Maternal and Child Health Services Title V Block Grant

Florida

FY 2019 Application/ FY 2017 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Florida HEALTH

Vision: To be the **Healthiest State** in the Nation

Rick Scott
Governor

Celeste Philip, MD, MPH
Surgeon General and Secretary

July 13, 2018

HRSA Grants Application Center
910 Clopper Road, Suite 155 South
Gaithersburg, MD 20878

Dear Sir or Madam:

Enclosed is Florida's Maternal and Child Health Services Title V Block Grant for FY2019. Authority has been delegated by the Governor to the Department of Health State Surgeon General to submit this grant application.

Having given the required assurances and certifications, we request your approval of the Maternal and Child Health Block Grant Application for FY2019.

If you have any questions, please contact Bob Peck at (850) 558-9595.

Sincerely,

Leslie M. Beitsch, MD, JD
Deputy Secretary for Health

Dawn M. McWilliams
Budget and Revenue Management Chief
Office of Budget and Revenue Management

Florida Department of Health
Office of the State Surgeon General
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FloridaHealth.gov

PHAB Accredited Health Department
Public Health Accreditation Board

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The Florida Department of Health is responsible for administering the Title V Maternal and Child Health Block Grant, encompassing the Maternal and Child Health (MCH) and Children and Youth with Special Health Care Needs (CYSHCN) programs. These programs fall within the auspices of the Division of Community Health Promotion and the Office of Children's Medical Services (CMS) Managed Care Plan and Specialty Programs.

In Florida, Title V programs serve a large, diverse population. Florida is the third most populous state in the country, with an estimated population of 21 million citizens, of which 77.6 percent are white; 16.8 percent black; and 5.5 percent are other races, mixed race, or unknown. The racial, ethnic, and cultural diversity of Florida's population creates unique challenges as well as increased opportunities. Diversity helps us recognize and respect the customs, behaviors, and traditions of others, allowing for bridges of trust, respect, and understanding to be built across cultures.

Priorities to meet the needs of the Title V population include the promotion of safe sleep behaviors, breastfeeding, and smoking cessation to reduce poor outcomes. Children are encouraged to be more physically active. Improving access to care for women and dental care access for children and women are important priorities. Priorities for children and youth with special health care needs include access to medical homes, primary care, and transition to adult life. Additional priorities include improving mental health services for all children and addressing social determinants of health.

The five-year needs assessment and continual assessment during interim years drive the state's Title V MCH program. State priorities were selected through the needs assessment process and cover each of the five health domains. Each of the state priorities includes specific language directed at addressing and eliminating disparities. These priorities also determined the eight national performance measures (NPMs) chosen for programmatic focus.

Strategies identified to address priority needs and selected performance measures are implemented through a variety of mechanisms, including statewide projects administered through the state health office, Schedule C funding through a statement of work with county health departments, contracts with Healthy Start Coalitions, Florida's Perinatal Quality Collaborative, and other partners and stakeholders or some combination thereof. Resources and partnerships are leveraged to maximize the reach of Title V.

The state Title V program plays an important role in supporting and ensuring comprehensive, coordinated, and family-centered services. These efforts begin with reviewing epidemiologic research and reports, and collecting and studying data to ensure our efforts and decision-making are data-driven and factually relevant. The Title V program works with other programs within the Department of Health to ensure comprehensive, coordinated services are available to the people of Florida, particularly women, pregnant women, infants, and children. The Bureau of Family Health Services' Maternal and Child Health Section and the Office of Children's Medical Services (CMS) Managed Care Plan and Specialty Programs have primary responsibility for the Title V application and oversight of Title V activities. Other programs we coordinate with include, but are not limited to: Chronic Disease Prevention; School Health; Adolescent Health; Family Planning; Public Health Dental; Violence and Injury Prevention; Bureau of Tobacco Free Florida, Early Steps and Newborn Screening, and Communicable Diseases. In addition, CMS conducts regular bi-directional communication with community teams to assist with strategic planning, and Family Voice representation is incorporated into feedback loops, workgroups, and planning efforts.

The Title V program also coordinates with numerous public and private partners across the state. Under the leadership of the State Surgeon General, the Title V program works with a diverse group of partners who make up Florida's public health system, including a range of stakeholders such as state and local government agencies, health care providers, employers, community groups, universities and schools, nonprofit organizations, and advocacy groups. Examples include the county health departments, Florida Healthy Start Coalitions, the March of Dimes, the Florida Perinatal Quality Collaborative, the Agency for Health Care Administration, the Department of Children and Families, and on the national level, the Association of Maternal & Child Health Programs, National Maternal Child Health Workforce Development Center, Centers for Disease Control, and the Association of State and Territorial Health Officers. CMS partnerships include the University of Florida's Pediatric Pulmonary Center, University of South Florida Department of Pediatrics Adolescent Medicine and College of Behavioral & Community Sciences, the University of Miami's Mailman Center for Child Development, the Family Café, the Family Network on Disabilities of Florida, and the Foundation for Sickle Cell Disease Research.

Efforts to improve health have traditionally looked to the health care system as the key driver of health and health outcomes. However, the Department recognizes that improving health and achieving health equity requires broader approaches that address social, economic, and environmental factors that influence health as well. These approaches are expanding partnerships beyond the traditional partners.

In serving the CYSHCN population, CMS is redesigning its Title V structure with an emphasis on quality and access. Utilizing the conceptual framework for the MCH pyramid of health services with a focus on the foundational level of infrastructure-building services, public health services and systems are being strengthened for access and utilization, driven by community needs assessments and based on national standards and intentional planning with integrated system partners. Transformational planning of its health care delivery system for direct care services focuses on the goals of improved services and access for improved outcomes for CYSHCN and their families.

MCH has also made strides to address quality of care and access to services, at a time when the need for care for the Title V population seems ever more prevalent. Our MCH program remains focused on the racial disparity evidenced by our indicators and exhibited in poorer health outcomes for certain races. MCH has begun to focus more heavily on social determinants of health, to address the disparity of people who are disadvantaged through additional factors such as levels of income or education, or simply the area in which they live.

Certain communities in Florida face greater health challenges than others. The Department's ongoing efforts to address avoidable inequalities, historical and contemporary injustices, and to eliminate health disparities, would not be possible without the leadership of our county health officers and the cooperation of our valuable partners at the federal, state, local, tribal, and territorial levels.

Following is a discussion of our priorities and corresponding performance measures and justification for selection through our statewide needs assessment process:

Domain: Women/Maternal Health

NPM 1: Percent of women with a past year preventive medical visit

ESM 1.1: The number of interconception services provided to Healthy Start clients

State Priority: Improve access to health care for women to improve preconception and interconception health, specifically women who face significant barriers to better health

Women's health, at all ages of the lifespan and for those whose circumstances make them vulnerable to poor health, is important and contributes to the well-being of Florida's families. The Title V program focuses on interconception/preconception (ICC/PCC) health, fully recognizing the importance of improving the health of all women of reproductive age to ensure better birth outcomes and healthier babies.

NPM 14.1: Percent of women who smoke during pregnancy

ESM 14.1: The number of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to Healthy Start clients

State Priority: Promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children

Smoking during pregnancy increases the risk of miscarriage and certain birth defects. It can cause premature birth and low birth weight. Smoking is also a risk factor for sudden infant death syndrome (SIDS), as secondhand smoke doubles an infant's risk of SIDS.

Domain: Perinatal/Infant Health

NPM 4: A) Percent of infants who are ever breastfed, and B) Percent of infants breastfed exclusively for 6 months

ESM 4.1: The number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation.

State Priority: Promote breastfeeding to ensure better health for infants and children and reduce low food security

There is a clear link to the state's priority to promote breastfeeding as a means of ensuring better health and reducing low food security. Breastfeeding is recognized as a major health benefit to infant and mother as well as an enhancement of maternal/child bonding.

NPM 5**:** A) Percent of infants placed to sleep on their backs, B) Percent of infants placed to sleep on a separate approved sleep surface, C) Percent of infants placed to sleep without soft objects or loose bedding

ESM 5.2: The number of birthing hospitals that are Safe Sleep Certified

State Priority: Promote safe and healthy infant sleep behaviors and environments, including improving support systems and the daily living conditions that make safe sleep practices challenging

The decline in the incidence of SIDS has plateaued in recent years. Concurrently, sleep-related deaths, including suffocation, asphyxia, and entrapment; and ill-defined or unspecified causes of death have increased in incidence. Focusing on a safe sleep environment can reduce the risk of all sleep-related infant deaths, including SIDS.

Domain: Child Health

NPM 8.1: Percent of children ages 6-11 and adolescents ages 12-17 who are physically active at least 60 minutes per day

ESM 8.1: The number of school districts that apply for the evidence-based Florida Healthy School District recognition

State Priority: Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment

Studies show that for many children, a decline in physical activity begins in middle school, but children who continue to be physically active through high school have a much better chance of being physically active adults. Focusing on children and adolescents to increase physical activity can have a tremendous impact on improving health throughout the lifespan.

SPM 2: The percentage of low-income children under age 21 who access dental care

State Priority: Improve dental care access for children and pregnant women

Oral health is vitally important to overall health and well-being. Good oral health habits and access to routine dental care should be established early in life. Poor oral health can affect school attendance and a child's ability to learn.

SPM 3: The percentage of parents who read to their young child

State Priority: Address the social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies

Encouraging parents to read to their child has a positive impact on children, including but not limited to, increased positive parenting, improvement in the parent-child bond, and improved language development in children.

Domain: Adolescent Health

NPM 9: Percent of adolescents, ages 12-17, who are bullied or who bully others

ESM 9.1: The number of students who participate in an evidence-based program that promotes positive youth development and non-violence intervention skills

State Priority: Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment

Bullying is a serious detriment to a child's health, sense of well-being, safety, education, and emotional development; and greatly increases the risk of self-injury and suicide. Bullying is a new priority and provides the opportunity for the Department to improve health throughout the lifespan by reducing the percentage of adolescents who are bullied and increasing the proportion of students who graduate.

Domain: Children and Youth with Special Health Care Needs

NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

ESM 11.2: Percent of family satisfaction with access to care received in a patient centered medical home and

primary care for children that have special health care needs

State Priority: Increase access to medical homes and primary care for children and youth with special health care needs

A patient-centered medical home (PCMH) provides accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective medical care. It is especially advantageous for CYSHCN as they require coordination of care between providers.

NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

ESM 12.2: Percent of satisfaction with youth with special health care needs who report having access to community-based resources necessary to make transition to adult health care

State Priority: Improve health care transition to all aspects of adult life for adolescents and young adults with special health care needs

The successful health transition of youth and young adults with and without special health care needs, is essential to individual self-determination and self-management.

SPM 1: The percentage of children who need mental health services that actually receive mental health services

State Priority: Improve access to appropriate mental health services to all children

Access to behavioral/mental health services is a priority need. Without early diagnosis and treatment, children with mental health conditions may have problems at home, school, and socially.

SPM 4 - The percentage of individuals who received workforce development that reported improved public health competency and capacity

State Priority: Increase access to medical homes and primary care for children with special health care needs

Building upon disciplinary expertise and cultivating public health strategic skills is critical for building effective systems of care encompassing the community and state level.

III.A.2. How Title V Funds Support State MCH Efforts

As MCH issues become increasingly complicated, the Department views this as their responsibility to use convening power to create networks, funding collaborative work and supporting quality research about what works and what changes can be made at the systems level to improve outcomes. This approach requires partnerships with other funders and groups of organizations able to make a difference to the issue in question on a larger scale. Scaling successful interventions is too big a job for any one funder to successfully take on.

System change can be a long process and partners understand the need to be willing to fund for the long-term and encourage the inevitable learning, adaptation, and even failure that takes place over time. This allows partners to see themselves as part of the solution and consider the role they play as well as return on investment, both from a business stance and overall population effect.

The Department successfully implemented system changes through its partnership with the Florida Perinatal Quality Collaborative and extended relationships with other partners such as the Florida Hospital Association and Florida's Medicaid Agency to roll out a long-acting reversible contraception initiative. Another example is the funding of the Florida Pregnancy-Associated Mortality Review team and the Urgent Mortality Messages disseminated to prompt systems changes within hospital settings. Both examples are discussed more thoroughly in this application.

III.A.3. MCH Success Story

One example of a successful federal-state Title V partnership in action is our efforts to increase the use of long-acting reversible contraception (LARC) immediately after delivery to reduce the number of unintended pregnancies and improve maternal and child health. The consequences of unintended or closely spaced pregnancies include poor pregnancy outcomes (i.e., low birth weight, preterm birth, small for gestational age), delayed initiation of prenatal care, lower breastfeeding rates, and higher risk of maternal depression and potential future child maltreatment.

The Department is currently contracting with the Florida Perinatal Quality Collaborative (FPQC) at the University of South Florida, to implement the Postpartum Long-Acting Reversible Contraceptives Quality Improvement Initiative. The purpose of the initiative is to reduce the number of unintended and closely spaced pregnancies by working collaboratively with maternal health care providers and hospitals to develop and implement policies to improve the use of LARC methods immediately after delivery.

The Department also worked with Florida's Medicaid agency, the Agency for Health Care Administration (AHCA), and the Association of State and Territorial Health Officers (ASTHO) to increase access to LARCs nationwide.

III.B. Overview of the State

The mission of the Florida Department of Health is to protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts. The Department's goal is to be the healthiest state in the nation. Our values are illustrated by the acronym ICARE:

- Innovation: We search for creative solutions and manage resources wisely.
- Collaboration: We use teamwork to achieve common goals and solve problems.
- Accountability: We perform with integrity and respect.
- Responsiveness: We achieve our mission by serving our customers and engaging our partners.
- Excellence: We promote quality outcomes through learning and continuous performance improvement.

Accomplishing our mission begins with fundamental plans of action. The Department's State Health Improvement Plan (SHIP) establishes goals for the public health system, which includes: state and local government agencies, health care providers, employers, community groups, universities and schools, nonprofit organizations, and advocacy groups. The Department uses a collaborative planning process to foster shared ownership and responsibility for the plan's implementation, with the goal of efficient and targeted collective action to improve the health of Floridians.

The Department led a diverse group of stakeholders to build Florida's SHIP for 2017-2021. The partnership conducted a comprehensive state health assessment to identify the most important health issues. The SHIP Steering Committee recently set five-year priorities based on the health issues and strategic opportunities identified in the assessment. Workgroups identified goals, strategies, and measurable objectives around each priority issue.

Additional plans include the Agency Strategic Plan, which provides a unified vision and framework for action. This plan positions the Department to operate as a sustainable integrated public health system and provide Florida's residents and visitors with quality public health services The Long-Range Program Plan provides the framework and justification for the agency budget. It is a goal-based plan with a five-year planning horizon and focuses on agency priorities in achieving the goals and objectives of the state.

In 2016, the Department received first-in-the-nation national accreditation as an integrated Department of Health through the Public Health Accreditation Board (PHAB). This seal of accreditation signifies that the unified Department, including the state health office and all 67 county health departments (CHDs), has been rigorously examined and meets or exceeds national standards for public health performance management and continuous quality improvement. The Department is required to provide examples of quality improvement activities to demonstrate conformity with the PHAB standards and to maintain accreditation status. Seeking and maintaining accreditation status has stimulated quality and performance improvement opportunities within the Department; improved visibility, credibility and reputation among community partners and public health peers within the state and nationally; improved identification and use of evidence-based programs and metrics; and increased cross-department collaboration.

The Title V MCH and CYSHCN directors, along with MCH and CMS staff, utilize various methods to determine the importance, magnitude, value, and priority of competing factors that impact health services delivery. The five-year needs assessment and continual assessment during interim years provides valuable direction. Many of the Department's priorities, policies, and services originate through legislative bills, statutory regulations, administrative rules, and directives from the State Surgeon General. Priorities for improving public health are addressed through a variety of plans that address collaboration with our partners as well as internal agency priorities. The Title V program receives input and advice from statewide partnerships, stakeholders, and other agencies and organizations.

Comprehensive community health assessment and health improvement planning are the foundations for improving and promoting healthier communities. County health departments use a common process for collecting, analyzing, and using data to educate and mobilize communities, develop priorities, gather resources, and plan and implement actions to improve public health.

At the state and local levels, three critical assessments provide the basis for action: community health status assessment, forces of change assessment, and local public health system assessment using the National Public Health Performance Standards Program. Assessment findings inform the selection of strategic community health priorities. Goals, strategies, and measurable objectives are used to develop a community health improvement plan that includes implementation strategies and action plans. Two important, tangible products of these efforts are state and community health status profile reports and state and community health improvement plans, resulting in state and local documents reflecting each area's needs and priorities.

The Department has identified the following seven performance measures listed below in equal priority to each other, all of which have impact on the MCH and CYSHCN population:

1. Childhood Vaccines – Increase vaccination to prevent disease and keep all children protected from health threats. High immunization levels lower disease incidence, lower health care costs, and protect travelers from vaccine-preventable diseases. Increasing access to and availability of vaccines help keep families and communities protected from emerging health threats and improve overall school attendance.

2. Health Equity – Ensure Floridians in all communities have opportunities to achieve healthier outcomes. Florida has experienced lower morbidity and mortality rates across several diseases, but gaps continue to exist. All Floridians should be able to attain the highest level of health, regardless of gender, race, ethnicity, age, geographic location, or physical and developmental differences. Eliminating health gaps between different communities in Florida is a strategic priority for the Department.

3. Trauma Services – Develop a trauma system that ensures the highest quality service. Florida will have an integrated trauma system that drives performance through data reporting and competition with a goal of ensuring quality outcomes for severely injured patients.

4. HIV Infections – Reduce the incidence of HIV infections through a comprehensive program to prevent the transmission of HIV and provide care and treatment to those already infected. By reducing the incidence of HIV, more Floridians will live longer, healthier lives.

5. Infant Mortality – Reduce infant mortality to improve health outcomes for all infants. Infant mortality is a key measure of a population’s health. While the overall infant mortality rate has reached historic lows in recent years, these improvements have not been uniform across all groups, particularly among black infants. Reducing the black infant mortality rate will improve health outcomes for Florida’s children, families, and communities.

6. Inhaled Nicotine – Decrease inhaled nicotine use to provide a longer and healthier life. Cigarette smoking remains a major cause of cancer deaths in the United States. E-cigarette use among youth is on the rise with a 539 percent increase since 2011. Florida has led the nation with innovative strategies to teach young people about the dangers of smoking and give current smokers the resources and support they need to quit.

7. Licensure Time – Decrease time to issue licenses to health care professionals so they may serve medical

needs more quickly. By decreasing the licensure processing time, health care professionals will be able to get to work in a timelier manner.

The Department has also adopted the National Association of City and County Health Officials' Protocol for Assessing Community Excellence in Environmental Health - PACE EH. For several years, the Bureau of Environmental Health has supported county health departments to work with their communities and address environmental health concerns. Collectively, county health departments who have implemented PACE EH in communities have become a national model, and provided evidence that communities can identify environment and urban planning issues as environmental health issues and address the social determinants of health. All projects are designed to open the lines of communication between the county health departments and affected communities.

Addressing the needs of children with special needs is the primary focus of our Office of Children's Medical Services Managed Care Plan and Specialty Programs. Florida has over 1,000,000 children and youth with special health care needs and over 100,000 children with medical complexities.

In 2011, the Florida Legislature created Part IV of Chapter 409, Florida Statutes, directing the Agency for Health Care Administration (AHCA) to create the Statewide Medicaid Managed Care (SMMC) program. As a subset of the SMMC, the SMMC Managed Medical Assistance program was fully implemented in 2014 with the components of Managed Medical Assistance and Long Term Care. The SMMC program is designed to promote patient-centered care, personal responsibility, and active patient participation; provide fully integrated care with access to providers and services through a uniform statewide program; and implement innovations in reimbursement methodologies, plan quality, and plan accountability. The CMS Managed Care Plan (CMS Plan) is a specialty plan option for clinically eligible children and youth with special health care needs (CYSHCN). The CMS Plan provides a broad range of medical, therapeutic, and supportive services for eligible children. The CMS Plan's statewide provider network includes over 39,000 primary care providers, specialists, hospitals, university medical centers, and other health care providers. Over 60,000 of Florida's CYSHCN are enrolled in the Children's Medical Services Plan, receiving direct care services for their medical, behavioral, and developmental needs. Care coordination services increase the number of children who receive well-child visits, immunizations, flu vaccinations, follow up, and linkage to services.

Future endeavors for the CMS Plan include a transformation of its health care delivery system for direct care services, including care coordination, for enrollees. This new model was conceived with comprehensive stakeholder input at the family, provider, and community levels; as well as state and national experts. With the improved health plan model, CMS hopes to have flexibility in payments to providers, increase care coordination services, and the ability to offer families valuable "in lieu of" services and enhanced benefits for improved services and access.

CMS is strengthening its public health services and systems for all CYSHCN with the creation of Regional Networks for Access and Quality (RNAQs) and Statewide Networks for Access and Quality (SNAQs). The goal is to improve access and quality for CYSHCN no matter what health insurance they have or where they may live. The focus is to align our Title V priorities, addressing social determinants of health and emerging themes from community needs assessments in the development or strengthening of community systems approaches, including the integration of multisector service systems to maximize outcomes for CYSHCN.

Florida has 18 pediatric children's hospitals statewide to serve the acute, chronic, and complex needs of children. To ensure CYSHCN receive the health care services they require, CMS partners with a network of primary care providers, federally qualified health centers, and pediatric specialists. CMS is working to increase access to specialty services that have limited provider networks through telehealth opportunities. A statewide workgroup has convened and their recommendations will be infused into expansion activities. CMS is in the planning phase for the

implementation of behavioral health services in the primary care setting. Implementation pilots for these models will inform decision making and future planning.

To effectively plan for improving health, it is imperative to understand health is shaped by the social, economic, and environmental conditions in which we live, and the available and accessible community resources. It is necessary to address the conditions that produce our health rather than only treating medical conditions after they occur. This section discusses the principal characteristics important to understanding the health status and needs of not only Florida's population but more specifically the MCH and CYSHCN population.

According to statewide population estimates conducted by the Florida Legislature, Office of Economic and Demographic Research, Florida has a total population of 20.6 million citizens, following only California and Texas as the third most populous state. Between 2010 and 2017, Florida's population increased by 9.2 percent. The most recent demographic data as of July 1, 2017, show 77.6 percent of Florida's population is white,16.9 percent black, and 5.5 percent other races, mixed race, or unknown. Of the total population by ethnicity, 25 percent are Hispanic and 75 percent non-Hispanic. More than half of the state's population (51.6 percent) is between the ages of 25-64 and 28.6 percent are between the ages of 0-24. Florida's population 65 and older comprise 19.8 percent of the state's population compared to just 15.2 percent in this age group nationally in July 1, 2016. A greater percentage of health care resources are expended on the elderly population in Florida compared to other states.

The Office of Minority Health and Health Equity, led by the Senior Health Equity Officer, serves as the Department's coordinating office for consultative services and training in the areas of cultural and linguistic competency, partnership building, program development and implementation, and other related comprehensive efforts to address the heath needs of minority and underrepresented populations. The Office promotes the integration of culturally and linguistically appropriate services within health-related programs across the state to ensure the needs of the state's racial and ethnic minority communities are addressed, as well as the needs of people who are lesbian, bisexual, gay, and transgendered (LGBT).

The Department established a Health Equity Program Council to focus on the issue of health equity. The council is comprised of county health department officers and leaders in the state health office. The council guides county health department and state health office efforts by monitoring emerging research and expanding and implementing evidence-based practices statewide.

The first project of the Health Equity Program Council was Florida's Healthy Babies Initiative, the Department's direct response to focus on the black-white infant mortality gap. During phase one of the initiative, the Department invested $1.5 million in Title V funding. Funding was provided to the county health departments to conduct an enhanced data analysis on infant mortality, including an environmental scan of existing pertinent programs, and to host a community action-planning meeting to examine disparities in infant deaths, the role of social determinants of health, and to propose local action. Phase IV begins July 2018 with the selection of six evidenced-based projects for county health departments to select one or more from. The workplan templates are attached as Supporting Document 2.

Another overarching initiative within the Department is Healthiest Weight Florida, a public-private collaboration bringing together state agencies, nonprofit organizations, businesses, and entire communities to help children and adults make consistent, informed choices about healthy eating and active living. The initiative works closely with partners to leverage existing resources to maximize reach and impact. These partners include the business community; hospitals; non-governmental organizations; nonprofit agencies; other federal, state, or local government agencies; and volunteer coalitions.

Encouraging physical activity and healthier food choices has a positive impact on birth outcomes and child health.

Women who are healthier before and during pregnancy lessen the risk of maternal and infant morbidity and mortality.

Several factors determine what people eat, but access to healthy food and beverages has a major influence. Finding healthy food is not always convenient. Studies have found that people buy food that is readily available. Today, it is often the case that communities with the highest rates of obesity are also places where residents have few opportunities to conveniently purchase nutritious, affordable food.

Following the Centers for Disease Control and Prevention (CDC) declaration of a national opioid epidemic, Florida's Governor signed Executive Order 17-146 on May 3, 2017 directing the Surgeon General to declare a statewide public health emergency. Signing the emergency order allowed the state to immediately draw down more than $27 million in federal grant funding from the United States Department of Health and Human Services (HHS) Opioid State Targeted Response Grant, which was awarded to Florida in April 2017 to provide prevention, treatment, and recovery support services to address this epidemic. The State Surgeon General issued a standing order for Naloxone, an emergency treatment for opioid overdose, ensuring first responders have immediate access to this lifesaving drug to respond to opioid overdoses.

In 2014, neonatal abstinence syndrome (NAS) became a reportable condition in Florida. MCH epidemiologists worked with Department staff, the CDC, state academic partners, and clinical experts on validating hospital inpatient discharge records as a means of passive NAS surveillance. This work serves as a guide to help state health agencies across the nation make informed decisions on how to conduct NAS surveillance. Additionally, the data is being used to initiate quality improvement initiatives at the local level.

On July 1, 2014, the operation of the Healthy Start Medicaid-funded Waiver and SOBRA (MomCare) components were moved from the Department to AHCA. AHCA now contracts with an administrative services organization called the Healthy Start MomCare Network (HSMN) representing all 32 state Healthy Start Coalitions. The HSMN contracts with the coalitions to provide counseling, education, risk-reduction, and case management services, and quality assurance for all enrollees of the Waiver and SOBRA services. Medicaid-eligible clients are part of Florida's Managed Medical Assistance Program. Each plan's programs and procedures include agreements with the local coalition to provide risk-appropriate care coordination for pregnant women and infants, consistent with AHCA policies and the MomCare Network. The plans are tasked with establishing specific programs and procedures to improve pregnancy outcomes and infant health, including coordination with the Healthy Start program, immunization programs, and referral to WIC.

Florida shares borders with the reservations of two tribal governments, the Seminole Tribe and the Miccosukee Tribe. These governments have their own public safety and emergency services for reservation residents, but a substantial portion of their tribal citizens live outside the reservation boundaries. The Department established the American Indian Health Advisory Committee to provide guidance on issues impacting American Indian populations in Florida. The committee consists of representatives from tribes and stakeholders serving American Indian communities and staff from the Office of Minority Health and Health Equity.

Florida is also home to many non-governmental tribal communities, whose members may be spread out geographically but who gather frequently to maintain their community's identity, culture, language, traditional knowledge, and traditional ways. These groups do not have government status either as a preference, or because their structure is not suited to political governance, or because they cannot provide documentation that they maintained a tribal government during the years that it was illegal to do so. A subset of this category would be American Indian Christian Churches, which bring members and descendants of various American Indian nations together around a shared faith practice that incorporates inter-tribal practices in their worship. Another subset of this

category would be American Indian associations that organize cultural gatherings that are open to visitors. Yet another subset are American Indian associations concerned with activism in favor of American Indian causes.

Per the 2010 Census, individuals in Florida identifying as only Native American comprise a total of 71,458. In addition, Native Americans experienced a 33.5 percent increase in identification as Native Americans (alone) over the 10-year (2000-2010) period. This is a greater increase than white or black (alone) over the same period.

Florida is a temporary home to well over 100 million tourists and visitors each year, which presents challenges to the state's public health system. In 2017, Florida welcomed 116.5 million tourists, a 3.6 percent increase over 2016, and the highest number in any year despite losing 1.8 million visitors due to Hurricane Irma. Migrant farm workers and unauthorized immigrants also have a significant impact on the state's public health services and resources. Florida was home to 850,000 unauthorized immigrants in 2014, compared to 925,000 in 2012 and a peak of 1,050,000 in 2007. California and Texas are the only states with greater numbers of unauthorized immigrants. If citizenship questions are added to the 2020 census, Florida could see a reduction in total census numbers, and a possible reduction in federal funding such as Title V, education, and transportation funds, as well as a possible reduction in our total number of congressional representatives.

The racial, ethnic, and cultural diversity of Florida's population creates unique challenges as well as increased opportunities. This diversity makes Florida a more interesting place to live, work, and play. As the racial and ethnic make-up of the country, our state, our workplaces, and schools become increasingly varied, it is important that we recognize and value these differences. People from diverse cultures contribute language skills, new ways of thinking, new knowledge, and different experiences. Diversity helps us recognize and respect the customs, behaviors, and traditions of others, allowing for bridges of trust, respect, and understanding to be built across cultures.

The Title V program, along with private and public health providers, contributes to meeting the challenges that come with the state's diverse group of residents, immigrants, tourists, and visitors. The Department supports the culturally diverse MCH population by tailoring services provided through the Title V program to meet the needs of different cultures. Educational materials are developed in English, Spanish, and Haitian Creole. The Department contracts with Language Line Services to provide telephonic interpretation services in over 180 languages, allowing a client to communicate with a health care provider through a conference or three-way calling system. Language Line Services also provides written translation services in over 100 languages and translates documents such as health-related educational materials into multiple languages.

The health of the economy plays a major role in the health status of the state's MCH population. The economy in Florida has been recovering since the economic downturn suffered during the most recent nationwide recession. The average annual wage in Florida currently stands at 87.6 percent of the national average. Florida's economy is heavily reliant upon the service-related industry, where minimum wage jobs with little or no benefits are more the norm than the exception. A lack of well-paying jobs makes it difficult for many individuals and families to meet their basic needs. Those households most disproportionately affected are female-headed households, blacks, Hispanics, people living with a disability, and unskilled recent immigrants. According to the latest final numbers from the U.S. Bureau of Labor and Statistics, Florida's unemployment rate was 3.9 percent in April 2018, the same as the 3.9 percent for the nation. Florida had a four-year adjusted cohort graduation rate for public high schools of 77.9 percent. In comparison, the corresponding national rate was 83.2 percent during the 2014-15 school year.

With a total area of 58,560 square miles, Florida ranks 22nd among states in total area and 8th in the nation in population density. Driving from Pensacola in the western panhandle of Florida to Key West at the southernmost point is nearly an 800-mile journey. The 1,200 miles of coastline become a target during hurricane season, and 2,276 miles of tidal shoreline are subject to concerns regarding water quality and fish and wildlife habitat

degradation. A recent study by a private data analysis firm ranked Florida as the state with the highest level of risk from natural hazards.

With the threat of tropical depressions and hurricanes looming every summer, the Department takes emergency preparedness seriously for all sorts of possible threats or disasters. Florida's Public Health Preparedness effort is an excellent model of public-private cooperation. Funding made available post-9/11 facilitated conversations beyond just emergencies that enhanced the integration of services and systems among state, federal, local, and private entities. Well organized public-private partnerships benefit from the strengths and competencies of both systems.

When hurricanes approach, the Department operates and staffs Special Needs Shelters (SpNS) to allow people with special or complicated medical needs, their family members, and aides to safely shelter from the storms, with nurses on hand to assist with their needs. As of 2017, there were 129 SpNS across the state. In 2017, during Hurricane Irma alone, a total of 115 SpNS were opened, serving 12,107 people. For that storm, more shelters were opened and more people were served than the entire 2011 year, the next busiest year for SpNS usage.

At-risk or vulnerable populations include those groups whose needs may not be fully integrated into planning for disaster response. These populations include persons with physical, cognitive, or developmental disabilities. Included in this group are persons with limited English proficiency, the geographically or culturally isolated, medically or chemically dependent, homeless, frail elderly, children, and pregnant women. Meeting the needs of vulnerable populations during or following a disaster is a key component of public health and medical preparedness planning. CMS collaborates with the county health departments in planning for disasters, staffing the special needs shelters around the state, and assisting in recovery efforts. In 2017, displaced Hurricane Maria evacuees from Puerto Rico, including CYSHCN, received assistance in obtaining medical and psychosocial resources and services from CMS as part of the recovery efforts.

The basic statutory authority for MCH is section 383.011, F.S, Administration of Maternal and Child Health Programs. The statute authorizes the Department to administer and provide MCH programs, including prenatal care programs, the WIC program, and the Child Care Food Program. This statute also designates the Department to be the agency that receives the federal MCH and Preventive Health Services Block Grant funds.

Section 383.216, F.S., authorizes prenatal and infant coalitions for the purpose of establishing partnerships among the private sector, the public sector, state government, local government, community alliances, and MCH providers and advocates, for coordinated community-based prenatal and infant health care. Chapter 64F-2, Florida Administrative Code, establishes rules governing coalition responsibilities and operations. Chapter 64F-3, FAC, establishes rules governing Healthy Start care coordination and services.

Section 383.014, F.S, authorizes screening and identification of all pregnant women entering prenatal care and all infants born in Florida, for conditions associated with poor pregnancy outcomes and increased risk of infant mortality and morbidity. This statute also governs screening for metabolic disorders and other hereditary and congenital disorders. Chapter 64C-7, FAC, establishes rules governing prenatal and infant screening for risk factors associated with poor outcomes, and rules related to metabolic, hereditary, and congenital disorders.

The basic statutory authority for CYSHCN and their families is Chapter 391, F.S., known as the Children's Medical Services Act. Section 391.016, F.S., establishes the Children's Medical Services Program, and defines two primary functions: provide to children and youth with special health care needs a family-centered, comprehensive, and coordinated statewide managed system of care that links community-based health care with multidisciplinary, regional, and tertiary pediatric specialty care; and provide essential preventive, evaluative, and early intervention

services for children at-risk for or having special health care needs, to prevent or reduce long-term disabilities.

III.C. Needs Assessment

FY 2019 Application/FY 2017 Annual Report Update

The Maternal and Child Health Block Grant Needs Assessment conducted in 2015 is the guiding document for the MCH and CYSHCN programs. Partners and users of the needs assessment include county health departments, health districts, health planning organizations, health and social service organizations, federally qualified health centers, partner agencies, social service agencies, academic institutions, and numerous other organizations. Within the Department, it is used for improvement planning; agency strategic planning; workforce assessment planning; informing, educating and empowering residents about maternal and child health issues; and identifying research and innovation opportunities.

Department staff bears statutory responsibility for the ongoing monitoring of the needs assessment; however, the Department is only one part of the MCH and CYSHCN system. Efficient collaboration and coordination with other agencies, non-governmental organizations, institutions, and informal associations play an essential role in the needs assessment process.

Continual monitoring identifies priority health and quality of life issues and provides a focus for the organizations and entities that contribute to the MCH and CYSHCN system. Assessing strengths and weaknesses identifies the important health issues that are emerging or in need of potential new direction, and may also identify additional health issues as perceived by residents and consumers. Lastly, continual monitoring and assessment determine forces that impact the way the MCH and CYSHCN system operates, including areas such as legislation, funding and funding shifts, and technology or other impending changes that may affect state residents, visitors, tourists or the system itself. These changes may provide opportunities for improvement and efficiency.

The Department continues to gather and publish data on pregnancy-related deaths. Florida's Pregnancy-Associated Mortality Review (PAMR) 2016 Report was finalized, and shared on the Department's Internet site. The 2016 data update report provides an overview and comparisons of pregnancy-related death data and trends for Florida between the years 2006 and 2016.

Florida PAMR established an action subcommittee and produced two infographics with Urgent Maternal Mortality Messages (UMMM) to providers on hemorrhage-placental disorders and peripartum cardiomyopathy. These messages were distributed to providers through Florida perinatal professional associations such as the District XII American Congress of Obstetricians and Gynecologists; Association of Women's Health, Obstetric and Neonatal Nurses, Association of Certified Nurse Midwives; and the Florida Perinatal Quality Collaborative. A new UMMM on Maternal Early Warning Systems for hospitals is currently in production. The work of the PAMR committee drives the Department's priority that all of Florida's mothers and infants receive high-quality, evidence-based perinatal care to help ensure the best health outcomes possible.

In 2018, Florida PAMR began using the Maternal Mortality Review Information Application (MMRIA) data system developed by the CDC. The MMRIA data system is designed to empower the maternal mortality review community to create action through a common data language and bring standardization to the maternal mortality review process across the nation. MMRIA is designed to support standardized case abstraction; case narrative development; documentation of committee deliberations on pregnancy relatedness, preventability and contributing factors; and routine analyses. MMRIA will improve efficiency and sustainability of the PAMR project. Over the next year, PAMR will continue to incorporate the MMRIA system into the maternal review process and will receive technical support from the CDC to help become accustomed to the new system.

Due to concerns about mental health and pregnancy, PAMR is forming a mental health subcommittee. This multidisciplinary subcommittee will discuss if there is a relationship between mental health, suicide, substance abuse and pregnancy.

Florida PAMR is also featured on the Association of Maternal and Child Health Programs (AMCHP) Review to Action website at: www.reviewtoaction.org, where PAMR briefs and annual reports are available for viewing. Plans for the coming year include adding additional resources used by Florida PAMR to the website.

The Children's Medical Services (CMS) Managed Care Plan (CMS Plan), held a series of public meetings and family forums in 2017 to gather feedback related to the plan's health care delivery model. Following those events, the CMS Plan worked with an international consulting firm to develop a new health plan model, encompassing improvements and enhancements based on family, community, staff, and provider input and feedback. The new model is scheduled to be operational in January 2019. The CMS Plan has a large-scale project plan and team working to ensure continuity of care and continuity in the system throughout the transition to the new model. Quality healthcare delivery and outcomes will continue to be a central focus of the plan and will expand on traditional Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures to include quality of life measures as well. This will be accomplished by continuing to engage families and communities in the plan's ongoing needs assessment/identification efforts, including the formation of the Children and Youth with Special Health Care Needs Technical Advisory Panel, which will include family and youth representation.

To increase workforce capacity during this shift, CMS worked with local leadership teams to gather team member feedback to develop a comprehensive yearlong plan to increase staff skills and knowledge. As a foundational element, all plans include MCH Navigator trainings. Additionally, all staff are encouraged to take leadership skills building modules, developed in-house, that focus on developing leadership skills in all team members. Care coordinators will be strengthening their case management abilities and other staff may choose to be trained as community health workers.

CMS participated in the MCH Workforce Development Center's 2017 Cohort for the state performance measure related to behavior health. Part of the work completed for that project included an environmental scan and readiness assessments related to integrating behavioral health with primary care throughout the state. This has helped the Florida team understand where to focus efforts for additional integration activities and where to focus efforts to provide support for new initiatives where no integration is occurring. While access to behavioral health and mental health services was clearly identified as a need during the most recent five-year needs assessment, it continues to be highlighted as an extreme need, as evidenced by ongoing feedback received and current events.

The CMS Plan receives satisfaction survey feedback on enrollees of the health plan. CMS is working with the University of Florida's Institute for Child Health Policy (ICHP) to develop a survey intended to canvas a broader population of families with children and youth with special health care needs, regardless of insurer or insurance status, to help inform the CYSHCN priorities and policies in Florida. With the assistance of the Family Network on Disabilities, Family STAR, and other family partners, CMS and ICHP plans to release its first survey in 2018.

A specific effort is being made by the Department to operationalize a health equity framework into all program and policy work beginning with the needs assessment process and findings and culminating into the State Health Improvement Plan and Agency Strategic Plan. The framework includes:

- Improving the accessibility of the health system through outreach, location, physical design, opening hours, and other policies.

- Improving the patient-centeredness of the system by providing culturally competent care, interpretation services, and assisting patients and families who face social and economic barriers to care.
- Partnering with other sectors to improve population health.

The block grant outlines innovations and opportunities for operationalizing each of these aspects of health equity to advance on and improve our needs assessment findings.

Following are some changes since last year's application in the Department's leadership positions that provides oversight to Title V:

Jeffrey P. Brosco, MD, PhD, was named as Deputy Secretary for Children's Medical Services in July 2017.

Shamarial Roberson, DrPH, MPH, was named Interim Division Director for Community Health Promotion in February 2018.

Leslie M. Beitsch, MD, JD was named Deputy Secretary for Health in April 2018.

Emerging Public Health Issues

While not emerging, the opioid crisis continues to be a major issue in Florida. Florida's Governor signed an executive order on May 3, 2017 directing the State Health Officer and Surgeon General to declare the opioid crisis a statewide public health emergency. Signing the emergency order allowed the state to immediately draw down more than $27 million in federal grant funding from the United States Department of Health and Human Services (HHS) Opioid State Targeted Response Grant, awarded to Florida in April 2017 to provide prevention, treatment, and recovery support services to address this epidemic.

A number of Florida cities have begun the process of suing pharmaceutical companies for their alleged role in worsening the opioid addiction crisis, including Miami and Jacksonville. Miami has experienced a 20 percent increase in opioid deaths from 2015 to 2016. In 2017, Jacksonville was among the worst in Florida for babies born addicted to opiate drugs, and the city was averaging about three deaths a day due to opioid overdoses. In April 2018, Florida Attorney General Pam Bondi announced the state will file a lawsuit against drug companies, as opposed to joining a federal lawsuit already in progress.

Although substance use is not a state priority or performance measure, the impact of this crisis on pregnant women, infants, and families deserves a response. Using Title V funds, the Department contracted with the FPQC to establish a Neonatal Abstinence Workgroup to plan a hospital-based initiative on neonatal abstinence syndrome. We are in the process of recruiting hospitals to participate in the initiative.

Gun violence is another public health issue that, while always evident, has emerged into a more visible public health issue. Florida has experienced two horrific incidents in recent years, one in June 2016 at the Pulse nightclub in Orlando, where 49 people were killed and 58 others were wounded, in what was then the deadliest mass shooting in the U.S., and remains the deadliest incident of violence against the LBGT community in U.S. history. Deemed a terrorist attack, it did not seem to invoke the level of outrage that followed the February 2018 shooting at a high school in Parkland Florida, in which 17 students and faculty were killed and 17 more were wounded. Students from Marjorie Stoneman Douglas High marched on the state capital and demanded action from the Governor and Legislature. The result was the passing of a bill that imposed the following gun control measures: a new three-day waiting period for the purchase of all firearms; raising the age to buy a gun from 18 to 21, and banning bump stocks.

The bill also approved $400 million for mental health and for security programs that could introduce thousands of guns in Florida schools through the arming of school personnel or additional police or sheriff officers on campus.

Understandably, mass shootings elicit a strong public response, but they are only one part of a larger picture. Once the sole domain of criminal justice, gun violence is increasingly being understood as a public health concern, with growing interest in learning how the issue affects populations, not just individuals. Discussion includes and attention is being paid to: how to prevent gun violence; whether policies like a ban on assault rifles are needed; and guidance such as how best to talk to your children about protecting themselves or how to protect our children from guns in our own homes.

A 2011 law passed in Florida dubbed *Docs vs. Glocks* prevented physicians from asking about gun ownership by patients or family members, and from entering information about gun ownership into the patient's record. This prevented, for example, pediatricians from asking about gun ownership so they could inform parents about gun safety. After a lengthy legal battle, the law was struck down in June 2017, based on the decision that it violated the first amendment rights of doctors.

Another law passed in 2011 prohibits cities and counties from filing any rules, ordinances, or regulations regarding firearms or ammunitions. This prevents, for example, a city to restrict carrying weapons into a city park, or restrictions from discharging firearms within neighborhoods. The law allows the state to force cities to pay up to $100,000 plus legal fees if they violate the state law, and the state may assess a civil fine up to $5,000 on any elected or appointed government official under whose jurisdiction the violation occurred. Since the shooting at Marjory Stoneman Douglas High School, 13 cities have already filed lawsuits saying the law violates both the U.S. and Florida constitutions,

Although gun violence is not a state priority or performance measure, the impact of these most recent actions require attention from not only a public health perspective but from a maternal and child health approach.

FY 2018 Application/FY 2016 Annual Report Update

The Maternal and Child Health Block Grant Needs Assessment conducted in 2015 is the guiding document for the MCH and CSHCN programs. Partners and users of the needs assessment include county health departments, health districts, health planning organizations, health and social service organizations, federally qualified health centers, partner agencies, social service agencies, academic institutions, social service agencies, and numerous other organizations. Within the Department, it is used for improvement planning; agency strategic planning; workforce assessment planning; informing, educating and empowering residents about maternal and child health issues; and identifying research and innovation opportunities.

Department staff bears statutory responsibility for the ongoing monitoring of the needs assessment; however, the Department is only one part of the MCH and CSHCN system. Efficient collaboration and coordination with other agencies, non-governmental organizations, institutions, and informal associations play an essential role in the needs assessment process.

Continual monitoring identifies priority health and quality of life issues and provides a focus for the organizations and entities that contribute to the MCH and CSHCN system. Assessing strengths and weaknesses identifies the important health issues that are emerging or in need of potential new direction, and may also identify additional health issues as perceived by residents and consumers. Lastly, continual monitoring and assessment determine forces that impact the way the MCH and CSHCN system operates, including areas such as legislation, funding and funding shifts, and technology or other impending changes that may affect state residents, visitors, tourists or the system itself, changes that may provide opportunities for improvement and efficiency.

The Department continues to address the priorities identified in the five-year needs assessment conducted in 2015 for the FY2018 application.

The Zika virus surfaced in 2016 with an urgent need to address the impact on birth outcomes and child health. Florida has a high volume of international travelers between Florida and affected locations, and has experienced local transmission of other exotic mosquito-borne diseases in the past. Florida has been gearing up for another year of probable Zika outbreaks as the weather warms. The Department is addressing the Zika virus in several ways, which are discussed more thoroughly in section II.F.5. Emerging Issues.

A second emerging issue is the impact of opioid abuse as mentioned in the Executive Summary and is also discussed more thoroughly in II.F.5. Emerging Issues.

The Department continues to gather and publish data on pregnancy-related deaths. Florida’s Pregnancy-Associated Mortality Review (PAMR) 2014 Report was finalized, and shared on the Department’s internet site. The 2014 data update report provides an overview and comparisons of pregnancy-related death data and trends for Florida between the years 2005 and 2014.

Florida PAMR established an action subcommittee and produced three infographics with Urgent Maternal Mortality Messages to providers on hemorrhage-placental disorders, peripartum cardiomyopathy, and maternal morbidity. These messages were distributed to providers through Florida perinatal professional associations such as District XII American Congress of Obstetricians and Gynecologists, Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN), Association of Certified Nurse Midwives (ACNM), and the Florida Perinatal Quality Collaborative (FPQC). The work of the PAMR committee drives the Department’s priority that all of Florida’s mothers and infants receive high quality, evidence-based perinatal care to help ensure the best health outcomes possible.

Florida PAMR is preparing to pilot the Maternal Mortality Review Information Application (MMRIA) developed by the CDC. This is a data system designed to empower the maternal mortality review community to create action through a common data language. MMRIA is designed to support standardized: case abstraction, case narrative development, documentation of committee deliberations on pregnancy relatedness, preventability and contributing factors, and routine analyses. PAMR is exploring this option to improve efficiency and sustainability of the project. Over the next year, plans are to obtain equipment and receive technical support from the CDC and educate the PAMR team on the capabilities of the system.

Florida PAMR is also featured on the Association of Maternal and Child Health Programs (AMCHP) Review to Action website at: www.reviewtoaction.org where PAMR briefs and annual reports are available for viewing. Plans for the coming year include adding additional resources used by Florida PAMR to the website.

The Department examined ZIP code-level life expectancy across the state, an indicator that enables public health officials to examine health disparities by place and identify areas where underlying factors such as health behaviors and social determinants may be targeted for public health intervention. Consistency across indicators and the availability of a variety of social determinants of health data at this geographic level will allow for in-depth investigation into health disparities by place among Florida residents. Public Health Research staff explored different types of calculations to examine health disparities, creating life expectancy estimates by race/ethnicity and gender. One-on-one focus groups were held at six county health departments to discuss these findings and decide how the counties could use this data, what types of questions these estimates might raise, and what additional information counties would like to see presented with the estimates. Many were interested in having access to more social determinant of health type data such as poverty.

The Department continues to seek ways to partner and assist Florida's American Indian population. Staff participated in the 2017 International Indigenous Nursing Research Summit to facilitate the development of partnerships to address barriers to the attainment of health equity in Indigenous peoples.

The Department is developing a tool that will allow Florida American Indian communities access to disaster preparedness resources to fit their unique cultural beliefs and traditions. The project includes development of a geospatial mapping application that stores and provides access to county and state data sources. It requires little or no training to use. The application empowers tribal communities and its members, with real-time data and resources to prepare for natural disasters. The tool will be completed in 2017.

The Department was selected to participate in an 18-month technical assistance project through AMCHP to create a data partnership and memorandum of agreement between the state's Medicaid and Title V programs. The project's purpose is to increase the capacity of state MCH programs to access Medicaid data to evaluate population health needs and guide programmatic interventions. The data sharing agreement was signed in May 2017 and the project is ongoing. The Medicaid claims, encounter, and eligibility data will be used to evaluate outcomes of Medicaid women who receive MCH and Family Planning Program services and initiate and implement quality improvement projects, and will enhance the data needed to support the State Action Plan priorities, objectives, and strategies.

The *Florida Life Course Indicator Report* was published online and can be found at: www.flhealth.gov/floridalifecourse. This comprehensive state-level report provides baseline measures of the 59 life course indicators selected in a project led by AMCHP and participating partners. The goal of the report is to establish a knowledge base about the Life Course Theory and to promote the use of the life course indicators by public health practitioners. The report is available to download in subsections based on topics such as *Community Well-Being* and *Reproductive Life Experiences*. The Executive Summary provides a high-level overview of all the

indicators and identifies cohesion between the Life Course Theory and current Department priority areas, including the social determinants of health. This work is a wonderful addition to the needs assessment and State Work Plans to more adequately drive and improve the strategies developed to address the MCH and CSHCN priorities and performance measures.

Florida continues to participate as one of the selected states in the Alliance for Innovation on Maternal Health program. The Florida Perinatal Quality Collaborative is continuing to submit aggregate data for the Hypertension in Pregnancy hospital quality improvement project and participates on regular data and program topic calls.

The CMS Managed Care Plan (CMS Plan) is currently working with families, CMS leadership, and CMS family support workers to develop a Person and Family Engagement Strategic Plan. Activities and objectives will begin in July 2017. Objectives and strategies are based on the Centers for Medicare and Medicaid's 2016 *Person and Family Engagement Strategy* and on the *Standards for Systems of Care for Children and Youth with Special Health Care Needs.* CMS will continue to seek input from families and family leaders for the strategies and objectives within the strategic plan.

In 2017, the CMS Plan held a series of public meetings and family forums in order to gather feedback related to the Plan's health care delivery model. CMS has received input from families, stakeholders, advocates, and providers.

In 2016, the CMS Plan developed internal performance measures and electronic reports to track outcomes related to Healthcare Effectiveness Data and Information Set measures. These activities allow CMS care coordinators to track activities related to over 30 measures related to the CMS Plan members' health outcomes. Next steps will include implementing activities at the person/family level in order to achieve improved health outcomes, as well as focusing on data analysis to inform decisions related to care coordination activities.

CMS continues to plan and build the infrastructure to promote the concept of the PCMH. CMS is now working with HealthARCH at the University of Central Florida to identify and provide guidance to providers in Florida who are ready to achieve PCMH recognition.

CMS continues to build on existing transition resources both nationally and in the state to create a robust transition program through medical home and care coordination services. Current data elements are being considered for incorporation into the CMS electronic care coordination system to capture information on the six core elements of transition and associated activities.

CMS is working with state partners and the National MCH Workforce Development Center to explore statewide opportunities to leverage and align resources, staff, and programs to meet our state priority of improving access to appropriate mental health services to all children.

The 2017 legislative session established $2.5 million in recurring general revenue for the CMS Safety Net Program. This allocation will be used to provide uninsured and underinsured children with special health care needs access to medically necessary services. CMS will conduct ongoing needs assessment and project management activities to ensure the money allocated for the Safety Net Program is filling a need in Florida.

Following are some changes since last year's application in the Department's leadership positions that provides oversight to Title V:

Kelli T. Wells, MD, was named Deputy Secretary for Health in March 2017.

Cindy Dick, MBA, CPM, was named Assistant Deputy Secretary for Health in March 2017.

Shay Chapman, BSN, MBA, was named Bureau Chief for the Bureau of Family Health Services and Title V MCH Director in September 2016.

FY 2017 Application/FY 2015 Annual Report Update

The Florida Department of Health continues to address the priorities identified in the five-year needs assessment conducted in 2015 for the FY2016 application. Three additional priorities have been added regarding dental care access for children and pregnant women; access to appropriate mental health services for children; and addressing the social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies. Staff developed three state performance measures to address these priorities, and will continue to track and expand upon strategies and objectives for these state measures over the next three years of the current five-year block grant cycle. While it is too early to determine through data alone whether our focus on identified priorities has been successful, the needs assessment heightened the attention given to issues and needs, invigorating both staff and partners in their efforts to address ongoing and newly identified health needs.

An urgent need has become evident since the last application, the need to address the Zika virus and its possible impact on birth outcomes and child health. Florida has a high volume of international travelers between Florida and affected locations, and has experienced local transmission of other exotic mosquito-borne diseases in the past. The Department is addressing the Zika virus in a number of ways, which are more thoroughly discussed in section II.F.5. Emerging Issues.

The Department has conducted or published data from a number of activities regarding data collection and analysis since the last needs assessment. Florida's Pregnancy-Associated Mortality Review (PAMR) 2013 Report was finalized, and disseminated on the Department's internet site. The 2013 data update report provides an overview and comparisons of pregnancy-related death data and trends for Florida between the years 1999 and 2013.

Additionally, as a result of a PAMR process quality improvement (QI) project, the PAMR Committee initiated a QI project to assess the preventability of pregnancy-related deaths. For each case, the committee reached consensus on whether the death appeared to have been preventable and to what degree the death was preventable. The results were presented as a poster presentation at the 5th Annual Florida Perinatal Quality Collaborative Conference and was the first place winner. The work of the PAMR committee drives the Department's priority that all of Florida's mothers and infants will have the best health outcomes possible through receiving high quality, evidence-based perinatal care.

The Department recently examined Zip code-level life expectancy across the state, an indicator that enables public health officials to examine health disparities by place and identify areas where underlying factors such as health behaviors and social determinants may be targeted for public health intervention. Consistency across indicators and the availability of a variety of social determinants of health data at this geographic level will allow for in-depth investigation into health disparities by place among Florida residents. Next steps include assessing the relationship between social determinants and life expectancy, and incorporating this data into community health assessments and targeted interventions throughout the state.

Racial disparities in health care access among American Indians and Alaska Natives (AI/AN) were also examined. There are about 151,408 AI/AN living in Florida, representing approximately 1 percent of the total population. AI/ANs face persistent disparities in health status and health care. Although special health insurance policies were created for AI/ANs, the uninsured rate among AI/ANs in Florida is 35 percent, considerably higher than Florida's overall prevalence of 20.8 percent. These findings provide important information to policy makers and assist the Department in expanding efforts to address and diminish these racial disparities. The abstract for this study was selected as one of five awardees nationwide for the Ninth annual Robert Wood Johnson Foundation National Award for Outstanding Epidemiology Practice in Addressing Racial and Ethnic Disparities.

The Department used vital statistics birth records, from counties with the lowest breastfeeding initiation, to select hospitals where the Baby-Friendly Hospital Initiative could impact women with the greatest need. Fifteen local health departments were funded to provided mini-grants, technical assistance, and support to 24 birthing facilities to work towards achieving the *Ten Steps to Successful Breastfeeding.*

A Department study looked at characteristics and barriers associated with a preventive dental visit during pregnancy

among new mothers in Florida. Identified barriers to care were significantly associated with not receiving a preventive dental visit. In particular, relative to new mothers who received a preventive dental visit, the following were more likely to not receive a preventive dental visit: women with no preconception teeth cleaning, women without prenatal education, and women without dental insurance during pregnancy. Programmatic efforts should focus on promoting preconception health for all women, reinforcing the safety and appropriateness of dental care during pregnancy to both expectant mothers and providers, and expanding accessibility and coverage of dental services during pregnancy.

Weighted data from the 2012 and 2013 Florida Pregnancy Risk Assessment Monitoring System (PRAMS) matched to birth certificates was used to examine the receipt of a postpartum visit and postpartum contraception use among new mothers. Women with a postpartum visit are more likely to use a more effective postpartum contraceptive method. The study found that receipt of a postpartum visit and any postpartum contraceptive use is high in Florida, as 88.6 percent of new mothers received a postpartum visit and 87 percent of new mothers used some form of contraception.

Florida was one of 12 states that participated in the AMCHP Birth Outcomes Collaborative: Building a Culture of Quality to Demonstrate Value and Improve Equity. Data was collected and summarized through key informant interviews along with publicly available data about statewide MCH programs. Florida's project identified potential gaps or duplications impacting quality and equity in the maternal and child health system within the state. The information is being used to update and enhance existing programs.

Florida is participating in AMCHP's Data Linkage: Phase I – MCH and Medicaid Data Partnerships technical assistance project. The project is intended to increase the capacity of state MCH programs to access Medicaid data to assess population health needs and guide programmatic interventions. The goal is to establish a formal data sharing agreement between the Department's MCH program and the Agency for Health Care Administration's (AHCA) Medicaid program.

As part of an ongoing needs assessment, MCH staff will utilize a health provider survey addressing knowledge, attitudes, and practice regarding safe sleep environment education for parents and caregivers. The survey results will be used to develop appropriate training for health care providers.

Florida's Title V Program and the Public Health Dental Program (PHDP) worked collaboratively to apply for AMCHP's Analytic Action Learning Collaborative. Florida was one of five teams selected nationwide to participate on a return on investment (ROI) project. Through the project, Florida's Title V and PHDP staff members conducted an in-depth logic model for a dental sealant ROI analysis for children up to age 20 receiving at least one dental sealant at a county health department dental program.

The project confirmed that dental sealants provided at Florida County Health Departments have an 88 percent ROI; for every $1 invested in dental sealants, $1.88 is saved in dental treatment costs. The potential for a higher ROI exists for minority races, as they experience a greater incidence of untreated tooth decay. For black children the ROI can be 133 percent; for every $1 invested in dental sealants for black children, $2.33 is saved in dental treatment costs. Tooth decay is the single most common chronic childhood disease, and children with oral health problems are three times more likely to miss school. Establishing concrete evidence of the sealant program's cost effectiveness and cost savings confirms the need to expand and continue sealant programs throughout the state.

Florida was one of seven state teams that participated in the Life Course Metrics Project. The team was multi-disciplinary and included MCH program and epidemiology staff, community partners, and members from CMS, Medicaid, chronic disease, home visiting, and academic programs. Team members used the conceptual framework identified by the National Expert Panel to search the literature and propose life course indicators; write comprehensive descriptions of the indicators; screen proposed indicators for usability, data availability, and other criteria identified by the expert panel; rate and vote on each of the selected indicators; and help finalize the recommended indicators.

Florida is also one of several states participating in the Alliance for Innovation on Maternal Health program. The Florida Perinatal Quality Collaborative introduced the program at its Hypertension in Pregnancy Initiative kick off

meeting in November 2015. Participants discussed a number of topics including hypertension in pregnancy, maternal morbidity and mortality, initiative implementation, and data collection. The training included a personal account of preeclampsia from the patient perspective, as well as a presentation on the importance of taking the patient's perspective into account before, during, and after delivery. The meeting also included a hospital problem-solving session, a blood pressure clinic, and a hypertensive event simulation.

Children's Medical Services (CMS) continues to evaluate ongoing initiatives, emerging issues, and priorities. CMS State Health Office leadership and regional leadership, including the CMS Regional Medical Directors, assist in the identification and evaluation of CMS systems and services. Routine and ongoing communications between CMS staff have been key in identifying needs and developing action steps for improvements.

The CMS Managed Care Plan (CMS Plan) is developing internal performance measures and electronic reports to continuously track outcomes related to Healthcare Effectiveness Data and Information Set measures. These activities will allow CMS care coordinators to track activities that result in meeting over 30 measures related to the CMS Plan members' health outcomes. Implementation of the performance measurement plan and staff training will be complete in 2016.

The CMS Plan continues to improve its electronic system to enhance documentation and reporting capabilities to increase accountability of CMS reports and staff in order to meet the needs of CSHCN and their families. Additionally, a CMS care coordination portal has been developed to address the continuing needs of the care coordinators related to training, information sharing, and resource identification. This portal will enhance the knowledge base of CMS staff to promote effective care coordination.

The 2016 legislative session established $5 million in recurring general revenue for the CMS Safety Net Program. This allocation will be used to provide uninsured and underinsured children with special health care needs access to medically necessary services. CMS will conduct ongoing needs assessment and project management activities to ensure that the money allocated for the Safety Net Program is filling a need in Florida.

CMS established an internal workgroup for Patient Centered Medical Home (PCMH) activities and anticipates expanding the workgroup to include external partners and stakeholders as the activities progress. The group will assist in the implementation of the medical home model by identifying the best assessment tools and identify the barriers and education/training needs of providers currently in a medical home and those desiring to participate in a medical home.

For 2016, CMS continues to plan and build the infrastructure to promote the concept of the PCMH. CMS plans to build on the data and information collected from the Children's Health Insurance Reauthorization Program Act Quality Improvement Project (Florida-Illinois PCMH Demonstration Project) to successfully promote and encourage PCMH concepts throughout the state.

CMS will continue to collaborate with state transition experts to build on existing transition resources in the state to create a robust transition program through medical home and care coordination services. Documentation and accountability of CMS reports and services provided to Children and Youth with Special Health Care Needs (CYSHCN) and their families is being addressed through availability of training and education. CMS will continue to work with FloridaHATS on the development and dissemination of transition education to educators and support staff through the use of school-based education modules. CMS will continue to evaluate the transition needs of the state to ensure that information sharing is occurring and that available resources are being utilized.

Following are some changes in the Department's Title V leadership positions since last year's needs assessment.

Celeste Philip, MD, MPH, was appointed as Florida State Surgeon General and Secretary of Health in May 2016. Previously, Dr. Philip served as the Deputy Secretary for Health and the Deputy State Health Officer for Children's Medical Services. Dr. Philip is the Title V CSHCN Director in Florida.

Anna Likos, MD, MPH, is presently serving as Acting Deputy Secretary for Health and as the State Epidemiologist. Dr. Likos previously served as the Department's Director for the Division of Disease Control and Health Protection.

Shay Chapman, BSN, MBA, was named as Interim Chief for the Bureau of Family Health Services and as the Interim Title V MCH Director in Florida. Ms. Chapman’s previous experience with the Department includes serving as Chief of the Bureau of Chronic Disease Prevention and administrator of the School, Adolescent, and Reproductive Health Section.

John Curran, MD, was appointed as the Deputy Secretary for Children's Medical Services (CMS) in May 2016. Dr. Curran provides oversight for the Office of the CMS Managed Care Plan and Specialty Programs, the Division of Children's Medical Services and CMS area offices.

Shannon F. Hughes, CPM, ASQ-CQIA, has moved from interim to actual Director of the Division of Community Health Promotion.

Five-Year Needs Assessment Summary
(as submitted with the FY 2016 Application/FY 2014 Annual Report)

II.B.1. Process

In 2010, the Florida Department of Health completed a more data-driven Title V Needs Assessment than in previous years. Logic models, health problem analyses, and five-year work plans were developed for the top priorities selected. A major emphasis was placed on coordinating the selected priorities with the Department's State Health Improvement Plan (SHIP), the Agency Strategic Plan, the Collaborative Improvement and Innovation Network (CoIIN) priorities, and the partners engaged in the activities addressing the priorities. The intent was to focus efforts across the Department and state for collective impact.

As the Department began the 2015 Five-Year Needs Assessment process, an internal Advisory Workgroup and a statewide Advisory Workgroup were established. The internal workgroup included staff from sections and divisions across the Department. The statewide Advisory Workgroup consisted of Department staff and various partners from throughout Florida, including local health departments, Healthy Start Coalitions, local advocacy organizations, and university partners. Because of the extensive analysis conducted during the 2010 Needs Assessment, a decision was made to use the prior assessment as the foundation on which to build for the 2015 five-year process. This decision allows the Department to continue to focus on key areas that were showing progress in moving the needle and to also add or refine priority areas.

On June 23, 2014, the first publicly noticed statewide Advisory Workgroup met via conference call. Department staff provided an overview of the needs assessment process, plans were developed, and input was received from workgroup members. Over the course of the next few meetings, a web-based electronic survey was developed and sent to 55 MCH stakeholders, professionals, and partners who were asked to complete the survey and distribute the survey to consumers, other members of the community, and community partners; some of whom posted the survey on Facebook pages. The purpose of the survey was to obtain feedback on which MCH topics should be identified as priorities for the state. A total of 708 individuals completed the survey during a two-week period in August 2014. This was the highest response rate for any MCH needs assessment survey ever conducted by the Department. Respondents were asked to select their top five MCH priorities from a list of 18 health issues. The top ranking issues were: adequate health insurance coverage, substance exposed newborns, black-white disparities in infant mortality, breastfeeding, well-woman care, oral health for children, developmental screening, and physical activity.

On September 9, 2014, a statewide MCH capacity survey was distributed to partner MCH organizations to help assess the capacity to address the 10 Essential Services of MCH/Public Health. The survey was modeled after California's 2010 Stakeholder Assessment Survey and allowed for a comprehensive statewide assessment, not just an assessment of the Florida Department of Health's capacity.

Once the surveys were completed and the results analyzed, Department staff developed topic briefs within their areas of expertise to describe the 15 MCH topics that fell under the six identified population domains. Various data sources were used to complete the data briefs, including: the Florida Pregnancy Risk Assessment Monitoring System (PRAMS) Report; the Behavioral Risk Factor Surveillance System; the Youth Risk Behavior Survey; and Florida Community Health Assessment Resource Tool Set (CHARTS), the Department's website for Florida public health statistics and community health data.

The topic briefs were distributed to stakeholders along with a scoring sheet. The reviewers of the topic briefs followed a structured quantitative approach to score and rank the MCH topics based on the content of the data briefs. Department staff used this information to engage in a qualitative approach where they used the quantitative information from the scoring sheet to guide leadership discussions that ultimately led to the final prioritization of the MCH topics.

In early 2015, a Sub-Advisory Workgroup met to lead the final needs assessment process. Two meetings with representatives from small, medium, and large local health departments and representatives from Florida's urban and rural Healthy Start Coalitions helped determine the final priorities and assess the Department's capacity to address the priorities. During these meetings, staff conducted a Strengths, Weaknesses, Opportunities, and Threat (SWOT) analysis, a structured planning method used to evaluate strengths, weaknesses, opportunities and threats. A modified tool from the Association of Maternal and Child Health Programs (AMCHP) CAST-V process was used to quantitatively assess the Department's capacity needs for every opportunity identified from the SWOT analysis. The specific components of the capacity assessment were: importance, cost, time, commitment, and feasibility. After the prioritization of the capacity needs, action plans were developed to address the identified capacity needs while specifying action steps, designated staff persons, timelines, and plans for monitoring results.

Children's Medical Services (CMS), the Division responsible for administering Title V for Children with Special Health Care Needs (CSHCN), engaged in a needs assessment process specific to that population. The goal of the CMS Needs

Assessment Team was to identify CSHCN priorities for continued and new initiatives to improve quality of care and outcomes for CSHCN. The Needs Assessment Team included CMS Medical Directors: CMS Nursing Directors, CMS Central Office Staff: CMS Providers; parents of CSHCN; and CMS partners, including the Florida School for the Deaf and Blind, Easter Seals, Department of Children and Families, Center for Autism and Related Disorders (several offices represented), Early Steps, local health departments, the Florida Department of Education, the Florida Developmental Disabilities Council, the University of Florida Pediatric Pulmonary Center, and several Florida Universities. The framework used for the CSHCN Needs Assessment was to first engage families and stakeholders for input to assess needs, then to examine strengths and capacity, and finally selecting priorities and setting performance objectives as outlined in an action plan. The CSHCN Needs Assessment Team utilized an Advisory Group, consisting of CMS Central Office Management and two consultants for the project, a research consultant and a project manager, to steer the direction of the needs assessment process. This Advisory Group provided the CMS Needs Assessment Team with valuable feedback related to the needs assessment activities. Families and stakeholders were asked to complete surveys and participate in workgroups developing the action plans.

CMS assessed the program's strengths by reviewing recent University of Florida Institute for Child Health Policy data. Strengths were also examined by SWOT analysis for each identified priority need. CSHCN needs were first examined by two convenience surveys regarding perceived CSHCN priority areas. Issue briefs, SWOT analyses, and capacity scores were determined for each identified need. The issue briefs addressed the public health issue, magnitude and trend, national and state goals, current state initiatives, public health strategies, and capacity. The issue briefs included national and state data sources where applicable, including the 2009-2010 National Survey of Children with Special Health Care Needs and the Evaluation of the Integrated Care Systems for Title XXI Enrollees, June 2014; Evaluation of Non-Reform and Reform Healthcare for Title XIX Enrollees, June 2014, and the Mental Health Chartbook. Priorities were determined through the results of the two convenience surveys and through a review of the maternal and child health priorities. A total of 11 needs were identified as top priorities. These 11 top priorities were examined further with issue briefs, capacity needs worksheets, and SWOT analyses.

Information was collected and compiled on the 11 needs into "issue packages" consisting of an issue brief and two CAST-5 assessment tools; the SWOT and the capacity needs. Issue packages were then scored individually by CMS state program directors. Based upon issue package scores, needs assessment findings, and review of the Title V MCH Block Grant Guidance, CMS leadership selected three priorities to focus on for the five-year action plan: medical home, transition, and mental health. Three workgroups were created to focus on each priority area to develop an action plan. The workgroups were chaired by CMS Regional Nursing Directors and had input from CMS staff, CMS Medical Directors, parents, providers, and partner agencies.

II.B.2. Findings

II.B.2.a. MCH Population Needs

Women/Maternal Health

A number of pertinent indicators provide insight into the health status of women, pregnant women, mothers, and infants up to age 1 as they relate to the Women's/ Maternal Health, Perinatal/Infant Health domains. The most recent edition of the PRAMS Report provides useful insight into the health and behaviors of women in Florida. A total of 28.8 percent of women were dieting before pregnancy, and 44.2 percent were exercising three or more days a week. PRAMS showed that 16.8 percent of women regularly used prescription medications before pregnancy, 8.8 percent were being checked or treated for diabetes, 10.4 percent were checked for high blood pressure, 9.7 percent were checked or treated for depression or anxiety, and 25.3 percent had discussions about family medical history with a health care worker before pregnancy. A total of 33.7 percent of new moms reported that they were uninsured before pregnancy, and 58.1 percent participated in WIC. A total of 21.4 percent of women reported that they smoked cigarettes before pregnancy, while only 8.6 percent smoked during pregnancy. A total of 51.2 percent of women reported that they drank before pregnancy, while only 7.9 percent drank during pregnancy.

Racial disparity is evident in pregnancy related mortality rates (PRMR). From 2005-2012, the Florida Pregnancy-Associated Mortality Review (PAMR) classified 321 cases as pregnancy-related deaths (PRDs). During this period, the pregnancy related mortality ratios for non-Hispanic black women were significantly higher when compared with non-Hispanic white and Hispanic women. For example, in 2012 the maternal mortality ratio per 1,000 live births was 60.7 for non-Hispanic black

women, 8.4 for non-Hispanic white women, and 1.7 for Hispanic women.

Three of the goals of the Department are: reduce the rate of maternal deaths per 100,000 live births from 20.2 to 16.0; increase from 17 percent to 21 percent women having a live birth who received preconception counseling about healthy lifestyle behaviors and prevention strategies from a health care practitioner prior to pregnancy; and increase from 83 percent to 84.5 percent of pregnant women receiving prenatal care during the first trimester. Preconception health, early entry into prenatal care, and the reduction of pregnancy-related morbidity (hemorrhage, hypertensive disorders, and cardiomyopathy) are important factors for the reduction in PRDs and the disparity between higher rates of maternal mortality for black women compared to white women.

The Department is funding interconception care (ICC) and early entry into prenatal care through Florida's Healthy Start program. ICC is provided to a woman who has previously been pregnant and is capable of becoming pregnant in the future who has risk factors that may lead to a poor pregnancy outcome and is also a Healthy Start prenatal client; a mother who is being provided services on behalf of her Healthy Start infant, or any non-pregnant woman who had a pregnancy and has risk factors that may lead to a poor subsequent pregnancy outcome. Healthy Start Coalitions are responsible for assisting a pregnant woman with obtaining early access to prenatal care to mitigate risk factors and improve outcomes for mother and baby.

Perinatal/Infant Health

In Florida, overall infant mortality rates (IMR) have declined from 6.9 infant deaths per 1,000 live births in 2009 to 6.1 infant deaths per 1,000 live births in 2013. The non-Hispanic white infant mortality has remained relatively flat with an IMR of 4.9 infant deaths per 1,000 live births in 2009 and 5.0 infant deaths per 1,000 live births in 2013. Between 2009 and 2012, non-Hispanic black infant mortality rates declined significantly from 12.7 to a historic low of 10.5 infant deaths per 1,000 live births and remained at the same IMR in 2013. With Florida's recent declines in non-Hispanic black infant mortality, the infant mortality disparity between non-Hispanic black and non-Hispanic white infants have decreased from a ratio of 2.6:1 in 2009 to 2.1:1 in 2013. However, it is important to note that despite this decline in the magnitude of disparity, non-Hispanic black infant mortality rates have consistently remained more than two times higher than non-Hispanic white and Hispanic infant mortality rates.

During the same time period, the neonatal mortality rate declined from 4.5 per 1,000 to 4.0 per 1,000. The postneonatal mortality rate declined from 2.4 per 1,000 to 2.1 per 1,000. The perinatal mortality rate declined from 11.5 per 1,000 to 11.0 per 1,000.

The Department is addressing black-white disparities in infant mortality by providing and facilitating primary care for women an men, preconception care and counseling, prenatal care, infant health services, ICC and counseling, and other preventive heal services. The Department, maternal and child health practitioners, and community partners realize confronting inequities in he access, interventions and outcomes requires examining care systems, individual risk factors, community resources and deficits and cultural factors that interact to influence and/or determine health outcomes, including infant mortality.

- The Department is participating in the national CoIIN that focuses on strategies to implement best programs, policies, and practices to reduce infant mortality, ensure health equity, and eliminate health disparities.
- Florida Healthy Start Coalitions conduct inclusive planning and service delivery approaches that incorporate all Florida communities as partners and participants in disparity elimination.
- The Department has established a Sudden Unexpected Infant Death (SUID) Workgroup comprised of maternal and child health internal and external partners to understand factors related to specific causes of death that contribute to black-white disparities in infant mortality and factors that contribute to caregivers not utilizing infant safe sleep placement. Developing health messages and interventions that are both culturally respectful and informative to our diverse populations is also an important activity for the workgroup.

Overall, Florida safe sleep trends are comparable to trends in other states. According to data from the 2011 Florida PRAMS Report, 67.2 percent of infants were placed to sleep on their backs and 39.4 percent never bed-shared. The lowest percentages for both of these safe sleep behaviors were among non-Hispanic black infants.

In 2013, 92 percent (3,037 out of 3,300) of Very Low Birth Weight (VLBW) infants born in Florida were delivered at facilities for high-risk deliveries and neonates, an increase from 88.2 percent (3,279 out of 3,715) in 2009. No clear or consistent racial/ethnic disparities were observed. From 2003-2006, 75 percent of VLBW infants were born at Level III hospitals or subspecialty perinatal centers. In 2013, 92 percent of VLBW infants in Florida were delivered at high-risk facilities.

The Department provides statewide access to high-risk perinatal care through 11 designated Regional Perinatal Intensive Care Centers (RPICCs). RPICCs provide perinatal intensive care services that contribute to the well-being and development of a healthy society. This regionalized network of hospitals also includes obstetrical care for high-risk pregnant women at obstetrical satellite clinics in rural areas. Each RPICC facility provides community outreach, education, and consultative support to other obstetricians and Level II and Level III neonatal intensive care units in their area in addition to inpatient and

outpatient services.

Through community and provider education, the RPICCs increase awareness of services provided, thus enhancing accessibility to appropriate levels of care. Many RPICCs also participate in the Florida Perinatal Quality Collaborative (FPQC), a collective of perinatal-related organizations, individuals, health professionals, advocates, policymakers, hospitals and payers. The RPICCs also provide staffing for the emergency medical transportation of high-risk pregnant women and sick or low birth weight newborns from outlying hospitals to the appropriate level facility for care.

The Department will continue to support services to increase the percentage of VLBW infants who deliver and receive care at hospitals with Level III neonatal intensive care units. Plans include the continuation of high-risk obstetrical satellite clinics, continued encouragement of participation in the FPQC by the designated RPICC staff, and the continuation of the designated RPICCs. The Department will continue to monitor the RPICCs to ensure appropriate placement of neonates in the Level III NICUs.

Child Health and Adolescent Health

Each year in Florida, 1 in 10 children (age 19 and younger) are injured seriously enough to require a visit to the emergency room or admission to the hospital. While statewide unintentional injury rates remained steady in recent years, Florida's age-adjusted injury death rates are higher than the national average. In 2011, Florida's age-adjusted injury death rate for all unintentional injuries (41.8 per 100,000) was higher than the national average (39.0 per 100,000) by 7.2 percent. Among children, the trend worsens. Florida's age-specific injury death rate for unintentional drowning among children 1-4 was 7.2 per 100,000, and was 166.7 percent higher than the national average of 2.7 per 100,000. Racial/ethnic disparities exist such that unintentional injury rates are substantially higher among non-Hispanic black children than among non-Hispanic white and Hispanic children.

Safe Kids Florida, led by the Department's Injury Prevention Program, uses local coalitions to provide and promote leadership to reduce unintentional childhood injury and death. Safe Kids Florida works to reduce unintentional injury and death by promoting community awareness and education, supporting public policies and programs that reduce injury, and providing safety education on various risk areas including traffic and water safety. Currently, there are 13 Safe Kids coalitions across the state covering 81 percent of Florida's population 19 and under.

Florida leads the country in drowning deaths of children age 1-4. In 2011, the Injury Prevention Program launched the *Waterproof FL: Pool Safety is Everyone's Responsibility* initiative. This campaign, focusing on early childhood drowning prevention, identifies supervision, barriers, and emergency preparedness as three layers to increase pool safety. The WaterproofFL website (http://www.floridahealth.gov/alternatesites/waterprooffl/) offers an online toolkit for partners, advocates, and parents across the state. In May 2014, the Florida Department of Children and Families (DCF) launched its *Eyes on the Kids* campaign, also targeting water safety. Since the program was launched, the age-adjusted drowning rate has dropped from 1.82 per 100,000 in 2011, to 1.79 per 100,000 in 2012, and to 1.77 per 100,000 in 2013.

The *2009-2013 Florida Injury Prevention Strategic Plan* provides the prioritizing steps to reducing injury across the state. The plan serves as a successor to Florida's 2004-2008 *Injury Prevention Strategic Plan*. Florida is the first state injury prevention program to complete the implementation of an existing five-year strategic plan while drafting a successor plan. The Florida Injury Prevention Advisory Council includes over 50 individuals from organizations across the state, and serves to guide the implementation of the state plan. One of the goals in this plan was early childhood drowning prevention. The number of drowning deaths for 2009-2013 for 1-9 year olds was reduced by 5 percent compared to the previous five-year period of 2004-2008.

The adolescent age group has lower well care visit rates compared to adults and young children. These rates likely reflect the challenges of reaching and engaging adolescents in preventive and primary health care. In 2011/2012, the prevalence of children 12-17 with no preventative medical care visits during the past 12 months was 19.8 percent in Florida and 18.2 percent in the nation. According to 2011/2012 data from the National Survey of Children's Health, no significant racial/ethnic disparities existed among children younger than 18 regarding preventative medical care visits.

Prior to 2011, youth physical activity was captured as two separate measures – vigorous physical activity and moderate physical activity. Beginning in 2011, the Centers for Disease Control and Prevention (CDC) changed their approach and began collecting the combined total time youth participated in both vigorous and moderate physical activity. Therefore, trend data for this measure are not available.

In 2013, Florida male public high school students (34.1 percent) had a significantly higher prevalence of meeting the current federal physical guidelines for aerobic physical activity than females (16.4 percent). Non-Hispanic (NH) white (28.0 percent) public high school students had a significantly higher prevalence of this behavior than NH black (23.6 percent) and Hispanic (21.3 percent) public high schools students.

According to the Behavioral Risk Factor Surveillance System (BRFSS), 62.8 percent of Florida residents age 18 and older were overweight or obese in 2013. This percentage ranked Florida 17th in the nation, as 16 states had lower percentages.

Persons are classified as overweight or obese if their body mass index (BMI) is 25 or greater. In response to the high rate of obesity, the Department launched the Healthiest Weight Florida initiative in early 2013. The Department has many initiatives and programs in place to increase physical activity among children and adolescents. Ongoing projects include working with early childhood education centers and schools to develop and implement policies relating to physical activity of the children and adolescents while they are in the centers/schools. Many other groups are also focused on increasing physical activity among youth. Programs such as the Alliance for a Healthier Generation's Healthy Schools Program and the Healthier United States Schools Challenge emphasize the importance of incorporating physical activity into the school day and teaching children and their parents about the importance of physical activity. Additional efforts are focused on improving the environments our children live in that encourage physical activity. Examples include schools that make their playgrounds available to the public after school hours, cities improving streets to include bike paths and walking lanes, and the Safe Routes to Schools Program.

Children with Special Health Care Needs

Findings from the CMS needs assessment confirm what others have found regarding the needs of the CSHCN population. The literature tells us that a patient centered medical home (PCMH) is of particular importance to children with special health care needs. Data from the 2009-2010 National Survey of Children with Special Health Care Needs shows that 36.2 percent of children in Florida have a PCMH, compared to 43 percent nationally. The 2009-2010 National Survey of Children with Special Health Care Needs also shows that 37 percent of Florida's children with special health care needs are receiving appropriate transition services, compared to 40 percent nationally. Transition services are vital to children and youth with special health care needs as it improves lifelong functioning and well-being. In addition to medical home and transition being top priorities for Florida, mental health was also identified through the needs assessment to be of extreme importance. Mental health conditions are oftentimes chronic conditions that can interfere with healthy development and continue through the lifespan. Without early diagnosis and treatment, children with mental health conditions may have problems at home, in school, and socially. Left untreated, these conditions may persist into adulthood. The CDC estimates that one in five children under 18 has a diagnosable mental health disorder and one in 10 youths have a serious mental health problem that is severe enough to impair their function; yet four out of five children who need mental health services do not receive them.

Other Findings/Strengths/Needs

Maternal deaths are increasing in Florida. In the period 2001–2003 there were 63 maternal deaths and the ratio was 10.1 per 100,000 births. In the period 2011–2013 there were 154 maternal deaths and the ratio was 24.0 per 100,000 births. In addition to PAMR activities described earlier, Florida is also addressing maternal mortality and morbidity through participation in the Every Mother Initiative (EMI), Action Learning Collaborative (ALC), sponsored by the Association of Maternal and Child Health Programs (AMCHP) and with funding support from Merck for Mothers. Florida joined five other states to form a multidisciplinary team to identify strategies to strengthen and enhance their maternal mortality surveillance systems, anchored in their maternal mortality reviews, and use the data from the reviews to develop and implement population-based strategies and policy change. Core components include in-person and virtual technical assistance, peer-to-peer site visits between teams, and a translation support sub-award to help fund implementation of maternal mortality review recommendations.

During fiscal year 2013-14, the Public Health Dental Program implemented a statewide oral health surveillance system to collect data on specific oral health indicators to provide information about unmet dental needs, workforce deficiencies, access to care barriers, and populations at risk for poor oral health outcomes. Specific goals of the surveillance system include: monitor the status of high risk populations; identify unmet dental needs and barriers to care for disparate populations; assess workforce shortages and the distribution of Medicaid providers; and develop policies and programs to address barriers to care and service limitation. In 2014, the first Florida Third Grade Oral Health Surveillance Survey was conducted to assess the level of caries experience and unmet dental needs of third grade students. The surveillance survey was conducted in a representative sample of schools screening over 2,000 third-grade students for evidence of caries experience, untreated decay, and presence of dental sealants. Preliminary data show that 23.4 percent had untreated caries, 43.1 percent had the presence of either untreated or treated (restored or filled) tooth decay, 36.9 percent had sealants present, 4.9 percent needed urgent care, and 18.3 percent needed early dental care.

Through the issue briefs and SWOT analyses, current efforts for the CSHCN population were examined for each priority need. Through the Children's Health Insurance Reauthorization Program Act (CHIPRA) grant project, Florida identified medical home strategies that worked well in several Florida locations. Florida's CHIPRA report will be utilized to determine

what strategies should be encouraged, as well as utilizing other recognized tool kits. CMS has implemented care coordination guidelines and performance standards that outline transition education standards for CMS care coordinators to follow. Further education and training across professions needs to occur in order to raise awareness about the importance of transition activities. A transition strategy that will require development is engaging and empowering youths to partner in decision-making related to their health care. The needs assessment allowed CMS to research Florida's capacity to address mental health and the next steps will include developing actionable strategies to improve the outcomes of children and youth with mental health conditions.

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

The Florida Department of Health is directed by the State Surgeon General, Secretary of Health, who is appointed by and is a direct report to the Governor. The Surgeon General is responsible for overall leadership and policy direction of the Department. The Surgeon General is assisted by the following key staff:

Chief of Staff: oversees the offices of Communications, Legislative Planning, and Performance and Quality Improvement.

Deputy Secretary for Administration: oversees many of the Department's key support functions including the Office of Budget and Revenue Management, Division of Administration, which includes the Bureaus of Finance and Accounting, General Services, and Personnel and Human Resource Management; the Division of Disability Determination; the Office of Information Technology; and the Division of Medical Quality Assurance.

Deputy Secretary for County Health Systems: provides oversight and direction to the state's local health department directors and administrators who are responsible for the 67 local health departments; and the Division of Public Health Statistics and Performance Management.

Deputy Secretary for Health and Deputy State Health Officer for Children's Medical Services: oversees the divisions of Children's Medical Services; Community Health Promotion; Disease Control and Health Protection; Emergency Preparedness and Community Support; as well as the 22 CMS Regional/Area Offices, the Office of Compassionate Use, and the Office of Minority Health.

The Florida Department of Health is responsible for the administration of programs carried out with allotments under Title V, as authorized under Section 383.011(1)(f), Florida Statutes. The majority of these programs fall within the auspices of the Division of Community Health Promotion and the Division of Children's Medical Services. The Title V Maternal and Child Health and Children with Special Health Care Needs programs are located within these divisions. Kris-Tena Albers, ARNP, CNM, Chief of the Bureau of Family Health Services, serves as the Title V MCH Director. Cassandra Pasley, BSN, JD, Division Director for Children's Medical Services, serves as the Title V CSHCN Director.

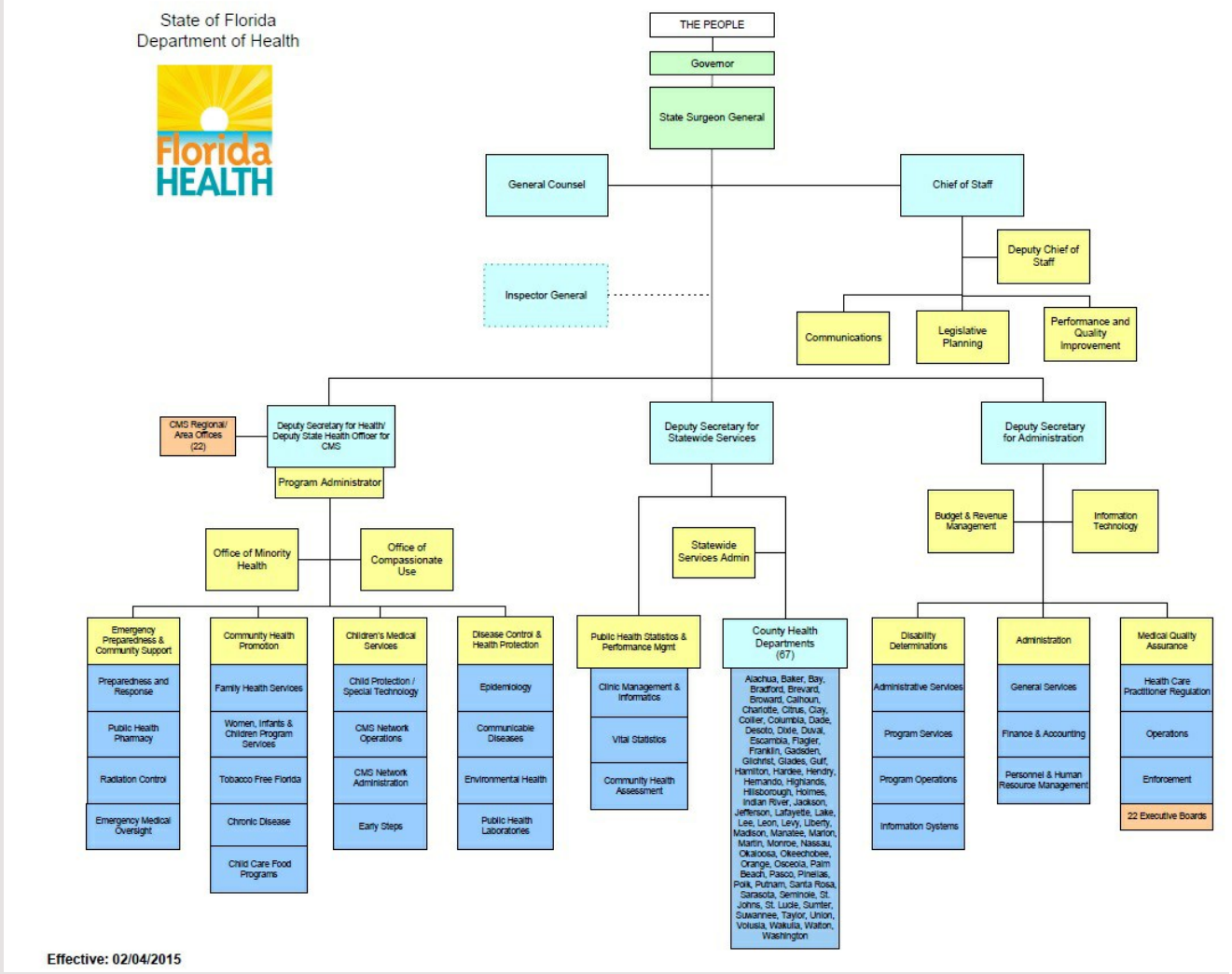
The Division Director of Community Health Promotion provides leadership, policy, and procedural direction for the Division, which includes the Bureaus of Child Care Food Programs, Chronic Disease Prevention, Family Health Services, Tobacco Free Florida, and WIC Program Services.

The Bureau of Family Health Services is responsible for many of the Title V activities related to pregnant women, mothers, infants, and children. The Bureau Chief provides oversight and direction for the Public Health Dental Program; the Prevention Services and Quality Management (PSQM) Section; the Maternal and Child Health (MCH) Section; and the School, Adolescent, and Reproductive Health (SARH) Section.

The PSQM Section includes the Refugee Health Program and the Sexual Violence Prevention Program. The SARH Section includes the School Health Program, the Adolescent Health Program, and the Family Planning Program.

The MCH Section includes the Healthy Start Program; the MCH Program which has, among other responsibilities, PAMR and Fetal and Infant Mortality Review (FIMR); and the Grants/Data/Budget/Procurement unit, which has primary responsibility for coordinating and collating information for the Title V MCH Block Grant application, managing the MCH Block Grant, and providing program guidance based on monitoring the performance indicators and conducting data analysis.

Below is the organizational table for the Florida Department of Health. The table is also included as a supporting document attachment.



II.B.2.b.ii. Agency Capacity

Children's Medical Services is statutorily charged to administer the Children with Special Health Care Needs program in accordance with Title V of the Social Security Act. Additionally, CMS is responsible for providing children and youth with special health care needs a family-centered, comprehensive, and coordinated statewide managed system of care that links community-based health care with multidisciplinary, regional, and tertiary pediatric specialty care. This is in line with Florida's Department of Health mission to protect, promote and improve the health of all people in Florida through integrated state, county, and community efforts.

Children's Medical Services is also able to serve CSHCN as an optional specialty plan through the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) Program for CSHCN who meet clinical eligibility criteria.

Florida KidCare is Florida's children health insurance program (CHIP) and has four partner agencies: Medicaid, DCF, CMS, and Florida Healthy Kids Corporation. Children's Medical Services is an option for children who meet clinical eligibility criteria. The Florida KidCare Coordinating Council reviews and makes recommendations concerning the implementation and operation of the Florida KidCare program. Council membership includes representatives from the Department of Health, the DCF, the Agency for Health Care Administration (AHCA), the Florida Healthy Kids Corporation, the Department of Insurance, local government, health insurance companies, health maintenance organizations, health care providers, families participating in the program, and organizations representing low-income families.

The CMS Safety Net Program serves CSHCN from birth to 21 years of age who do not qualify for Medicaid or Title XXI, but who are unable to access, due to lack of providers or lack of financial resources, specialized services that are medically necessary or essential family support services. Families are required to participate financially in the cost of care based on a sliding fee scale. The CMS Safety Net Program is not health insurance. The program provides a limited health services package for the enrollee's primary and secondary qualifying conditions, selected by the parent or legal guardian, and are provided based on the availability of funds. All services require prior authorization.

Infants identified through the Newborn Screening Program with a positive screen may also receive confirmatory testing through CMS, as a payer of last resort, if needed.

Early Steps is Florida's early intervention system that offers services to eligible infants and toddlers, birth to 36 months, with significant delays or a condition likely to result in a developmental delay. Early intervention is provided to support families and caregivers in developing the competence and confidence to help their child learn and develop. Early Steps uses a Team Based Primary Service Provider approach that aims to empower each eligible family by providing a comprehensive team of professionals from the beginning of services through transition. The goal is for the family to receive strong support from one person, provide a comprehensive team of professionals from beginning to end, and for the family to have fewer appointments and more time to be a "family." Services are provided to the family and child where they live, learn, and play, to enable the family to implement developmentally appropriate learning opportunities during everyday activities and routines. There are 15 Early Steps offices in Florida.

CMS also works closely with Florida's university systems, hospitals, hospices, pediatricians, and specialists through established statewide programs to ensure quality health care services are provided to children with special health care needs. These programs include the CMS Cardiac Program; the CMS Craniofacial, Cleft Lip/ Cleft Palate Program; the Comprehensive Children's Kidney Failure Centers Program; the CMS Hematology/Oncology Program; the CMS HIV Program; the Partners in Care: Together for Kids Program, Florida's Pediatric Program for All Inclusive Care; and the RPICC Program.

As part of the objectives of the Title V MCH Program, the Public Health Dental Program (PHDP) collaborates with other state agencies and not-for-profit organizations to plan and implement programs to address the oral health needs of children and families. The PHDP is involved in the development of a state oral health action plan with the AHCA to increase the number of children who receive dental services through Medicaid and CHIP programs. Policy development for the Medicaid State Action Plan includes; revising billing codes and dental services to expand coverage for preventive services, such as dental sealants and fluoride varnish, and the integration of dental care with medical and behavioral health care provided through medical managed care plans to assist families in identifying a medical/dental home for services.

The PHDP also participates in dental health initiatives planned by the Oral Health Florida Coalition. This organization is comprised of a wide group of agencies that work in partnership to address their mission to *promote and advocate for optimal oral health and well-being of all persons in Florida*. The PHDP actively participates on action teams and the leadership council to support initiatives to increase oral health services for children and families in Florida.

Through the support of funding from the MCHBG and in collaboration and partnership with the Florida Dental Hygiene Association and Florida Head Start Centers, the PHDP was able to conduct a Head Start Oral Health Surveillance Project, looking at Head Start children across the state. This project is important for identifying the unmet dental needs of very young children and for assisting high risk families with establishing a dental home and identifying local resources for continuing dental care. The project was completed in May 2015, and the Department hopes to have preliminary results from the surveillance project within the next few months.

The PHDP, in conjunction with the Oral Health Florida Sealant Action Team, promotes the use of a cost efficient dental hygienist workforce model for School-based Sealant Program service delivery. The local health department dental programs, Federally Qualified Health Centers, and local oral health coalitions across the state are providing preventive services to children in Title I schools. Providing services to the children in school settings eliminates many barriers that impact access to dental care. School-based sealant programs are supported by MCHBG funding making it possible to reach high risk children in need of dental services and to improve dental outcomes for all children in the state.

During state fiscal year (SFY) 2013-2014, school-based sealant programs provided services across 35 counties in Florida.

Dental sealant programs served over 300 Title I Schools, resulting in 50,552 children being screened, 18,291 children receiving 49,050 sealants, 28,803 cleanings and 23,170 fluoride varnish applications. This is a 150 percent increase over the 33,643 children served during SFY 2012-2013. Three local health department programs developed and implemented a school-based sealant program with the support of MCHBG funding in SFY 2014-15. Current school-based programs exist in 38 counties, in part, due to MCHBG funding support for the start-up costs of multiple new programs.

In FY 2014-15, MCHBG funding assisted the PHDP to support water fluoridation activities implemented by the Oral Health Florida Coalition in local communities. Funding supported training and education activities for local communities involved in water fluoridation campaigns. Local training programs assisted in educating citizens and local authorities about the benefits of water fluoridation and helped local communities to organize grassroots activities in support of local campaigns.

CMS works closely with several sister agencies, including the AHCA, the DCF, the Agency for Persons with Disabilities, the Department of Education, Florida's Office of Early Learning, the Guardian Ad Litem Program, and the Department of Juvenile Justice, to ensure services are delivered through a seamless, coordinated system. CMS also works with the Family Network on Disabilities and the Family Café to educate families about engaging in health care decisions. Additionally, CMS works closely with the Florida Health and Transition Services (FloridaHATS) to educate and promote awareness related to health care transition. Additional partners of CMS working to improve the quality of care and outcomes for children with special health care needs include Florida Hospices, Florida School for the Deaf and Blind, Easter Seals, Centers for Autism and Related Disorders, and the Florida Developmental Disabilities Council.

II.B.2.b.iii. MCH Workforce Development and Capacity

At the Florida Department of Health Central Office, there are 23 full-time staff within the Maternal and Child Health Section. Title V provides funding for 15 of those positions. Within the School, Adolescent, and Reproductive Health Section, there are 22 positions, two of which are funded by Title V. There are seven positions within the Public Health Dental Program, one of which is funded by Title V. Statewide, there are approximately 2,900 Department staff working in positions directly related to Title V.

In Children's Medical Services, there are a total of 710 full-time positions. Of that total, 679 are within the Children's Medical Services Managed Care Plan, 12 are with the Child Protection Teams, 12 are with the Newborn Screening Program, and seven are with the Early Steps Program. None of these positions are funded with Title V funds.

Executive level and senior level management employees who support MCH activities and program staff who contribute to the state's program and health policy planning, evaluation, and data analysis capabilities include the following:

John H. Armstrong, MD, FACS, was appointed by Governor Scott as Florida State Surgeon General and Secretary of Health in April 2012. Previously, he was Chief Medical Officer of the University of South Florida (USF) Health Center for Advanced Medical Learning and Simulation; Surgical Director of the USF Health American College of Surgeons Accredited Education Institute; and Associate Professor of Surgery, Department of Surgery, USF Morsani College of Medicine. He previously served as the Trauma Medical Director at Shands Hospital at the University of Florida Medical Center, and was a 2011 Exemplary Teacher at the University of Florida College of Medicine.

Celeste Philip, MD, MPH, serves as the Deputy Secretary for Health and the Deputy State Health Officer for Children's Medical Services. Dr. Philip's previous experience within the Department includes serving as Interim Director for the Department of Health (DOH) in Volusia, Calhoun and Liberty counties, and as Interim Bureau Chief for the Department's Bureau of Communicable Diseases. In addition, she was the Medical Director for DOH in Polk County and Assistant Director for DOH in Volusia County. Dr. Philip has worked with the Department of Health since 2008. She is board-certified in family medicine and preventive medicine/public health, and her MPH is in maternal and child health.

Kim Barnhill, MS, MPH, serves as the Deputy Secretary for County Health Systems. Her previous experience with the Department includes directing preventive dental programs for over three dozen counties, serving as the Administrator for Department of Health in Madison and Jefferson counties, and serving as Chief of Staff. Ms. Barnhill has worked with the Department since 1992.

Shannon F. Hughes, CPM, ASQ-CQIA, currently serves as the Interim Director of the Division of Community Health Promotion, which includes the Bureaus of Child Care Food Programs, Chronic Disease Prevention, Tobacco Free Florida, Family Health Services, and WIC Program Services. Ms. Hughes also serves as the Chief of the Bureau of Tobacco Free

Florida. She has worked with the Department since 1986 in a variety of programs and capacities, and her most recent previous position was Director of Workforce Development.

Katherine Kamiya, MEd, serves as the Operations Manager in the Director's Office for the Division of Community Health Promotion. She joined the division in 2007, bringing over 25 years of experience in direct services, administration, and executive leadership with organizations addressing the needs of at-risk children and families. In her current role, Ms. Kamiya coordinates legislative bill tracking, continuity of operations, employee orientation and recognition, and other strategic special projects for the Division of Community Health Promotion.

Kris-Tena Albers, ARNP, CNM, MN, serves as the Chief for the Bureau of Family Health Services, under which the Title V programs are located, and is the Title V MCH Director in Florida. Ms. Albers formerly served as the Executive Community Health Nursing Director for the Maternal and Child Health Section from 2008 to 2012. Her previous work experience includes work within the Department's Office of Public Health Preparedness and in Public Health Nursing. She has also worked in the private sector as a certified nurse midwife, an adjunct instructor for nursing students, and in other nursing positions focusing on women's health.

Carol Scoggins, MS, joined the MCH Section in 2009 as the Program Administrator for the MCH team and in 2012 was promoted to her current position as Section Administrator of the Maternal and Child Health Section. Her previous work within the Department includes working in WIC and the Child and Adolescent Health Unit. She has worked in the Division of Community Health Promotion since 2004.

Christina Canty, MPA, CPM, joined the MCH Section in June 2012 as the Program Administrator for the unit within the MCH Section responsible for budget, procurement, grants, and data analysis. Since joining the Department in April 2003, she has served as the Title V Abstinence Education Program Director, Administrator for the former Adult and Community Health Unit, and as assistant to the Bureau Chief for Family Health Services.

Rhonda Brown, RN, BSN joined the MCH Section in May 2012 and serves as the Program Administrator for the MCH Program. Prior to that, Ms. Brown worked for six years in CMS in the RPICC Program.

Daniel Thompson, MPH, works in the MCH Section as a Training and Research Consultant/Data Analyst and has been in this position since 2001. Mr. Thompson's previous positions at the Department include statistician, computer programmer, systems analyst, and epidemiologist.

Cassandra G. Pasley, BSN, JD, serves as Director of the Division of Children's Medical Services, and is the Title V Children with Special Health Care Needs Director in Florida. Ms. Pasley served as the Chief for the Bureau of Health Care Practitioner Regulation in the Division of Medical Quality Assurance for nine years before joining CMS in 2014. Ms. Pasley's previous work experience includes work within the Department of Business and Professional Regulation, AHCA, and serving as a sergeant and nurse in the United States Army.

Kelli Stannard, RN, BSN, joined Children's Medical Services in 2009. Currently, Ms. Stannard is the Chief for the Bureau of Network Operations in the Division of Children's Medical Services and supports Ms. Pasley in her role as the Title V Children with Special Health Care Needs Director.

Cheryl Clark, DrPH, RHIA, is a senior MCH epidemiologist within the Division of Children's Medical Services. She also serves as the Project Director of the State Systems Development Initiative (SSDI) grant, which funds supplemental data support to Florida's MCH Title V program. Dr. Clark has worked at the Department since 2000, conducting analysis and providing advice and direction on issues such as racial disparity, perinatal health, child maltreatment/neglect, and program evaluation.

The Department has developed and implemented a comprehensive State Health Improvement Plan and an Agency Strategic Plan. Each plan outlines several strategic issue areas to be addressed. One strategic issue area is access to care. Under the access to care strategic issue area are objectives outlining activities pertaining to the promotion and provision of culturally appropriate approaches to service delivery. They are as follows:

By September 30, 2015, the Department and DCF will identify or include objectives in agency strategic plans that address the provision of Culturally and Linguistically Appropriate Services (CLAS). Both Departments have the promotion and provision of CLAS indicated as priorities in their strategic plans and their long range plans.

By June 30, 2015, the Department will facilitate development of a self-assessment of Cultural and Linguistically Appropriate Services (CLAS) that can be used across many provider settings. Instead of facilitating the development of a tool, the Department decided to utilize a tool developed by the Georgetown University Center for Cultural Competence called the *Cultural and Linguistic Competence Policy Assessment*. A total of 40 of the Department's 67 local health departments utilized the tool to conduct CLAS assessments. Data collected from the assessments will be utilized by the the Department's Office of Minority Health and Office of Performance and Quality Assurance to develop elements of CLAS to be integrated into the Department's ongoing quality improvement processes.

II.B.2.c. Partnerships, Collaboration, and Coordination

The Department has and continues to cultivate a number of collaborative partnerships aimed at furthering its MCH goals and objectives, several of which are discussed below.

Since 1993, the Department has been awarded the SSDI grant, which serves as a complement to the Title V MCHBG Program. The primary goal of the SSDI grant is to promote the use of data and analytical work to support evidence-based MCH decision-making.

The Department, as the state Title V agency, will partner with the MIECHV program to develop and test Coordinated Intake and Referral models using the Department's universal prenatal and infant risk screens. This project will be implemented using a Learning Collaborative approach. Participation by at least six diverse communities (rural, mid-size, and urban) will be solicited through a request for proposal process. Sites will be required to organize local teams comprised of people representing local Healthy Start Coalitions, local health departments, home visiting programs providing services in the community, Medicaid Managed Care Plans, and referral agencies.

The Title V program coordinates with the Bureau of Child Care Food Programs (CCFP) in a number of ways. In September 2014, the CCFP emailed immunization flyers (Immunization Requirements for Childcare and Florida Vaccines for Children Program) to approximately 1,900 CCFP contractors. The email also included information on where to find their new online training module *Creating a Breastfeeding Friendly Child Care Facility*. In February 2015, CCFP sent out information to their contractors to spread the word about creating a safe sleep environment for babies at home, in daycare, or with a caregiver.

The Division of Public Health Statistics and Performance Management has the primary responsibility for facilitating the collection, analysis, and dissemination of health statistical data; the implementation of the local health department clinic management system; and coordination of community health assessment and health improvement planning processes. The MCH Section works closely with this Division in several areas including: management of departmental computer systems; review of requests for MCH data; review of research proposals; and performing analyses and evaluations of MCH initiatives and programs.

The Department receives funding each year from the Administration for Children and Families to administer the Title V Abstinence Education Program. The goal of the program is to decrease teen sexual activity and reduce the incidence of teen births and sexually transmitted diseases through promotion of sexual abstinence. Through 2014, more than 750,000 youth between the ages of 9 and 18 have participated in abstinence education classes and activities by way of school-based and community-based programs.

The Department was awarded funding from the federal Office of Adolescent Health in 2010 for a five-year grant to conduct an evaluation of evidence-based programming. The Department implements the Teen Outreach Program (TOP) with approximately 7,000 youth in mainstream public high schools in Florida. TOP is a positive youth development curriculum that has been proven to reduce teen pregnancy, school suspension, and school course failure. Teens receive a minimum of 25 lessons over a nine-month span. Program participants actively learn about goal setting, character education, healthy relationships, and pregnancy prevention. Teens spend these hours as active partners in planning, acting, reflecting on, and celebrating their work. Teens also participate in a minimum of 20 community service learning hours.

The Department receives funding each year from the Federal Office of Population Affairs for the Title X Family Planning Grant. The Department's Family Planning Program provides services using minimum guidelines for routine contraceptive management. Services include: education and counseling; history and physical assessment; provision of contraceptives; and treatment of related problems such as anemia and sexually transmitted infections. Florida has a robust statewide program with 67 local health departments and 171 clinic sites throughout the state. All women and men of childbearing age are able to receive services. Priority is given to teens and women ages 20-44 that are at or below 150 percent of the federal poverty level.

There are two federally recognized tribes in Florida - the Miccosukee Tribe of Indians of Florida and the Seminole Tribe of Florida. While these are the two main tribes whose governmental headquarters are located in Florida, there are people of American Indian descent from more than 150 different tribes, each with their own distinct set of cultural beliefs. In total, the federally-recognized tribes comprise less than an estimated 5 percent of the American Indian population in the state. Because of discrimination and removal policies in the South, many American Indians were forced to hide their identity and try to assimilate. As a result, addressing the needs of this diverse population can be a challenge. Working with the American Indian population in the South requires time and commitment to develop trust among the tribal members because of decades of historical mistreatment.

The Office of Minority Health supports and provides resources to a volunteer committee called the American Indian Health Advisory Council (AIHAC). The AIHAC was formed initially in the HIV/AIDS Program Prevention Section. Since its inception,

the AIHAC has grown to serve as a resource for agencies and officials such as the Department of Health and its various programs, Florida American Indian governments, American Indian non-governmental organizations, and other organizations that serve American Indian persons, households and/or descendants in Florida. The AIHAC serves by providing a forum for discussion of the health, health care needs, and concerns of American Indian persons. In 2014, the MCH section attended an AIHAC meeting to share information on the Healthy Start program and tobacco cessation.

The Florida Department of Health partners with Florida State University (FSU) to encourage nursing students to intern with the Department. The Department also has a partnership with Florida Agricultural and Mechanical University (FAMU) to encourage students working towards their Masters of Public Health degree to participate in a summer rotation between their first and second years. These initiatives are described more fully in the Workforce Development section of the narrative.

The Department participates in and contracts with the Florida Perinatal Quality Collaborative (FPQC), which is located at the University of South Florida, Lawton and Rhea Chiles Center for Healthy Mothers and Babies. The FPQC seeks to create an all-inclusive culture of cooperation and transparency across the specialties of obstetrics, neonatology, pediatrics and all fields engaged in maternal and infant health care by bringing together the specific expertise of physicians, nurses, nurse-midwives and all specialists involved with perinatal-related health care. In FY 2014-2015, Title V funding provided to the FPQC allowed for the development and implementation of an Obstetric Hemorrhage Prevention initiative; and in FY 2015-16 the Department plans to contract with the FPQC to develop and implement a Hypertension in Pregnancy/Preeclampsia quality improvement project.

CMS contracts with the University of South Florida (USF) for the Florida Health and Transition Services (FloridaHATS) Program to collaborate with communities to develop local/regional health care transition coalition sites in Pensacola, Jacksonville, and Tampa.

CMS area offices may choose to employ a Family Support Worker who has personal experience raising a child with special needs. Additionally, each Early Steps Office has a Family Resource Specialist. In 2014 and 2015, a family representative attended the annual AMCHP conference to represent the Department’s Division of CMS and the MCH Section.

The Family Network on Disabilities is Florida’s Family to Family Health Information Center. Children’s Medical Services works with this organization and the Family Café to promote family involvement in health care decision-making.

During the 2015 Needs Assessment, CMS identified several family representatives to participate on the CSHCN Needs Assessment Advisory Group. The workgroups created regarding the selected priorities also had family representation. Additionally, a family survey was conducted during the Needs Assessment to gather information related to family perceived health care needs.

The Department's PHDP, in partnership with the Florida Dental Hygiene Association and Head Start, launched an oral health surveillance project to provide oral health screenings in 48 Head Start centers across 29 counties. Screening teams consisting of a dental hygienist and a recorder reached over 2,000 Head Start children and provided screenings, oral health education and referrals for follow-up care through providers in local health departments, Federally Qualified Health Centers, and private dentists registered as Medicaid providers.

In 2014, with the assistance of Title V funding, local health department dental clinics provided over 257,000 dental services to approximately 47,000 children ages 0–5. The PHDP promotes prevention and emphasizes the importance of public health measures such as dental sealants and community water fluoridation through collaborative activities implemented by dental partner organizations.

III.D. Financial Narrative

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$18,996,748	$18,996,748	$18,996,748	$18,996,748
State Funds	$169,459,883	$169,459,883	$169,459,883	$169,459,883
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$188,456,631	$188,456,631	$188,456,631	$188,456,631
Other Federal Funds	$378,242,185	$378,242,185	$631,011,471	$608,138,617
Total	$566,698,816	$566,698,816	$819,468,102	$796,595,248

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$18,984,911	$18,984,911	$19,243,069	
State Funds	$155,212,322	$155,212,322	$155,212,322	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$174,197,233	$174,197,233	$174,455,391	
Other Federal Funds	$14,466,727	$15,247,136	$28,194,845	
Total	$188,663,960	$189,444,369	$202,650,236	

	2019	
	Budgeted	Expended
Federal Allocation	$20,922,688	
State Funds	$155,212,322	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$176,135,010	
Other Federal Funds	$16,568,999	
Total	$192,704,009	

III.D.1. Expenditures

As in prior years, the Department has established an ongoing commitment to provide maternal and child health services to women and children within Florida. This commitment includes continued support to local health departments, local programs, and other providers for maternal and child health.

The expenditures for FY2017 are presented in Forms 2, 3a, and 3b of the Title V Block Grant application. The Department received $18,984,111 in Title V funds in FY 2017 (October 1, 2016- September 30, 2017), and plans to expend the full amount by the end of the grant period (September 30, 2018). As in prior years, the Department will meet the Title V requirement as specified in Section 501(a)(1)(D): a 30/30/10 split, as shown on Form 2.

In addition to the $8,539,800 allocated for children and youth with special health care needs (CYSHCN) from the MCH Block Grant, Children's Medical Services (CMS) has various other federal funding sources. CMS receives $731,036,227 for Title XIX, $99,811,638 for XXI of Medicaid, and $802,011 CHIP funding supports the operations of the CMS Plan and the services provided to our members. For Medicaid and CHIP related activities, CMS draws down the allowable federal match.

CMS also receives $18,805,858 in general revenue and $2,766,525 for additional programs and activities separate from the CMS Plan. This includes $1,613,263 used for safety net funds that provide direct health care services for CYSHCN that are either uninsured or underinsured.

As indicated on Form 5, CMS served 86,231 CYSHCN between the Medicaid, CHIP, and safety net populations. This past year, we centralized our intake and referral processes in order to gain efficiencies and ultimately screen more children for our services. Florida Healthy Kids also conducts outreach campaigns annually. The CMS teams in the field attend community events regularly to increase awareness for our various programs.

CMS provided funding to two universities to coordinate several behavioral health projects, including telepsychiatry, provider education and family resource identification.

CMS works closely with the Florida Health and Transition Services (HATS) Program at the University of South Florida for transition related activities. CMS provides funding to Florida HATS for website hosting; transition consultation; resource identification; and education for youth, families, and providers.

This past year, CMS began funding practice transformation technical assistance through the University of Central Florida for practices ready to become patient-centered medical homes.

Additionally, Title V funding supports various specialty projects and programs, including: Craniofacial and Cleft Lip/Palate Centers, Regional Perinatal Intensive Care Centers, Hematology/Oncology Programs, HIV Programs, Children's Comprehensive Kidney Failure Centers and various CMS Clinics.

Title V funds also support outreach and education activities for the Information Clearing House on Developmental Disabilities. The Information Clearinghouse on Developmental Disabilities Advisory Council, mandated by section 383.141, Florida Statutes, was created to advise the Department in establishing and maintaining a clearinghouse of information related to developmental disabilities on its website, Bright Expectations.gov. The clearinghouse provides resources and information on developmental disabilities for pregnant women, health care providers, parents, and families. The council is composed of health care providers and caregivers who provide health care services for persons who have developmental disabilities. The council consists of nine members, serving four year terms, as

follows:

- Three members appointed by the Governor
- Three members appointed by the President of the Senate
- Three members appointed by the Speaker of the House of Representatives

CMS is currently designing an in-house data system for the Medical Foster Care, Children's Multidisciplinary Assessment Teams, Safety Net, and Title V field activities directly related to patient-centered medical homes, transition, and behavioral health.

CMS received a $5,000,000 reduction in general revenue funding for SFY 18-19, and is working to identify the best method to administer these cuts to minimize the impact on programs and services. Additionally, CMS will begin working with programs to identify techniques to reconfigure program composition and goals to ensure funds are maximized and are specifically working towards improving health outcomes.

Title V funds were expended to enhance the MCH system of care and ensure more infants have the best possible start in life. Title V funds were provided for interconception care (ICC), which is not reimbursable by Medicaid, through the Healthy Start program. In partnership with the March of Dimes, the Department used Title V funds to co-fund the Healthy Start Coalition of Hillsborough County (Tampa), to develop a statewide ICC curriculum to be implemented July 1, 2018 through all 32 Healthy Start Coalitions.

The provision of long-acting reversible contraception in hospitals after delivery was greatly enhanced using Title V Funds, through a partnership with the Florida Perinatal Quality Collaborative (FPQC). The Department's MCH Section also partnered with the March of Dimes and Florida's Prematurity Prevention Partnership project using Title V to co-fund nine community teams in a project with the Healthy Start Coalitions as the community leads.

As a component of Florida's Healthy Babies Initiative, the Department allocated Title V funding to all 67 county health departments and required them to conduct or enhance a data analysis project on infant mortality (including an environmental scan of existing pertinent programs) and to host one or more community meetings to increase awareness of disparities in infant deaths and the role of social determinants of health.

To increase the percentage of parents who read to their young children, the Department provided Title V funding to county health departments through Schedule C and a statement of work that included an option to create a reading rich environment in waiting room areas equipped with children's reading tables, chairs, bookshelves, children's books, etc. Funds were also available to establish a Reach Out and Read (ROR) program.

In the following additional examples, Title V funds were used to:

- Promote school-based sealant programs to children and increase positive consent rates from parents by producing and disseminating a postcard that explains dental sealants and their effectiveness in preventing tooth decay.
- Translate the Mothers and Babies curriculum into Creole, one of the three most widely spoken languages in Florida, to train Healthy Start care coordinators in Haitian communities.
- Support the Florida Breastfeeding Coalition to enhance current efforts and expand capacity for projects related to breastfeeding promotion.

III.D.2. Budget

Florida's FY 2019 MCH program budget totals $20,922,668, which is an overall increase of $1,679,069 (8.7 percent) from the budgeted amount for FY 2018. States must match every four dollars of federal Title V money they receive by at least three dollars of state and/or local money. The required state general fund match for Florida for FY2019 is $15,692,001.

The Title V program complies with allocating and spending at least 30 percent of the federal allotment for preventive and primary services for children and at least 30 percent for services for children with special health care needs. A total of $6,747,011 is budgeted toward preventive and primary services for children, which is 32.2 percent of the FY2019 estimated allotment. A total of $8,585,354 is budgeted towards children with special health care needs, which is 41 percent of the total allotment.

For FY2019, the estimated administrative cost is $1,844,123 or 8.9 percent of the federal allotment, well below the 10 percent threshold for administrative spending. The budgeted administrative costs in this application represent the grant funds used to administer the Title V program for MCH and include but are not limited to contract management, budgeting, personnel, and clerical support for these functions. State MCH Funds: State general funds for FY 2019 are anticipated to be $155,212,322. Florida will continue to provide the maintenance of effort amount of $155,212,322 as required.

For FY2019, the Department has budgeted a total of $16,568,999 in other federal funds under the control of the Title V MCH Director. This includes $4,435,757 for the State Abstinence Education Grant, $1,602,422 for the Rape Prevention and Education Program, and $10,530,800 for Title X Family Planning.

For the coming year, CMS plans to expend funds similarly to the outlined financial narrative. In addition, CMS is planning to shift to a new health plan model beginning in January 2019. In preparation for this, some administrative and infrastructure funds will shift with the new health plan model, allowing CMS to design and implement programs that are more aligned with the Standards for Systems of Care for Children and Youth with Special Health Care Needs 2.0. For example, the CMS team is working with the MCH Workforce Development Center to design Regional Networks for Access and Quality (RNAQs). In this concept, local RNAQs will receive MCH Block Grant funds to address activities that support the MCH Pyramid. They will focus on the local system of care, ensuring that the system locally is designed to meet the needs for CYSHCN and families. This may look like a telehealth initiative, or it may look like providing an essential non-Medicaid covered service to outpatient clinics in the area. CMS will also utilize the RNAQs to focus locally on Florida’s CYSHCN Title V priorities.

In addition to RNAQs, the CMS team may use MCH Block Grant funds to explore the restructuring and possible expansion of current specialty programs such as the Craniofacial and Cleft Lip/Palate Centers, Regional Perinatal Intensive Care Centers, Hematology/Oncology Programs, HIV Programs and Children’s Comprehensive Kidney Failure Centers in to Statewide Networks for Access and Quality (SNAQs). By taking existing programs and structuring them in such a way that they can all benefit from a quality collaborative-type model, CMS feels that health outcomes will improve for a broader CYSHCN population.

In the coming year, CMS is planning to provide support to the University of Florida’s Pediatric Pulmonary Center for more capacity-building opportunities for family representatives in MCH careers.

Additionally, CMS is planning to work with the University of Florida’s Institute for Child Health Policy to administer a survey that will help CMS assess the broader Florida system of care for CYSHCN and their families. CMS plans to

partner with the Florida Network on Disabilities to disseminate this survey to families of CYSHCN.

Lastly, CMS is planning on launching an initiative to increase the number of families, including families of CYSHCN that have access to IRS certified tax preparation services for the purpose of receiving their earned income tax credit (EITC). By linking more people to their EITC, CMS expects to see improved health benefits and quality of life for families in Florida. MCH staff will participate with CMS in this initiative with plans to expand through the Florida Healthy Babies initiative, to improve the quality of life for families in Florida and address the racial disparity gap in infant and maternal mortality.

Title V funding will continue to be provided through Schedule C and a Statement of Work to all 67 county health departments. Depending on their local needs, CHDs are able to provide well-woman preventative health visits; prenatal care; education for chronic disease management and prevention for pregnant women; preconception health counseling; reproductive health services; dental care services for pregnant women and children with an emphasis on children up to age 6; and activities that promote access to care, health literacy, community engagement and/or establishment of policies that positively influence social and economic conditions to address the social determinants of health.

The Department will continue to use Title V funding for four regional part-time nurse abstractors (as needed), an epi staff for data analysis, and additional staff as needed to support the statewide volunteer Pregnancy Associated Mortality Review (PAMR) team. The Department's MCH Section will continue to partner with the March of Dimes and Florida's Prematurity Prevention Partnership project using Title V to co-fund nine community teams in a project with the Healthy Start Coalitions serving as the community leads.

For the coming year, Title V funds have been budgeted towards the following activities and initiatives to enhance service delivery and positive health outcomes for the MCH population:

- A position will be placed at the Florida March of Dimes to expand, enhance, track, and evaluate the community team's projects and ensure they are aligned with proven interventions to reduce preterm birth.
- The Department will continue to use Title V funding to provide interconception care (ICC), which is not reimbursable by Medicaid, through the Healthy Start program.
- Contracts with 11 Fetal Infant Mortality Review (FIMR) projects through the Healthy Start program to provide for the implementation of FIMR services to address the behavioral, environmental, and structural processes that may impact fetal and infant deaths, to learn more about why infants die, and to propose recommendations for change.
- Contract with the FPQC to engage perinatal stakeholders to improve maternal and infant health outcomes through design, implementation, and evaluation of processes, and to enhance quality improvement efforts.
- Contract with the Ounce of Prevention Fund of Florida to identify, fund, and evaluate innovative prevention programs for at-risk children and families using general revenue funding. One specific project under this contract is to provide culturally linguistic and age appropriate books to Reach Out and Read sites throughout Florida to support one of the MCH priorities and performance measures. Additionally, the remaining projects under this GR funded contract support Title V by administering a public awareness campaign selected by the Department and directed at one of the states MCH priority areas.
- Provide support to the Florida Breastfeeding Coalition to enhance current efforts and expand capacity for projects related to breastfeeding promotion and provide technical assistance.
- Continuing support of the FPQC's hospital-based quality improvement project, the Mother's Own Milk (MOM) Initiative, by promoting-evidence-based interventions to increase the use of breast milk for very low birth weight infants in Florida's neonatal intensive care units.
- Continuing development and enhancement of the Public Health Dental Program's (PHDP) FLOSS Database, to improve functionality, enhance data quality and accuracy, and meet the dynamic business needs of the

PHDP and FLOSS users

- Continuing to establish new school-based sealant programs in Florida.
- Continue Title V funding for county health departments to create a reading rich environment in waiting room areas equipped with children's reading tables, chairs, bookshelves, and children's books. Funds may also be used to establish a Reach Out and Read (ROR) program
- Title V funding will be available to county health departments to establish a Best Babies Zone (BBZ) Initiative. BBZ is a place-based, multi-site, multi-sector approach to reducing disparities in infant mortality and birth outcomes by mobilizing community residents and organizational partners to address the social and economic determinants of health.
- Title V funding will be available to county health departments to establish a Fresh Access Bucks (FAB) Initiative. Fresh Access Bucks encourages healthy behaviors by making fresh, local produce more affordable and accessible to SNAP recipients while supporting Florida farmers and enhancing local economies. FAB increases the purchasing power of SNAP participants by providing a one-to-one match for Florida grown fruits and vegetables. A SNAP cardholder who spends $10 of their benefits receives an additional $10 to purchase more fresh, local produce. The goals of FAB are to increase access to and affordability of fruits and vegetables in underserved communities and increase awareness of the importance of eating fresh fruits and vegetables. This program strategically targets farmer's markets in and around food deserts, low-income communities, and along transportation routes.
- Title V funding will be available to county health departments to implement the Protocol for Assessing Community Excellence in Environmental Health (PACE EH) in high-need communities, to assess neighborhood and community identified social determinants of health needs and provide action plans to address the top issues as defined by the communities.
- Title V funding will be available to county health departments to facilitate partnerships with local birthing hospitals to obtain Cribs for Kids Safe Sleep Hospital Certification.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Florida

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

MCH and CMS partnerships that are critical to accomplishing the goals and mission of the MCH Block Grant include, but are not limited to, interagency, cross agency, community, state, and national relationships. Cross agency partnerships include the Agency for Health Care Administration (Florida's Medicaid Agency) and the Department of Children and Families.

For MCH, community, state, and national relationships include the Department's county health departments, Florida Healthy Start Coalitions, the March of Dimes, and the Florida Perinatal Quality Collaborative. CMS relationships include family organization partnerships with Family Network Disabilities and their Family STAR program, Family Café, and the National Association on Mental Illness. Both MCH and CMS partner with the Association of Maternal & Child Health Programs (AMCHP) and the National Maternal Child Health Workforce Development Center.

CMS worked closely with the workforce development center as a 2017 and 2018 state cohort. The knowledge, skills building, and tools related to systems integration, change management/adaptive leadership, and evidence-based decision making continues to be utilized in addressing cross cutting systems issues impacting children and youth with special health care needs (CYSHCN).

Established leadership roles and relationships in regional communities provide a local voice to drive needs and state action planning. CMS has partnerships with many of the state's university systems to facilitate the achievement of its Title V priorities including the University of Central Florida and their HealthARCH program for patient-centered medical home transformation and the University South Florida (USF) for health care transition. MCH partners with the USF Florida Perinatal Quality Collaborative and the USF Lawton and Rhea Chiles Center for Healthy Mothers and Babies on numerous issues and initiatives. MCH partnered with Northwestern University, Florida's MIECHV program, and the Florida Association of Healthy Start Coalitions to implement the Mothers and Babies curriculum as a component of Florida's Healthy Start and MIECHV programs.

The life course model plays an important role in the establishment of MCH activities. The MCH Section assists pregnant and interconception women, infants, and children up to age 3 in obtaining the health care, education, and social support needed to ensure an optimal chance at better health across the lifespan. The section is responsible for the oversight of the MCH Block Grant and program direction for public health activities as they relate to advancing the health of the maternal and child population. The goals of the program are to promote positive maternal and infant health outcomes and early childhood development. To provide program direction, MCH epidemiologists examine life course indicators that are related to infant mortality and data on health outcomes that are related to infant mortality and maternal mortality.

CMS is at a new juncture as a Title V program. CMS is focused on infrastructure rebuilding as it transforms its health care delivery systems for CYSHCN, ensuring access to quality primary care and specialty health services. CMS is strengthening its public health services and systems for all CYSHCN with the creation of Regional and State Networks for Access and Quality. Utilizing the life course perspective as a framework and building off the *Standards for Systems of Care for Children and Youth with Special Health Care Needs 2.0*, CMS is strategically planning with the focus on community needs, using the Mobilizing for Action through Planning and Partnerships (MAPP) process, and driven by family voice. The needs assessment framework includes Forces of Change: National Standards for System of Care, Statewide Systems of Care Assessment Tool; GOT Transition Assessment; and others as determined appropriate. Needs assessment results will drive action planning with implementation of AMCHP's National Consensus Standards for Systems of Care for CYSCHN, and an emphasis on whole-community systems

approaches with the prioritization given to the linkage or integration of multisector services systems to maximize protective factors and minimize risks for CYSHCN.

Community and state-level planning for CMS and MCH will focus on ensuring the availability of services and supports during critical or sensitive periods, looking at both the service systems and community-based initiatives, to address services, facilitation of access, and additional supports and resources as needed. Authentic family engagement, and intentional application of health equity in continually assessing the possibility for disparity in the incorporation of population and community-based strategies, will help address social determinants of health, changing environments, and other root causes of poor health outcomes.

III.E.2.b. Supportive Administrative Systems and Processes

III.E.2.b.i. MCH Workforce Development

Title V plays an important role in allowing the Department to maintain capacity within the Title V workforce. Title V funding helps ensure the Department can maintain an adequate workforce in the Central Office to preserve, enhance, and expand services for the Title V population.

The Department encourages MCH program staff to complete the AMCHP MCH Leadership Competencies module. Participants in the training learn how to identify core MCH leadership competencies, outline the knowledge and skill areas required of MCH leaders, provide a conceptual framework for the development of an MCH leader, and describe how MCH leadership competencies might be used by a variety of audiences.

Each year, CDC contracts with the University of Illinois at Chicago to provide a distance learning course in Public Health Epidemiology for practicing MCH epidemiology professionals. MCH also engages with public health professional educational programs including the CDC/CSTE Applied Epidemiology Fellowship Program, the Graduate Student Epidemiology Program, the CDC/Harvard School of Public Health Practicum, and other experiences through partnerships with local universities.

To further workforce development, the Bureau of Family Health Services began a monthly Scientific Journal Club in February 2017. Participating in a journal club is a great way to practice critical and analytic thinking skills while expanding knowledge about a public health topic. Staff participating in Journal Club read an assigned article ahead of time and come ready to engage in active discussion with colleagues from across the bureau.

The Department offers staff numerous learning/development trainings on-site as the opportunity arises. Examples include an eight-hour seminar entitled *Keys to Effective Public Speaking*, presented by Julie Carrier, a national speaker, author, and brain-based learning expert, in March 2018. In May, Dr. John Riggs of Stetson University, spoke to staff on *Continually Adjusting to New Environments ("Change"): Why Responding to Shifts in Strategic Importance Is Necessary to Sustain Organizational Success.*

The State of Florida Library provides state employees with a library account. Through this service, MCH staff can access hundreds of databases and can request journal articles and other materials, most at no charge.

CMS staff participated in the National MCH Workforce Development center in 2017 and again in the 2018 cohort. The information and tools learned as part of this experience have been shared and utilized on other MCH initiatives statewide with staff at all levels.

CMS utilized the MCH Leadership Competencies modules by packaging them with supplemental materials and collaborative group discussions. These modules were then strategically marketed through state blog news casts, emails, and word of mouth to staff. Successful completion of modules by staff will result in certificate of attendance and/or continuing education units. CMS promoted strengths-based leadership in key positions, including an assessment of individual leadership strengths, training, and action ideas to practice applying strengths. Data was used to determine specific strengths of individuals and groups for future planning and development.

Due to new care models based on value rather than volume, there is increasing prominence of quality measurement and evaluation functions. CMS is enhancing workforce training and growth to staff statewide by sponsoring evidenced-based training that focuses on core competencies and industry standards for case management and community health workers. The training ensures staff have the proper education, skills, and experience needed to deliver appropriate services in the achievement of desirable outcomes for population health.

CMS established a Motivational Interviewing Learning Collaborative with a sampling of staff from around the state, to explore the use of this evidenced-based practice and its potential fit in working with families of children and youth with special health care needs (CYSHCN).

CMS furthered their collaboration with the University of Florida's Pediatric Pulmonary Center and their family leader for statewide training to support and increase the skills of family leaders across organizations.

It should be noted that in the event of an emergency, unless granted a temporary exemption from emergency duty, all Department of Health employees may be required to work before, during and/or beyond their normal hours or days in a special needs shelter, Red Cross shelter, Emergency Operations Command Center; or perform other emergency duties, including but not limited to response to or threats involving any disaster or threat of disaster, man-made or natural.

III.E.2.b.ii. Family Partnership

The Department builds and strengthens family/consumer partnerships for the state's MCH population, including CYSHCN, in many ways. Following is a description of some of those efforts.

A primary responsibility of Florida's statewide Healthy Start program is to develop comprehensive systems of care for pregnant women and infants within their local communities. To ensure these systems of care are relevant in addressing adverse maternal and infant health outcomes, communities must be involved in all aspects of Healthy Start service planning, provision, strategic planning, and evaluation activities.

To effectively reduce infant mortality and poor birth outcomes, health disparities in the social, economic, and physical environment must be addressed at the community level. Beginning in July 2018, Healthy Start Coalitions are tasked with completing community development activities to address the social determinants of health. The seven determinants that will be targeted by the coalitions are based on a comprehensive approach to improving maternal and child health outcomes using the social-ecological framework for health, the life course perspective, and the social determinants of health model. A robust body of research has identified correlations of infant mortality and poor birth outcome to socioeconomic status inequalities and environmental conditions, in addition to protective and risk factors associated with the social determinants of health. Inequities in the social, economic, and physical environment are operationalized as housing, employment, education, and transportation determinants. These are modifiable generators of structural inequalities around which local policies, programs, and services are centered and coalition activities can be structured. The crosscutting factors of poverty, racism, and toxic stress are underlying causes that create cumulative, persistent sources of stress, which have been consistently correlated with poor birth outcomes and infant mortality. By facilitating a strategic and holistic approach to health equity, the coalitions are empowered to do transformative interventions at the community level.

Section 383.216, Florida Statutes, mandates that the membership of each of Florida's local Healthy Start Coalitions include consumers of prenatal care, primary care, or family planning services, and that at least two consumers be low-income or Medicaid-eligible. The statute further stipulates that the membership of each prenatal and infant health care coalition shall represent the recipient community and the community at large; and shall represent the racial, ethnic, and gender composition of the community.

Community involvement is an important contributing factor to the success of a Healthy Start Coalition. Such involvement requires coalition leadership be knowledgeable of and understand the communities in which they serve, as well as, allow for input and engagement of community members and consumers in the work of the coalition to achieve the program's intent and purpose.

Providers of Healthy Start services must provide culturally and linguistically appropriate services (CLAS) to the best of their ability in order to reach the diverse population of Florida. One of the goals contained in the Department's State Health Improvement Plan addresses the provision of equal access to culturally and linguistically competent care. The provision of CLAS to Healthy Start participants is to be considered during program planning, recruitment of bilingual staff, and in the availability of diverse educational materials and classes.

Consumers are also valuable contributors in various advisory roles. With the support of the legislature, the Department was authorized in section 383.141, Florida Statutes, to create an Information Clearinghouse on Developmental Disabilities website to provide information for parents and families on Down syndrome and other prenatally diagnosed developmental disabilities. During the 2018 legislative session, $250,000 of MCH Block Grant funds were earmarked to conduct a statewide marketing campaign to promote Bright Expectations, the Information Clearinghouse on Developmental Disabilities website.

Additionally, the statute authorized the establishment of an Advisory Council charged with providing technical assistance to the Department. The Council consists of nine members appointed by the Governor, Speaker of the House, and Senate President. Each of the appointees is a parent of a child with a unique ability. The Council has been instrumental in providing a parent's perspective in information gathered and made available to health care providers for use in counseling pregnant women whose unborn children have been prenatally diagnosed with developmental disabilities. The Council worked with the Department's Office of Communications and provided feedback in the development of materials, postcards, and posters to promote the website. They also developed a video for the website and promote it through Twitter and Facebook, providing continual feedback from consumers.

The School Health Services Act (section 381.0056, Florida Statutes) requires each school district to have a School Health Advisory Committee (SHAC). The SHAC must have a broad and diverse representation from the community and work closely with the local health department and school district on the development of the biennial school health services plan. The SHAC must, at a minimum, include members who represent the eight component areas of the Coordinated School Health framework proposed by the CDC for planning and coordinating school health activities. Parents are included in the SHAC membership and assist in strategic and program planning.

Additional program planning and quality improvement is enhanced through consumer input in other ways. The MCH program integrates Title V with Florida's MIECHV by incorporating family engagement and information gained through the MIECHV program's evaluation. The MIECHV program evaluation team conducted in-depth, semi-structured phone interviews with English-speaking and Spanish-speaking home visiting participants from the five initially funded programs. Each family received a flyer from their home visitor with a short description of the evaluation, the contact information for the MIECHV Evaluation Team, and a notice that participants would receive a $25 Walmart gift card for their participation. Those interested set up a phone interview during a time that was most convenient for them. Interviews were conducted with the family member who self-identified as the primary caregiver of a child enrolled in the MIECHV Program.

CMS, in partnership with the University of Florida Pediatric Pulmonary Center, has the overarching goal of professional development and training for their family partners/leaders as professionals. Specifically, CMS is sponsoring the development of six educational activities and a conference focused on training and professional development for family leaders and organizations across the state on an annual basis. A needs assessment to determine the type of training and professional development opportunities family and youth leaders desire will be completed. The results of needs assessment will form as a foundation for a statewide family advisory group and future activities.

The Family Network on Disabilities, and its Family STAR program, is Florida's Family to Family Health Information Center. Children's Medical Services works with this partner to promote family involvement in health care decision-making. CMS is actively collaborating with Family Network on Disabilities to explore ways to coordinate on several projects.

The Family Café serves as a source of information for individuals with disabilities on an ongoing basis in various ways. It produces an annual publication in the fall entitled *The Questions & Answers Book*. This publication is created by distributing unanswered questions submitted by conference attendees. The Family Café distributes those questions to the relevant state agencies, and collates the responses in a single reference guide. In addition, the Family Café operates a website designed to provide information and networking opportunities to its visitors. The Family Café is fortunate to have a network of volunteers called delegates. The Family Café delegates receive special leadership training at the annual conference, and act as resources and representatives in their home communities. They serve in part as the link to families of CYSHCN year-round, while representing commitment to

fostering community leadership.

CMS formed the Children and Youth with Special Health Care Needs Technical Advisory Panel, whose purpose is to look at best practices and initiatives that focus on quality health care and improved health outcomes for CYSHCN. Family and youth representation is included on this panel, as well as the perspective from a representative for the Family Network on Disabilities.

In 2017, CMS held a series of public meetings and family forums to gather feedback related to the CMS Plan's health care delivery model. CMS has received input from families, stakeholders, advocates, and providers. The family forums created a space for families to have a voice, and to be open and honest regarding the health care services they receive. CMS incorporated the data and recommendations from these activities in the remodeling of their health care delivery model.

Family participation was intentional in working with the National Maternal Child Health Workforce Development Centers cohorts for both 2017 and 2018. Each year, a family representative is sponsored and accompanies CMS to the annual AMCHP conference. This family representative is helping CMS and MCH establish linkages with families in Florida, and ensures that Florida's families receive relevant AMCHP information.

CMS is working on improving access to children with behavioral health needs. Family participation on the workgroup for this project included the Family Network on Disabilities, the National Alliance for Mental Illness, and a CMS family representative. Their perspective and input help drive the action plan.

CMS is strategically planning for the development of their Regional Network Access and Quality centers. Family representation and perspective is included in the statewide steering committee for this project, and their perspective helped to plan and develop the framework for the local community needs assessments that will be conducted statewide. The local community needs assessments, which will include family input, will advise future Title V action planning for CYSHCN. The Family Network on Disabilities has joined as a partner and will help with dissemination of electronic surveys to families throughout the state.

Family voice includes youth voice, and CMS is working with established and new partners in the expansion of youth councils throughout the state. Activities include promoting outreach and awareness and youth voice and perspective in the updating of transition self-management guidelines and other materials.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

The Florida State Systems Development Initiative (SSDI) program submitted a successful, non-competitive application for the 2017-2022 project period, which continues to be utilized to support Florida's Title V Block Grant through supplemental data initiatives. The focus remains primarily on children and youth with special healthcare needs, abused and neglected children, and strengthening Title V programs that serve these populations. The Florida SSDI program resides within the Division of Children's Medical Services, which has allowed for a concentrated focus on the evaluation, analysis, and accessibility of data sets directly effecting these groups of children maintained within the Department. Efforts to expand these initiatives into other divisions within the Department are currently underway.

SSDI resources allocated for Florida have been vital in the ongoing efforts to track and improve electronic access to MCH health indicators. A major resource and platform currently being utilized to accomplish these directives is FLHealthCHARTS, which houses a community health resource tool set managed by the Department's Division of Public Health Statistics and Performance Management and the Bureau of Vital Statistics. Through this platform, the SSDI program has generated additional MCH indicators that include new profiles and keyword searches designed to capture data relevant to Title V performance measures. These endeavors have provided new MCH categories within FLHealthCHARTS that encompass data points related to newborn screenings and CYSHCN. The funding received through the SSDI grant acted as the primary funding source necessary for programming the information into the public forum.

Initiating linkages between data resources remains a key SSDI objective, particularly within Title V programs that serve the same or similar populations. Currently, the SSDI team has begun linking databases within CMS to track vulnerable populations of children through each stage of development, beginning with newborn screening and culminating in the Early Steps and Child Protection Team programs. Expanding on these initiatives, SSDI staff are collaborating with key Department partners to improve important data infrastructure to track children with increased vulnerabilities. These populations include children enrolled in the Manage Health Care Plan, and an implemented example is the Event Notification System as well as children found in the Florida Birth Defects Registry. These linkages are providing valuable insight into the efficiency and reliability of programs within the Department that serve MCH populations, and will be a fundamental resource regarding future data-driven decisions required for timely collection and reporting of MCH-related materials.

Research to evaluate emerging issues that impact MCH populations served by Title V programs is ongoing. These include utilizing state-level population data (ex: Behavioral Risk Factor Surveillance System, Child Abuse Death Review, vital statistics, etc.), workgroups, and other opportunities to advance Title V program evaluation. These initiatives also improve interagency and intra-agency communication that has translated into improved data systems while simultaneously decreasing redundancy in efforts. To note, SSDI staff have assisted with several initiatives that support strategies within the State Action Plan:

- Child Safety Collaborative Improvement and Innovation Networks: Interpersonal violence prevention strategy team
- State Health Improvement Plan: MCH Priority Area Workgroup (focusing on CYSHCN in Florida)

Overall, the Florida SSDI program is committed to supporting the data needs of the Title V Block grant, and finding innovative methods to serve Florida's MCH population through data sharing initiatives.

The Department's Maternal and Child Health section currently has three epidemiologists on staff dedicated to collecting and reporting timely MCH data requests. They have access to numerous data files, including but not limited to: vital records, screening, Florida CHARTS, Medicaid data, PAMR and FIMR data, and data across

numerous Department programs.

The MCH Section and AHCA's Division of Medicaid participated in a national learning collaborative facilitated by the Association of Maternal & Child Health Programs. The goal of the project was to establish a long-term data sharing partnership to increase the ability of staff to access and analyze data that informs policy, programs, and practice, to improve the health of Florida's MCH and Medicaid populations. The proposed projects of mutual interest to the Department and AHCA were to conduct an evaluation to assess maternal and infant health outcomes in the Medicaid population who do and do not receive Florida's Healthy Start Program services, and to examine postpartum contraceptive use among women on Medicaid.

As a result of the learning collaborative, in May 2017, MCH Epi staff successfully established the formal data sharing agreement with AHCA. AHCA provides Medicaid claims, encounters, and eligibility data to the Department, and in turn, the Department provides AHCA with copies of any evaluation and analytic reports resulting from analysis of AHCA data prior to public release.

III.E.2.b.iv. Health Care Delivery System

Approximately 47 percent of Florida's children are enrolled in Medicaid and about 85 percent of Florida's Medicaid population receives services through a managed care delivery system. Children's Medical Services and AHCA work closely to ensure CYSHCN are provided quality health care and related services through a cohesive system of care. Children are identified during the XIX and XXI eligibility and enrollment process as being potentially clinically eligible for the CMS Plan. Upon referral, CMS conducts eligibility determinations and files are sent electronically daily back to the referring entity. CMS works with XIX and XXI to ensure that the public and providers are aware of the CMS Plan as a specialty plan option for CYSHCN.

CMS works with Florida Medicaid, Florida KidCare, and community partners to identify children that are uninsured and underinsured. When a child is identified, the CMS team works to enroll them in the CMS Safety Net Program, which will pay for certain direct services depending on the child's needs.

The CMS Clinical Eligibility Team is trained to support families calling for clinical eligibility determinations, by also assessing for additional needs and providing linkages to additional resources to families. This helps Florida families to be equipped with information on available resources for their child.

Through the agreement between the Department of Health and AHCA, CMS operates the Children's Multidisciplinary Assessment Teams (CMAT) in Florida, as well as the Medical Foster Care (MFC) Program Teams. The CMATs provide level of reimbursement determinations for MFC children and level of care determinations for children entering skilled nursing facilities. AHCA and Agency for Persons with Disabilities also participate in the CMAT process, as well as families and providers. CMAT also serves as the delegated authority to complete the Preadmission Screening and Resident Review process for individuals under age 21.

Florida's Medical Foster Care Program is also a partnership between the Department and AHCA, in addition to the Department of Children and Families. CMS trains MFC families, which are Medicaid providers. CMS also provides ongoing technical assistance to MFC families and provides both nursing and social work support and case management while in the MFC Program. MFC families are reimbursed through Medicaid.

CMS administers Early Steps, Florida's Individuals with Disabilities Education Act, Part C early intervention program. CMS contracts with Early Steps providers across the state, and AHCA participates in monitoring these programs for compliance and program operations.

CMS continues to work with AHCA regarding several waivers that the CYSHCN population benefits from. The Program for All-Inclusive Care for Children is a program administered by CMS and AHCA, and serves children with life-threatening and life-limiting illnesses. Through partnerships with hospices, children enrolled in the program are provided with pain and symptom management services, including nursing and social services supports, activity therapies, and respite care. Additionally, children enrolled in the CMS Plan receive care coordination that includes coordinating services through the CMS Plan and through any long-term care or home and community-based services waivers.

III.E.2.c State Action Plan Narrative by Domain

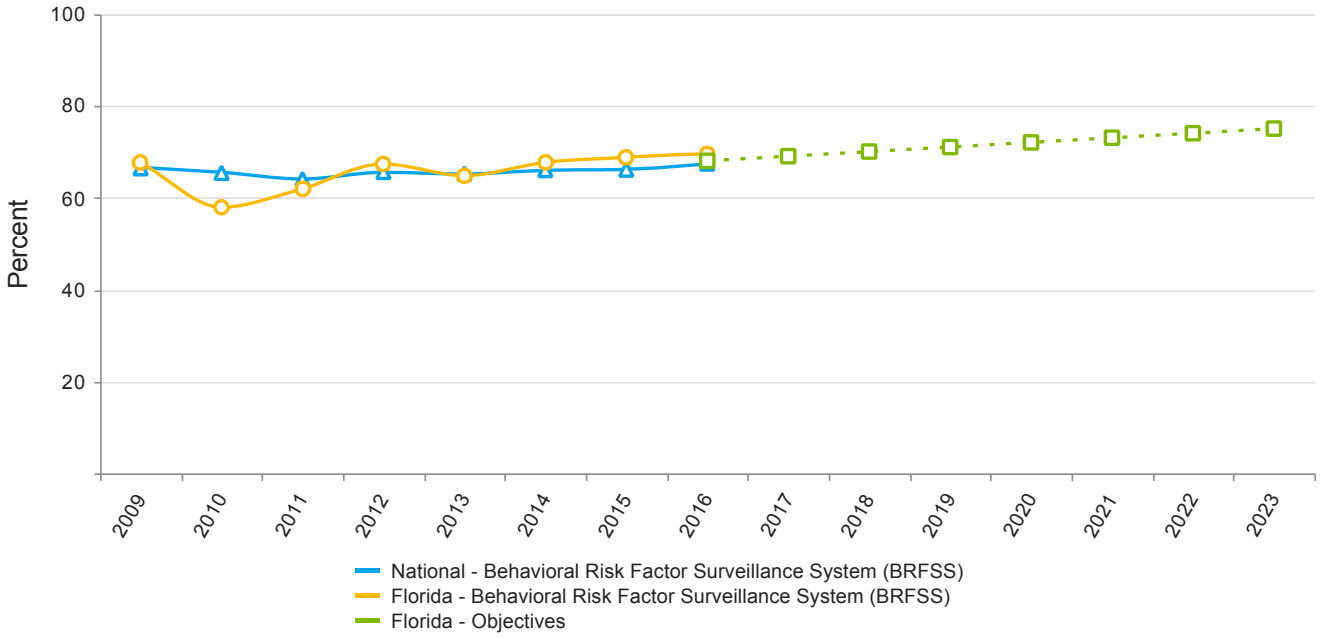
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	178.9	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2012_2016	22.3	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2016	8.7 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2016	10.2 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2016	26.3 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2015	6.6	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	6.2	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2015	4.4	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	1.8	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2015	243.0	NPM 1 NPM 14.1
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	81.2	NPM 14.1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS	Data Not Available	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2015	7.2	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	86.7 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	19.3	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS	Data Not Available	NPM 1

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Baseline Indicators and Annual Objectives



Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2016	**2017**
Annual Objective	68	69
Annual Indicator	68.8	69.6
Numerator	2,287,771	2,337,875
Denominator	3,324,933	3,359,251
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	70.0	71.0	72.0	73.0	74.0	75.0

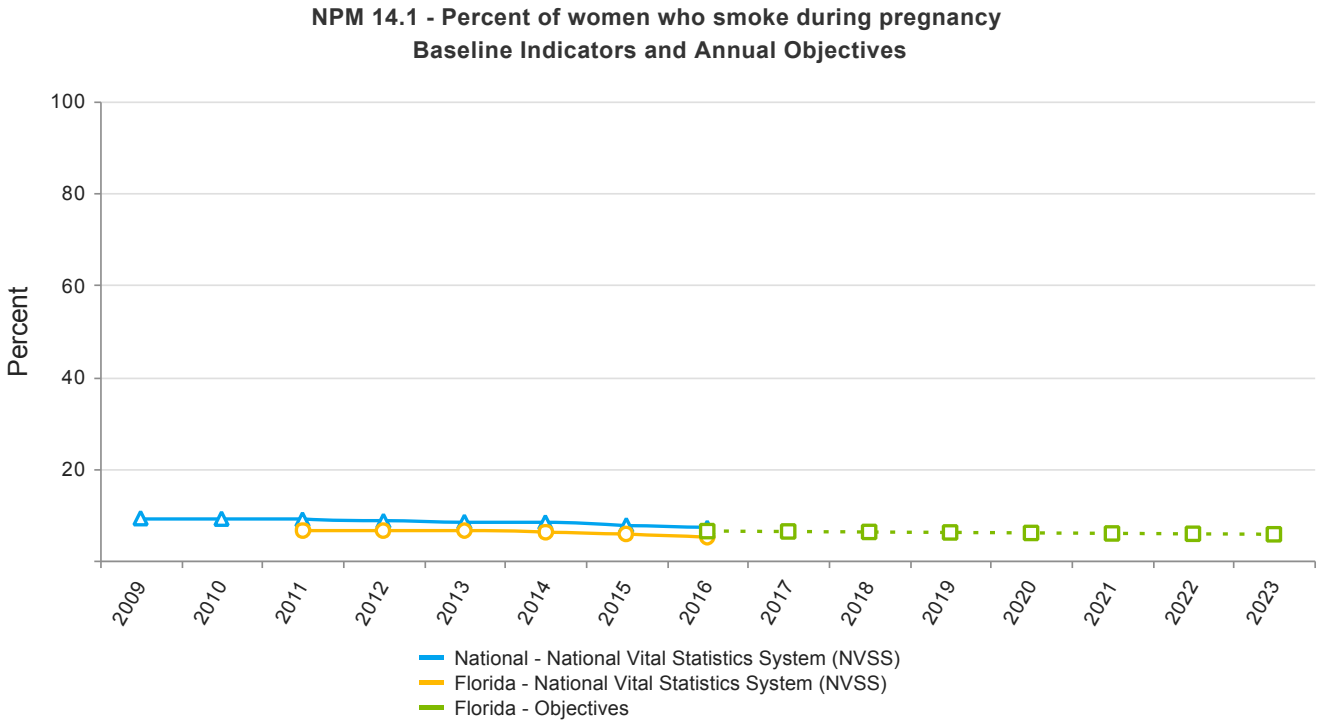
Evidence-Based or –Informed Strategy Measures

ESM 1.1 - The number of interconception services provided to Healthy Start clients

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		27,000
Annual Indicator	25,558	43,507
Numerator		
Denominator		
Data Source	Well Family System	Well Family System
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	44,000.0	44,500.0	45,000.0	45,500.0	46,000.0	46,500.0



Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2016	**2017**
Annual Objective	6.5	6.4
Annual Indicator	5.8	5.1
Numerator	12,970	11,454
Denominator	223,231	224,109
Data Source	NVSS	NVSS
Data Source Year	2015	2016

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	6.3	6.2	6.1	6.0	5.9	5.8

Evidence-Based or –Informed Strategy Measures

ESM 14.1.1 - The number of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to Healthy Start clients

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	7,000.0	7,250.0	7,500.0	7,750.0	8,000.0

State Action Plan Table

State Action Plan Table (Florida) - Women/Maternal Health - Entry 1

Priority Need

Improve access to health care for women to improve preconception and interconception health, specifically women who face significant barriers to better health.

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

1. By December 31, 2021, increase the rate of female teens (13-17 years of age) who have completed the first dose of HPV vaccine from 57.2 percent (National Immunization Teen Survey: 2014) to 70 percent.

2. By December 31, 2021, decrease the number of syphilis cases among women ages 15-44 years from 1,011 (PRISM: 2016) to 859.

3. By December 31, 2021, increase percent of new mothers in Florida who received information about how to prepare for a healthy pregnancy and baby prior to pregnancy from 22.8 percent (FL-PRAMS: 2014) to 30 percent.

4. By December 31, 2020 increase the percentage of treatment started for Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP) eligible women diagnosed with cervical cancer or cervical precancer that initiate treatment from 50 percent in 2017 to 75 percent in 2020.

5. By Dec. 31, 2018, reduce the rate of late-stage (advanced stage) female breast cancer from 41.3 per 100,000 (2012) to 40.2 per 100,000.

6. By Dec. 31, 2018, reduce invasive cervical cancer from 8.4 per 100,000 (2012) to 8.0 per 100,000.

7. By December 31, 2021, increase the number of individuals at risk of type 2 diabetes participating in the CDC Recognized Diabetes Prevention programs from 4,340 (CDC-Diabetes Prevention Recognition Program Quarterly Report: 2016) to 10,000.

8. By December 31, 2021, increase the percentage of adults with hypertension served by Federally Qualified Health Centers who have their blood pressure adequately controlled (<140/90) from 60.6 percent (HRSA Health Center Program Grantee Data: 2015) to 72.7 percent.

Strategies
1. Collaborate with the Division of Disease Control and Health Protection/Bureau of Communicable Diseases to promote awareness and support community partnerships to increase access to immunizations, and to increase immunization rates for vaccine preventable diseases in Florida’s teens through educational outreach events, vaccine distribution clinics, monitoring site visits, and media campaigns.
2. Collaborate with the Division of Disease Control and Health Protection/Bureau of Communicable Diseases to reduce the number of syphilis cases through provider and public awareness, enhanced surveillance, and expanded quality improvement activities.
3. Develop and/or identify an evidence-based interconception health curriculum for statewide implementation in the Healthy Start program.
4a. Collaborate with the Division of Community Health Promotion to help educate women regarding the importance of cervical cancer screening and on the importance of cervical cancer treatment.
4b. Collaborate with the Division of Community Health Promotion to help promote and identify community organizations that provide cervical cancer treatment to women who are not eligible for Medicaid services.
5. Collaborate with the Division of Community Health Promotion to help educate women who are eligible for the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP) and non-program eligible women on the importance of breast cancer screening through multiple avenues.
6. Collaborate with the Division of Community Health Promotion to help recruit women who meet FBCCEDP's criteria as well as non-program women, and educate them of importance of cervical cancer screening.
7. Collaborate with the Bureau of Chronic Disease Prevention to promote policy and systems change to healthcare providers to increase adherence to clinical best practices and national recommendations for chronic disease prevention and increase utilization of available resources.
8. Collaborate with the Bureau of Chronic Disease Prevention to promote policy and systems change to healthcare providers to increase team-based care and care coordination approaches for chronic disease treatment and management to ensure optimal and equitable care for all segments of the population.

ESMs	Status
ESM 1.1 - The number of interconception services provided to Healthy Start clients	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (Florida) - Women/Maternal Health - Entry 2

Priority Need

Promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children.

NPM

NPM 14.1 - Percent of women who smoke during pregnancy

Objectives

1. By December 31, 2021, increase the number of referrals to Tobacco Free Florida Quit Services from 20,533 (DOH-Tobacco-Free Florida Quit Line Providers: 2016) to 23,000.

2. By September 30, 2020, decrease the percentage of women who smoked cigarettes in the three months prior to becoming pregnant from 19.1 percent in 2014 (2014 PRAMS Report) to 16.6 percent.

Strategies

1. Collaborate with the Bureau of Tobacco Free Florida to promote pregnant women in the Healthy Start program to participate in the Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) and refer to the Tobacco Free Florida Quit Line.

2a. Increase the number of health care providers who address the dangers of smoking and tobacco use in the preconception visit.

2b. Develop/update trainings on preconception health to include information about the dangers of tobacco.

2c. Increase the number of health care providers who utilize preconception health screening tools and resources to identify smokers.

ESMs	Status
ESM 14.1.1 - The number of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to Healthy Start clients	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

In 2016, a total of 34.8 percent of women age 18-44 in Florida did not have a routine checkup (BRFSS). In 2016, a total of 38.6 percent of non-Hispanic white women, 25.7 percent of non-Hispanic black women, and 35.4 percent of Hispanic women did not have a routine checkup in the last year (BRFSS).

Good health care for a woman considers the different stages of the woman's life, from adolescence to old age. It means caring for all her needs, throughout her life course. For too many years, women's health care meant little more than maternal health services, such as care during pregnancy and birth. These services are necessary, but they only address motherhood, a fraction of a woman's health needs.

Women's health needs include the well-being of a woman's body, mind, and spirit. A woman's health is affected not just by the way her body is made, but by the social, cultural, and economic conditions in which she lives.

Improving women's health means addressing the "root causes" of ill health, including poverty, gender, and racial inequality, and other forms of oppression. While men's health is also affected by these factors, women as a group are treated differently than men. Women usually have less power and lower status in the family and community. This basic inequality means:

- More women than men suffer from lack of access to resources like money, food, land, and mobility.
- More women than men are denied the education and skills to support and protect themselves.
- More women than men lack access to important health information and services.
- More women than men lack power and control over their lives and basic health care decisions.
- Poor women, women with darker skin, migrant women, and women from ethnic minority groups experience even more challenges than other women.

This larger view helps us to understand and work to change the underlying root causes, the many factors that influence and affect women's health. These may not be visible, but they are important to promoting life and well-being.

Using this approach in a broader, more inclusive, and more realistic way to impact women's health and the health of the entire community, the Department has reassessed, updated, and realigned the strategies and objectives to address the state priority to improve access to health care for women to improve preconception and interconception health, specifically women who face significant barriers to better health. The national performance measure selected for this priority is NPM 1: Percent of women with a past year preventive medical visit. The realignment incorporates the Department's State Health Improvement Plan and the Agency Strategic Plan with the MCH Block Grant strategies and objectives, providing a universal approach to addressing women's health across the lifespan.

We have known for years that behaviors established during childhood are critical for lifelong health. Many chronic diseases are established much earlier than previously thought. For example, obese children age 5 to 8 already have an average of two or more cardiovascular disease markers, such as high blood pressure or high cholesterol. In addition to early disease processes, obesity predisposes children to the most severe forms of obesity in adulthood. Nearly 40 percent of obese children become morbidly obese as adults.

As women move from childhood into early adulthood, too many women of childbearing age already suffer from chronic conditions or use substances that can adversely affect pregnancy outcomes, leading to miscarriage, infant death, birth defects, or other complications for mothers and infants. According to the 2015 Pregnancy Risk Assessment Monitoring System (PRAMS), among women age 18 to 44 who recently gave birth in Florida, approximately 9 percent had asthma, 5 percent had hypertension, 2 percent had diabetes, 7 percent had

depression, 47 percent were overweight or obese, 6 percent were underweight, and 10 percent smoked before becoming pregnant.

The need to intervene early in the lives of women, for their own health and that of their babies, can best be met through the joint efforts of maternal and child health, chronic disease prevention, communicable disease, and environmental health. Working across the lifespan no longer receives the occasional puzzled look over why reproductive health work crosses with topics such as tobacco control, diabetes, cancer, and nutrition.

Today, the logic is clear. Issues of maternal and child health are recognized as being inextricably linked to the prevention and control of chronic disease. At the most basic level, the link is forged during pregnancy and the postpartum period, when health care providers have the opportunity to screen and treat mothers for chronic diseases, such as diabetes, and to counsel mothers on associated risk factors, such as poor nutrition and smoking. However, the links extend well beyond these obvious connections. On the one hand, the work brings heightened awareness to the importance of early intervention and its implications for lifelong health. On the other hand, expertise from diverse fields, such as tobacco control, nutrition, and diabetes, is needed to adequately address the issues of maternal, infant, and family health.

The plan for the coming year will incorporate the realignment of strategies and objectives to better address and impact the state's progress in achieving its established performance measure targets and programmatic impacts. What follows is a summary of the past year's programmatic activities.

The Department's MCH Section provides oversight of the maternal and child health system of care, the Healthy Start Program, and the oversight and monitoring of the state's Healthy Start Coalitions. Healthy Start services are available to pregnant women, infants, and children up to age 3 based on risks and availability of services. Healthy Start services are also available to women between pregnancies who are at-risk for a subsequent poor pregnancy outcome.

Services include:

- Universal prenatal and infant risk screening
- Interconception education and counseling
- Breastfeeding education and support
- Care coordination
- Childbirth education
- Smoking cessation
- Health and parenting education for at-risk women and their children up to age 3
- Education, counseling, and referrals for access to care
- Nutrition counseling

The MCH Section continued to adopt, implement, and integrate evidence-based practices into the Healthy Start program to address issues that affect the health of women and infants. The Healthy Start program uses the Department's Health Management System and the Coalition's Well Family System to enable the program to track the time and number of services provided to a participant for data collection purposes.

The Department uses Title V funding to provide interconception care (ICC), which is not reimbursable by Medicaid, through the Healthy Start program. The ICC services are provided to women who have had a pregnancy and are high-risk of having a poor birth outcome for a subsequent pregnancy. Reasons for a high-risk determination could be a previous fetal or infant loss; a low birth weight or preterm baby; a chronic disease such as hypertension, obesity, or diabetes; previous pre-eclampsia or eclampsia; previous gestational diabetes; substance use or abuse;

depression; or any other condition that could result in poor birth outcomes.

In partnership with the March of Dimes, the Department used Title V funds to co-fund the Healthy Start Coalition of Hillsborough County (Tampa), to develop a statewide ICC curriculum to be implemented July 1, 2018 through all 32 Healthy Start Coalitions. The curriculum includes topics on accessing health care, baby spacing, body mass index, healthy weight, chronic health conditions, contraceptive use, environmental risk factors, folic acid intake, infections, establishing a medical home, mental health, nutrition, oral health, physical activity, the relationship of poor pregnancy outcomes and future pregnancy outcomes, and substance use including the effects of opioids. The curriculum works to educate women on ways to improve their health for themselves while highlighting how improving their health may help improve future pregnancy outcomes.

During the prenatal participant's third trimester, one key question will be asked, "Would you like to become pregnant in the next year?" Based on her response, the participant will complete either the Show Your Love Life plan, the Baby-to-Be plan, or the Healthy Woman plan. The goals she sets in her reproductive life plan will be the guiding factor for the curricular education provided during face-to-face visits.

Training on the Healthy Start Interconception Curriculum took place during the 2017/2018 contract year. The Healthy Start coalitions implemented a train-the-trainer approach to ensure every Healthy Start care coordinator receives the required training.

The Northwestern University Feinberg School of Medicine was awarded a $400,000 grant from the Robert Wood Johnson Foundation to evaluate the effectiveness of their evidenced-based Mothers and Babies curriculum in a home visiting environment. Northwestern University partnered with the Department, Florida's MIECHV program, and the Florida Association of Healthy Start Coalitions to implement the Mothers and Babies evidence-based curriculum as a component of Florida's Healthy Start and MIECHV programs. Along with the research study, Healthy Start care coordinators statewide were trained to provide depression screening and interventions based on screening results, one of which is the Mothers and Babies curriculum. Because the curriculum is only available in English and Spanish, Title V funding was used to translate the curriculum into Creole, one of the three most spoken languages in Florida. By implementing this curriculum, the Department assists Florida women in lowering their stress levels, which will enable them to concentrate on better health practices for themselves.

The Department provided many services to women at local health departments located in each of Florida's 67 counties. Services for women include: family/reproductive health planning; STD and HIV/AIDS screening, prevention, treatment, and control; breast and cervical cancer early detection; immunizations; prenatal care (in 23 counties); health assessments; community education; and other activities such as Healthiest Weight Florida.

Title V funding was provided through Schedule C and a Statement of Work to all of 67 CHDs to provide well-woman preventative health visits; prenatal care; education for chronic disease management and prevention for pregnant women; preconception health counseling; reproductive health services; dental care services for pregnant women and children with an emphasis on children up to age 6; and activities that promote access to care, health literacy, community engagement and/or establishment of policies that positively influence social and economic conditions to address the social determinants of health.

The Department's MCH section revised departmental technical assistance guidelines for preconception and interconception education and counseling for women of childbearing years to incorporate more specific guidance and resources for interconception education.

In October 2016, the Department, in partnership with Florida's Medicaid agency as lead, began participation in the Association of State and Territorial Health Officers (ASTHO) Increasing Access to Contraception Learning Community, along with other key stakeholder and partners. The goal of the learning community was to improve the capacity of states to successfully increase access to long-acting reversible contraception (LARC) by facilitating state-to-state sharing of promising strategies and common challenges, providing technical assistance on implementation barriers and working through solutions, and documenting lessons learned to share with other states looking to adopt LARC policies. Through the project, ASTHO provided the following to assist states to implement LARC policy and programmatic changes:

- Technical assistance to states.
- New materials documenting state experiences.
- Joint technical assistance with the CDC Division of Reproductive Health, Centers of Medicare and Medicaid Services, and Office of Population Affairs.
- Promoting existing ASTHO, federal, and state-developed materials.
- Forming process and outcome evaluations to assist states with tracking progress and identifying areas that need to be addressed/elevated.

Florida's plan was to implement system-wide changes to eliminate barriers to accessing reproductive health care, while also addressing health disparities. Addressing all women of reproductive age, with a focus on the underinsured and Medicaid populations, Florida will accomplish these activities through two goals:

- Implementing statewide policy change to provide immediate postpartum LARC in an inpatient hospital setting.
- Removing barriers to same day access to highly effective, reversible methods of contraception in clinic settings.

As a result of participation in the learning collaborative and ongoing discussions with AHCA, Florida's Medicaid agency will be offering reimbursement for immediate postpartum insertion of LARCs, in addition to, but separate from, labor and delivery reimbursement. Access to immediate postpartum insertion of LARCs will increase the instances of appropriate birth spacing and increase opportunities for interconception care, resulting in improved outcomes for newborns and mothers.

As part of the ASTHO Learning Community, a pilot project was initiated in Duval County through the Northeast Florida Healthy Start Coalition, funded with Title V funds. The pilot project worked with Florida's Medicaid agency to unbundle postpartum LARC and delivery fees, developed billing procedures with insurance carriers, and provided education for providers and patients.

Building on the pilot project, the Department contracted with the Florida Perinatal Quality Collaborative (FPQC) at the University of South Florida, to implement a LARC quality improvement initiative. The FPQC partnered with the American College of Obstetricians and Gynecologists) District XII, the Florida Chapter of the Association of Women's Health, Obstetric, and Neonatal Nurses, AHCA, United Healthcare as well as Aetna Medicaid Managed Care. With the support of these professional organizations and a change in Medicaid policy allowing for the unbundling of LARCs in the immediate postpartum period, FPQC established the Access Postpartum LARC Initiative. The purpose of the initiative was to work collaboratively with maternal health care providers and hospitals to develop and implement policies to improve the use of LARC methods immediately after delivery, to reduce the number of unintended and closely spaced pregnancies. Highly-effective contraception, such as LARCs, can help reduce maternal and infant mortality.

Hospital recruitment for the LARC Initiative began in the summer of 2017. The initiative launched in the fall of 2017, with 10 Florida hospitals and obstetrical and gynecology residency clinics. The LARC Initiative has two phases, the

pre-implementation phase and the implementation phase. The pre-implementation phase focuses on creating and modifying hospital systems to enable acquisition and reimbursement for immediate postpartum LARC placement. This phase allows hospitals to engage their pharmacy, billing, administration and IT departments to make the necessary changes to their formularies, inventories, coding systems as well as the electronic health records. The implementation phase focuses on the delivery of the immediate postpartum LARC. Providers will be trained in LARC insertion and contraception choice counseling, and begin offering LARCs to patients. The initiative will end March 2019, with the goal to have at least 80 percent of participating hospitals able to provide immediate postpartum LARCs.

The Department's MCH Section contracts with the Florida Pregnancy Care Network to implement the Department's Florida Pregnancy Support Services Program. The program is a network of nonprofit pregnancy support centers that provide support and assistance to women, men, and their families faced with difficult pregnancy decisions. Services include free pregnancy tests, peer counseling, and referrals; and most of the centers offer classes on pregnancy, childbirth, parenting, and personal finance management. Funding is provided through the General Appropriations Act through proviso language for Crisis Pregnancy Centers.

During the 2016 state legislative session, funding was increased to a total of $4,000,000 and proviso language was added to include wellness services. The funding and proviso was included again during the 2017 legislative session. The program piloted wellness services, such as well woman exams for nonpregnant women 18 and older (available to uninsured women who have a state-issued photo ID). An STI testing pilot project also took place. The project serves men and women, minors, and adults.

During the 2018 legislative session, HB 41 codified the program into law. The Department's MCH Section promotes the availability of the services to the Florida Association of Healthy Start Coalitions and to the county health departments as a referral source.

Reduction of maternal death is a national and state priority. Florida's Pregnancy-Associated Mortality Review is an ongoing system of surveillance that collects and analyzes information related to maternal deaths to promote system improvements through evidence-based actions aimed at preventing future untimely deaths. Florida's PAMR team is a public-private partnership. Actions of the team include reports covering multiple years of review, which are beneficial for evaluating trends and proposing recommendations for change. In addition to monitoring annual data and trends, select topics are chosen for further analysis to obtain a more complete understanding of a particular issue or condition and promote the development of targeted actions that may prevent future deaths. The FPQC is one method that is used for moving recommendations to action through quality improvement projects. The Department uses Title V funding for four regional part-time nurse abstractors (as needed), an epi staff for data analysis, and additional staff as needed to support the statewide volunteer PAMR team.

A recurring recommendation from the PAMR team is to stress the importance of a woman receiving education on preconception health and the need to have a medical home to manage chronic disease processes and to maintain optimal weight. Florida's PAMR data also notes that non-Hispanic black women are significantly more likely to die from pregnancy complications compared to non-Hispanic white and Hispanic women. Between 2007 and 2016, the pregnancy-related mortality ratio for non-Hispanic black women was significantly higher than for non-Hispanic white and Hispanic women. In response to issues determined by PAMR, the MCH Section collaborated with the Bureau of Chronic Disease prevention to analyze data that will enable the Department to identify strategies to increase the number of preventative services for women of reproductive age.

The PAMR Action Subcommittee was formed to develop timely messages and action items, to support initiatives

related to preventing maternal deaths in Florida titled Urgent Maternal Mortality Messages for Providers. The messages for providers contain information on risk assessment and counseling prior to delivery and in the interconception period and are guided by the professional recommendations from the quarterly statewide PAMR review. Distribution of the messages is accomplished through Florida professional organizations such as the American College of Obstetricians and Gynecologists, District XII; American College of Nurse Midwives; FPQC, and others. The messages distributed to providers are on the topics of hemorrhage-placental disorders and peripartum cardiomyopathy. A third message is currently in development on maternal morbidity.

The Department also published briefs on PAMR findings that were distributed to professional organizations through the PAMR team representatives and posted on the Department website:

- *Florida's Pregnancy-Associated Mortality Review 2016 update*
- *Pregnancy-Related Deaths due to Hemorrhage, 2003-2015*
- *Assessing Prenatal Risk Screening and Severe Maternal Morbidity in Florida 2010-2014*
- *Florida Maternal Substance Use Deaths, 2005-2016*

The Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) curriculum, an evidence-based program for smoking cessation, has been incorporated in the Healthy Start program and coding specifications for smoking cessation have been revised to measure SCRIPT implementation. From the time SCRIPT was adopted as the tobacco cessation counseling intervention, provider training has been revised based on feedback from staff.

The Department's MCH Section partnered with the March of Dimes and Florida's Prematurity Prevention Partnership project using Title V to co-fund nine community teams in a project with the Healthy Start Coalitions as the community leads. The purpose of the project was to reduce preterm births and reduce racial and ethnic disparities in preterm births. The community projects were tasked with creating meaningful, cross-sector, multidisciplinary approaches designed to address one or more of the following elements: preconception health; ensuring appropriate preventative treatment for women at-risk of preterm birth; discouraging early elective deliveries and preventing unintended pregnancies; and promoting optimal birth spacing. The implemented projects must be evidence-based or research-informed. In addition, Title V funding was budgeted to establish an OPS position to work with the March of Dimes to expand, enhance, track, and evaluate the community team's projects and ensure they are aligned with proven interventions to reduce preterm birth. The position will also assist with the statewide Florida Prematurity Prevention Partnership and provide assistance to the Chair of the Prematurity Prevention Workgroup. The Chair is held by the Department's Bureau Chief of Family Health Services for a two-year commitment. The Department established a Memorandum of Agreement between the Department and the March of Dimes.

An emerging issue is the opioid crises. MCH Section staff are participating as team members for the Policy Academy on Pregnant Women with Opioid Use Disorders in Depth Technical Assistance project with the National Center for Substance Abuse and Child Welfare. Florida's Department of Children and Families (DCF) serves as the lead agency, as they are the recipient of the SAMHSA grant. The goals are to:

- Ensure any pregnant woman in a substance use disorder (SUD) program during their pregnancy will be care coordinated in a system of care by Florida's Healthy Start program and DCF Child Welfare and will enter the hospital with an initial plan of safe care. These actions will be coordinated with the hospital and MMA plans as appropriate.
- Ensure any mother in SUD treatment with an infant (under the age of 1) has a plan of safe care and is working the plan including referrals to early intervention.
- Ensure women who give birth to infants who are identified as substance affected, have entry to behavioral health treatment and services and are coordinated with Healthy Start, MMA plans and/or Child Welfare as appropriate.
- Ensure treatment components of the plan of safe care for women entering behavioral health treatment after

giving birth to a substance affected infant are implemented and coordinated with Healthy Start, MMA plans and/or Child Welfare as appropriate.

These goals will not only help improve Florida's maternal and infant birth outcomes, but also aid in the state's response to the opioid crises.

Deaths related to substance use accounted for 30 percent of all non-pregnancy-related maternal deaths in 2016 in Florida, an increase from 23 percent in 2015. Although substance overdose deaths are not typically categorized as pregnancy-related, the PAMR team deemed it necessary to start reviewing and analyzing some of the cases where the death occurs during pregnancy and involves substance abuse. Reviewing these cases allows the PAMR case review team to make recommendations, such as the need for community services and treatment facilities for pregnant women with substance use or abuse problems. A PAMR subcommittee has recently formed to discuss the relation between substance abuse and mental health, as well as the need to include a mental health discipline on the PAMR case review team.

In addition to contracting with the state Healthy Start Coalitions, the MCH Section provided oversight and monitoring of the following contracts to address maternal and women's health priorities:

- Contracts with 11 Fetal Infant Mortality Review (FIMR) projects through the Healthy Start program to provide for the implementation of FIMR services to address the behavioral, environmental, and structural processes that may impact fetal and infant deaths, to learn more about why infants die and to propose recommendations for change. These contracts are funded with Title V.
- Contract with the Family Health Line to provide counseling, information, and referrals related to women, pregnant women, and child health issues for all callers in Florida through a toll-free hotline. Services will be consistent with the individual needs of each caller. This contract is funded through Title V.
- Contract with the Ounce of Prevention Fund of Florida to identify, fund, and evaluate innovative prevention programs for at-risk children and families and to raise awareness of maternal and child health initiatives such as Text4baby, Healthiest Weight, safe sleep, and Reach Out and Read campaigns throughout the state, with a focus on television and radio advertisements. This contract was funded through general revenue.
- Contract with the Florida Pregnancy Care Network to establish, implement, and monitor a comprehensive system of care through subcontracts that provide pregnancy support services that solely promote and encourage childbirth to women who suspect or are experiencing unplanned pregnancies. Services will include employability skill training to clients through the *Win at Work* program, a program that addresses work equity. This contract was funded through general revenue.
- Contract with the FPQC to engage perinatal stakeholders to improve maternal and infant health outcomes through design, implementation, and evaluation of processes, and to enhance quality improvement efforts. This contract was funded through Title V.
- Contract with the Florida Association of Healthy Start Coalitions to implement the evidence-based Nurse-Family Partnership home visiting model, with the intent to strengthen and improve the coordination of client support services and provide model-specific services to improve benefits for at risk populations. This contract was funded through general revenue but was not appropriated funds during the 2018 Legislative Session.

Promoting tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children is the second priority that falls within the Women's Health Domain. We selected NPM 14.1 Percent of women who smoke during pregnancy to address this priority.

In Florida, 13.3 percent of women reported smoking in 2016. Smoking during pregnancy increases the risk of miscarriage and certain birth defects such as cleft lip or cleft palate. It can also cause premature birth and low birth

weight and is a risk factor for SIDS. Secondhand smoke exposure doubles an infant's risk of SIDS and increases a child's risk of respiratory infections and common ear infections. Children with asthma who are exposed to secondhand smoke are likely to experience more frequent and more severe attacks, which can put their lives in danger.

The MCH Section continues to collaborate with the Bureau of Tobacco Free Florida on the promotion of program services to reduce tobacco use. Media messaging was distributed to all the counties in Florida through county health departments or community based organizations. Paid media advertisements were run in Miami, Tampa, Jacksonville, Orlando, and Tallahassee and capitalized on the *How to Quit* campaign. The number of anti-tobacco impressions for both cessation and prevention media (paid and earned) totaled 3,691,799,696.

There are continuing efforts with the airing of the most successful TV and radio media advertisements (as identified by Tobacco Free Florida Media Evaluation) tagged with thefactsnow.com. This is ongoing through the end of December 2020.

The Florida Association of Healthy Start Coalitions continued to promote SCRIPT as the primary smoking cessation program for pregnant women in Florida. Program specific revisions that increased the emphasis on practical application knowledge and skills in tobacco cessation and in using the curriculum with clients were implemented to the train-the-trainer guidelines. As a result, 82 percent of survey respondents indicated they now know enough about the SCRIPT curriculum to feel confident in supporting families with smoking cessation.

An evaluation of the SCRIPT and the Baby and Me Tobacco Free programs was completed. This evaluation found that SCRIPT follows an evidence-based program that guides women through the 5 A's approach, motivation through carbon monoxide readings, and utilization of self-help materials. The evaluation also found that in Florida, SCRIPT has been implemented throughout the state and there is evidence to suggest the program can produce a satisfactory rate of reduction and abstinence at the statewide level commensurable to smaller scale adoption. While the Baby and Me Tobacco Free program is more costly than SCRIPT, it provides postpartum relapse support that the SCRIPT program does not.

Healthy Start Coalitions have incorporated evidence-based smoking cessation programs into their curriculum, and Family Health Line staff have been trained on the SCRIPT program to increase referrals to Healthy Start and SCRIPT.

Women/Maternal Health - Application Year

The state priority need for the Maternal/Women's Health Domain is to improve access to health care for women to improve preconception and interconception health, specifically women who face significant barriers to better health.

The national performance measure selected for this priority was NPM 1: Percent of women with a past year preventive medical visit. The Department has identified objectives and strategies to improve the health of Florida's women.

Using a broader, more inclusive, and more realistic way to impact women's health and the health of the entire community, the Department has reassessed, updated, and realigned the strategies and objectives to address the state priority to improve access to health care for women and to improve preconception and interconception health, specifically women who face significant barriers to better health.

Pregnancy provides an opportunity to promote women's overall health and establish a strong foundation for children's health. A child's health during the prenatal, infancy, and early childhood periods influences his or her health later in life. The Department, through the state's Healthy Start program, provides care coordination services to pregnant women at risk for preterm or low birth weight infants. This is an optimal opportunity to ensure pregnant women receive prenatal care, including screening for conditions such as gestational diabetes, monitoring for potential complications, and education to encourage healthy behaviors such as smoking cessation and healthy eating.

Preconception health provides opportunities to promote the health of women before they become pregnant through improved access to health care, whether it be through an actual well-care visit or through services offered through the Department's other programs such as diabetes prevention and breast or cervical cancer screening. With half of all U.S. pregnancies unplanned, preconception health and health care are important for all people of reproductive age. Primary care for women encompasses screening and assessment, health promotion and counseling, and brief interventions or referrals for additional services when warranted.

The Department will purposefully breakdown internal silos and better integrate existing Department programs and services for women, and share those resources and educational opportunities through the Healthy Start program and other contracted providers of services for women and men of reproductive age.

The Department will continue to build and strengthen state and community partnerships to develop comprehensive systems of care for women and use data to inform program development and policy change. Partnerships between Florida's Title V MCH program and other state and community agencies such as Florida's Medicaid agency; providers; home visiting programs including the MIECHV program; local health departments; and community health centers are critical to developing and advancing comprehensive preconception health efforts at the state and local level as well as the overall system of care for women.

Strong state leadership and an ongoing structure such as the Department's State Health Improvement Plan, the integrated county health departments, and the Florida Perinatal Quality Collaborative are core elements of sustained success and the ability to make improvements to policies, programs, and services for not only low-income women and their families but all women and families in Florida.

The Department will continue to use Title V funding to provide interconception care (ICC), which is not reimbursable by Medicaid, through the Healthy Start program. Now that the ICC curriculum has been developed, with staff trained and implemented statewide, Healthy Start contract management staff at the state level will closely monitor the

number of women served. Additionally, a plan is in development to evaluate the implementation of the ICC curriculum. The purpose of the evaluation is to assess how consistently and accurately the care coordinators are delivering this new standardized curriculum and program across the counties/coalitions. The following are two overarching evaluation questions: (1) Are the care coordinators comfortable with the new standardized curriculum and pathway? and (2) Are the care coordinators implementing the curriculum with fidelity? The former question seeks to determine whether the care coordinators are comfortable with administering the new standardized curriculum and pathway in terms of the quality of training they received, their self-perceived comprehension of the different components of the pathway and curriculum, and their overall self-assessed familiarity with the content. The latter question seeks to determine how consistently the care coordinators are delivering the curriculum: are they implementing the curriculum with fidelity or loyalty to the standardized curriculum, are they carrying out each component as it is intended, etc.

Title V funding will continue to be provided through Schedule C and a Statement of Work to all 67 county health departments to provide well-woman preventative health visits; prenatal care; education for chronic disease management and prevention for pregnant women; preconception health counseling; reproductive health services; dental care services for pregnant women and children with an emphasis on children up to age 6; and activities that promote access to care, health literacy, community engagement and/or establishment of policies that positively influence social and economic conditions to address the social determinants of health.

The Department will continue the contract with the FPQC to implement the postpartum LARC quality improvement initiative. The initiative will end March 2019, with the goal to have at least 80 percent of participating hospitals able to provide immediate postpartum LARCs.

The Department's MCH Section will continue to contract with the Florida Pregnancy Care Network to implement the Department's Florida Pregnancy Support Services Program. The program is a network of nonprofit crisis pregnancy centers that provide support and assistance to women, men, and their families faced with difficult pregnancy decisions. Services include free pregnancy tests, peer counseling, and referrals; and most of the centers offer classes on pregnancy, childbirth, parenting, and personal finance management. Funding is provided through the General Appropriations Act. During the 2018 legislative session, HB 41 codified the program into law. The program also provides wellness services such as well woman exams for non-pregnant women 18 and older (available to uninsured women who have a state-issued photo ID) and STI testing. The Department provides technical support to the program on evidence based models and promotes the availability of the wellness services to the Florida Association of Healthy Start Coalitions and to the county health departments as a referral source.

The Department will continue to use Title V funding for four regional part-time nurse abstractors (as needed), an epi staff person for data analysis, and additional staff as needed to support the statewide volunteer PAMR team. Reduction of maternal death is a national and state priority. Florida's Pregnancy-Associated Mortality Review is an ongoing system of surveillance that collects and analyzes information related to maternal deaths to promote system improvements through evidence-based actions aimed at preventing future untimely deaths. Florida's PAMR team is a public-private partnership. Actions of the team include reports covering multiple years of review, which are beneficial for evaluating trends and proposing recommendations for change. In addition to monitoring annual data and trends, select topics are chosen for further analysis to obtain a more complete understanding of a particular issue or condition and promote the development of targeted actions that may prevent future deaths. The FPQC is one method that is used for moving recommendations to action through quality improvement projects.

A recurring recommendation from the PAMR team is to stress the importance of a woman receiving education on preconception health and the need to have a medical home to manage chronic disease processes and to maintain optimal weight. Florida's PAMR data also notes that non-Hispanic black women are significantly more likely to die

from pregnancy complications compared to non-Hispanic white and Hispanic women.

The PAMR team will continue to develop timely messages and action items, to support initiatives related to preventing maternal deaths in Florida and develop briefs on PAMR findings to distribute to professional organizations through the PAMR team representatives, and post the messages on the Department website.

The Department's MCH Section will continue to partner with the March of Dimes and Florida's Prematurity Prevention Partnership project using Title V to co-fund nine community teams in a project with the Healthy Start Coalitions as the community leads. The project began in 2017 and will continue to 2019. The purpose of the project is to reduce preterm births and reduce racial and ethnic disparities in preterm births.

Using Title V funding, an OPS position will be placed at the Florida March of Dimes to expand, enhance, track, and evaluate the community team's projects and ensure they are aligned with proven interventions to reduce preterm birth. The position will also assist with the statewide Florida Prematurity Prevention Partnership and provide assistance to the Chair of the Prematurity Prevention Workgroup. The Chair is held by the Department's Bureau Chief of Family Health Services for a two-year commitment.

MCH Section staff will continue to serve on the core team for the Policy Academy on Pregnant Women with Opioid Use Disorders In-Depth Technical Assistance Project with the National Center for Substance Abuse and Child Welfare. Florida's Department of Children and Families (DCF) serves as the lead agency as they are the recipient of the SAMHSA grant.

The MCH program will continue to collaborate with the Bureau of Tobacco Free Florida to look at Florida's data more closely regarding the interaction between socioeconomic status and race on birth outcomes as they relate to smoking and preterm birth, particularly among black women. There are racial and ethnic differences in the age of onset of smoking with black women initiating smoking later than white women. Prevention interventions should continue beyond adolescence well into the adult years, especially for black women.

The Tobacco Free Florida program has spent more than 10 years bringing awareness to the dangers of tobacco, while also providing free resources that have helped tens of thousands of Floridians to quit. The program has made remarkable progress in helping reduce tobacco use across the state. Today, there are 451,000 fewer smokers in Florida, despite the growing population.

However, when it comes to tobacco use and exposure to secondhand smoke, there are still many geographic and demographic inequalities across our state. Nearly 2.5 million adults in Florida, 15.5 percent of the adult population, still smoke cigarettes.

There are large populations of Floridians, including many children, for whom tobacco use and exposure to secondhand smoke is a daily fact of life. These groups are disproportionately impacted by the health burden of tobacco use, which is especially high among certain subpopulations, including racial and ethnic minorities, low-income individuals, the LGBT community, and those with mental health conditions.

For example, smoking among white, non-Hispanic adults in Florida has declined since 2012, but smoking among blacks and Hispanics in Florida has not changed significantly. Lower income cigarette smokers suffer more from diseases caused by smoking than smokers with higher incomes. Tobacco use is higher among Florida adults who are not heterosexual as compared to heterosexual adults. Adults reporting poor mental health have higher smoking rates than adults reporting good mental health.

It's not a coincidence that these disparities in tobacco use exist. The tobacco industry has a long history of heavily marketing its products to vulnerable populations. There is a higher density of tobacco retailers in communities with higher percentages of blacks, Hispanics, people living below the poverty line, or women older than 25 without a high school diploma.

Studies have found nearly double the number of tobacco retailers near where smokers with serious mental illnesses live, versus near where other members of the general population live. Tobacco companies advertise at pride festivals and other LGBT community events and contribute to local and national LGBT and HIV/AIDS organizations.

The Department will begin researching ways to provide postpartum cessation or relapse support in addition to the SCRIPT program. The evaluation of SCRIPT found that SCRIPT efficacy has only been examined through 90 days postpartum, potentially falling short of long-term support for mothers postpartum. By incorporating a postpartum support program, women in the interconception period are reached as well.

The Department continues to promote Tobacco Free Florida's *Quit Your Way*. The Florida Quitline is available 24 hours a day, seven days a week, offering telephone counseling in English, Spanish, and other languages through a translation service. Pregnant tobacco users who are ready to quit receive expanded services including 10 counseling sessions, and with a medical release they may receive a two-week starter kit of nicotine replacement therapy. Self-help materials are also provided by mail.

Tobacco users may also access resources to help them quit through Florida's WebCoach online service. Tobacco users can plan their quit date and even receive nicotine replacement therapy through the free online service. The telephone and online services also provide another feature to help tobacco users quit, Text2Quit. Text2Quit is a new digital service that texts positive messages to tobacco users before, during, and after they quit.

The MCH section will collaborate with the Bureau of Tobacco Free Florida to update the www.tobaccofreeflorida.com website with information relevant to pregnant women. This will include information on quit resources available during pregnancy and information on the effects of smoking during pregnancy and on the baby once born.

The Department will continue to collaborate with the Bureau of Tobacco Free Florida to educate residents on the negative effects of tobacco through a media campaign utilizing proven messages to encourage tobacco cessation. The Bureau of Tobacco Free Florida utilizes media housed in the CDC's resource center, so the campaign's $21 million budget is focused primarily on media placement. The Tobacco Free Florida brand has over a 90 percent brand recognition.

County health departments, Healthy Start Coalitions, and Department staff will continue to monitor prenatal smoking indicators and compliance with guidelines on counseling pregnant women and women of childbearing age on the dangers of tobacco use and second-hand smoke.

Family planning providers across the state will screen their clients for the extent of tobacco use, and provide information on Florida's *Quit Your Way*. The Department will continue to encourage all health care providers to counsel women of childbearing age and all pregnant women on the dangers of tobacco use as well as the dangers of secondhand smoke. The Department will also continue to monitor compliance with the chapter of the *Healthy Start Standards and Guidelines* that focuses on tobacco cessation.

The Department is committed to helping Florida residents in all corners of the state reach their fullest health potential by living tobacco free lives.

In addition to initiatives previously described, the Department will continue to support staff with Title V funding to provide oversight and monitoring of the following contracts (discussed more fully in the Annual Report section) to address maternal and women's health priorities:

- Contracts with 11 Fetal Infant Mortality Review (FIMR) projects to provide for the implementation of FIMR services.
- Contract with the Family Health Line, a toll-free hotline to provide information and referrals on maternal and child health topics.
- Contract with the Ounce of Prevention Fund of Florida to identify, fund, and evaluate innovative prevention programs.
- Contract with the FPQC to engage perinatal stakeholders to improve maternal and infant health outcomes at the systems level.

Perinatal/Infant Health

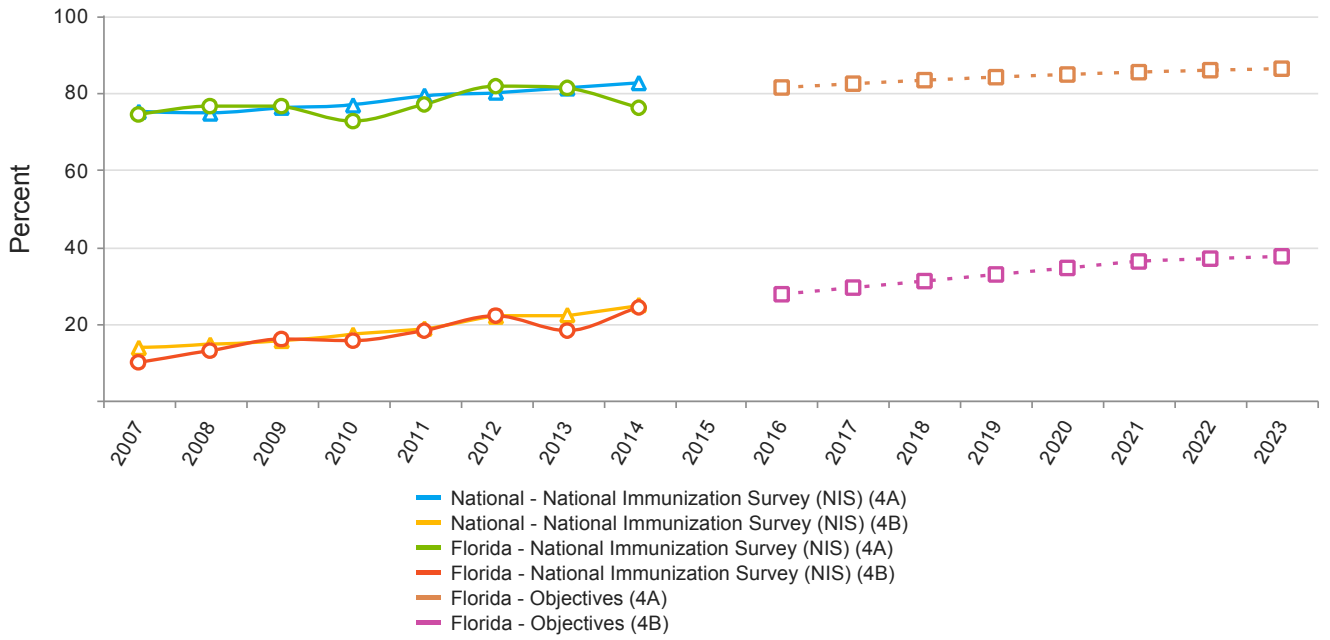
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	6.2	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	1.8	NPM 4 NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	81.2	NPM 4 NPM 5

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Baseline Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	**2017**
Annual Objective	81.3	82.3
Annual Indicator	81.1	76.1
Numerator	171,099	155,283
Denominator	210,888	203,992
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	83.2	84.0	84.7	85.3	85.8	86.2

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	**2017**
Annual Objective	27.7	29.4
Annual Indicator	18.4	24.3
Numerator	37,940	49,156
Denominator	206,047	201,974
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	31.1	32.8	34.5	36.2	36.9	37.5

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - The number of birthing hospitals implementing steps to becoming a Baby Steps to Baby Friendly hospital or implementing steps to achieve a Florida Breastfeeding Coalition's Quest for Quality Maternity Care Award

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		42
Annual Indicator	41	42
Numerator		
Denominator		
Data Source	Chronic Disease Program	Chronic Disease Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

ESM 4.2 - The number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	19.0	20.0	21.0	22.0	23.0

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
Baseline Indicators and Annual Objectives

NPM 5A - Percent of infants placed to sleep on their backs

FAD for this measure is not available for the State.

State Provided Data		
	2016	2017
Annual Objective	78.3	73.3
Annual Indicator	69.5	74
Numerator		
Denominator		
Data Source	FL PRAMS Data	FL PRAMS Data
Data Source Year	2014	2015
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	74.5	75.4	76.3	77.1	77.9	78.7

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	78
Numerator	
Denominator	
Data Source	FI PRAMS Data
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	82.0	83.0	84.0	85.0	86.0

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	60
Numerator	
Denominator	
Data Source	FI PRAMS Data
Data Source Year	2015
Provisional or Final ?	Provisional

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	62.0	63.0	64.0	65.0	66.0

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - The number of birthing hospitals implementing steps to become Safe Sleep Certified

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		15
Annual Indicator	10	13
Numerator		
Denominator		
Data Source	Maternal and Child Health Section	Maternal and Child Health Section
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

ESM 5.2 - The number of birthing hospitals that are Safe Sleep Certified

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	17.0	19.0	21.0	23.0	25.0

State Action Plan Table

State Action Plan Table (Florida) - Perinatal/Infant Health - Entry 1

Priority Need

Promote breastfeeding to ensure better health for infants and children and reduce low food security.

NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objectives

1. By December 31, 2021, increase the number of Baby-Friendly Hospitals from 10 (2017) to 20.

2. By December 31, 2021, increase the number of breastfeeding-friendly work places from 111 (2017) to 220.

3. By December 31, 2021, increase the number of breastfeeding-friendly early care and education programs from 230 (2017) to 300.

4. By April 30, 2019, increase the number of very low birth weight infants in Florida's NICUs who receive at least 50 percent of their feedings as their mother's own milk at discharge from 45.7 percent (2013) to 68.6 percent.

Strategies

1a. Using the Florida Healthy Babies Initiative, develop a plan to encourage hospitals to establish policies and protocols in support of breastfeeding and becoming a Baby Steps to Baby Friendly hospital or a Florida Breastfeeding Coalition's Quest for Quality Maternity Care Award recipient.

1b. Support the Bureau of Chronic Disease in their efforts to provide technical assistance to hospitals, work places, and early care and education program to implement breastfeeding policies and programs by partnering with the Florida Breastfeeding Coalition and the Florida Child Care Food Program.

2. Support the breastfeeding/pumping in the Department's workplace policy.

3. Improve access to breastfeeding support for Healthy Start clients not eligible for WIC.

4a. Contract with the FPQC to implement the Mothers Own Milk (MOM) hospital-based quality improvement initiative that promotes evidence-based interventions to increase the use of breast milk for VLBW infants in the NICU.

4b. Support the FPQC with helping hospitals participating in the MOM Initiative to implement key practice interventions.

4c. Support the FPQC in monitoring outcome measures from hospitals participating in the MOM Initiative.

ESMs	Status
ESM 4.1 - The number of birthing hospitals implementing steps to becoming a Baby Steps to Baby Friendly hospital or implementing steps to achieve a Florida Breastfeeding Coalition's Quest for Quality Maternity Care Award	Inactive
ESM 4.2 - The number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation.	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Florida) - Perinatal/Infant Health - Entry 2

Priority Need

Promote safe and healthy infant sleep behaviors and environments, including improving support systems and the daily living conditions that make safe sleep practices challenging.

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

1. By December 31, 2021 reduce percent of black mothers in Florida whose infant sleeps in bed with a parent or anyone else from 26.4 percent (2014) to 24.8 percent.

2. By December 31, 2021, increase percent of black mothers in Florida who placed their infant on their back to sleep from 56.4 percent (2014) to 58.4 percent.

Strategies

1a. Advance safe sleep behaviors among families and infant caregivers with an emphasis on disparate populations.

1b. Conduct a safe sleep survey of pediatricians, family practice physicians, pediatric nurse practitioners, birthing hospitals, and other medical providers practicing and/or located in Florida that provide services to pregnant women, postpartum women, and infants.

1c. Develop an evaluation plan for the implementation of the safe sleep survey.

2a. Implement a statewide Safe Sleep Certification model in birthing hospitals located in Florida.

2b. Using the Florida Healthy Babies Initiative, inventory and evaluate safe sleep activities currently implemented statewide.

2c. Partner with national organizations, such as the National Institute of Child Health Quality, to promote safe sleep initiatives and support local service providers (e.g. hospitals and social services) that interact with high risk populations.

ESMs	Status
ESM 5.1 - The number of birthing hospitals implementing steps to become Safe Sleep Certified	Inactive
ESM 5.2 - The number of birthing hospitals that are Safe Sleep Certified	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Safe infant sleep and breastfeeding are significant protective factors against infant mortality. From 2007 to 2016, breastfeeding initiation, for all races, increased from 77.6 percent to 86 percent. During this period, breastfeeding initiation percentages increased and the gap between the breastfeeding percentages for non-Hispanic black and white infants decreased. However, the percentages for non-Hispanic black infants are still the lowest of the racial/ethnic groups examined. Per the CDC, the 2011 percentage of exclusive breastfeeding at three months in Florida is low (38.9 percent) but comparable to that in the nation (40.7 percent). However, Florida is doing worse than the nation on breastfeeding support. The percent of live births occurring in Baby Friendly hospitals in 2017 was 17.3 percent in Florida and approximately 25 percent in the nation.

In Florida, sudden and unexpected infant death (SUID) consistently ranks in the top four leading causes of postneonatal infant death. In 2016, the rate was approximately one SUID per 1,000 live births in Florida for all racial and ethnic groups. However, non-Hispanic black infants experience rates that are consistently two times higher than the rates among other ethnic groups. From 2014-2016, most of SUID-related cases were due to unintentional injuries from suffocation or strangulation in bed (n=234 cases), with highest rates among non-Hispanic black infants.

The Department engaged in several activities through a variety of public-private partnerships to improve rates of breastfeeding initiation and duration. With Title V funding, the Florida Healthy Start Coalitions and the county health departments partner to provide needed services including: prenatal care, support services, and breastfeeding education and support to all participating pregnant women. Services provided to pregnant women encourage breastfeeding in the early postpartum period. These services also provide anticipatory guidance and support to prevent breastfeeding problems and address barriers to breastfeeding. Breastfeeding education and services provided to postpartum women promote the continuation and exclusivity of breastfeeding and enable women to overcome any perceived or actual breastfeeding problems.

The Department participated in the Safe Sleep CoIIN. The CoIIN aligns with the Department’s State Health Improvement Plan to ensure health equity; eliminate health disparities; and implement best programs, policies, and practices to reduce infant mortality. Safe sleep for infants is a priority strategy. In 2015, Florida chose the Sarasota Safe Sleep Initiative as the pilot project for the Safe Sleep CoIIN. The initiative continues to provide safe sleep education to all child care centers in Sarasota County on safe sleep practices. Additionally, the Initiative provides Safe Sleep Kits to needy families in the county through Child Protective Investigators and Healthy Start Care Coordinators.

Florida began the development of the Florida Safe Sleep Hospital Certification Project, a partnership with birthing hospitals to train health care professionals, who may not always provide current information or model correct safe sleep practices. The activities of the project are to: train hospital staff and provide materials for distribution to patients; encourage each hospital to develop a Safe Sleep policy and submit an annual report on educational activities and staff compliance; and assess whether proposed activities address disparities.

Florida’s Safe Sleep Hospital Certification Project was chosen to participate in the 2017 Centers for Disease Control and Prevention and Harvard School of Public Health MCH Program Evaluation Practicum. The on-site practicum was completed January 2017. A final evaluation plan write-up, with consolidated findings and recommendations to the program, was a final product of the practicum and is being used as a resource as the project continues to develop.

The Department has established a SUID Workgroup. The purpose of the workgroup is to create a coordinated, integrated system of policies and practices, and align Title V activities with the Department’s State Health

Improvement Plan objectives, Agency Strategic Plan, and other safe sleep-related activities. The workgroup assists in the development and implementation of evidence-based, culturally, and linguistically appropriate strategies to promote safe sleep behaviors and safe sleeping environments. Membership includes representatives from several state agencies, Healthy Start Coalitions, medical personnel, the Florida Breastfeeding Coalition, the Florida SIDS Alliance, the Florida Hospital Association, and parents.

As a component of Florida's Healthy Babies Initiative, all 67 county health departments were given a base amount of Title V funding and required to conduct or enhance a data analysis project on infant mortality (including an environmental scan of existing pertinent programs) and to host one or more community meetings to increase awareness of disparities in infant deaths and the role of social determinants of health. Based on discussions and outcomes of community meetings, each county health department was required to submit an action plan to address disparities in infant mortality. Action plans were reviewed by subject matter experts in the program offices through a lens of identifying proposed strategies and best practices that could be applied and have statewide impact. Feedback was provided to each county on their action plan. The most commonly proposed strategies and themes identified in the counties' local plans were: breastfeeding, smoking reduction among pregnant women, safe sleep, and increased WIC access and utilization.

A multiphase marketing contract with a university partner in Florida was initiated to complete a literature review to identify and evaluate previous research and evidence-based practices related to infant mortality and associated protective factors (e.g. breastfeeding, safe sleep, smoking cessation for pregnant women, obesity in pregnancy, etc.) among disparate populations.

Multiple safe sleep programs in Florida communities provided safe sleep information, cribs, and infant onesies with safe sleep messages this past year. A toolkit for physicians that included safe sleep information was distributed in some parts of the state. With grant funding of $50,000 from WellCare, cribs were distributed in each county in the state. A standardized education component focusing on the risks associated with unsafe sleep practices and a safe sleep environment checklist was completed with each crib recipient.

The Department, the Department of Children and Families, other Florida government agencies, state officials, nonprofit organizations, and first responders came together to launch the Safe Sleep Campaign. The campaign included public outreach as well as free online training and materials for Florida's first responders to promote safe sleep practices during routine calls and interactions with the public. The continuing campaign encourages the public to donate new Pack 'n Plays (portable cribs) to designated locations, which are then distributed to needy families through the local Healthy Start Coalitions and participating home visiting programs.

The Department conducted a health problem analysis of contributing factors to SUID and developed a logic model at the state level to address these risk factors with outcome measures to assess strategy effectiveness. These two documents have been instrumental in the development of a state work plan to address SUID.

The Department contracted with the FPQC to develop and implement a breastfeeding project, Mother's Own Milk (MOM), in Florida's NICUs. The project is a hospital-based quality improvement initiative designed to promote best practices related to providing breast milk, especially to Florida's most vulnerable VLBW infants.

There are currently 25 Florida hospital NICUs participating in the MOM project. More than 70 participants from all 25 hospitals attended the MOM mid-project meeting in Orlando. With support of the Department and Title V funding, FPQC is helping hospitals participating in the MOM Initiative to implement the following key practice interventions:

- Provide maternal education and advocate for mother's own milk.
- Document a mother's informed decision to provide her own breastmilk to her newborn.

- Provide at least one lactation consultation within 24 hours of a NICU admission.
- Initiate breast pumping within six hours after the birth of the newborn.
- Provide and ensure access to breast pumps to mothers of babies in the NICU.
- Provide breastfeeding education and measure competencies for hospital staff.
- Provide education to mothers on hand expression, pumping, and colostrum collection.
- Provide mother's own milk by the time the newborn is 3 days old.
- Have a process in place to monitor mother's own milk supply.
- Standardize guidelines for skin-to-skin care, weighing, monitoring non-nutritive breastfeeding, transitioning to nutritive breastfeeding, using nipple shields, and developing discharge feeding plans and follow-up.

The mid-project meeting provided hospitals a chance to share their successes and challenges in implementing the evidence-based, best practice interventions of the MOM Initiative.

FPQC is monitoring the following outcome measures from hospitals participating in the MOM Initiative:

- Intent to provide mother's own milk
- Mother's own milk volume ≥ 500ml/day at 7 days old, 14 days old, and 28 days old
- More than 50 percent of feeding volume comprised of mother's own milk at 7 days old, 14 days old, 28 days old and by discharge
- Nutritive breastfeeding within seven days of discharge

A MOM semi-annual data report shows the number of VLBW infants receiving at least half of their feeding as their mother's milk increased from 38 percent to 50 percent by July 2017. A final data report will be provided by FPQC at the end of the initiative.

The Baby Steps to Baby Friendly (BSBF) project, a component of Florida's Healthy Babies Initiative, has motivated and incentivized hospitals in Florida to improve maternity care breastfeeding practices and policies and achieve recognition. Of the 41 counties in Florida with birthing hospitals, 32 have participated in a least one phase of the Baby Steps to Baby Friendly (BSBF) Project. A total of 22 counties participating in at least one phase of BSBF had a breastfeeding initiation rate that was significantly lower than the state rate in 2015. Of the 116 eligible birthing hospitals in Florida, 66 have participated in at least one phase of BSBF.

Florida's Enhanced Breastfeeding Project is addressing health inequities to mitigate breastfeeding disparities among vulnerable populations including rural, minority, and low socioeconomic communities. There are 20 county health departments implementing two to three evidenced based strategies within their local communities as part of the project.

Qualitative review of hospital success stories and anecdotal evidence have shown that the BSBF project has also served as a catalyst for community engagement. New breastfeeding support groups in rural areas and local breastfeeding coalitions have been established because of the project.

Duration of breastfeeding is an identified concern, with known contributing factors including lack of breastfeeding support in the workplace. Having access to proper equipment, such as an electric breast pump for mothers returning to work, is essential to breastfeeding success. A statewide commitment to give babies the best start is evidenced by efforts from Florida's Medicaid agency. As of June 20, 2016, Florida Medicaid's Durable Medical Equipment Fee schedule covers breast pumps, demonstrating a commitment to promote the best nutrition and the best start for Florida's babies.

Title V funding was provided to the Florida Breastfeeding Coalition to enhance current efforts and expand capacity for projects related to breastfeeding promotion.

Modeling breastfeeding friendly practices in the workplace will become more evident in the coming year as the following strategies come to fruition. The Department piloted a Breastfeeding at Work project. Employees who are breastfeeding infants up to the age of 6 months are encouraged to bring their infants to the workplace with supervisory approval and contingent upon the safety of the work environment. The pilot demonstrates the Department's commitment to breastfeeding promotion and normalizes the daily aspects of infant care. This strategy will serve as an example to local health departments as well as public and private partners. The Department is in the process of approving a Health at Work Policy that incorporates standards for breastfeeding or pumping in the workplace.

MCH epidemiology staff housed in the MCH Section perform analysis of Department programs impacting the MCH population. One study showed the receipt of breastfeeding peer counseling services are associated with increased breastfeeding initiation and duration. Additionally, the study showed that non-Hispanic black participants are less likely to initiate breastfeeding and continue to breastfeed at 6 months. To address this issue, the MCH program is updating Florida's Healthy Start Standards and Guidelines to include the importance of personal, social, and cultural factors when providing breastfeeding education to clients.

Data from the 2013 Florida Pregnancy Risk Assessment Monitoring System (PRAMS) show that the percent of Florida women who initiate breastfeeding is higher, at 87.9 percent, than the Healthy People 2020 goal of 81.9 percent. However, duration drops quickly to 72.5 percent at 4+ weeks and to 52.4 percent at 12+ weeks. This survey is a valuable tool for recognizing trends and identifying a focus for breastfeeding promotion efforts. Survey data can be found at: http://www.floridahealth.gov/ percent5C/statistics-and-data/survey-data/pregnancy-risk-assessment-monitoring-system/_documents/reports/prams2013.pdf

Perinatal/Infant Health - Application Year

The Department has developed objectives and strategies to increase the number of breastfed infants as well as the duration they are fed breast milk. Breastfeeding promotion strategies have been incorporated into several initiatives through various community settings such as hospitals and childcare facilities. This will continue to be carried out through active partnerships between the county health departments and their communities, Florida's Healthy Start Coalitions, and other partners and stakeholders.

With funding from Title V, administered through the Florida's Healthy Babies Initiative, county health departments will continue to encourage and support hospitals in pursuing Baby Steps to Baby Friendly policies and practices. The project initially began in March 2015, with funding from the Preventive Health and Health Services Block Grant, through the Bureau of Chronic Disease Prevention.

The Department will continue to provide Title V funding to the Florida Breastfeeding Coalition to provide technical assistance

The Department will continue efforts to target the most vulnerable infants in our state by aiming to increase the number of VLBW infants who receive breast milk. Title V funds will continue to support the FPQC's hospital-based quality improvement project, the Mother's Own Milk (MOM) Initiative, by promoting-evidence-based interventions to increase the use of breast milk for VLBW infants in Florida's NICUs. The MOM Initiative will enter a sustainability phase starting July 1, 2018 through April 30, 2019. The sustainability phase will allow the FPQC, with support from the Department, to continue providing technical assistance, encouragement, and guidance to hospitals who participated in the MOM Initiative and are interested in continuing the ongoing efforts. By May 31, 2018, FPQC will develop a technical assistance plan, that includes phone conferences, webinars, and site visits, for hospitals participating in the MOM Initiative sustainability phase.

The Department is partnering with Dr. Stacy Scott, Executive Director of the Global Infant Safe Sleep Initiative, to initiate a working relationship with African-American Greek Organizations in Florida to strengthen our safe sleep promotion activities in African-American communities. The Department will support community efforts by providing resources, such as toolkits, materials, and supplies. County health departments with safe sleep and breastfeeding action plans will contribute to the execution of local efforts.

New evidence-based models to promote infant sleep behaviors and to support safe conditions are being pursued by the Department. MCH epidemiology staff will survey health care providers to determine knowledge of safe sleep resources and safe sleep education provided to their patients. The assessment of provider knowledge will determine barriers or knowledge deficits and guide targeted provider education and resource development.

The Department is in the process of developing a partnership with Cribs For Kids, Charlie's Kids Foundation, and the Florida Hospitals Association to implement the Florida Safe Sleep Hospital Certification Project. Cribs for Kids will administer the Safe Sleep Certification process, Charlie's Kids will disseminate Safe Sleep children's books, and the Florida Hospital Association will be a key partner in gaining access to birthing hospitals.

The Department is participating in the National Institute for Children's Health Quality's (NICHQ) National Action Partnership to Promote Safe Sleep Improvement and Innovation Network (NAPPSS-INN) Initiative. The purpose of NAPPSS-IIN is to make safe infant sleep and breastfeeding a national norm. The project is a five-year cooperative agreement running from July 2017 to July 2022. Through this effort, the Department, with the support of NICHQ, will secure partnerships within Florida communities to develop, pilot, and implement a safe infant sleep and breastfeeding safety bundle within hospitals, child care, and social services settings. We have built a roster of 14

leaders from public and private sectors in the state, including the Executive Office of the Governor, March of Dimes, the Florida Perinatal Quality Collaborative, the Florida SIDS Alliance, and the American College of Obstetrics & Gynecology to serve as members of our state's Community of Practice, which engages in a process of collective learning through the implementation of safe infant sleep and breastfeeding safety bundle.

The objective of the project is to move from campaigns to conversations in promoting safe infant sleep and breastfeeding and translating evidence-based practices into "safety bundles" to improve the processes of care and patient outcomes in safe sleep and breastfeeding. Specifically, the project aims to increase infant caregiver adoption of safe infant sleep practices as recommended by the American Academy of Pediatrics, as well as breastfeeding, by empowering champions for these protective behaviors within systems that serve at-risk families.

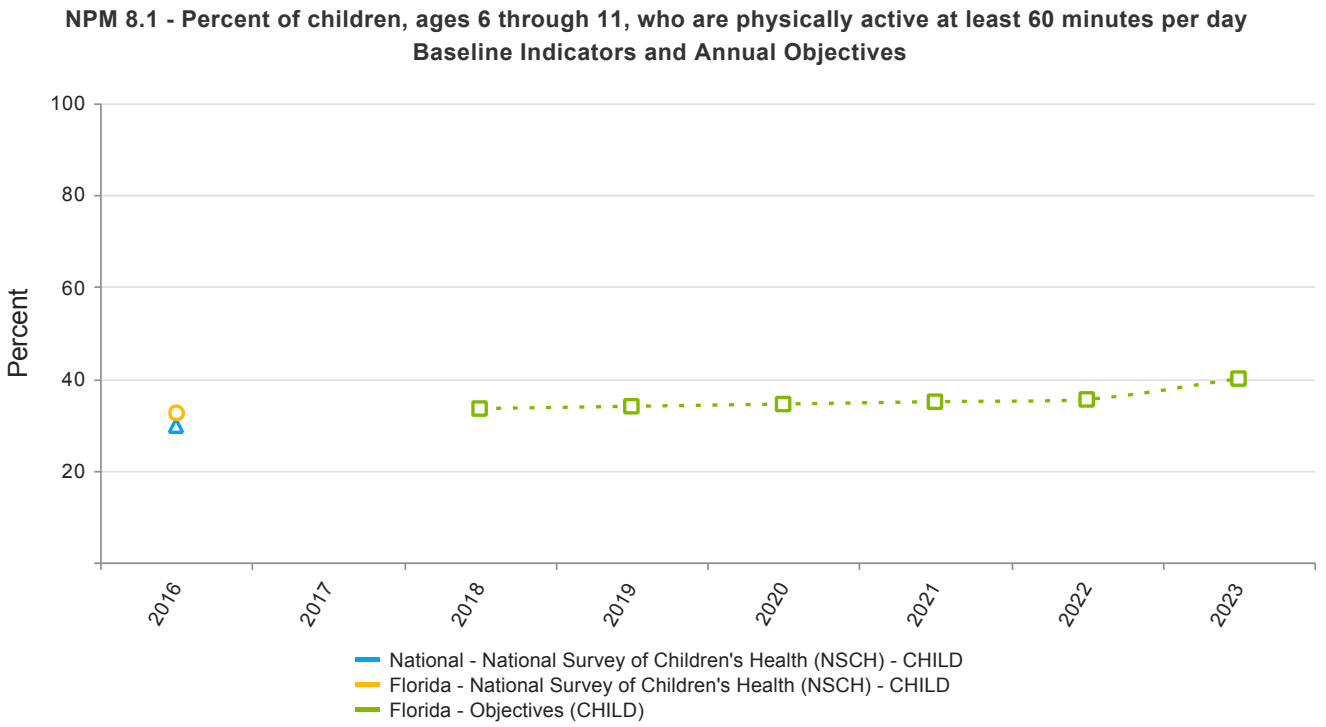
The data that we will use for tracking the third element of this national performance measure, *percent of infants placed to sleep without soft objects or loose bedding,* is currently being collected during the 2016–2019 Phase VIII of the Florida Pregnancy Risk Assessment Monitoring System (PRAMS). We should receive data for the first year of Phase VIII, 2016, by the end of 2018. Florida has no other local data source that would facilitate the assessment of this measure.

Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	86.7 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016	17.9 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	12.7 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2015	12.3 %	NPM 8.1

National Performance Measures



Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CHILD		
	2016	**2017**
Annual Objective		
Annual Indicator		32.5
Numerator		428,914
Denominator		1,321,058
Data Source		NSCH-CHILD
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	33.5	34.0	34.5	35.0	35.5	40.0

Evidence-Based or –Informed Strategy Measures

ESM 8.1.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	54.0	55.0	56.0	57.0	58.0

State Performance Measures

SPM 2 - The percentage of low-income children under age 21 who access dental care.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		37.4
Annual Indicator	35.9	37.4
Numerator	986,425	1,037,798
Denominator	2,745,598	2,774,485
Data Source	Florida Agency for Health Care Administration	Florida Agency for Health Care Administration
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	38.9	40.4	41.9	43.4	44.9	45.4

SPM 3 - The percentage of parents who read to their young child age 0-5 years

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		45.1
Annual Indicator	42.6	34.2
Numerator	545,146	435,455
Denominator	1,279,782	1,273,260
Data Source	2011/12 National Survey of Children's Health	2016 National Survey of Child Health
Data Source Year	2011/2012	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	34.7	35.2	35.7	36.2	36.7	37.2

State Action Plan Table

State Action Plan Table (Florida) - Child Health - Entry 1

Priority Need

Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment.

NPM

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Objectives

1. By December 31, 2021, increase the number of schools ever achieving the Healthier US Schools Challenge award from 507 (2016) to 800.

2. By December 31, 2021, increase the percentage of Florida's population within one mile of bike lane and/or shared use paths from 42 percent (2017) to 45 percent.

3. By June 30, 2019, increase the number of Florida counties where registered school nurses are implementing Healthy Lifestyle Interventions (5210-based) from seven to 15.

4. By June 30, 2019, increase the percentage of body mass index (BMI) intervention screening referrals for students at or above the 95th percentile that results in students receiving services from a healthcare provider from 31.6 percent (2016-17 baseline) to 36.6 percent. (This measure is the sum of completed referrals to healthcare providers and completed Healthy Lifestyle interventions by registered school nurses.)

5. Increase by 10 percent the number of Florida counties (school districts) that apply for recognition as a Florida Healthy District for the 2019-21 period compared to the number of districts that applied for the 2018-20 period.

Strategies

1. Promote/educate county school health programs about the use of the Healthy Lifestyle Intervention Individualized Healthcare Plan and coding this service data in the Department's Health Management System. Promote the Intervention on at least one School Health Services Program statewide conference call and during county School Health Program on-site monitoring meetings conducted by school health liaisons during the 2018–19 school year.

2. Promote/educate county school health programs on the requirements, application process, and benefits of becoming a Florida Healthy District on at least one School Health Services Program statewide conference call and during county school program onsite monitoring meetings conducted by school health liaisons during the 2018–19 school year.

3. Continue School Health Services Program involvement in the Florida Partnership for Healthy Schools (formerly the Florida Coordinated School Health Partnership), the Healthy District Collaborative, and the Interagency Collaborative by participating in meetings, conferences, and strategic planning.

4. Promote the Center for Disease Control and Prevention's Whole School, Whole Community, Whole Child approach by educating county school health programs on strategies to expand school health advisory committee representation, including student/parent involvement, on at least one School Health Services Program statewide conference call and during county school health program on-site monitoring meetings conducted by school health liaisons during the 2018–19 school year.

5. Promote policy, systems, and environmental approaches to increasing physical activity opportunities within the built environment for Floridians of all ages through coordination with local governments and stakeholders such as the Florida Department of Transportation, the Florida Recreation and Parks Association, East Central Florida Regional Planning Council, the Florida Department of Agriculture and Consumer Services, the Florida Department of Education and Florida Action for Healthy Kids.

ESMs	Status
ESM 8.1.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.	Active

NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

State Action Plan Table (Florida) - Child Health - Entry 2

Priority Need

Improve dental care access for children and pregnant women.

SPM

SPM 2 - The percentage of low-income children under age 21 who access dental care.

Objectives

1. By June 30, 2019 increase the number of low-income children under age 21 receiving a preventive dental service from a school-based sealant program from 94,000 children (SFY 2016-2017) to 98,700 children, an increase of 5 percent.

2. By September 30, 2019, increase the number of school-based sealant programs (internal or external) completing annual reports in FLOSS from 58 programs (SFY 2016-2017) to 61 programs.

3. By June 30, 2019, increase the number of schools reached by school-based sealant programs (internal or external) from 784 schools (SFY 2016-2017) to 823 schools, an increase of 5 percent.

Strategies

1. Partner with community agencies and organizations to improve data completeness related to statewide school-based sealant program efforts. Encourage participation in the FLOSS database and offer technical assistance as needed.

2. Increase the number of children participating in existing school-based sealant programs by implementing proven strategies to increase consent rate, such as educating parents, attending community events, and routine distribution of forms.

3. Improve the quality and sustainability of existing CHD school-based sealant programs by providing continued technical assistance and training and in-person site visits and program evaluations related to financial sustainability as requested.

State Action Plan Table (Florida) - Child Health - Entry 3

Priority Need

Address the social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies.

SPM

SPM 3 - The percentage of parents who read to their young child age 0-5 years

Objectives

1. By December 31, 2021, increase the number of partners and local county health departments participating in the Reach Out and Read program from 100 in 2017 to 120 total sites.

2. By December 31, 2021, increase the number of books distributed to parents and children through the Ounce of Prevention Fund of Florida from 26,612 in 2017 to 31,900 in 2021.

Strategies

1. Partner with local health departments in their childhood immunization, dental clinics, and well-child visits to encourage reading using the Reach Out and Read model, where a health professional distributes books to children at a well-child visit and emphasizes key reading strategies to parents (example: the importance of reading aloud to a child daily).

In 2016–17, Florida's pre-kindergarten through 12th grade student population numbered about 2.8 million students, residing in 67 counties that are geographically, socio-culturally, and economically diverse. Among this student population, there were 724,573 reported student health conditions, which included life-threatening allergies (35,327 students); asthma (199,088 students); cardiac conditions (14,098 students); diabetes (7,889 students); mental health conditions (21,436 students); and seizure disorder (19,955 students). Body mass index (BMI) screening results indicated that 347,972 students (61.6 percent) were at a healthy weight; whereas, a combined 193,809 students (34.31 percent) had BMI results at or above the 85th percentile (overweight and obese categories). At least eight Florida districts implemented a Coordinated School Physical Activity Program (CSPAP) component and at least two districts implemented adaptive CSPAP components.

The Department's School Health Program, within the Bureau of Chronic Disease Prevention (BCDP), continued its statewide leadership in ensuring the provision of health and health education services to children in all of Florida's public and participating nonpublic schools. The program provided oversight and technical assistance to all 67 county school health programs, including county health departments, local education agencies, and their community partners, pursuant to Florida statutes and the Florida Administrative Code.

Local county health departments, in collaboration with local education agencies and community partners, worked to ensure Florida's pre-kindergarten through 12th grade students had access to health services that assess, protect, and promote their health and ability to achieve their individual potential. During 2016–17, the school health program performed 34 on-site programmatic monitoring visits, two vision service provider contract monitoring visits, and conducted four statewide programmatic conference calls.

The Department and the Florida Department of Education (DOE) partnered and promoted implementation of the Coordinated School Health approach in Florida public schools. The BCDP worked with DOE's Office of Healthy Schools to support the Florida Partnership for Healthy Schools Healthy School District self-assessment and recognition program. As part of this collaboration, the school health program reviewed and scored the health services section of counties' applications.

In addition, the school health program continued to develop partnerships with the Florida School Health Association and the Florida Association of School Nurses and presented programmatic updates at their 2017 annual conferences. Also, the program continued its commitment to support the National Association of School Nurses (NASN) initiative, Stand Up and Be Counted, by providing 2016–17 state-level data for a national standardized minimum dataset of key school health indicators.

Each year, our school health program at the Central Office hosts a walking school bus event. During Walking School Bus events, adult volunteers ensure the safety of Florida High students (K-12) by walking them to school once a month. This activity helps promote physical activity and wellness for students and Department staff alike.

Oral health is essential to general health and well-being. There is a strong correlation between poor oral health status and other systemic diseases, such as diabetes, heart disease, respiratory disease, stroke, and preterm and low-weight births. Tooth decay (dental caries) is a transmissible, infectious oral disease resulting from an imbalance of multiple risk factors and protective factors over time. Though the prevalence and severity of tooth decay has declined among school-aged children in recent years, it remains a significant problem in some populations, particularly among certain racial and ethnic groups and low-income children.

Dental caries (tooth decay) remain the most common preventable chronic infectious disease among young children

and adolescents in the United States. Dental caries are five times more common than asthma. Nationally in 2015-2016, approximately 43.1 percent of youth age 2 to 19 had dental caries (untreated and treated decay) in their primary or permanent teeth. Among children age 6 to11, approximately 45.2 percent had dental caries and 15.3 percent had untreated decay, with rates for black and Hispanic children being higher than for white and Asian children. If dental decay is left untreated, it can cause pain and infection leading to problems with chewing, swallowing, speaking, and learning. These problems jeopardize children's physical growth, self-esteem, and capacity to socialize.

Poor oral health is also associated with missing school and poor school performance. It is estimated that U.S. children miss more than 51 million school hours annually due to dental problems. Children with poor oral health are three times more likely to miss school and four times more likely to perform poorly when compared to their healthy counterparts. Additionally, parents miss on average 2.5 days from work per year due to their children's dental problems.

A cost-effective way of preventing tooth decay are dental sealants. Dental sealants are thin protective coatings that adhere to the chewing surfaces of the back teeth (molars) and prevent the acid of leftover food particles from creating holes, or cavities, in the teeth. Dental sealants can prevent up to 80 percent of cavities and protect teeth for several years. While children with dental sealants have increased over time, low income children are 20 percent less likely to have them and are twice more likely to have untreated decay than high-income children. Barriers from receiving dental sealants or other dental care include the lack of access to dental services, dental care costs, and inadequate oral health literacy.

Oral health data are needed for ongoing surveillance, establishing the burden of oral health disease, and informing statewide programmatic planning efforts. To address the need for state level oral health surveillance data, the Florida Department of Health's Public Health Dental Program (PHDP) has established a surveillance system for monitoring oral health status, risk factors, and access to dental services among various populations. The PHDP has completed surveillance projects on third grade children (2013-2014), Early Head Start and Head Start children (2014-2015), and older adults in congregate meal sites (2015-2016). This is Florida's second statewide oral health surveillance of Florida's third grade children.

Title V supported the continued development and enhancement of the Public Health Dental Program's FLOSS Database. The two newest modules include the School-Based Sealant Program Module and the Oral Health Surveillance Module. The School-Based Sealant Program Module is being used by all agencies and programs in Florida to enter aggregate data and information regarding their local programs. The Public Health Dental Program (PHDP) collected data for the first time during fall 2017 to represent children served and services provided during school year 2016-2017. The system is accessible by both internal and external partners and serves as the true statewide data warehouse for this important public health dental measure for children. The Oral Health Surveillance Module is used to collect and validate data using the Basic Screening Survey Methodology, for populations such as preschool and school age children. The 2017-2018 Head Start Oral Health Screening Project used this new module for the first time to collect oral health indicators and consent form questions entered by external screeners in the field and then validated against paper records by PHDP staff. Using the FLOSS database for this data collection and validation has reduced data entry errors and improved overall data quality. During SFY 2018-2019, Title V funding will continue to support development of the FLOSS database to improve functionality, enhance data quality and accuracy, and meet the dynamic business needs of the PHDP and FLOSS users.

The Department's Public Health Dental Program released the *Oral Health Status of Florida's Third Grade Children 2016-2017* report.

Key Findings:

- Approximately one in four children (25.1 percent) had untreated decay.
    - The prevalence of untreated decay was highest for non-Hispanic black children (34.6 percent) and for children without any dental insurance (32.8 percent).
- Nearly half of children (45.5 percent) had dental caries (treated or untreated decay).
    - More than half of children from schools with the highest percent of students enrolled in free/reduced lunch had caries experience (52.2 percent).
    - Children reporting toothaches had the highest rate of dental caries experience (68.1 percent).
- Over a third of children (40.1 percent) had at least one dental sealant.
    - The prevalence of dental sealants was highest for children from schools with less than 25 percent of students enrolled in free/reduced lunch (52.5 percent).
- Early dental treatment need among Florida's third grade population was 20.6 percent.
- Urgent dental treatment need among Florida's third grade population was 3.0 percent.
- Children covered with private dental insurance had the lowest rate of each oral indicator of need and the highest rate of dental sealants compared to children who had Medicaid or no dental insurance.

Florida's overall third grade population estimates are in alignment with the Healthy People 2020 goals related to the prevalence of untreated decay, dental caries, and dental sealants among children ages 6 to 9. (Table 1).

Table 1. Oral Health Status of Florida's Third Grade Population compared to National Healthy People 2020 Goals

Oral Health Indicator	Florida's Status 2016-2017	National Target for Children 6-9 Based on Healthy People 2020 Goals
Dental Caries Experience	45.5 percent	49.0 percent
Untreated Dental Decay	25.1 percent	25.9 percent
Dental Sealants	40.5 percent	28.1 percent

The Department works to make continued progress to improve access to preventive dental care for children in Florida. Continued collaborative partnerships with school-based dental programs to share information on evidence-based prevention and early intervention practices facilitates the promotion of oral disease prevention efforts (dental SHAC development will be a primary l sealants) starting in school-aged children.

To increase the percentage of parents who read to their young children, Title V funding was provided to county health departments through Schedule C and a statement of work, with an option to create a reading rich environment in waiting room areas such as a child's reading table and chairs, a bookshelf, children's books, etc. Funds were also available to establish a Reach Out and Read (ROR) program. ROR is an evidence-based early intervention model that encourages literacy and school readiness. ROR gives young children a foundation for success by incorporating books into pediatric care and encourages families to read aloud together. ROR medical providers encourage families to read aloud and engage with their infants, toddlers, and preschoolers every day. Additionally, medical providers give books to children at more than 10 well-child visits from infancy until they start school.

Literacy is a known factor impacting the social determinants of health. Healthy People 2020 includes school readiness and literacy in the early and middle childhood domains and objectives.

As recommended by the American Academy of Pediatrics, ROR incorporates early literacy into pediatric practice,

equipping parents with tools and knowledge to ensure that their children are prepared to learn when they start school. Through this evidence-based intervention, parents learn new ways to stimulate their children's literacy development, have more books in their home, and read to their children more. Parents are supported as their children's first and most important teachers, and children are given a foundation for success.

Child Health - Application Year

The school health program will continue to fulfill statutory and agency mandates to ensure the provision of school health services to children in all of Florida's public and participating nonpublic schools. County health departments, in cooperation with local education agencies and other partners, will be responsible for ensuring Florida's 2.8 million pre-kindergarten through 12th grade students have access to health services that assess, protect, and promote their health and ability to learn.

School health services provided in all public schools include: nursing assessments; student health record reviews to ensure physical exam and immunization requirements meet statutory requirements; health services for chronic or complex health conditions requiring school-day management; first aid; medication administration; screening, referral and follow-up for vision, hearing, scoliosis and growth and development; preventive oral health programs; healthy lifestyle nursing interventions; emergency health services; health education classes; parent and staff consultations on student health issues; case management; and consultation for placement of students in exceptional student education programs. In addition, schools designated as Comprehensive or Full Service schools by local programs receive additional services that address many social determinants of students' health that impact educational achievement. County school health programs led by registered school nurses address health disparities and work to meet students' and families' needs every day (NASN, 2016).

The Department's BCDP and the School Health Program will continue to develop their collaborative partnerships with the Department of Education (DOE) Office of Healthy Schools and the Florida Partnership for Healthy Schools (Partnership) to promote implementation of the CDC's Whole School, Whole Community, Whole Child (WSCC) model in Florida's school districts. The WSCC model is an evidence-based approach to advance the development of state, district, and school infrastructures that promote and maintain health and wellness for students, families, communities, and school staff, and support students' academic achievement. The school health advisory committee (SHAC), a statutory requirement of each county school health program, is an important vehicle for counties to develop their WSCC models. However, gaining and maintaining SHAC representation from all 10 components of the WSCC model is an ongoing challenge for most county School Health Programs. To address this need, the School Health Program will conduct at least one statewide conference call during the 2018–19 school year to educate counties on SHAC development. Also, SHAC development will be a primary focus of liaisons' site monitoring meetings with county School Health Program staff.

The BCDP will work with DOE to advance the Partnership's Florida Healthy School District self-assessment and recognition program. In addition, the School Health Program will educate county School Health Programs on the requirements, application process, and benefits of becoming a Florida Healthy District on at least one programmatic statewide conference call and during county School Health Program on-site monitoring meetings during the 2018–19 school year. These activities will support Objective 3 to increase the number of Florida school districts that apply for recognition as a Florida Healthy District for the 2019-2021 period.

The Florida Healthy School District Self-Assessment Tool was developed by experts from state agencies, school districts, and community partners to assist school districts in achieving the highest standards related to the CDC's Coordinated School Health and WSCC models, based on district infrastructure, policy, programs, and practices identified from national and state guidelines, best practices and Florida statutes. This planning tool helps school districts determine where they are currently and what they could do to remove health-related barriers to learning as they work towards recognition as a Florida Healthy District. Districts are encouraged to include school superintendents, school boards, school administrators, school nurses, component area experts, parents, and the SHAC in the assessment process.

The School Health Program will promote school nurses' use of the Healthy Lifestyle Intervention by educating county School Health Programs about the Healthy Lifestyle Individualized Healthcare Plan and coding this service in the Department's data system. This training will be provided on at least one programmatic statewide conference call and will be a focus of liaisons' site monitoring meetings with county School Health Program staff during the 2018–19 school year. These activities will support Objectives 1 and 2.

Challenges:

- Florida's registered school nurse to student ratio is 1 to 2,382 (2016–17); whereas the National Association of School Nurses (NASN), American Academy of Pediatrics, and American Academy of Nursing recommend one school nurse for every school. Inadequate nurse staffing causes school nurses to devote the majority of their workday to meeting students' basic health and safety needs and limits their ability to organize and conduct health education/promotion activities and additional nursing services such as the Healthy Lifestyle Intervention.
- Between school years 2010–11 and 2016–17, reported chronic and complex conditions among pre-kindergarten through 12th grade students increased 28.9 percent (from 562,085 to 724,573).
- 7.3 percent of Florida's children under age 19 are uninsured according to the United States Census Bureau Small Area Health Insurance Estimates (2015). For many students, the school nurse is the only licensed healthcare professional to which they have access, including for clinical guidance and support to practice a healthy lifestyle.
- The shift in community primary care services from county health departments to private healthcare providers, such as federally qualified health centers, presents challenges to ensuring that students in need of follow-up care receive needed services.
- School districts' prioritization of academic and standardized testing schedules presents ongoing challenges to including school health activities in the school day, including health education/promotion and initiatives to increase students' physical activity.

Title V funding has been consistently used to establish new school-based sealant programs in Florida. These evidence-based programs increase access and reduce barriers to preventive dental care for low-income children. During SFY 2016-2017, Title V funding was used to support the expansion of dental sealant programs in seven counties with high unmet needs due to a lack of dental providers, transportation barriers, and low social economic factors influencing access to care. These dental sealant programs provided preventive services to school-aged children. Final data reveal that 3,563 children were screened, and 7,849 dental sealants, 3,375 fluoride varnish applications, and 3,424 oral health instructions were provided at these six counties during SFY 2016-2017. During SFY 2017-2018, six additional counties were funded for start-up costs for new school-based sealant programs; data on services provided are not yet available for these programs. For the first time during SFY 2018-2019, Title V funding will be used to expand existing programs that have been proven sustainable. This means that more schools will be accessed and more children will be served across Florida by Department school-based sealant programs. It is anticipated that 1-2 new programs and 3-4 existing programs will be awarded funding during SFY 2018-2019.

To promote these school-based sealant programs to children and increase positive consent rates from parents, a postcard explaining dental sealants and their effectiveness in preventing tooth decay was produced and disseminated to each of the new programs, utilizing Title V funding. The postcards incorporate best practices for health literacy and implementation of healthy oral health behaviors in second and third grade children, the target population of the school-based sealant programs. The postcard encourages discussion of improved oral hygiene, specifically the benefits of dental sealants, between teachers, children, and their parents or guardians. The PHDP will continue to provide Florida school-based sealant programs with quality improvement and assurance guidance, technical assistance, and training to ensure local program efficiencies and increased capacity of children are served

through these programs.

The PHDP will continue to partner with other state agencies and not-for-profit organizations, such as Oral Health Florida, to plan and implement programs to benefit the oral health needs of children and families. The PHDP actively participates on various Oral Health Florida action teams (committees) and the leadership council, to support initiatives to increase oral health services for children and families in Florida. The PHDP, in coordination with the Oral Health Florida Sealant Action Team, will continue to promote the use of a cost efficient dental hygienist workforce model for school-based sealant programs service delivery. Working with county health department dental programs, FQHCs, and local oral health coalitions across the state, preventive services will continue to be provided to low income children in Title I Schools. Providing services to children in school settings eliminates many barriers that impact access to dental care. School-based sealant programs are supported by Title V funding and make it possible to reach high-risk children in need of dental services and improve dental outcomes for children in the state. During the coming year, the PHDP will continue to increase statewide data capacity and serve as the state's school-based sealant programs data warehouse across all agencies through the FLOSS Database. Participation in the FLOSS database, especially for outside entities, can be encouraged through the Oral Health Florida Sealant Action Team.

To increase the percentage of parents who read to their young children, Title V funding will continue to be available to county health departments through Schedule C and a statement of work with an option to create a reading rich environment in waiting room areas such as a child's reading table and chairs, a bookshelf, children's books, etc. Funds may also be used to establish a Reach Out and Read (ROR) program.

In April 2018, Florida Children's Council released a statewide report that finds current policies adversely impact Florida's low-income families. With more than four million children and youth calling Florida home, and 45 percent of them living in economically struggling households, it is clear that many programs designed to help families become financially stable and self-sufficient fail to work. If children from low-income homes are to reach their full potential, there is a significant need to eliminate the current silos addressing adult-oriented and child-oriented programs separately. The report provides a roadmap of action to improve economic stability and child outcomes for families with young children in poverty.

Positive child and youth outcomes, financial stability for families, and economic vitality for businesses are interrelated goals. There is a clear need to rethink social service policy and align work-based solutions with child and family supports. These two-generational strategies provide a framework for developing systems that support strong child and youth outcomes within the context of family.

In Florida, many low-income households have working parents but they remain poor despite their efforts to progress toward economic prosperity. While accessing social services can provide needed financial supports for households, in many instances income eligibility requirements force parents to choose between wage increases and critical needs of children, such as child care. This reality has significant implications not only for the children and family, but employers and the economy.

Assisting parents to connect with opportunities to increase economic stability, increases their power to improve the likelihood of future success for their children.

Nationally there is growing interest to address the sources of family adversity, which have the potential to promote long-term positive outcomes by producing positive changes in family income, environment, stress, and relationships. Research cites "cliff effects" as a particularly problematic disincentive associated with many work support policies. Cliff effects penalize households financially for progressing beyond income thresholds of work support eligibility.

There are systemic barriers that hinder a family's ability to become economically self-sufficient and by strategically aligning systems of care, there is the opportunity to ensure that all children live in stable and nurturing environments.

Access to affordable child care stands out as perhaps the singularly most important social service in recognition of its impact on the entire family while providing clear economic benefit to employers and communities. In short, child care is an instrumental support to parents by reducing stress, achieving personal growth through education and training, and increasing critical skills and capabilities through education and training that lead to economic and family stability.

Quality child care, in particular the quality of the teacher-child interactions, has been consistently linked to positive developmental outcomes for children, including cognitive, language and literacy development, and core executive functioning skills such as communication, problem-solving and critical thinking. These are the foundational outcomes needed for academic and later career success. For children of low-income families, it has been well-documented that before there is an achievement gap, there is a "readiness" gap and the beneficial influences of quality child care are particularly strong for supporting kindergarten readiness.

Addressing this issue in a two-generational framework is essential in informing a commitment to cross-system collaboration and improved system alignment strategies that give Florida's youngest citizens their best chance at success.

Families with young children in poverty have different household survival budgets needs than individuals in poverty. Reforming social services for families with young children is timely and necessary. Aligning social services such as workforce development and child care can create the opportunity for a pathway to prosperity.

Florida is a vibrant and growing state that has its share of opportunities and challenges. To ensure that we secure paths to prosperity for all Floridians, especially the nearly one million kids living in poverty, we must focus on bold and broad strategies that consider two-generation approaches.

Research is clear that poverty is the single greatest threat to children's development and overall well-being. Approximately 45 percent of children in Florida are from low-income households with parents who work. Poverty greatly impedes children's ability to learn and contributes to social, emotional, and behavioral problems. Poverty also can contribute to poor physical and mental health.

Although work support benefits associated with the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 provided significant reform and have helped recipients maintain employment and survive on limited incomes, there are differing impacts for individuals versus families with young children. Analysis of social services in Florida revealed that policies have been structurally established to effectively support an individual in poverty working toward economic self-sufficiency. By stark contrast, there are disparities in economic stabilization for families with young children in poverty. Through the analysis of six major social service programs, the impact of fiscal cliffs for families with young children in poverty have been documented. Opportunities for policy improvements have been identified, as well as proposed reform measures with more effective strategies to improve outcomes for children and economic self-sufficiency for families.

As part of the solution to address this issue, the Department is participating in AMCHP's Infant Mortality CoIIN SDOH project. Increasing Health Equity capacity in the public health workforce and integrating health equity principles and frameworks into policies and programs is a priority of the Department. Key maternal and child health outcomes and risk factors are heavily influenced by health inequities and the social determinants of health, which

requires public health efforts to go beyond traditional services and interventions to impact change in populations affected by disparate health outcomes. To effectively address existing health inequities in Florida, public health agencies and organizations will need to first deliver learning opportunities to the public health workforce to increase individual professional competencies and increase organizational capacity to advance health equity. To then integrate health equity into the public health system and communities requires incorporating elements of health equity into policies and programs that impact maternal and child health populations. Our participation will help the Department establish a process for formally assessing MCH policies and programs from a healthy equity perspective by December 31, 2018.

Another part of the solution is the Department's continued support of the Florida's Healthy Babies Initiative where Title V funding is allocated for county health departments to select one or more of the following projects to implement in their respective communities and previously discussed under the D.2 Budget:

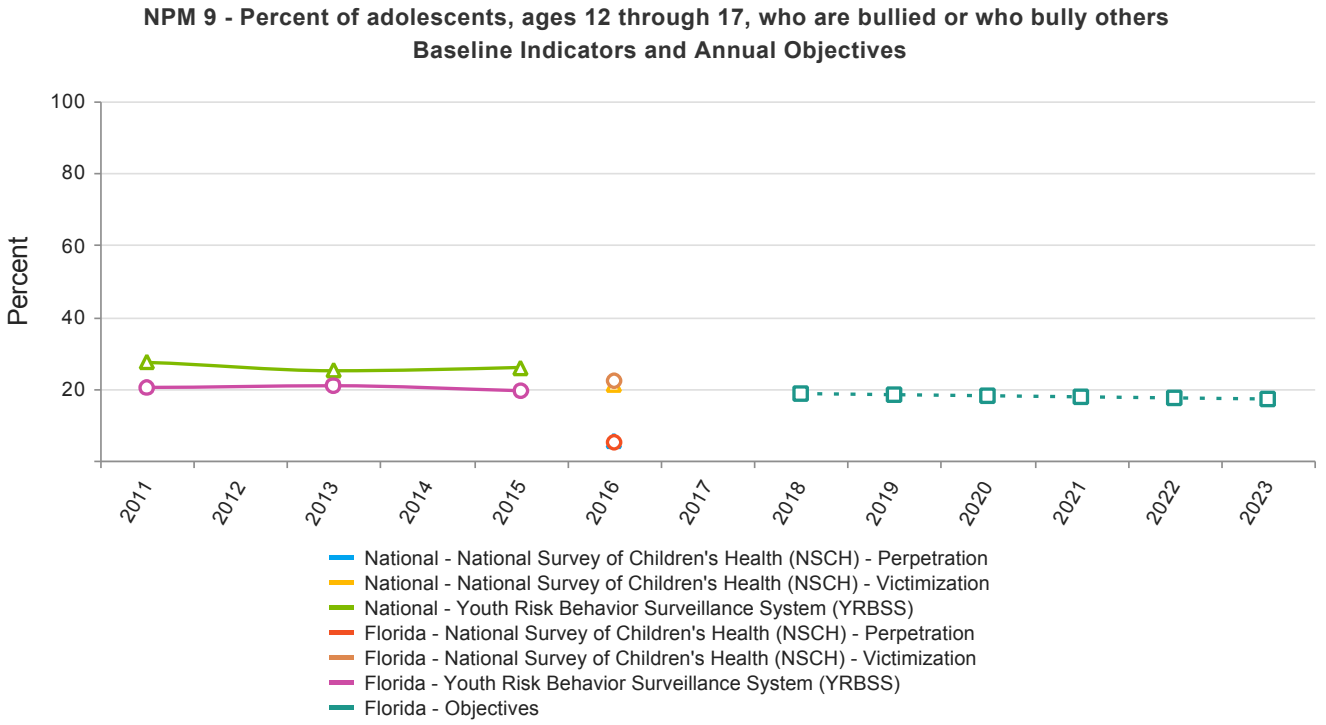
- Title V funding will continue to be available to county health departments to establish a Reach Out and Read (ROR) program and/or create a reading rich environment in waiting room areas such as a child's reading table and chairs, a bookshelf, and children's books.
- Establish a Best Babies Zone (BBZ) Initiative to reduce disparities in infant mortality and birth outcomes by mobilizing community residents and organizational partners to address the social and economic determinants of health.
- Establish a Fresh Access Bucks (FAB) Initiative to encourage healthy behaviors by making fresh, local produce more affordable and accessible to SNAP recipients while supporting Florida's farmers and enhancing our local economies.
- Implement the Protocol for Assessing Community Excellence in Environmental Health (PACE EH) in communities of high need to assess neighborhood and community identified social determinants of health needs and provide action plans to address the top issues as defined by the communities.

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2016	35.6	NPM 9
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2014_2016	7.9	NPM 9

National Performance Measures



Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2016	**2017**
Annual Objective	20.2	19
Annual Indicator	19.5	19.5
Numerator	150,914	150,914
Denominator	772,407	772,407
Data Source	YRBSS	YRBSS
Data Source Year	2015	2015

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Perpetration	
	2017
Annual Objective	
Annual Indicator	5.1
Numerator	72,001
Denominator	1,409,777
Data Source	NSCHP
Data Source Year	2016

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Victimization	
	2017
Annual Objective	
Annual Indicator	22.3
Numerator	313,655
Denominator	1,404,246
Data Source	NSCHV
Data Source Year	2016

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	18.7	18.4	18.1	17.8	17.5	17.2

Evidence-Based or –Informed Strategy Measures

ESM 9.1 - The number of high schools implementing the evidence-based Green Dot violence prevention and intervention strategy

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		6
Annual Indicator	6	6
Numerator		
Denominator		
Data Source	Sexual Violence Prevention Program	Sexual Violence Prevention Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

ESM 9.2 - The number of students who participate in an evidence-based program that promotes positive youth development and non-violence intervention skills

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	13,100.0	13,500.0	13,900.0	14,300.0	14,700.0

State Action Plan Table

State Action Plan Table (Florida) - Adolescent Health - Entry 1

Priority Need

Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment.

NPM

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Objectives

1. By September 30, 2019, decrease the number of Florida high school students who experienced bullying on school property from 14.3 percent (2017) to 13 percent (2019).

2. By September 30, 2019, decrease the number of Florida high school students who experienced electronic bullying in the past 12 months from 11.5 percent (2017) to 10 percent (2019).

3. By September 30, 2019, increase the number of youth participating in positive youth development programs from 12,300 in 2017 to 12,700.

Strategies

1a. Partner with community agencies and organizations to promote bullying prevention initiatives.

1b. Coordinate with the Department of Education's Safe Schools Program to integrate additional anti-bullying and violence prevention messages.

2. Increase the number of youth with access to resources and hotlines related to violence and bullying prevention.

3a. Promote the use of evidence-based curriculums.

3b. Ensure that youth are receiving STD/HIV information and sexual risk avoidance strategies.

3c. Provide positive youth development education to encourage healthy behaviors and the reduction of risky behaviors.

ESMs	Status
ESM 9.1 - The number of high schools implementing the evidence-based Green Dot violence prevention and intervention strategy	Inactive
ESM 9.2 - The number of students who participate in an evidence-based program that promotes positive youth development and non-violence intervention skills	Active

NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Adolescent Health - Annual Report

The Adolescent Health Program (AHP) continues its work to increase the percentage of youth making positive and healthy choices and improve the health of adolescents and young adults by decreasing the percentage of youth engaging in risky behaviors that lead to teen pregnancy, sexually transmitted diseases, substance abuse, and violence. The AHP continues to implement the Sexual Risk Avoidance Program, which began in 2010.

The Sexual Risk Avoidance Program funded 18 providers, 11 local health departments, and four community or faith-based providers in middle school, high school, and community settings. In the 2016-2017 grant year, the Sexual Risk Avoidance Program was successfully delivered to 12,175 youth and to 2,550 parents and guardians.

The Title V Abstinence Education Grant, from the Administration of Children and Families, funded local health departments and community and faith-based organizations to implement evidence-based sexual risk avoidance education curricula including *Choosing the Best*, *Making A Difference*, *Promoting Health Among Teens*, and *Real Essentials*. The curricula encourage parent and guardian involvement. The parent programs reinforce healthy behaviors, encourage positive attitudes, and reduce risk-taking behaviors. All classes were delivered in school or community-based settings. Monitoring of all providers was carried out to evaluate and ensure fidelity to the curriculum. The monitoring, conducted by program contract managers, included classroom observation of the instructor providing education classes to assess adherence to the curriculum.

While there were no major changes to the state plan, the emergence and prevalence of Zika required the AHP to reframe education for teen parents. While the core curriculum remained the same, supplemental speakers were utilized to convey the seriousness of Zika and preventative measures for anyone of child-bearing age. The challenge of disseminating a sincere and relevant message for young adults included a joint effort between AHP staff, Department's Office of Communications, and local health educators.

Section 1006.147, Florida Statutes, was signed into law in 2008. The statute requires Florida school districts to adopt a policy prohibiting bullying and harassment of students and staff on school grounds or school transportation, at school-sponsored events, and through the use of data or computer software accessed through school computer systems or networks. The DOE Office of Safe Schools has created a model policy against bullying and harassment that school districts can use to craft their individual policies.

Bullying is a serious detriment to a child's health, sense of well-being, safety, education, and emotional development, and greatly increases the risk of self-injury and suicide. According to the 2015 CDC YRBS survey, 15 percent of Florida students were bullied on school property and 11.6 percent were bullied electronically. Bullying is defined as an attack or intimidation with the intention to cause fear, distress, or harm that is either physical (hitting, punching), verbal (name calling, teasing), or psychological/relational (rumors, social exclusion); a real or perceived imbalance of power between the bully and the victim; and repeated attacks or intimidation between the same children over time. Data from the 2015 Youth Risk Behavior Survey indicate that a significantly higher number of students experiencing bullying described their grades as Ds and Fs in school during the past 12 months. The number of ninth grade students reporting being bullied is significantly higher than for students in 10^{th}, 11^{th}, and 12^{th} grade. Female students are significantly more likely than males to have experienced some form of bullying, name calling, or teasing in the past year.

The MCH Section hosted a student from the Graduate Student Epidemiology Program to examine the association between bullying and the use of tobacco, drugs, and alcohol among high school students in Florida, using 2011-2015 data from the Florida Youth Risk Behavior Survey. The student found that current substance use was associated with any victimization and more strongly associated with cyber victimization. Decreasing the prevalence of bullying and

substance use among high school students is imperative for promoting good mental health and well-being. This report has been submitted for publication in a peer-reviewed journal.

Adolescent Health - Application Year

The Adolescent Health Program (AHP) works to promote, protect, and improve the health of all Florida youth. As a means of working toward health equity, the AHP ensures inclusion of sexual minority populations including youth in the LGBT community. All providers funded by the AHP participate in annual, mandatory training that builds upon inclusivity. Training includes:

- Value-neutrality best practices.
- Facilitation skills that create a safe space.
- Mandatory reporting guidelines.
- State-specific sexually transmitted disease updates.
- Anti-bullying resources, education, and promotional materials.
- Curriculum adaptation that includes gender neutral or LGBT-specific couple references (as permitted by each school district).
- Linkages to services that serve and support LGBT youth.

The AHP continues to work to increase the percentage of youth making positive and healthy choices, with the intention of improving the health of adolescents and young adults by decreasing the percentage of youth engaging in risky behaviors that lead to teen pregnancy, sexually transmitted diseases, substance abuse, and violence.

The AHP also continues to implement the Sexual Risk Avoidance Grant from the Administration of Children and Families that began in 2010. This program provides $3,772,364 per year to fund county health departments and community-based organizations. The funded providers use evidence-based, proven-effective sexual risk avoidance education curricula including *Choosing the Best*, *Making A Difference*, *Promoting Health Among Teens*, and *Real Essentials* to deliver the program. All classes are delivered in school or community-based settings. Providers are monitored regularly to ensure fidelity to the curricula and adherence to grant guidelines. The monitoring, conducted by program contract managers, includes observation of the educator conducting classes with youth and or parents/significant adults.

The AHP is currently funding 17 providers through September 2018. These providers include 13 local health departments and four community-based providers in middle school, high school, and community settings. As part of a new funding opportunity, a request for application will be released during the summer of 2018, with awarded providers tentatively beginning work in the fall of 2018. Collaborations and partnerships with local health departments, schools, school districts, community-based organizations, and juvenile justice centers are critical to the projects. Schools and school districts agreeing to allow facilitators and instructors to provide the curriculum in their educational facilities are imperative to the success of the programs.

Students who are perceived as different by other students are more likely to be bullied. These more vulnerable students include LGBT youth; students with physical, learning, or mental health disabilities; and students who are targeted for differences in race, ethnicity, or religion. Both students who bully and students who are bullied can suffer lasting psychological effects, including post-traumatic stress disorder (PTSD).

The best deterrent to bullying and cyberbullying is to create a culture of acceptance and communication. Such a culture empowers students to find positive ways to resolve conflicts and includes administration, teachers, and other staff who can support students in making constructive decisions and respond proactively when aggression of any kind exists on the school campus.

The Department's Violence and Injury Prevention Program (VIPP) addresses statewide injury (both intentional and unintentional) prevention priorities by providing technical assistance, information, and resources to community

partners. One of the programs to address bullying is the evidence-based Green Dot strategy in local high schools. The Green Dot strategy is a comprehensive approach to violence prevention, capitalizing on the power of peer and cultural influence across all levels of the socioecological model.

Green Dot is built on the premise that a cultural shift is necessary to measurably reduce the perpetration of power-based personal violence. To create a cultural shift, a critical mass of peer influencers must engage in a new behavior to make violence less sustainable within any given community. The new behavior includes identification of personal connection to violence, barriers to intervention, workaround solutions for barriers, and opportunities to identify risk factors for power-based personal violence before it occurs. Prevention in the form of behavior modeling through social media and conversations is also a component of Green Dot. The intervention focuses on teen dating violence, bullying, sexual harassment, stalking, and sexual assault.

It is also imperative to take a closer look at the effects of trauma on children and young adults as it is far more pervasive than adults imagine. The National Survey of Children's Exposure to Violence found that over 60 percent of children surveyed experienced some form of trauma, crime, or abuse in the prior year, with some experiencing multiple traumas. Often, children and adolescents do not have the necessary coping skills to manage the impact of stressful or traumatic events. As such, as many as one in three students who experience a traumatic event might exhibit symptoms of PTSD. Following a child's exposure to a traumatic event, parents and teachers are likely to observe the following symptoms:

- Reexperiencing — constantly thinking about the event, replaying it over in their minds, nightmares.
- Avoidance — consciously trying to avoid engagement, trying not to think about the event.
- Negative Cognitions and Mood — blaming others or self, diminished interest in pleasurable activities, inability to remember key aspects of the event.
- Arousal — being on edge, being on the lookout, constantly being worried.

Symptoms resulting from trauma can directly impact a student’s ability to learn. Students might be distracted by intrusive thoughts about the event that prevent them from paying attention in class, studying, or doing well on a test. Exposure to violence can lead to decreased IQ and reading ability. Some students might avoid going to school altogether.

Exposure to violence and other traumatic events can disrupt a youths’ ability to relate to others and to successfully manage emotions. In the classroom setting, this can lead to poor behavior, which can result in reduced instructional time, suspensions, and expulsions. Long-term results of exposure to violence include lower grade point averages and reduced graduation rates, along with increased incidences of teen pregnancy, joblessness, and poverty.

The root causes of and complex factors contributing to violence are found at the individual, family, community, and societal levels. All systems and disciplines can and must play a valuable role in preventing violence, reducing harm, and mitigating the lifelong effects of violence and trauma.

Research and action in preventing violence in schools and communities includes improving the environments in which young people live and learn; implementing policies and programs that establish new norms for nonviolent behaviors; equipping young people with competencies for positive development; and providing opportunities for employment, mentoring, substance abuse treatment, and access to health and mental health services, including trauma-informed care.

The Department applies a public health approach to violence prevention, concentrating primarily on preventing youth violence, intimate partner violence, and exposure to trauma. This approach involves research, evaluation, and training and technical assistance across many of society’s systems, such as schools, law enforcement and the

courts, mental health, child welfare, and juvenile justice agencies. The Department's priority to address the social determinants of health is embedded throughout this application and the commitment of leadership as evidenced by the State Health Improvement Plan and Agency Strategic Plan to impact Florida's long-term health outcomes.

Children with Special Health Care Needs

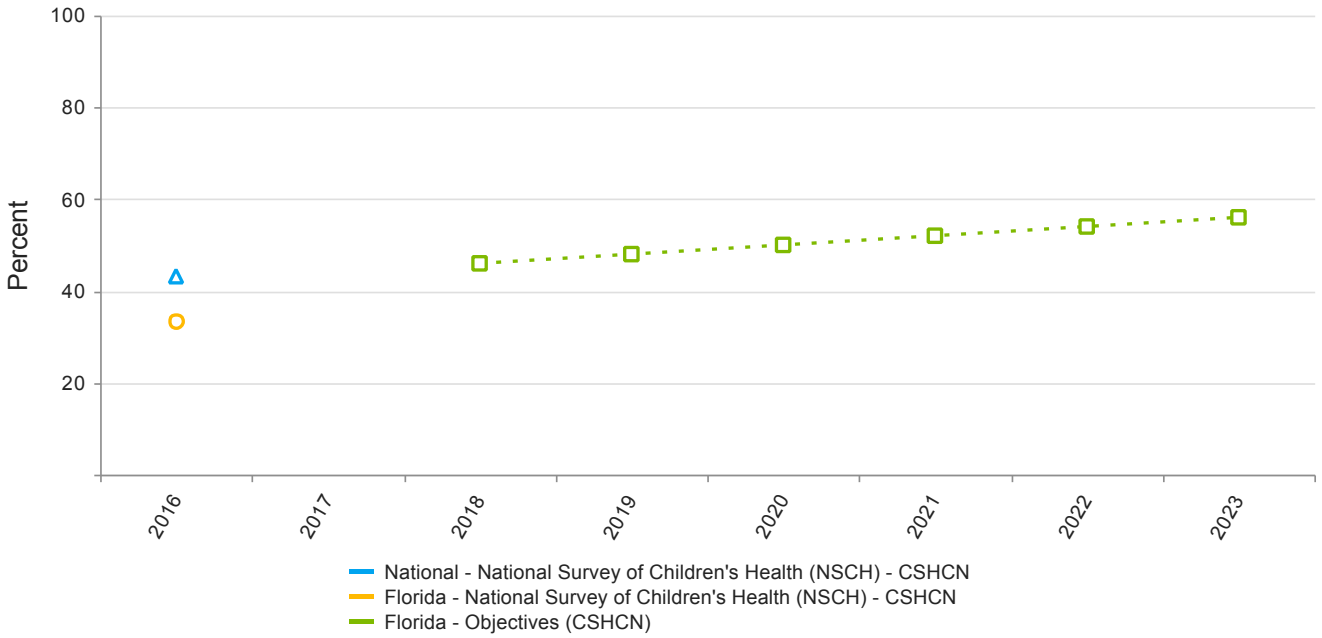
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016	9.8 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016	49.1 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	86.7 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2016	5.0 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Baseline Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		33.5
Numerator		298,857
Denominator		891,111
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	46.0	48.0	50.0	52.0	54.0	56.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Number of pediatric providers in Florida who have received information related to the Patient Centered Medical Home (PCMH) and who have completed a Medical Home Assessment Tool for their practice.

Measure Status:	Inactive - Replaced

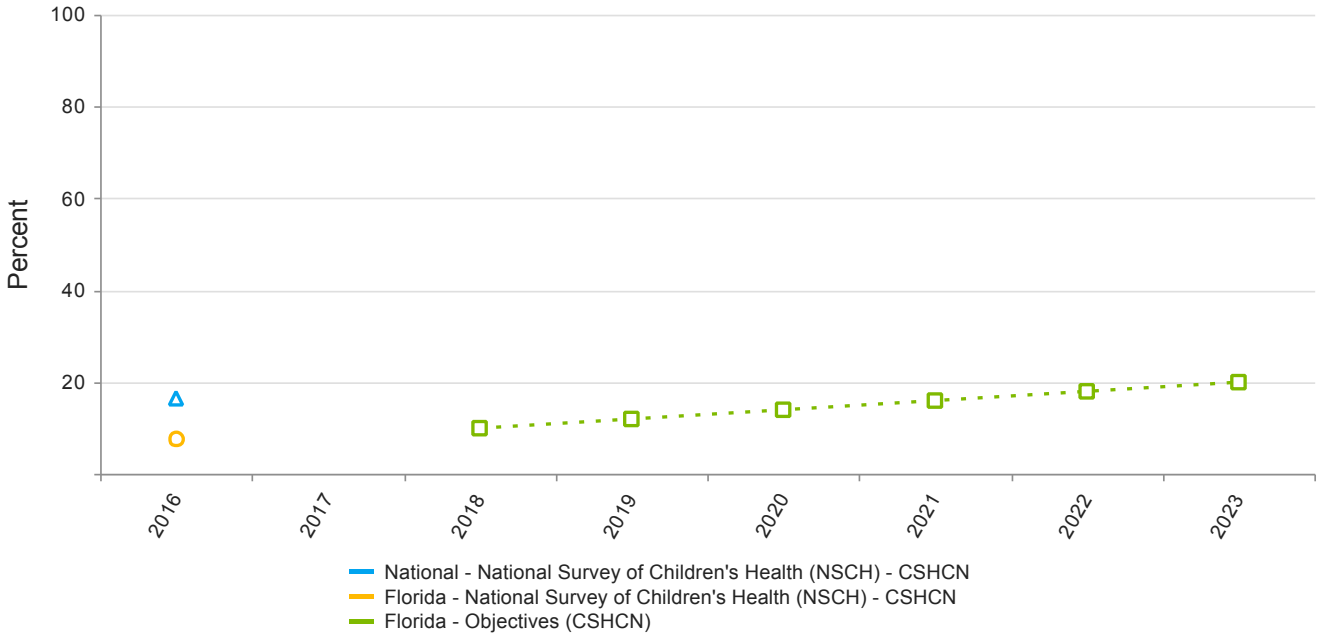
State Provided Data		
	2016	2017
Annual Objective		500
Annual Indicator	0	500
Numerator		
Denominator		
Data Source	Florida Children's Medical Services	Florida Children's Medical Services
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Provisional

ESM 11.2 - Percent of satisfaction of access to care for families of children with special health care needs who received care in a patient centered medical home or by a primary care provider.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	50.0	55.0	60.0	65.0	70.0

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Baseline Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		7.5
Numerator		27,551
Denominator		368,685
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	10.0	12.0	14.0	16.0	18.0	20.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Number of pediatric providers in Florida who have practices that have a Health Care Transition (HCT) policy or youth with readiness assessment (with physicals) and plans of care.

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		500
Annual Indicator	0	500
Numerator		
Denominator		
Data Source	Florida Children's Medical Services	Florida Childrens Medical Services
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Provisional

ESM 12.2 - Percent of satisfaction of access for youth with special health care needs who report having access to community-based resources necessary to make transition to adult health care.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	50.0	55.0	60.0	65.0	70.0

State Performance Measures

SPM 1 - The percentage of children that need mental health services that actually receive mental health services.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		58
Annual Indicator	57.7	49.1
Numerator		
Denominator		
Data Source	National Survey of Children's Health	National Survey of Children's Health
Data Source Year	2011/2012	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	50.0	51.0	52.0	53.0	54.0	55.0

SPM 4 - The percentage of individuals who received workforce development that reported improved public health competency and capacity.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	75.0	80.0	85.0	90.0	95.0

State Action Plan Table

State Action Plan Table (Florida) - Children with Special Health Care Needs - Entry 1

Priority Need

Increase access to medical homes and primary care for children with special health care needs.

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

1. By September 30, 2019, increase the number of pediatric providers in Florida identified as having a certified, recognized and/or accredited patient-centered medical home model by 5 percent.

2. By September 30, 2019, document the baseline of family satisfaction with access to care in a patient-centered medical home and primary care setting as evidenced by survey results.

3. By September 30, 2019, 100 percent of CMS Title V staff receive patient-centered medical home education and training annually as evidenced by electronic reporting systems.

Strategies

1a. Assess number and type of current patient-centered medical homes.

1b. Provide education, resources, and technical assistance to primary care providers for practice transformation towards patient-centered medical homeness.

2a. Assess family satisfaction with access to PCMH. Provide feedback, education, and technical assistance to practice for quality improvement initiatives.

2b. Create online repository for recognized PCMHs for families to be able to access.

3. CMS Title V staff will receive patient-centered medical home training during orientation and annually with completion documented through an electronic reporting system.

ESMs	Status
ESM 11.1 - Number of pediatric providers in Florida who have received information related to the Patient Centered Medical Home (PCMH) and who have completed a Medical Home Assessment Tool for their practice.	Inactive
ESM 11.2 - Percent of satisfaction of access to care for families of children with special health care needs who received care in a patient centered medical home or by a primary care provider.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

State Action Plan Table (Florida) - Children with Special Health Care Needs - Entry 2

Priority Need

Improve health care transition to all aspects of adult life for adolescents and young adults with special health care needs.

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

1. By September 30, 2019, 100 percent of CMS Title V staff will receive transition-specific education and training annually as evidenced by electronic reporting systems.

2. By September 30, 2019, increase by 10 percent the number of providers who receive transition-specific education, training, and resources as evidenced by verbal, written, and/or electronic reporting.

3. By September 30, 2019, document the baseline number of educators who receive transition- education, training, and resources as evidenced by electronic reporting systems for baseline assessment.

4. By September 30, 2019, document percentage of children and families who accessed Department sponsored transition-education websites as evidenced by electronic reporting systems.

5. By September 30, 2019, 75 percent youth and families with special health care needs will report having access to community-based resources necessary to facilitate and achieve successful health care transition when surveyed.

6. By September 30, 2019, increase youth with special health care needs voice in transition program activities as evidenced by a 5 percent increase in the type and number of youth-led health and education transition-specific activities.

Strategies

1. CMS Title V staff will receive transition education during orientation and annually with completion documented through an electronic reporting system.

2. Providers are provided with transition education, training, and resources. Promote the six core elements of health care transition per national guidelines.

3. Educators are provided with transition education, training, and resources.

4. Assess, develop, monitor, improve quality, and promote public access to transition-specific, age-appropriate education materials to support the aspects of health, work/school, self-determination, and self-management for children with special health care needs.

5. Assess, develop, monitor, improve quality, and promote community-based resources and other supports necessary to facilitate and achieve successful health care transition for patients and families with special health care needs.

6. Promote growth in the youth voice and program involvement at the community, state, and national level for health and education transition-specific activities.

ESMs	Status
ESM 12.1 - Number of pediatric providers in Florida who have practices that have a Health Care Transition (HCT) policy or youth with readiness assessment (with physicals) and plans of care.	Inactive
ESM 12.2 - Percent of satisfaction of access for youth with special health care needs who report having access to community-based resources necessary to make transition to adult health care.	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Florida) - Children with Special Health Care Needs - Entry 3

Priority Need

Improve access to appropriate mental health services to all children.

SPM

SPM 1 - The percentage of children that need mental health services that actually receive mental health services.

Objectives

1. By September 30, 2019, 100 percent of CMS Title V staff receive education and training on issues related to pediatric behavioral health annually as evidenced by electronic reporting systems.

2. By September 30, 2019, increase by 5 percent the number of primary care and specialty care providers who receive pediatric behavioral health education and training as evidenced by manual and electronic reporting systems.

3. By September 30, 2019, increase by 5 percent the number of providers who were provided or accessed electronically behavioral health resources as evidenced by manual and electronic reporting systems.

4. By September 30, 2019, determine the percentage of children and families who were provided or accessed electronically behavioral health education materials or resources as evidenced by manual and electronic reporting systems.

5. By September 30, 2019, determine collaboration efforts with primary care and behavioral health partners at local, state and national level as evidenced by meeting attendance, type of activities, memorandum of agreements/understandings and contracts and the Wilder Collaboration Factors Inventory.

Strategies

1. CMS Title V staff will receive behavioral health education during orientation and annually with completion documented through an electronic reporting system.

2. Providers will be offered opportunities for education/training for pediatric behavioral health care diagnosis including infant mental health, autism spectrum disorder and other emerging topics identified

3. Providers are equipped with resources to help improve access to behavioral health care.

4. Provide children and families with educational and other resources (i.e. parent based screening tools, resources, websites, directories) to promote access to behavioral health services.

5. Build system of care capacity for behavioral health services statewide with stakeholders at the local, state, and national level. Promote evidenced based strategies such as integrated care. Pilot behavioral health implementation projects. Evaluate Results. Build Sustainability. Replicate efforts that show promising practices.

State Action Plan Table (Florida) - Children with Special Health Care Needs - Entry 4

Priority Need

Increase access to medical homes and primary care for children with special health care needs.

SPM

SPM 4 - The percentage of individuals who received workforce development that reported improved public health competency and capacity.

Objectives

1. By September 30, 2019, 100 percent of CMS Title V staff will receive workforce development training as evidenced by electronic and manual reporting systems.

2. By September 30, 2019, 85 percent of CMS Title V staff will report having an increase in public health knowledge and skill set as a result of participating in workforce development trainings as evidenced by electronic and manual self-reporting surveys.

Strategies

1a. CMS Central Office will convene a statewide workgroup to strategically plan the development of the workforce training.

1b. CMS Title V staff will complete needs assessment surveying what type of training they feel they need to transition from direct care services to public health services.

1c. CMS will partner with the National Maternal Child Health Workforce Development Center or other national stakeholder for assistance in the planning, development, and implementation of the workforce training.

1d. CMS will implement workforce development utilizing various adult learning methods in a variety of venues including: face-to-face, webinars, coaching calls, etc.

2a. CMS leadership will develop specific skill building modules in change management/adaptive leadership, systems integration and evidenced-based decision making,

2b. CMS leadership will evaluate staff perception of increased public health knowledge and skill set after each training session.

2c. CMS leadership will analyze the results of each training session and utilizing the continuous quality improvement planning cycle for future training needs.

2d. CMS leadership will develop additional trainings as workforce needs are identified.

Children with Special Health Care Needs - Annual Report

Florida has 4.1 million children, and of those, there are approximately 1,000,000 children that have special health care needs with 100,000 children having a medical complexity (serious and chronic medical conditions). For those with medical complexity, they represent a third of the spending, 40 percent of deaths, and 25 percent of hospital days. Florida has 18 pediatric children hospitals statewide to serve the acute, chronic, and complex needs of children.

In accordance with Section 501 [42 U.S.C. 701] (a)(1)(D), the Department's Children's Medical Services (CMS) provides family-centered, community-based, coordinated care for children with special health care needs, and participates in activities that promote and develop community-based systems of services for children with special health care needs and their families

CMS programmatic efforts includes the use of evidenced-based or evidenced-informed approaches with national, state, and family experts to guide decision making, to address identified priority needs in the areas of access to patient-centered medical homes; health care transition and access to mental/behavioral health services.

CMS partnered with HealthARCH (Advancing Resources to Change Healthcare), a National Committee for Quality Assurance (NCQA) partner in quality, to assess providers' readiness and interest in patient-centered medical home (PCMH) practice transformation. Surveys were developed, distributed, and electronically posted. Information gathered included current medical home designation, as well as readiness indicators for practice transformation. UCF HealthArch provided technical assistance support to 12 pediatric practices regarding PCMH practice transformation; additional cohorts are forthcoming. Outreach to promote awareness and provide education to providers and community organizations is conducted by CMS regional consultants and 59 documented activities occurred in 2017.

For the priority need and NPM on transition, regular collaboration, consultation, and technical assistance occurred with our national GOT Transition Center for Health Care Transformation partner and state transition partner, Florida Health and Transition Services (HATS). An important objective for transition is for youth, families, and providers to have access to community-based resources necessary to facilitate and achieve successful health care transition. CMS and FloridaHATS, with technical assistance with GOT Transition, provided awareness, education, and resources to increase knowledge and skill sets for state and community partners including health care and school professionals, youth, and their families. CMS implemented regional consultants to assist in the promotion of the FloridaHATS web-based health services directory for young adults in Florida, assisting providers in developing transition policies, conducting activities, promoting the concepts found in the Six Core Elements of Healthcare Transition, and working to further or build regional transition coalitions throughout the state.

FloridaHATS continued to have oversight and direction of the health care transition coalitions in Florida. Transition collaborative partners include the Federally Qualified Health Centers, the Department of Education, the Division of Vocational Rehabilitation, the Agency for Persons with Disabilities, the Department of Juvenile Justice, and the Agency for Health Care Administration.

The Jacksonville Health and Transition Services program (JaxHATS) continues to provide clinic services and skill-building strategies to transitioning youths. Increasing the percentage of patients and families who receive transition-specific education and training annually is a component of this initiative. CMS provides transition education and information to its Managed Care Plan members ages 12 to 21 verbally, electronically, and in paper form. To do this, CMS staff are required to complete the FloridaHATS transition modules as part of their orientation training and annually. In addition, CMS care coordinators have access to the American Academy of Pediatrics' evidence-based

anticipatory guidance handouts through our Care Coordination Portal.

In reassessment of the alignment of the ESM associated with this NPM, a change from a focus on the provider to a focus on youth perspective was made to make certain their needs are being met and drive future quality improvement initiatives.

In addressing the priority need of access to behavioral/mental health service collaboration, CMS applied and was chosen by the National Maternal Child Workforce Development Center for their 2017 cohort. A multi-agency stakeholder workgroup was formed that included representation from the Department of Children and Families Office of Substance Abuse and Mental Health, the Agency for Health Care Administration, the Family Network on Disabilities, and the National Alliance for Mental Illness. The workgroup completed system mapping, and developed a logic model and an evaluation framework. The evidence-based approach of integrating behavioral health in the primary care setting was an identified strategy for this priority need. The model of integrated primary and behavioral health care addresses disparities related to provider expertise and training, geography, timeliness of treatment, and service coordination.

Regional consultants provided community and provider outreach to promote awareness, education, and resources for integrated primary and behavioral health models of care. Behavioral health indicators were intentionally included in the PCMH readiness assessment, conducted by HealthARCH, to be used as baseline data to build and/or scale up existing behavioral health integration practices.

A statewide summit focused on integration of behavioral health in the primary care setting was held in September 2017. Participants included primary care providers, psychiatrists, and behavioral health staff representing both those at the field and administration level (local and state). Topics included change management, adaptive leadership, social justice, trauma informed care, infant mental health, system of care, and the management of common behavioral health conditions in children.

Resources developed thus far for primary care providers include a behavioral health tool kit that is evidence-based for the management of common pediatric behavioral health condition such as attention deficit disorder, depression, anxiety, and autism. The tool kits include validated, reliable screening instruments; treatment decision algorithms; psychosocial support; and medication guidelines. The tool kits will be accessible through the website for providers to access electronically or print.

Other resources include a searchable statewide directory of behavioral health services that will be located on CMS's website and can be filtered by a variety of means including community, specialty, ages, insurance, languages offered, etc. This directory will be regularly updated to ensure current information. Pilot implementation projects for various models of integrated behavioral health services in a pediatric primary care setting were planned and will be executed in 2018.

While steady progress has been made, as part of implementation science, the focus of this initiative has been on the installation and initial implementation phases, including acquiring resources, preparing staff and organizational drivers, activating data systems, managing change, and initiating quality performance improvement cycles. Continued implementation, including further progress with strategies, activities, and needed system change, is expected to impact child health as a long-term outcome measure. It may take time to see an increase in the established performance measurement targets.

The CMS Plan has partnered with Concordia Behavioral Health to increase the number of CMS Plan enrollees with a behavioral health condition who receive behavioral health treatment including outpatient treatment, inpatient

treatment, and substance abuse services. Multidisciplinary staffing is regularly held to assist in the coordination of care for children and youth with complex behavioral health needs. Children's Medical Services created a state level behavioral health consultant position. The consultant assists regional CMS area offices in the coordination of care for complex cases and, when needed, sits in on the multidisciplinary staffing process to facilitate the coordination of care for escalated cases. The consultant works to identify system issues, identifying needed resources, and providing resolution, while working to bridge practice and policy gaps.

While staying the course with CMS's NPMs and SPMs, the ESMs were realigned to ensure data accuracy and refocus efforts on family and/or youth perspective of experience in driving future quality initiatives. Challenges resulting in changes to the state action plan for CMS include objectives that were not fully achievable or clearly measurable within the desired timeframe and workforce issues. For example, it took more time than anticipated for the creation, recruiting, and hiring of the regional consultants for the community and provider educational components that were built into the state action plan. Recruiting and hiring continues to be a challenge with only four out of the eight regions with a staffed consultant. Strategies for recruitment and retention are being actively explored.

Strategic planning for the future model of the CMS MMA plan will result in changes to the state action plan including focus on its locus of control to ensure achievable objectives, strategies, and activities. Updated ESMs and objectives that are specific, measurable, achievable, and timely will aid in next year's assessment of the overall achievement and effectiveness of the implemented program strategies and approaches. CMS developed and implemented a data system to capture needed information on priority need activities occurring throughout Florida's regions. This system will capture efforts to monitor progress and provide accurate reporting.

Children with Special Health Care Needs - Application Year

Florida will focus strategies and activities to meet the main objectives related to the three priority needs: transition, patient-centered medical home, and access to behavioral health services.

Florida will focus activities and strategies to continue to increase the number of pediatric providers that are certified, recognized, and/or accredited as a patient-centered medical home (PCMH). Florida's priority needs assessment included access to medical homes and primary care providers for CYSHCN, so this was included in the new ESM. The previous ESM that was associated with the NPM was replaced as it focused on providers. The updated ESM and objectives focuses on family satisfaction with access to care received by CYSHCN in a patient-centered medical home or primary care provider. Systematic review of studies demonstrates positive association between patient experience, clinical effectiveness, and patient safety. Experience is a main component of achieving high-quality care, and the inclusion of family perception of experience will help drive quality improvement initiatives.

CMS's partnership with HealthARCH at the University of Central Florida, the state's only designated NCQA Partner in Quality for PCMH practice transformation, will continue to conduct surveys to identify the number and types of current medical home designation for pediatric physicians and practices as well as readiness indicators for patient-centered medical home transformation. For 2018, a second cohort will receive technical assistance directly from HealthARCH in the achievement of their practice transformation.

CMS regional consultants will receive the necessary education and training to provide community and provider outreach, including awareness, education, and resources. Examples of resources include the use of the medical home assessment tool and HealthARCH survey and technical assistance. Data from this outreach will be collected to help capture the number and types of PCMH in Florida. The data received from both UCF HealthArch and CMS regional consultants will be used in CMS's public-facing website that will include a searchable directory for families, to facilitate locating PCMHs in their community.

CMS partners with the Institute for Child Health Policy at the University of Florida for the measurement of child health outcomes, and future surveys will include family's satisfaction with access to patient-centered medical homes and/or primary care providers of families of CYSHCN, regardless of insurance status. This data will be captured in their annual survey. Results obtained will help drive quality improvement initiatives.

Health Care Transition continues as an important priority need for Florida's CYSHCN program. The old ESM was removed as it focused on providers and was difficult to measure as it was written. The newly created ESM focuses on youth and family perspective of satisfaction with transition related resources needed to facilitate transition to adult health care. This new ESM will function as an indicator for quality improvement initiatives.

CMS staff will have the necessary education and training to understand the need and importance of transition, serving as a foundation to further support the education and training of providers, communities, families, and youth. Providers, educators, and community partners are identified as target audiences to promote transition awareness, education, training, and resources to be equipped for appropriate transition planning for youth. Utilizing CMS staff as regional consultants to provide this community outreach with face-to-face and online education, training, and technical assistance; facilitating access to resources. CMS's partnership with Florida HATS and GOT transition includes consultation, collaboration, and utilization of resources to facilitate quality improvement activities.

CMS is creating a public-facing website in conjunction with the continued sponsorship of the Florida HATS website. These websites will mirror each other in transition-based content including a transition health services directory, resources, and training providing multiple points of access for this valuable information. Data reporting systems will

monitor the number of website hits obtained in accessing the resources to determine utilization patterns and capture feedback from youth and families to inform future planning activities.

Youth and family perception of satisfaction, with access to community based resources necessary to facilitate and achieve successful health care transition, will help drive quality measures to ensure youth and family needs are met which is incorporated as the fifth objective. Community transition needs assessments are occurring in various regions across the state, and the results will inform future action planning. In areas identified by needs assessment results, pilots for multidisciplinary transition teams functioning as client specific transition navigators will be implemented to provide additional assistance to CYSHCN who need further transition support to achieve successful outcomes.

Youth voice needs to drive transition program development and activities. CMS is planning to increase youth voice and involvement, to create a program that meets their needs at the community, state, and national levels. Expansion of Regional Youth Transition Councils around the state is underway, and youth involvement in the creation and updating of transition materials, marketing strategies, and program and policy development is being planned. Efforts towards the development of a youth ambassador program that promotes and provides support for self-determination and self-management skills to youth in transition is actively being worked on. Increased support of the Jacksonville Health and Transition Services Program (JaxHATS) will facilitate access to transition clinic services and skill building strategies for transition youths, and will operate as a vehicle for future strategic planning with youth voice.

CMS is dedicated to improving access to services for children with mental/behavioral health conditions. Effectively addressing behavioral/mental health services for children requires a cross-systems collaborative approach. At the state level, the Department has partnered with its sister agencies, Florida's Department of Children and Families-Substance and Abuse Mental Health (DCF-SAMH) and the Agency for Health Care Administration (Medicaid); the Family Network on Disabilities; the National Alliance on Mental Illness; and other stakeholders to work on this initiative. This group of stakeholders participated in the 2017 cohort with the Maternal and Child Health Workforce Development, and a strong foundation was laid to continue to build upon as the action plan moves into full implementation for 2018. Cross system community partnerships will be furthered or established in the expansion phase of this initiative. The monitoring of collaboration efforts with primary care and behavioral health partners at the local, state, and national level will be measured utilizing the Wilder Collaboration Factor Inventory.

CMS staff will receive education and training on issues related to behavioral health conditions in children to increase their skill set to further promote awareness, education, and training to others. Education and training of primary and specialty care providers and community partners in the areas of pediatric behavioral health will be ongoing. National guidelines on integration practices and other evidence-based practices will be used to facilitate education and training activities. A variety of educational and training methods will be utilized including in-person face-to-face meetings, conferences, and on-line resources. Education and training topics will include major pediatric behavioral health diagnosis, including infant mental health, autism spectrum disorder, and other emerging topics identified.

To provide appropriate treatment, providers need to be equipped with the necessary resources to provide direct services or facilitate referrals to needed services. CMS is building a website for providers that will house content specific to behavioral health, including national and state-developed materials specific to this initiative. CMS is partnering with multiple Florida university systems for the development of needed resources to help build capacity at the primary care provider level, and with the maternal and child health workforce. CMS will develop recorded webinars for identified needs. Current planned topics for webinars include: management of common behavioral health diagnosis; co-occurring behavioral and development conditions; trauma informed care; and the opioid crisis. Recorded content will have corresponding continuing education units as a provider-staff incentive, and it will be accessible electronically through CMS and other identified partner's websites. Additional content will be developed

or provided based on needs assessment.

Other activities include the implementation of pilot sites with various models of behavioral health integration within the primary care setting. The University of South Florida College of Behavioral and Community Sciences entered into a contract with CMS for three implementation pilots focused on the use of tele-psychiatry integration models in a pediatric primary care setting. Another university partner will be implementing three additional integrated behavioral health models in the primary care setting based on national guidelines and framework provided by the Substance Abuse and Mental Health Services Administration (SAMHSA). Both pilots will capture child health outcomes, look at sustainability methods, and inform future planning for this initiative.

Parents also need access to education and other resources, to promote access to behavioral health services. The CMS website will be public-facing for families to access and have a specific area devoted to behavioral health. Content will include a variety of national, state, and evidence-based resources and educational materials. Examples of content include, but are not limited to, parent-based screening tools, anticipatory guidance, linkages to other appropriate websites, and a directory for treatment services in their community with filters and searches as described above. Content will be guided by feedback from families and other stakeholders.

CMS is strengthening its public health services and systems for all CYSHCN with the creation of Regional Networks for Access and Quality (RNAQs) and Statewide Networks for Access and Quality (SNAQs). The goal is to improve access and quality for CYSHCN no matter what health insurance they have or where they may live. The focus is to align our Title V priorities and the *Standards for Systems of Care for Children and Youth with Special Health Care Needs, 2.0*, addressing social determinants of health and emerging themes from community needs assessments in the development or strengthening of community systems approaches, including the integration of multisector service systems to maximize outcomes for CYSHCN. This project is part of the MCH Workforce Development Center's 2018 Cohort, and the statewide workgroup includes family voice and representation across the state and across professions.

In addition to RNAQs, CMS will be exploring the restructuring and possible expansion of current specialty programs such as the Craniofacial and Cleft Lip/Palate Centers, Regional Perinatal Intensive Care Centers, Hematology/Oncology Programs, HIV Programs and Children's Comprehensive Kidney Failure Centers into SNAQs. By taking existing programs and structuring them in such a way that they can all benefit from a quality collaborative-type model, CMS feels that health outcomes will improve for a broader CYSHCN population.

As part of the response to the school shooting in Parkland, Florida is investing $400 million to protect students, of which approximately $69 million will focus on improving access to mental health services. CMS is partnering with other state government agencies including the Department of Education and their school districts, the Department of Children and Families and their managing entities, and law enforcement and other community partners statewide to improve communication and collaboration in providing recommendations and an action plan on how to best meet the behavioral health needs of children in Florida.

Florida Department of Health, Office of Children's Medical Services, is under complete health care transformation efforts. Our existing public health workforce, who have specialized skills in the delivery of direct care services for CYSHCN, need to develop necessary strategic skills, expand their scope, and increase their competency as a public health workforce. Workforce development training will allow our current case management staff, supervisors and directors to learn the necessary skill set, strengthening our infrastructure to better impact population health outcomes.

Building upon disciplinary expertise and cultivating public health strategic skills is critical for building effective systems of care encompassing the community and state level. While internal organization benefits from the workforce capacity will certainly be realized, the external impact also has great implication. In carrying out the Department's Title V activities this workforce's primary focus is in community engagement with outreach, training, and education provided to families, providers, organizations, and leaders. In addition, this workforce will be a major stakeholder for our newly designed Regional Networks for Access and Quality (R-NAQs) and Statewide Networks for Access and Quality (S-NAQs). Learned skills will not only be applied to all the activities under Title V, but also shared with the community in a see one, do one, teach one (or pay it forward) model. Furthermore, with our R-NAQ and S-NAQ partnerships, key external stakeholders could potentially benefit from offered trainings, maximizing cross sector partnership for expanded external impact. A true transformational effort depends upon the engagement of the initial core team and then expansion to the larger statewide workforce and inclusion of external stakeholders.

Family and youth involvement is crucial and an integral to this proposal. Families and youths will be a part of our Regional Title V teams and share in the responsibilities of our outreach, training, and education activities. Therefore, it is imperative that they also receive the necessary strategic skills for their workforce development. In addition, inclusion of all Title V staff statewide will help us as a state to be sensitive and intentional in our planning for the individual needs of our various communities. Family and local-based insights will help inform needs and strategies to better understand and address health equities.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

The Department has a policy of seeking ongoing input on priorities and programs from partners and stakeholders. This is accomplished through advisory groups; workgroups; direct meetings with partners; surveying parents, providers and community organizations; program specific websites, our own Online Newsroom, and social media; and working with parent organizations.

During the 2015 Needs Assessment process, the MCH Section developed a web-based electronic survey that was sent to 55 MCH stakeholders, professionals, and partners who were then asked to complete the survey and distribute the survey to consumers, other members of the community, and community partners, some of whom posted the survey on Facebook pages. The purpose of the survey was to obtain feedback on which MCH topics should be identified as priorities for the state and thus become the basis for the 2016 MCHBG application. The response rate was the highest response rate for any MCH needs assessment survey ever conducted by the Department.

The framework used for the CYSHCN Needs Assessment was to first engage families and stakeholders for input to assess needs, then to examine strengths and capacity, and finally selecting priorities and setting performance objectives as outlined in the state action plan. The CYSHCN Needs Assessment utilized an advisory group to steer the direction of the needs assessment process. This core group provided the CMS Needs Assessment Team with valuable feedback related to the needs assessment activities. Families and stakeholders were also asked to complete surveys and participate in workgroups developing the action plans.

Public input was also gained through the state's 32 Healthy Start Coalition's local needs assessment and service delivery plan development and implementation. Consumer experience surveys and focus groups are heavily relied on for community input. Consumers must serve on the coalition boards and the boards must represent the racial, ethnic, gender composition, and socioeconomic diversity of the catchment population. In the course of developing their service delivery plans, coalitions use surveys to gain additional input from both providers and the general community, and share that information with the Department.

The state's 67 county health departments complete a Community Health Assessment and a Community Health Improvement Plan using the Mobilizing for Action through Planning and Partnership (MAPP) strategic approach. This process engages lead organizations in the community, local county and municipal governments, and residents to provide input and develop an understanding of the issues they feel are important, then prioritizes issues related to the community's health and quality of life.

As recipients of Title X funding, local health departments are required to establish an advisory committee of five to nine members who are broadly representative of the community, to review and approve all informational and educational materials prior to distribution. This helps ensure the materials are suitable for the population and community for which they are intended. The advisory committees also discuss and advise the local staff on community concerns and needs as they relate to the reproductive age population.

CMS has a long-standing relationship with private physicians, university health systems, hospitals, and regional and local programs that support CYSHCN. CMS has continuous communications with these groups to ensure continued understanding of the CYSCHN and our partners providing services to this population. Along with the representation of local health departments, Healthy Start Coalitions, health advocacy interest groups, universities, migrant and community health centers, hospitals, local medical societies, and others, this helps to ensure widespread inclusive input.

In 2017, CMS worked to incorporate public input, including family feedback, during the development phase of the invitation to negotiate for a new health plan model. CMS held a series of three public meetings in various locations of the state to seek diverse and comprehensive feedback. The input gathered at these meetings assisted CMS in identifying key elements desired by the public for a successful health plan model serving CYSHCN.

In 2018, CMS began conducting regional needs assessments using the MAPP framework. Using this framework for our needs assessments will allow us to collect feedback from community partners and families to improve the design and framework for the system of care in Florida serving CYSHCN and their families.

The Maternal and Child Health Block Grant and needs assessment documents are available over the Internet on the Department's website. In addition, the Department created an MCH Block Grant inbox dedicated to comments and suggestions regarding the block grant application. The block grant documents and the link to the inbox can be found at: http://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/mch-block-grant.html.

III.G. Technical Assistance

A fundamental first step in accessing health care in the United States is having a way to pay for it, either out of pocket, or through some form of private or public health insurance coverage. Since health care costs are often unpredictable as well as prohibitively expensive, health insurance is vital.

Medicaid eligibility for adults in states that did not expand their programs is quite limited. In states that did not expand their programs, such as Florida, many adults fell into a coverage gap of having incomes above Medicaid eligibility limits but below the lower limit for Marketplace premium tax credits. The majority of people in the coverage gap are working poor—that is, employed either part-time or full-time but still living below the poverty line. If they remain uninsured, adults in the coverage gap are likely to face barriers to needed health services or, if they do require medical care, potentially serious financial consequences. Many are in fair or poor health or are in the age range when health problems start to arise, but lack of coverage may lead them to postpone needed care due to the cost. While the safety net of clinics and hospitals that has traditionally served the uninsured population will continue to be an important source of care for the remaining uninsured, this system has been stretched in recent years due to increasing demand and limited resources.

Further, the racial and ethnic composition of the population that falls into the coverage gap indicate that decisions not to expand their Medicaid programs disproportionately affect people of color, particularly blacks. This disproportionate effect occurs because the racial and ethnic composition of states not expanding their programs differs from the ones that are expanding.

Technical assistance is requested in developing strategies to address the coverage gap, disparities in health coverage, and access and outcomes among people of color through Title V funding.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - FL Title V-Medicaid IAA MOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Glossary.pdf

Supporting Document #02 - Health Equity Workplan Templates.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Florida DOH ORG CHART.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Florida

	FY19 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 20,922,688	
A. Preventive and Primary Care for Children	$ 6,747,011	(32.2%)
B. Children with Special Health Care Needs	$ 8,585,354	(41%)
C. Title V Administrative Costs	$ 1,844,123	(8.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 17,176,488	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 155,212,322	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 155,212,322	
A. Your State's FY 1989 Maintenance of Effort Amount $ 155,212,322		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 176,135,010	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 16,568,999	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 192,704,009	

OTHER FEDERAL FUNDS	FY19 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 4,435,757
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 1,602,442
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 10,530,800

	FY17 Annual Report Budgeted		FY17 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 18,984,911		$ 18,984,911	
A. Preventive and Primary Care for Children	$ 5,881,919	(31%)	$ 5,881,920	(30.9%)
B. Children with Special Health Care Needs	$ 8,539,800	(45%)	$ 8,539,800	(44.9%)
C. Title V Administrative Costs	$ 1,807,880	(9.5%)	$ 1,807,880	(9.6%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 16,229,599		$ 16,229,600	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 155,212,322		$ 155,212,322	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 155,212,322		$ 155,212,322	
A. Your State's FY 1989 Maintenance of Effort Amount $ 155,212,322				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 174,197,233		$ 174,197,233	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 14,466,727		$ 15,247,136	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 188,663,960		$ 189,444,369	

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 2,738,485	$ 3,416,274
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 10,125,800	$ 10,228,420
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 1,602,442	$ 1,602,442

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**

Field Note:
It is anticipated that the entire grant award will be spent.

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Florida

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	$ 2,245,425	$ 1,882,136
2. Infants < 1 year	$ 1,500,775	$ 873,175
3. Children 1 through 21 Years	$ 6,747,011	$ 5,881,920
4. CSHCN	$ 8,585,354	$ 8,539,800
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 19,078,565	$ 17,177,031

IB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	$ 31,843,158	$ 31,013,982
2. Infants < 1 year	$ 21,052,196	$ 13,195,040
3. Children 1 through 21 Years	$ 95,904,450	$ 96,763,624
4. CSHCN	$ 6,412,518	$ 14,239,676
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 155,212,322	$ 155,212,322
Federal State MCH Block Grant Partnership Total	$ 174,290,887	$ 172,389,353

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Florida

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	$ 2,500,000	$ 3,533,991
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 2,500,000	$ 3,533,991
2. Enabling Services	$ 16,578,565	$ 13,643,040
3. Public Health Services and Systems	$ 1,844,123	$ 1,807,880
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 55,459
Physician/Office Services		$ 3,478,532
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 3,533,991
Federal Total	$ 20,922,688	$ 18,984,911

IIB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	$ 2,250,000	$ 1,326,902
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 2,250,000	$ 1,326,902
2. Enabling Services	$ 152,962,322	$ 153,885,420
3. Public Health Services and Systems	$ 0	$ 0
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 67,659
Physician/Office Services		$ 1,259,243
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 1,326,902
Non-Federal Total	$ 155,212,322	$ 155,212,322

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Florida

Total Births by Occurrence: 225,018 **Data Source Year: 2016**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	222,124 (98.7%)	1,289	406	406 (100.0%)

Program Name(s)				
3-Hydroxy-3-methyglutaric aciduria	3-Methylcrotonyl-CoA carboxylase deficiency	Argininosuccinic aciduria	Biotinidase deficiency	Carnitine uptake defect/carnitine transport defect
Citrullinemia, type I	Classic galactosemia	Classic phenylketonuria	Congenital adrenal hyperplasia	Critical congenital heart disease
Cystic fibrosis	Glutaric acidemia type I	Hearing loss	Holocarboxylase synthase deficiency	Homocystinuria
Isovaleric acidemia	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Maple syrup urine disease	Medium-chain acyl-CoA dehydrogenase deficiency	Methylmalonic acidemia (cobalamin disorders)
Methylmalonic acidemia (methylmalonyl-CoA mutase)	Primary congenital hypothyroidism	Propionic acidemia	S, ßeta-Thalassemia	S,C disease
S,S disease (Sickle cell anemia)	Severe combined immunodeficiences	ß-Ketothiolase deficiency	Trifunctional protein deficiency	Tyrosinemia, type I
Very long-chain acyl-CoA dehydrogenase deficiency				

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Hearing Loss	218,376 (97.0%)	9,341	287	284 (99.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The Florida Newborn Screening process follows the child from the point of identification through confirmatory testing and diagnosis.

Form Notes for Form 4:

Hearing loss is included under Other Newborn Screening Tests due to the difference in the number of newborns screened, related to a difference in the testing methodologies, however it is on RUSP as a core condition.

Field Level Notes for Form 4:

1.	**Field Name:**	**Hearing Loss - Referred For Treatment**
	Fiscal Year:	**2017**
	Column Name:	**Other Newborn**

Field Note:
Three confirmed cases not referred were families who were in the process of moving out-of-state, so staff had to deviate from the normal referral process.

Data Alerts: None

Form 5a
Count of Individuals Served by Title V

State: Florida

Annual Report Year 2017

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	138,674	94.4	1.3	4.3	0.0	0.0
2. Infants < 1 Year of Age	80,687	96.7	0.8	2.5	0.0	0.0
3. Children 1 through 21 Years of Age	353,899	96.8	0.8	2.4	0.0	0.0
3a. Children with Special Health Care Needs	83,485	78.7	19.4	1.9	0.0	0.0
4. Others	0					
Total	573,260					

Form Notes for Form 5a:

Florida data on source of coverage does not distinguish between other, none, and unknown. All numbers for columns D, E, and F are included in column D.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2017**
	Field Note: The pregnant women count is the count of women served in program components 25, 26 and 27 (Improved Pregnancy Outcome, Healthy Start Prenatal non-CHD, Healthy Start Prenatal CHD).	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2017**
	Field Note: The infant count is the count of infants (age = 0) served in program components 29, 30 and 31 (Child Health, Healthy Start Child – non-County Health Department (CHD), and Healthy Start Child - CHD)	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2017**
	Field Note: The children age 1 to 22 is the count of children age is 1 to 22served in program. components 29, 30 and 31 (Child Health, Healthy Start Child – non-CHD, and Healthy Start Child - CHD) during calendar 2017. The total CSHCN is included in this rule based on how the TVIS calculates the total, with the row for CSHCN not calculated in the total. Actual total for Row 3 Children 1-22 years of age was 270,414 (not including CSHCN).	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2017**
	Field Note: The CSHCN count is the unduplicated count of clients served under Title V during the reporting period. Even if a client has moved between CMS T19 and T21 programs during the reporting period, we still count him/her once.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2017**
	Field Note: Florida does not collect data on others. There are no fiscal categories for others to generate a total to include on form 3a, so we cannot establish a number for others. Those services are included in categories above.	

Data Alerts: None

Form 5b
Total Percentage of Populations Served by Title V

State: Florida

Annual Report Year 2017

Populations Served by Title V	Total % Served
1. Pregnant Women	79
2. Infants < 1 Year of Age	93
3. Children 1 through 21 Years of Age	60
3a. Children with Special Health Care Needs	12
4. Others	0

Form Notes for Form 5b:

TVIS rounded the percentages to whole numbers. More accurate percentages are:

Pregnant Women 79.2%
Infants < 1 93.4%
Children 1 to 22 59.9%
CSHCN 11.7%

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2017**
	Field Note: Pregnant women percentage calculated on the number of pregnant women screened for Healthy Start.	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2017**
	Field Note: Infant percentage calculated on the number of infants who received newborn screening.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2017**
	Field Note: Children 1-22 percentage calculated on the number of children in public schools plus number served in 5a.	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2017**
	Field Note: CSHCN percentage calculated on the total count of clients in CMS T19 and T21 programs during the reporting period, not unduplicated if a client moved between the two programs.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2017**
	Field Note: Florida does not collect data on others. There are no fiscal categories for others to generate a total to include on form 3a, so we cannot establish a number for others. Those services are included in categories above.	

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Florida

Annual Report Year 2017

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	223,027	93,879	48,084	66,623	243	6,633	181	3,359	4,025
Title V Served	138,313	58,221	29,820	41,318	151	4,114	113	2,084	2,492
Eligible for Title XIX	131,136	55,200	28,273	39,174	143	3,901	107	1,976	2,362
2. Total Infants in State	225,018	97,686	47,905	65,371	221	6,730	202	2,977	3,926
Title V Served	76,688	33,292	16,326	22,278	75	2,293	68	1,014	1,342
Eligible for Title XIX	74,191	32,208	15,794	21,553	72	2,218	66	981	1,299

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Florida

A. State MCH Toll-Free Telephone Lines	2019 Application Year	2017 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(850) 451-2229	(850) 245-2229
2. State MCH Toll-Free "Hotline" Name	Family Health Line	Family Health Line
3. Name of Contact Person for State MCH "Hotline"	Marcia Thomas-Simmons	Marcia Thomas-Simmons
4. Contact Person's Telephone Number	(850) 558-9598	(850) 558-9598
5. Number of Calls Received on the State MCH "Hotline"		11,001

B. Other Appropriate Methods	2019 Application Year	2017 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Florida

1. Title V Maternal and Child Health (MCH) Director	
Name	Shay Chapman, BSN, MBA
Title	Chief, Bureau of Family Health Services
Address 1	4052 Bald Cypress Way, Bin A-13
Address 2	
City/State/Zip	Tallahassee / FL / 32399
Telephone	(850) 245-4464
Extension	
Email	Shay.Chapman@flhealth.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Jeffrey Brosco, MD, PhD
Title	Deputy Secretary for Children's Medical Services
Address 1	4052 Bald Cypress Way, Bin A-06
Address 2	
City/State/Zip	Tallahassee / FL / 32399
Telephone	(850) 245-4213
Extension	
Email	Jeffrey.Brosco@flhealth.gov

3. State Family or Youth Leader (Optional)	
Name	Joane White
Title	Family Support Worker
Address 1	13101 Bruce B. Downs Blvd.
Address 2	
City/State/Zip	Tampa / FL / 33612
Telephone	(813) 396-9772
Extension	
Email	Joane.White@flhealth.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Florida

Application Year 2019

No.	Priority Need
1.	Promote safe and healthy infant sleep behaviors and environments, including improving support systems and the daily living conditions that make safe sleep practices challenging.
2.	Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment.
3.	Promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children.
4.	Promote breastfeeding to ensure better health for infants and children and reduce low food security.
5.	Improve access to health care for women to improve preconception and interconception health, specifically women who face significant barriers to better health.
6.	Increase access to medical homes and primary care for children with special health care needs.
7.	Improve health care transition to all aspects of adult life for adolescents and young adults with special health care needs.
8.	Improve dental care access for children and pregnant women.
9.	Improve access to appropriate mental health services to all children.
10.	Address the social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies.

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Promote safe and healthy infant sleep behaviors and environments including improving support systems, and daily living conditions that make safe sleep practices challenging.	Continued	
2.	Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment.	New	
3.	Promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children.	New	
4.	Promote breastfeeding to ensure better health for infants and children and reduce low food security.	New	
5.	Improve access to health care for women, specifically women who face significant barriers to better health, to improve preconception health.	New	
6.	Increase access to medical homes and primary care for children with special health care needs.	Continued	
7.	Improve health care transition for adolescents and young adults with special health care needs to all aspects of adult life.	Continued	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Florida

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	74.9 %	0.1 %	158,547	211,662
2015	75.7 %	0.1 %	161,407	213,229
2014	75.7 %	0.1 %	159,417	210,735
2013	73.2 %	0.1 %	152,189	207,988
2012	73.1 %	0.1 %	150,595	205,947
2011	73.8 %	0.1 %	150,478	203,797
2010	72.7 %	0.1 %	144,841	199,326
2009	71.7 %	0.1 %	149,827	209,106

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	178.9	3.4	2,832	158,276
2014	162.6	2.8	3,392	208,635
2013	151.8	2.7	3,113	205,039
2012	147.2	2.7	2,992	203,326
2011	144.1	2.7	2,938	203,908
2010	138.4	2.6	2,837	205,037
2009	127.8	2.5	2,683	210,025
2008	117.7	2.3	2,594	220,446

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2016	22.3	1.4	245	1,097,837
2011_2015	23.8	1.5	259	1,086,229
2010_2014	23.6	1.5	254	1,076,550
2009_2013	25.3	1.5	273	1,077,953
2008_2012	21.5	1.4	235	1,093,991
2007_2011	20.8	1.4	233	1,120,008
2006_2010	19.3	1.3	221	1,143,396
2005_2009	20.0	1.3	231	1,155,046

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	8.7 %	0.1 %	19,589	224,935
2015	8.6 %	0.1 %	19,306	224,193
2014	8.7 %	0.1 %	19,065	219,927
2013	8.5 %	0.1 %	18,346	215,338
2012	8.6 %	0.1 %	18,260	213,076
2011	8.7 %	0.1 %	18,527	213,363
2010	8.7 %	0.1 %	18,681	214,525
2009	8.7 %	0.1 %	19,247	221,319

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	10.2 %	0.1 %	22,822	224,921
2015	10.0 %	0.1 %	22,407	224,173
2014	9.9 %	0.1 %	21,846	219,909
2013	10.0 %	0.1 %	21,594	215,168
2012	10.2 %	0.1 %	21,810	212,925
2011	10.3 %	0.1 %	22,018	213,054
2010	10.5 %	0.1 %	22,436	214,301
2009	10.6 %	0.1 %	23,344	221,161

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	26.3 %	0.1 %	59,240	224,921
2015	25.7 %	0.1 %	57,676	224,173
2014	25.7 %	0.1 %	56,543	219,909
2013	26.4 %	0.1 %	56,704	215,168
2012	27.1 %	0.1 %	57,640	212,925
2011	27.8 %	0.1 %	59,291	213,054
2010	30.2 %	0.1 %	64,627	214,301
2009	32.1 %	0.1 %	70,945	221,161

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016/Q2-2017/Q1	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	4.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	6.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	6.6	0.2	1,486	224,944
2014	6.5	0.2	1,425	220,685
2013	6.6	0.2	1,417	216,119
2012	6.6	0.2	1,419	213,877
2011	6.9	0.2	1,473	214,141
2010	6.8	0.2	1,459	215,306
2009	6.8	0.2	1,520	222,137

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	6.2	0.2	1,399	224,269
2014	6.1	0.2	1,344	219,991
2013	6.1	0.2	1,322	215,407
2012	6.1	0.2	1,306	213,148
2011	6.5	0.2	1,379	213,414
2010	6.5	0.2	1,397	214,590
2009	6.9	0.2	1,527	221,394

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	4.4	0.1	986	224,269
2014	4.2	0.1	913	219,991
2013	4.0	0.1	868	215,407
2012	4.0	0.1	847	213,148
2011	4.3	0.1	920	213,414
2010	4.4	0.1	937	214,590
2009	4.5	0.1	994	221,394

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	1.8	0.1	413	224,269
2014	2.0	0.1	431	219,991
2013	2.1	0.1	454	215,407
2012	2.2	0.1	459	213,148
2011	2.2	0.1	459	213,414
2010	2.1	0.1	460	214,590
2009	2.4	0.1	533	221,394

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	243.0	10.4	545	224,269
2014	234.6	10.3	516	219,991
2013	227.5	10.3	490	215,407
2012	229.9	10.4	490	213,148
2011	245.5	10.7	524	213,414
2010	251.2	10.8	539	214,590
2009	257.9	10.8	571	221,394

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	81.2	6.0	182	224,269
2014	87.7	6.3	193	219,991
2013	93.8	6.6	202	215,407
2012	83.0	6.2	177	213,148
2011	82.0	6.2	175	213,414
2010	85.3	6.3	183	214,590
2009	86.3	6.3	191	221,394

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

FAD Not Available for this measure.

State Provided Data	
	2017
Annual Indicator	8.9
Numerator	19,420
Denominator	218,995
Data Source	FL PRAMS
Data Source Year	2015

NOM 10 - Notes:

Florida does not collect data on the percent of infants born with fetal alcohol exposure in the last three months of pregnancy.Data included is from the 2015 PRAMS survey, the number of women who report that they drank alcohol during the last three months of pregnancy.

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	7.2	0.2	1,156	160,465
2014	6.8	0.2	1,433	210,719
2013	6.4	0.2	1,319	207,144
2012	6.0	0.2	1,240	205,662
2011	6.0	0.2	1,229	206,301
2010	4.9	0.2	1,024	208,052
2009	3.5	0.1	740	213,310
2008	2.3	0.1	518	223,776

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	13.5 %	1.8 %	516,250	3,829,255

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	19.7	1.0	402	2,044,233
2015	20.3	1.0	410	2,015,646
2014	20.1	1.0	401	1,995,207
2013	19.5	1.0	385	1,975,876
2012	19.2	1.0	375	1,954,997
2011	20.7	1.0	402	1,941,084
2010	20.9	1.0	407	1,945,037
2009	21.3	1.1	412	1,936,378

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	35.6	1.2	834	2,343,610
2015	32.4	1.2	755	2,330,369
2014	31.6	1.2	730	2,309,604
2013	29.4	1.1	676	2,303,428
2012	31.8	1.2	734	2,309,847
2011	33.0	1.2	768	2,327,390
2010	32.2	1.2	759	2,359,229
2009	35.6	1.2	841	2,365,899

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	14.7	0.6	522	3,543,901
2013_2015	13.2	0.6	465	3,525,120
2012_2014	12.7	0.6	445	3,518,703
2011_2013	13.0	0.6	459	3,542,990
2010_2012	14.1	0.6	509	3,600,735
2009_2011	14.7	0.6	539	3,661,955
2008_2010	16.8	0.7	624	3,707,519
2007_2009	20.2	0.7	748	3,712,629

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	7.9	0.5	280	3,543,901
2013_2015	7.4	0.5	262	3,525,120
2012_2014	7.6	0.5	269	3,518,703
2011_2013	7.5	0.5	264	3,542,990
2010_2012	6.7	0.4	242	3,600,735
2009_2011	6.0	0.4	221	3,661,955
2008_2010	5.6	0.4	209	3,707,519
2007_2009	6.0	0.4	224	3,712,629

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	21.8 %	1.8 %	891,111	4,087,976

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	9.8 %	2.2 %	87,124	891,111

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	4.5 %	1.1 %	152,296	3,378,120

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	8.2 %	1.2 %	275,127	3,347,819

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	49.1 %	6.7 %	215,430	439,176

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	86.7 %	1.7 %	3,541,192	4,082,443

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	12.7 %	0.1 %	23,253	182,567
2012	13.7 %	0.1 %	23,575	171,832
2010	14.6 %	0.1 %	28,384	194,924
2008	15.0 %	0.1 %	22,538	150,046

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	12.3 %	0.6 %		
2013	11.6 %	0.6 %		
2011	11.5 %	0.6 %		
2009	10.3 %	0.5 %		
2007	11.2 %	0.7 %		
2005	10.8 %	0.5 %		

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	17.9 %	2.7 %	302,065	1,690,458

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	6.2 %	0.2 %	258,020	4,142,576
2015	6.9 %	0.2 %	281,867	4,102,077
2014	9.2 %	0.3 %	372,586	4,052,007
2013	11.0 %	0.3 %	443,880	4,025,110
2012	10.8 %	0.3 %	431,221	3,997,922
2011	11.9 %	0.3 %	474,740	3,992,737
2010	12.8 %	0.3 %	513,357	3,999,244
2009	14.8 %	0.3 %	600,227	4,056,356

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	67.1 %	4.3 %	217,900	324,777
2015	66.7 %	3.7 %	209,945	315,014
2014	72.7 %	4.4 %	227,360	312,870
2013	70.0 %	4.4 %	217,207	310,138
2012	68.6 %	3.8 %	213,601	311,516
2011	66.7 %	3.5 %	214,657	321,764
2010	68.2 %	3.5 %	231,322	339,366
2009	49.0 %	3.4 %	174,338	355,765

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	56.7 %	1.8 %	2,148,061	3,787,799
2015_2016	47.9 %	1.8 %	1,777,685	3,712,793
2014_2015	48.0 %	1.9 %	1,780,234	3,712,688
2013_2014	50.3 %	1.9 %	1,867,932	3,714,239
2012_2013	46.9 %	2.6 %	1,722,142	3,672,407
2011_2012	43.9 %	3.3 %	1,632,951	3,716,498
2010_2011	38.9 %	1.9 %	1,442,929	3,709,328
2009_2010	37.9 %	2.4 %	1,366,413	3,605,312

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	58.4 %	4.9 %	338,492	579,355
2015	62.5 %	4.9 %	359,256	574,582
2014	57.2 %	5.3 %	327,470	572,114
2013	49.7 %	5.2 %	283,474	570,577
2012	39.4 %	5.2 %	222,784	565,651
2011	50.0 %	4.5 %	282,686	565,363
2010	41.1 %	5.2 %	221,673	539,914
2009	39.3 %	4.3 %	217,892	554,254

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	53.5 %	4.7 %	323,140	603,548
2015	45.3 %	5.0 %	271,278	598,962
2014	41.0 %	5.1 %	244,885	597,836
2013	27.8 %	4.4 %	166,254	597,984
2012	21.4 %	4.8 %	127,078	594,763
2011	NR	NR	NR	NR

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	89.7 %	2.2 %	1,061,480	1,182,903
2015	87.3 %	2.5 %	1,024,631	1,173,544
2014	90.7 %	2.1 %	1,061,277	1,169,950
2013	84.8 %	2.8 %	990,810	1,168,561
2012	86.8 %	2.6 %	1,006,684	1,160,414
2011	77.5 %	2.7 %	899,634	1,160,986
2010	61.9 %	3.3 %	688,244	1,111,347
2009	47.2 %	3.1 %	536,871	1,137,222

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	76.3 %	2.9 %	902,900	1,182,903
2015	70.4 %	3.3 %	825,716	1,173,544
2014	72.2 %	3.4 %	844,322	1,169,950
2013	72.3 %	3.3 %	844,690	1,168,561
2012	68.6 %	3.5 %	796,377	1,160,414
2011	61.2 %	3.1 %	710,999	1,160,986
2010	55.1 %	3.4 %	612,809	1,111,347
2009	52.7 %	3.1 %	599,159	1,137,222

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	19.3	0.2	11,195	579,919
2015	20.8	0.2	11,957	574,463
2014	22.5	0.2	12,816	568,741
2013	24.6	0.2	13,962	568,335
2012	28.1	0.2	15,952	568,628
2011	29.6	0.2	17,125	578,320
2010	32.3	0.2	19,127	593,034
2009	36.6	0.3	22,021	601,533

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

FAD Not Available for this measure.

State Provided Data	
	2017
Annual Indicator	11.7
Numerator	25,143
Denominator	214,828
Data Source	FL PRAMS Data
Data Source Year	2015

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	5.0 %	1.2 %	201,082	4,062,104

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: Florida

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2016	**2017**
Annual Objective	68	69
Annual Indicator	68.8	69.6
Numerator	2,287,771	2,337,875
Denominator	3,324,933	3,359,251
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	70.0	71.0	72.0	73.0	74.0	75.0

Field Level Notes for Form 10a NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	**2017**
Annual Objective	81.3	82.3
Annual Indicator	81.1	76.1
Numerator	171,099	155,283
Denominator	210,888	203,992
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	83.2	84.0	84.7	85.3	85.8	86.2

Field Level Notes for Form 10a NPMs:

None

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	**2017**
Annual Objective	27.7	29.4
Annual Indicator	18.4	24.3
Numerator	37,940	49,156
Denominator	206,047	201,974
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	31.1	32.8	34.5	36.2	36.9	37.5

Field Level Notes for Form 10a NPMs:

None

NPM 5A - Percent of infants placed to sleep on their backs

FAD for this measure is not available for the State.

State Provided Data		
	2016	2017
Annual Objective	78.3	73.3
Annual Indicator	69.5	74
Numerator		
Denominator		
Data Source	FL PRAMS Data	FL PRAMS Data
Data Source Year	2014	2015
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	74.5	75.4	76.3	77.1	77.9	78.7

Field Level Notes for Form 10a NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	78
Numerator	
Denominator	
Data Source	FI PRAMS Data
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	82.0	83.0	84.0	85.0	86.0

Field Level Notes for Form 10a NPMs:

None

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	60
Numerator	
Denominator	
Data Source	FI PRAMS Data
Data Source Year	2015
Provisional or Final ?	Provisional

Annual Objectives					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	62.0	63.0	64.0	65.0	66.0

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
FL PRAMS data for this measure will be available late in 2018 or early 2019. Data provided is an estimate based on CDC data from 2014 that 55 percent of babies nationwide were sleeping with soft objects or loose bedding. Indicator and objectives will be updated when FL PRAMS data becomes available.

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CHILD		
	2016	**2017**
Annual Objective		
Annual Indicator		32.5
Numerator		428,914
Denominator		1,321,058
Data Source		NSCH-CHILD
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	33.5	34.0	34.5	35.0	35.5	40.0

Field Level Notes for Form 10a NPMs:

None

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2016	**2017**
Annual Objective	20.2	19
Annual Indicator	19.5	19.5
Numerator	150,914	150,914
Denominator	772,407	772,407
Data Source	YRBSS	YRBSS
Data Source Year	2015	2015

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Perpetration	
	2017
Annual Objective	
Annual Indicator	5.1
Numerator	72,001
Denominator	1,409,777
Data Source	NSCHP
Data Source Year	2016

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Victimization	
	2017
Annual Objective	
Annual Indicator	22.3
Numerator	313,655
Denominator	1,404,246
Data Source	NSCHV
Data Source Year	2016

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	18.7	18.4	18.1	17.8	17.5	17.2

Field Level Notes for Form 10a NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		33.5
Numerator		298,857
Denominator		891,111
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	46.0	48.0	50.0	52.0	54.0	56.0

Field Level Notes for Form 10a NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		7.5
Numerator		27,551
Denominator		368,685
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	10.0	12.0	14.0	16.0	18.0	20.0

Field Level Notes for Form 10a NPMs:

None

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2016	**2017**
Annual Objective	6.5	6.4
Annual Indicator	5.8	5.1
Numerator	12,970	11,454
Denominator	223,231	224,109
Data Source	NVSS	NVSS
Data Source Year	2015	2016

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	6.3	6.2	6.1	6.0	5.9	5.8

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: Florida

SPM 1 - The percentage of children that need mental health services that actually receive mental health services.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		58
Annual Indicator	57.7	49.1
Numerator		
Denominator		
Data Source	National Survey of Children's Health	National Survey of Children's Health
Data Source Year	2011/2012	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	50.0	51.0	52.0	53.0	54.0	55.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The survey methods changed from the 2011/12 survey when the 2016 indicator was determined and the 2016 survey when the 2017 indicator was determined. The apparent drop in percentage is due to the change in methodology rather than less children being served. Objectives were adjusted to reflect new data.

SPM 2 - The percentage of low-income children under age 21 who access dental care.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		37.4
Annual Indicator	35.9	37.4
Numerator	986,425	1,037,798
Denominator	2,745,598	2,774,485
Data Source	Florida Agency for Health Care Administration	Florida Agency for Health Care Administration
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	38.9	40.4	41.9	43.4	44.9	45.4

Field Level Notes for Form 10a SPMs:

None

SPM 3 - The percentage of parents who read to their young child age 0-5 years

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		45.1
Annual Indicator	42.6	34.2
Numerator	545,146	435,455
Denominator	1,279,782	1,273,260
Data Source	2011/12 National Survey of Children's Health	2016 National Survey of Child Health
Data Source Year	2011/2012	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	34.7	35.2	35.7	36.2	36.7	37.2

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The survey methods changed from the 2011/12 survey when the 2016 indicator was determined and the 2016 survey when the 2017 indicator was determined. The apparent drop in percentage is due to the change in methodology rather than less children being read to. Objectives were adjusted to reflect new data.

SPM 4 - The percentage of individuals who received workforce development that reported improved public health competency and capacity.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	75.0	80.0	85.0	90.0	95.0

Field Level Notes for Form 10a SPMs:

None

Form 10a
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Florida

ESM 1.1 - The number of interconception services provided to Healthy Start clients

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		27,000
Annual Indicator	25,558	43,507
Numerator		
Denominator		
Data Source	Well Family System	Well Family System
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	44,000.0	44,500.0	45,000.0	45,500.0	46,000.0	46,500.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
In 2017, Healthy Start Coalitions began reporting numbers in the new Well Family System. This caused the significant change in the indicator data, and required us to update the objectives.

ESM 4.1 - The number of birthing hospitals implementing steps to becoming a Baby Steps to Baby Friendly hospital or implementing steps to achieve a Florida Breastfeeding Coalition's Quest for Quality Maternity Care Award

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		42
Annual Indicator	41	42
Numerator		
Denominator		
Data Source	Chronic Disease Program	Chronic Disease Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Field Level Notes for Form 10a ESMs:

None

ESM 4.2 - The number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	19.0	20.0	21.0	22.0	23.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.1 - The number of birthing hospitals implementing steps to become Safe Sleep Certified

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		15
Annual Indicator	10	13
Numerator		
Denominator		
Data Source	Maternal and Child Health Section	Maternal and Child Health Section
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Field Level Notes for Form 10a ESMs:

None

ESM 5.2 - The number of birthing hospitals that are Safe Sleep Certified

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	17.0	19.0	21.0	23.0	25.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.1.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	54.0	55.0	56.0	57.0	58.0

Field Level Notes for Form 10a ESMs:

None

ESM 9.1 - The number of high schools implementing the evidence-based Green Dot violence prevention and intervention strategy

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		6
Annual Indicator	6	6
Numerator		
Denominator		
Data Source	Sexual Violence Prevention Program	Sexual Violence Prevention Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Field Level Notes for Form 10a ESMs:

None

ESM 9.2 - The number of students who participate in an evidence-based program that promotes positive youth development and non-violence intervention skills

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	13,100.0	13,500.0	13,900.0	14,300.0	14,700.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.1 - Number of pediatric providers in Florida who have received information related to the Patient Centered Medical Home (PCMH) and who have completed a Medical Home Assessment Tool for their practice.

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		500
Annual Indicator	0	500
Numerator		
Denominator		
Data Source	Florida Children's Medical Services	Florida Children's Medical Services
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Provisional

Field Level Notes for Form 10a ESMs:

None

ESM 11.2 - Percent of satisfaction of access to care for families of children with special health care needs who received care in a patient centered medical home or by a primary care provider.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	50.0	55.0	60.0	65.0	70.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.1 - Number of pediatric providers in Florida who have practices that have a Health Care Transition (HCT) policy or youth with readiness assessment (with physicals) and plans of care.

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		500
Annual Indicator	0	500
Numerator		
Denominator		
Data Source	Florida Children's Medical Services	Florida Childrens Medical Services
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Provisional

Field Level Notes for Form 10a ESMs:

None

ESM 12.2 - Percent of satisfaction of access for youth with special health care needs who report having access to community-based resources necessary to make transition to adult health care.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	50.0	55.0	60.0	65.0	70.0

Field Level Notes for Form 10a ESMs:

None

ESM 14.1.1 - The number of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to Healthy Start clients

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	7,000.0	7,250.0	7,500.0	7,750.0	8,000.0

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: Florida

SPM 1 - The percentage of children that need mental health services that actually receive mental health services.
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase the percentage of children with a mental/behavioral condition who receive treatment.
Definition:	**Numerator:** Number of children that needed mental health services that actually received mental health services. **Denominator:** Number of children that needed mental health services. **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MHMD-5: Increase the proportion of children with mental health problems who receive treatment.
Data Sources and Data Issues:	National Survey of Children's Health
Significance:	Linking children who have mental health and behavioral health conditions to timely and appropriate treatment will improve health outcomes and improve the child's ability to function optimally at home, at school, and in society

SPM 2 - The percentage of low-income children under age 21 who access dental care.
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To increase the number of eligible low-income children who receive dental care.
Definition:	**Numerator:** Number of Medicaid eligible children (unduplicated) age 0-20 receiving any dental or oral health service. **Denominator:** Total number of Medicaid eligible children age 0-20. **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	OH-8: Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year.
Data Sources and Data Issues:	Agency for Health Care Administration (Medicaid DSS)
Significance:	Oral health is vitally important to overall health and well-being. Oral health is much more than just healthy teeth. Oral health is a state of being free from chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects, periodontal disease, tooth decay and tooth loss, and other disease and disorders that affect the oral cavity. Good oral health also includes the ability to carry on basic human functions such as chewing, swallowing, speaking, smiling, and singing. These functions are critical in our communication with others and interaction with the world. Oral health is also firmly linked with overall health. Research has shown a link to diabetes, heart and lung disease, stroke, respiratory illnesses, and conditions of pregnant women including the delivery of pre-term and low birth weight infants. Changes in the mouth often are the first signs of problems elsewhere in the body, such as infectious diseases, immune disorders, nutritional deficiencies, and cancer. Maintaining good oral and physical health requires a multi-faceted approach including a healthy diet, proper exercise, access to health care professionals, and public health initiatives such as fluoridated community water and preventive dental services including dental sealants. Dental disease is largely preventable through effective health promotion and dental disease prevention programs. Collaborative partnerships among individuals, communities, health care providers and governing bodies are necessary to achieve optimal oral health in Florida.

SPM 3 - The percentage of parents who read to their young child age 0-5 years
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To increase the number of parents who read to their child age 0-5.
Definition:	**Numerator:** Number of children aged 0 to 5 years whose parents report that someone in their family read to the child every day in the past week. **Denominator:** Number of children aged 0 to 5 years. **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	EMC-2.3 Increase the proportion of parents who read to their young child.
Data Sources and Data Issues:	National Survey of Children's Health
Significance:	Encouraging parents to read to their child has a positive impact on children, including but not limited to, increased positive parenting, improvement in the parent-child bond, and improved language development in children.

SPM 4 - The percentage of individuals who received workforce development that reported improved public health competency and capacity.
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Establish a sustainable public health workforce, improving competency and capacity of the public health system serving Children and Youth with Special Health Care Needs.
Definition:	**Numerator:** Number of Title V staff, families and partners participating in a sponsored workforce development event reporting improved public heath competency and capacity. **Denominator:** Number of Title V staff, families and partners that participated in a sponsored workforce development event. **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	PHI-2 Increase the proportion of Tribal, State, and local public health personnel who receive continuing education consistent with the Core Competencies for Public Health Professionals
Data Sources and Data Issues:	Office of Children's Medical Services Managed Care Plan and Specialty Programs Data
Significance:	The development and implementation of a learning culture, with training and support activities, will improve competency and capacity of the public health agency's workforce. Necessary strategic skills development positions the Title V workforce to meet the evolving needs of the public. This includes improved access to care, quality improvement tools to drive transformation, and the promotion of integration within public health and across organizational boundaries including primary care, the community based service delivery systems and other key partnerships.

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: Florida

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Florida

ESM 1.1 - The number of interconception services provided to Healthy Start clients
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase the number of interconception care services provided to clients in the Healthy Start Program
Definition:	**Numerator:** Number of interconception services provided to Healthy Start clients **Denominator:** N/A **Unit Type:** Count **Unit Number:** 80,000
Data Sources and Data Issues:	Department of Health, Health Management System
Significance:	Interconception care helps providers identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management. The goal to improve the woman's health and help reduce health risks to her future baby, resulting in improved outcomes for newborns and mothers.

ESM 4.1 - The number of birthing hospitals implementing steps to becoming a Baby Steps to Baby Friendly hospital or implementing steps to achieve a Florida Breastfeeding Coalition's Quest for Quality Maternity Care Award
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Inactive - Replaced
Goal:	To increase the number of birthing hospitals in Florida that are implementing steps to become Baby Friendly Certified or implementing steps to achieve a Florida Breastfeeding Coalition's Quest for Quality Maternity Care Award.
Definition:	**Numerator:** Number of birthing hospitals in Florida that are implementing steps to becoming Baby Friendly or implementing steps to achieve a Florida Breastfeeding Coalition's Quest for Quality Maternity Care Award. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 60
Data Sources and Data Issues:	Internal documentation, numbers kept within the Maternal and Child Health Section. The number may decrease as hospitals reach certification.
Significance:	Baby Friendly birthing hospitals offer an optimal level of care for infant feeding and mother/baby bonding. They provide mothers with the information, confidence, and skills necessary to successfully initiate and continue breastfeeding their babies or feed formula safely. Breastfeeding provides the most complete nutrition possible, the optimal mix of nutrients and antibodies necessary for each baby to thrive. Studies have shown that breastfed children have far fewer and less serious illnesses than those who never receive breast milk, including a reduced risk of SIDS, childhood cancers, and diabetes. Recent studies show that women who breastfeed enjoy decreased risks of breast and ovarian cancer, anemia, and osteoporosis. Both mother and baby enjoy the emotional benefits of the very special and close relationship formed through breastfeeding.

ESM 4.2 - The number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation. NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation.
Definition:	**Numerator:** The number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Baby Steps to Baby Friendly USA multi-year tracker
Significance:	Baby Friendly birthing hospitals offer an optimal level of care for infant feeding and mother/baby bonding. They provide mothers with the information, confidence, and skills necessary to successfully initiate and continue breastfeeding their babies or feed formula safely. Breastfeeding provides the most complete nutrition possible, the optimal mix of nutrients and antibodies necessary for each baby to thrive. Studies have shown that breastfed children have far fewer and less serious illnesses than those who never receive breast milk, including a reduced risk of SIDS, childhood cancers, and diabetes. Recent studies show that women who breastfeed enjoy decreased risks of breast and ovarian cancer, anemia, and osteoporosis. Both mother and baby enjoy the emotional benefits of the very special and close relationship formed through breastfeeding.

ESM 5.1 - The number of birthing hospitals implementing steps to become Safe Sleep Certified
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Inactive - Replaced
Goal:	To increase the number of birthing hospitals in Florida that are Safe Sleep Certified.
Definition:	**Numerator:** Number of birthing hospitals in Florida that are Safe Sleep Certified. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 50
Data Sources and Data Issues:	Internal documentation, numbers kept within the Maternal and Child Health Section.
Significance:	Safe sleep guidelines are endorsed by the American Academy of Pediatrics, the National Institute of Health, the CDC and by other nationally recognized programs. A hospital safe sleep certification process would ensure that participating hospitals develop a policy to support safe sleep efforts and that trusted hospital professionals provide consistent safe sleep messaging to parents.

ESM 5.2 - The number of birthing hospitals that are Safe Sleep Certified
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To increase the number of Florida birthing hospitals that are Safe Sleep Certified.
Definition:	**Numerator:** Number of Florida birthing hospitals in Florida that are Safe Sleep Certified **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Cribs for Kids in Florida
Significance:	Safe sleep guidelines are endorsed by the American Academy of Pediatrics, the National Institute of Health, the CDC and by other nationally recognized programs. A hospital safe sleep certification process would ensure that participating hospitals develop a policy to support safe sleep efforts and that trusted hospital professionals provide consistent safe sleep messaging to parents.

ESM 8.1.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of students who attend schools in Florida Healthy School Districts.
Definition:	**Numerator:** The number of school districts that apply for the evidence-based Florida Healthy School District recognition. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Florida Partnership for Healthy Schools
Significance:	The Florida Healthy School District Self-Assessment Tool was developed by experts from state agencies, school districts, and community partners to assist districts in achieving the highest standards in infrastructure and the eight component areas of the Centers for Disease Control and Prevention's (CDC) Coordinated School Health (CSH) model. It was piloted, field tested and fully vetted prior to its release in 2009. Districts that earn recognition as a Florida Healthy School District have made a high level commitment to meeting the health needs of students and staff by removing barriers to learning and maximizing district resources through the implementation of the CSH/Whole School, Whole Community, Whole Child (WSCC) approach including physical education and physical activity.

ESM 9.1 - The number of high schools implementing the evidence-based Green Dot violence prevention and intervention strategy
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Inactive - Replaced
Goal:	To increase the number of high schools implementing Green Dot, so more students receive instruction on how to practice violence prevention and reduce power-based personal violence.
Definition:	**Numerator:** The number of schools implementing the Green Dot initiative. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	The number may stay the same as the program takes three to five years to implement.
Significance:	Bullying is a serious detriment to a child's health, sense of well-being, safety, education, and emotional development, and greatly increases the risk of self-injury and suicide.

ESM 9.2 - The number of students who participate in an evidence-based program that promotes positive youth development and non-violence intervention skills
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To increase the number of students who participate in an evidence based program that promotes positive youth development and non-violence intervention skills.
Definition:	**Numerator:** The number of students completing Positive Youth Development programs and the number of students participating in the Green Dot high School strategy overview and bystander training.. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 50,000
Data Sources and Data Issues:	Programmatic sign in sheets/class rosters and the Florida Department of Health Sexual Violence Data Registry
Significance:	Positive Youth Development is an evidence-based strategy that focuses on asset-building and goal-setting as a means of risk reduction. PYD programs have been proven to positively impact teen birth, healthy relationships, college and career preparation, and overall self-esteem. The PYD approach supports the physical, emotional, social and mental health of adolescents. Research shows risk factors such as poor social competence, low academic achievement, impulsiveness, truancy, and poverty increase an individual's risk of violence. Developing youth life skills, improving their participation and performance in school, and increasing their prospects for employment can help protect them from violence, both in childhood and later in life. Developing life skills for intervention and self-empowerment can help young people avoid violence, by improving their social and emotional competencies and teaching them how to deal effectively and non-violently with conflict.

ESM 11.1 - Number of pediatric providers in Florida who have received information related to the Patient Centered Medical Home (PCMH) and who have completed a Medical Home Assessment Tool for their practice.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Inactive - Replaced
Goal:	Increase access to medical homes and primary care for children with special health care needs.
Definition:	**Numerator:** Number of pediatric providers in Florida who have received information related to PCMH and who have completed a Medical Home Assessment Tool for their practice. **Denominator:** Number of pediatric providers in Florida. **Unit Type:** Count **Unit Number:** 10,000
Data Sources and Data Issues:	Florida Children's Medical Services
Significance:	Children and youth with special health care needs have varying degrees of medical complexities. Linking them to services within a patient-centered medical home ensures the patient and their family are partners in the decision making and the child receives comprehensive, coordinated, quality health care across a continuum.

ESM 11.2 - Percent of satisfaction of access to care for families of children with special health care needs who received care in a patient centered medical home or by a primary care provider.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To increase the percentage of family satisfaction with access to care received in a patient-centered medical home and/or primary care for children that have special health care needs.
Definition:	**Numerator:** Percent of families reporting at least an 80% satisfaction rate **Denominator:** All families surveyed **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Survey: University Florida Institute for Child Health Policy
Significance:	Patient experience is main component of achieving high-quality care. Systematic review of studies demonstrates positive association between patient experience and clinical effectiveness and patient safety, decreasing health care costs. The identified priority need included primary care, and not just patient-centered medical home, which necessitated the inclusion of this in the measure. The results of this measure will help drive quality improvement activities, driven by family input, to improve access.

ESM 12.1 - Number of pediatric providers in Florida who have practices that have a Health Care Transition (HCT) policy or youth with readiness assessment (with physicals) and plans of care.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

<table>
<tr><td>Measure Status:</td><td>Inactive - Replaced</td></tr>
<tr><td>Goal:</td><td>Increase the percent of youth with special health care needs who receive services necessary to transition to adult health care, work and independence.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of pediatric providers in Florida who have practices that have a HCT policy or youth with readiness assessment (with physicals) and plans of care.</td></tr>
<tr><td>Denominator:</td><td>Number of pediatric providers in Florida.</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>10,000</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Florida Children's Medical Services</td></tr>
<tr><td>Significance:</td><td>Linking youth who are transitioning from pediatric to adult health care services, school, and independence will improve health outcomes and improve the young adult’s ability to function optimally at home, at school and in society.</td></tr>
</table>

ESM 12.2 - Percent of satisfaction of access for youth with special health care needs who report having access to community-based resources necessary to make transition to adult health care.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	To increase the percent of youth satisfaction with access to community based resources necessary to make transition to adult health care.
Definition:	**Numerator:** Number of youth you have access to community-based resources to make transition to adult health care. **Denominator:** All youth surveyed **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Survey: University of Florida Institute for Child Health Policy
Significance:	The successful transition of youth and young adults with special health care needs, is essential to individual self-determination and self-management. Youth perception of satisfaction with access to community based resources needed to make a transition to adult health care will help drive quality measures to ensure their transition needs are met from their perspective. This will help drive program development and quality improvement activities to support the achievement of successful outcomes.

ESM 14.1.1 - The number of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to Healthy Start clients
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	To increase the number of pregnant women who receive Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services.
Definition:	**Numerator:** Number of SCRIPT services provided to Healthy Start clients. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 50,000
Data Sources and Data Issues:	Well Family System
Significance:	Smoking during pregnancy creates risks for adverse outcomes.

Form 11
Other State Data

State: Florida

The Form 11 data are available for review via the link below.

Form 11 Data