programs to support accurate records and appropriate reimbursement.

Subcontractor staff at the county health departments who have the appropriate credentials use the Florida Medicaid Web Portal (flmmis.com) to confirm eligibility. If needed, they also update the electronic case management file to correct any discrepancies.

For many enrolled clients, Medicaid information is already pre-populated in the Well Family System through the Healthy Start MomCare Network's collaboration with the Agency for Health Care Administration and the receipt of digital files.

This verification process helps the Coalition maximize revenue and support services provided by the County Health Departments under subcontract for Healthy Start and Connect programs.

However, the Coalition does not provide a fee for service arrangement for the provision of Healthy Start and Connect services with the Florida Department of Health and therefore does not seek reimbursement on a case-by-case basis. Medicaid funds supplement direct service funds received by the FDOH. The Coalition does prepare a year-end programmatic report to determine how funds used under the statutory authority of the FDOH are foundational and Medicaid funds are supplemental. The most recent calculations are below:

CI&R Services

2024-2025 Programmatic Service Delivery Report

Healthy Start Coalition of Jefferson, Madison & Taylor Counties, Inc.

Healthy Start Provider	Services Provided	DOH Contract Amount/Total Expenditures - CIR Services	Medicaid Contract Amount/Total Expenditures - CIR Services	DOH Contract Amount/Total Expenditures - Healthy Start Services	Medicaid Contract Amount/Total Expenditures - Healthy Start Services	Total Combined Funding	Total number of clients receiving services during contract year (by provider)	Total Cost per participant	Total number of Medicaid enrollees receiving services during contract year	DOH Allocation	DOH Surplus/Deficit	Medicaid Allocation	Medicaid Surplus/Deficit
Taylor County Health Department	CI&R services to eligible residents of Jefferson, Madison and Taylor County	17,960.00	13,760.00			31,720.00	640.00	49.56	494.00	7,236.13	10,723.88	24,483.88	(10,723.88)
Acuzena Hernandez	CI&R services to Spanish-speaking eligible residents of Jefferson, Madison and Taylor Counties	4,800.00	860.00	-		5,660.00	14.00	404.29	12.00	808.57	4,851.43	4,851.43	(4,851.43)
		22,760.00	14,620.00	-	-	37,380.00	654.00		506.00	8,044.70	15,575.30	29,335.30	(15,575.30)
							Average cost per participant	226.92					

Analysis:

The average cost of servingCIR participants is $196.21 per participant.

Healthy Start Services

2023-2024 Programmatic Service Delivery Report

Healthy Start Coalition of Jefferson, Madison & Taylor Counties, Inc.

Healthy Start Provider	Services Provided	DOH Contract Amount/Total Expenditures - CIR Services	Medicaid Contract Amount/Total Expenditures - CIR Services	DOH Contract Amount/Total Expenditures - Healthy Start Services	Medicaid Contract Amount/Total Expenditures - Healthy Start Services	Total Combined Funding	Total number of clients receiving services during contract year (by provider)	Total Cost per participant	Total number of Medicaid enrollees receiving services during contract year	DOH Allocation	DOH Surplus/Deficit	Medicaid Allocation	Medicaid Surplus/Deficit
Madison Co Health Department	Healthy Start services to eligible residents of Jefferson and Madison Counties		-	184,135.00	112,000.00	296,135.00	264.00	1,121.72	242.00	24,677.92	159,457.08	271,457.08	(159,457.08)
Taylor County Health Department	Healthy Start services to eligible residents of Taylor County		-	126,360.00	100,434.00	226,794.00	152.00	1,492.07	138.00	20,888.92	105,471.08	205,905.08	(105,471.08)
Acuzena Hernandez	Healthy Start services to Spanish-speaking eligible residents of Jefferson, Madison and Taylor Counties			43,200.00		43,200.00	28.00	1,542.86	24.00	6,171.43	37,028.57	37,028.57	(37,028.57)
				353,695.00	212,434.00	566,129.00	444.00		404.00	51,738.27	301,956.73	514,390.73	(301,956.73)
							Total Clients/Average Cost of services per Participant	1,385.55					
								$ 615,183.67					

Analysis:

The average cost of serving Healthy Start participants is $1,386 per participant.

DOH funds 62% of the cost, yet the total population served is 91% Medicaid. However, there is no infrastructure funding allocation methodology, and the existing funding structure would not support the system of care with Medicaid funding at levels that only support 30% of the total number of clients that come into the system of care in Jefferson, Madison and Taylor Counties.

Psychosocial Services

2024-2025 Programmatic Service Delivery Report

Healthy Start Coalition of Jefferson, Madison & Taylor Counties, Inc.

2023-2024 Programmatic Service Delivery Report	Services Provided	DOH Contract Amount/Total Expenditures - CIR Services	Medicaid Contract Amount/Total Expenditures - CIR Services	DOH Contract Amount/Total Expenditures - Healthy Start Services	Medicaid Contract Amount/Total Expenditures - Healthy Start Services	Total Combined Funding	Total number of clients receiving services during contract year (by provider)	Total Cost per participant	Total number of Medicaid enrollees receiving services during contract year	DOH Allocation	DOH Surplus/Deficit	Medicaid Allocation	Medicaid Surplus/Deficit
Battlefront Education & Wellness-**non Medicaid Provider**	Subcontracted Psychosocial Services			7,900.00	4,100.00	12,000.00	21.00	571.43	19.00	1,142.86	6,757.14	10,857.14	(6,757.14)
							Average Cost per client for psychosocial services	21.00	285.71				

Coordination with the Telehealth Maternity Care Program

Regional Partnership

The Healthy Start Coalition of Jefferson, Madison & Taylor Counties participates in a regional initiative to expand maternity care through telehealth across the Big Bend of Florida, the area served by Tallahassee Memorial Hospital (TMH).

Program Structure

TMH contracts with Capital Area Healthy Start (CAHSC) for services and system implementation. CAHSC then contracts with the Healthy Start Coalition of Jefferson, Madison & Taylor Counties to support maternal mental health services delivered through a telehealth provider using the Moving Beyond Depression™ framework.

Referrals and Additional Support

Referrals are made through Perinatal Navigators, who serve as the primary staff for the Maternity Care program and are based in obstetric offices in Leon County. The program also supports doula services for women in Jefferson, Madison, and Taylor Counties.

Funding

Total funding for FY 2025–2026 is $25,000.