Maternal and Child Health Services Title V Block Grant

Florida

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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.

Rick Scott
Governor

John H. Armstrong, MD, FACS
State Surgeon General & Secretary

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

July 13, 2015

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 Block Grant Application for FY2016. 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 FY2016.

If you have any questions, please contact Bob Peck at (850) 245-4465.

Sincerely,

Celeste Philip, MD, MPH
Deputy Secretary for Health
Deputy State Health Officer for CMS

Robert Herron
Chief
Office of Budget and Revenue Management

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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 C of the 2015 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 "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

The Florida Department of Health is responsible for administering the Title V Maternal and Child Health (MCH) Block Grant programs. The majority of these programs fall within the auspices of the Divisions of Community Health Promotion and Children's Medical Services (CMS). The MCH and Children with Special Health Care Needs (CSHCN) programs are located within these two divisions.

According to 2014 population estimates, 78.2 percent of Florida's nearly 20 million residents are white, 16.7 percent black, and 5.1 percent other. Of the total population, 23.8 percent are Hispanic and 76.2 percent non-Hispanic. More than half of the state's population (51.5 percent) is between the ages of 25-64 and 30.1 percent are between the ages of 0-24. The Department makes a concerted effort to support Florida's culturally diverse MCH population by tailoring services to meet the needs of different cultures.

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 six health domains. These priorities also determined the eight national performance measures (NPM) chosen for programmatic focus.

The following is a brief description of the state's Title V program with linkages to the selected state priorities, NPMs, the six health domains, and defined MCH population groups all of which are intended to "move the needle" in addressing the needs of Florida's mothers, infants, children and youth, and CSHCN. Although social determinants of health was not an available option to select from the national performance measures, the Department has made this a top priority of focus as it relates to maternal and child health and as a cross-cutting life course branding approach through all aspects of the Department's programs and culture.

NPM 1: Percent of women with a past year preventive medical visit
Health Domain: Women/Maternal Health
MCH Population Group: Pregnant women, mothers, and infants up to age 1
Selected State Priority: Improve access to health care for women, specifically women who face significant barriers to better health, to improve preconception health.

Women's health, at all ages of the lifespan and those whose circumstances have made them vulnerable to poor health, is important and contributes to the well-being of Florida's families. The Title V program focuses on both preconception and interconception health, fully recognizing the importance of improving the health of all women of reproductive age to ensure better birth outcomes and healthier babies. Florida's goal is that by 2018, 28 percent of women having a live birth will receive preconception counseling about healthy lifestyle behaviors and prevention strategies from a health care practitioner prior to pregnancy.

The Department is using Title V funds to help make available interconception/preconception care (ICC/PCC) through

the state's Healthy Start program. Neither ICC nor PCC is reimbursable by Medicaid. ICC/PCC services are offered to Healthy Start clients who have social or medical risk factors that may lead to a poor pregnancy outcome.

Reduction of maternal death is a national and state priority. Florida's Pregnancy Associated Mortality Review (PAMR) is an ongoing system of surveillance that collects and analyzes information related to maternal deaths in order to promote system improvements through evidence-based actions aimed at preventing future untimely deaths. The Florida Perinatal Quality Collaborative (FPQC) at the Lawton and Rhea Chiles Center for Healthy Mothers and Babies is contracted by the Department to engage perinatal stakeholders to improve maternal and infant health outcomes through design, implementation, and evaluation of processes, and to enhance quality improvement efforts.

NPM 4: A) Percent of infants who are ever breastfed, and B) Percent of infants breastfed exclusively for 6 months
Health Domain: Perinatal/Infant Health
MCH Population Group: Pregnant women, mothers, and infants up to age 1
Selected State Priority: Promote breastfeeding to ensure better health for infants and children and reduce low food security.

Breastfeeding is a new priority selected based on the 2015 needs assessment. There is a clear link to the state's priority to promote breastfeeding as a means of ensuring better health for infants and children and reducing low food security among children. Promoting breastfeeding is an important focus of the Title V program and is recognized as a major health benefit to infant and mother as well as an enhancement of maternal/child bonding. The Department provides breastfeeding promotion and support activities through a number of different programs, including the Women's, Infant and Children (WIC) program, the Child Care Food Program, Healthy Start, and the Bureau of Chronic Disease Prevention. The Title V program coordinates with the WIC program on many of their breastfeeding initiatives, such as breastfeeding peer counseling and establishing policies to promote and support breastfeeding as the preferred method of infant feeding.

NPM 5: Percent of infants placed to sleep on their backs
Health Domain: Perinatal/Infant Health
MCH Population Group: Pregnant women, mothers, and infants up to age 1
Selected State Priority: Promote safe and healthy infant sleep behaviors and environments including improving support systems, and daily living conditions that make safe sleep practices challenging.

The Department formed a statewide Sudden Unexpected Infant Death (SUID) Workgroup that provides input on the state work plan to reduce sleep-related infant deaths, and also created a logic model for conducting training efforts on Safe Sleep practices for health care providers, the Florida Hospital Association and other birthing centers, parents, caretakers, and the general public. The Title V program assisted with the development of training for WIC program staff to encourage discussion of safe sleep practices with clients and continued training for Healthy Start and local health department staff on how to deliver SUID risk reduction education at the local level. In February 2015, the Department updated its Brand Guide, the primary tool the Department uses for communicating with the public, partners and the legislature, to include a requirement that "All media exposure of infant sleeping must portray these infants in a safe sleep environment. A safe sleep environment is described as infants sleeping on their backs, alone, and in a crib." These activities, along with data showing that safe sleep initiatives have a significant impact on reducing infant mortality, made the selection of this measure a valid choice for "moving the needle" with the Title V program.

NPM 8: Percent of children ages 6-11 and adolescents ages 12-17 who are physically active at least 60 minutes per day
Health Domain: Child Health
MCH Population Group: Children
Selected 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.

The importance of physical activity to reduce obesity and improve health is a major focus of the Department's

Healthiest Weight Florida initiative. Studies show that for many children, a decline in physical activity begins in middle school, but children who continue to be physically active through middle school and 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 life span by reducing obesity and the risk of many chronic diseases.

As of the 2013-14 school year, 19.1 percent of Florida's first, third and sixth grade students were found to be in the obese category as defined by Centers for Disease Control guidelines, compared to 18.3 percent in 2012-2013. To address this issue and increase healthy eating and active living among children, the Department's School Health Services Program joined with the Department's Healthiest Weight Florida and its partners to provide schools with the Nature Play "Prescription" Program, linkages to the Farm to School and Fresh from Florida programs, guidance on 5-2-1-0 and similar programs, walking school bus programs, classroom gardens and much more. The School Health Services program is also collaborating with the Florida State University College of Medicine-Immokalee Health Education site and Healthiest Weight Florida to provide tools, such as the HealthyMe Florida toolkit, for obesity prevention and intervention for adolescents in rural or healthcare provider shortage areas.

NPM 9: Percent of adolescents, ages 12-17, who are bullied or who bully others
Health Domain: Adolescent Health
MCH Population Group: Children
Selected 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. In 2011, data shows that 33 percent of Florida public school students experienced some form of bullying. Data from the 2011 Youth Risk Behavior Survey indicates that a significantly higher number of students experiencing bullying described their grades as D's and F's in school during the past 12 months. The number of ninth grade students reporting being bullied is significantly higher than for students in 11th and 12th grades. Female students are significantly more likely than males to have experienced some form of bullying, name calling or teasing in the past year. Bullying is a new priority for the Title V program and provides the opportunity for the state to have an impact on improving health throughout the life span by reducing the percentage of adolescents bullied and increasing the proportion of students who graduate.

NPM 11: Percent of children with and without special health care needs having a medical home
Health Domain: CSHCN
MCH Population Group: CSHCN
Selected State Priority: Increase access to medical homes and primary care for children with special health care needs.

A patient-centered medical home (PCMH) provides accessible, continuous, comprehensive, family-centered, coordinated, and compassionate medical care. While all children should have a PCMH, the PCMH is especially advantageous for CSHCN as they typically require coordination of care between primary care specialists. As an example, children with attention deficit hyperactivity disorder (ADHD) plus other co-occurring conditions are less likely to have an unmet health care need and fewer missed school days when they have a PCMH.

CMS is working to increase the number of pediatric providers in the state who identify with a level of medical homeness. Medical homeness is described as a provider or practice where medical care is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. One of CMS' objectives is to increase the number of CSHCN in the state assigned to a provider who is practicing at a higher level of medical homeness by promoting and improving CSHCN assignments to CMS-credentialed primary care providers who identify with a level of medical homeness to provide support and education to pediatric providers in achieving higher levels of medical homeness.

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

Health Domain: CSHCN
MCH Population Group: CSHCN
Selected State Priority: Improve health care transition for adolescents and young adults with special health care needs to all aspects of adult life.

Health care transition continues as an important initiative for Florida's CSHCN Program and is one of CMS' priorities. Transition from pediatric to adult health care has become a priority nationwide and effective health care transition is especially important for CSHCN as they are less likely to finish school, go to college, or secure employment. When transition is successful, it can maximize lifelong functioning and well-being. Proactive coordination of patient, family, and provider responsibilities prior to a CSHCN becoming an adult, better equips youth to take ownership of their health care as adults.

CMS Managed Care Plan enrollees ages 12 to 21 receive information and resources related to transition and FloridaHATS continues to collaborate with CMS to provide transition education and awareness to Florida's communities. In 2014, FloridaHATS completed several comprehensive training modules that are available through their website. Additionally, FloridaHATS continues to have oversight and direction of the healthcare transition coalitions in Florida. Moreover, CMS also plans to identify a transition program consultant, explore more robust reporting options in the CMS data system, incorporate FloridaHATS as a component of the CMS transition program, and identify necessary resources for transition navigators, youth ambassadors, and programmatic operations.

NPM 14: A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes
Health Domain: Cross-Cutting or Life Course
MCH Population Group: Pregnant women, mothers, and infants up to age 1; Children; and CSHCN
Selected 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, such as cleft lip or cleft palate. It can cause premature birth and low birth weight. It is also a risk factor for SIDS, and secondhand smoke (SHS) doubles an infant's risk of SIDS. Exposure to SHS also increases a child's risk of respiratory infections, common ear infections, and for those with asthma, more frequent attacks, which can put their lives in danger.

Florida has identified a number of objectives and strategies to reduce the percentage of women who smoke during pregnancy and the percentage of children who live in households where someone smokes, including: increasing patient awareness and knowledge of the negative effects of smoking during pregnancy through provider education and training; incorporating evidence-based smoking cessation programs into Florida's Healthy Start Program curriculum; increasing the number of preconception women who quit smoking; increasing the awareness of the dangers of SHS; and increasing public awareness surrounding the dangers of E-Cigarettes.

II. Components of the Application/Annual Report

II.A. Overview of the State

The Florida Department of Health is the state agency with primary responsibility for protecting, promoting, and improving the health of all citizens and visitors within the state. Following is a discussion of the principal characteristics important to understanding the health status and needs of Florida's maternal and child health (MCH) population.

With a total population rapidly approaching 20 million citizens, Florida has now surpassed New York as the third most populous state following California and Texas. According to calendar year 2014 population estimates, 78.2 percent of Florida's population is white, 16.7 percent black, and 5.1 percent other. Of the total population, 23.8 percent are Hispanic and 76.2 percent non-Hispanic. More than half of the state's population (51.5 percent) is between the ages of 25-64 and 30.1 percent are between the ages of 0-24. Florida's population 65 and older comprise 18.4 percent of the state's population compared to just 13.4 percent in this age group nationally. This indicates that a greater percentage of health care resources are expended on the elderly population in Florida compared to other states. Of Florida's total population, 96.5 percent lived in urban areas and 3.5 percent lived in rural areas in 2014.

The racial, ethnic, and cultural diversity of Florida's population creates unique challenges as well as increased opportunities. This diversity actually 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. Cultural 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, contribute to meeting the challenges that come with the state's diverse group of residents, immigrants (authorized and unauthorized), tourists and visitors. The Department makes a concerted effort to support Florida's culturally diverse MCH population by tailoring services provided through the Title V program to meet the needs of different cultures. Health 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 the healthcare provider through a conference or three-way calling system. In order to translate health-related educational materials into multiple languages for use around the state, Language Line Services also provides written translation services in over 100 languages.

Florida is a temporary home to over 90 million tourists and visitors each year, which presents challenges to the state's public health system. Migrant farm workers and unauthorized immigrants also have a significant impact on the state's public health services and resources. Florida was home to 925,000 unauthorized immigrants in 2012, compared to a peak of 1,050,000 unauthorized immigrants in 2007. California and Texas are the only states with greater numbers of unauthorized immigrants.

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 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 5.7 percent in March 2015, compared to 5.5 percent for the nation. Florida had a high school graduation rate of 75.6 percent during the 2012-13 school year, compared to a national rate of 81.4 percent.

With a total area of 58,560 square miles, Florida ranks 22nd among states in total area. 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.

The Department has published a Florida Emergency Preparedness Guide for residents and visitors as a tool that includes tips on making an emergency plan, steps for making a disaster supply kit, information on community services, and contact information for emergency shelters. The guide is posted on the Department's Emergency Preparedness & Response website, and is available in English, Spanish, and Creole. It is important to note the website also includes helpful information for vulnerable populations. At-risk or vulnerable populations are often defined as those groups whose unique needs may not be fully integrated into planning for disaster response. These populations include, but are not limited to, persons with physical, cognitive or developmental disabilities. Also 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.

There are a number of current priorities and initiatives that provide direction and impact upon the state's Title V directives. The Title V MCH and Children with Special Health Care Needs administrators, along with MCH and Children's Medical Services (CMS) staff, utilize various methods to determine the importance, magnitude, value, and priority of competing factors that impact health services delivery in the state. The five-year needs assessment and continual assessment during interim years provides valuable direction. The Title V program receives input and advice from statewide partnerships, stakeholders, and other agencies and organizations. Many of our policies and services originate through legislative bills, statutory regulations, administrative rules, and directives from the State Surgeon General. Priorities are discussed in the State Priorities section of the Needs Assessment Summary, and initiatives are discussed throughout the document.

One key overarching initiative within the Department is Healthiest Weight Florida, a public-private collaboration bringing together state agencies, non-profit 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; non-profit 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.

Neonatal abstinence syndrome (NAS) continues to be a concern in Florida, particularly due to the widespread abuse of opioids such as prescription pain killers. NAS is a group of physiological and neurobehavioral symptoms experienced by newborns exposed to prescription or illicit drugs taken by a mother during pregnancy. Infants with NAS have prolonged hospital stays, experience serious medical complications, and place a tremendous strain on service systems. Between 2008 and 2011, data showed a dramatic increasing trend in NAS prevalence in Florida, with a 2.5 fold increase from 25.8 per 10,000 live births in 2008 to 66.7 per 10,000 live births in 2011. During that same time, racial/ethnic disparities existed such that NAS rates were substantially higher among non-Hispanic white infants than among non-Hispanic black and Hispanic infants. While still troubling, a recent Departmental report analyzing data from 2011 through 2013 revealed that the previous increasing trend has leveled to prevalence rates (PRs) between 66.7 to 69.6 per 10,000 live births. Infants born to white non-Hispanic women continue to have the

highest reported PR of NAS (PR = 131.5 per 10,000 live births). Live births among women with less than a high school education also have a high NAS PR (114.7 per 10,000 live births).

The Title V program addresses the problem of substance exposed infants through contracts with 32 Healthy Start Coalitions (HSCs) across the state to assess prenatal and infant health care needs. The HSCs provide screening, education and care coordination services for substance abusing pregnant women, and substance exposed newborns. The HSCs collaborate with local health departments, local child protection teams, providers of Healthy Start services, prenatal and pediatric care providers, the local CMS providers, Healthy Families Florida, substance abuse treatment providers, and the local Department of Children and Families (DCF) and their contracted providers, hospitals and birthing centers in forming interagency agreements to ensure coordinated, multi-agency assessment of and intervention for the health, safety, and service needs of women who abuse alcohol or other drugs during pregnancy, and of substance exposed children up to age 3.

In June 2011, Florida House Bill (HB) 7095 was signed in to law. Known as the “anti-pill mill” bill, the law toughened criminal and administrative penalties for doctors and clinics distributing opioids through a combination of dispensing bans and aggressive regulatory actions to close pill mills. The efforts of law enforcement and health care professional regulation reduced the number of Florida doctors dispensing high quantities of oxycodone. While these actions did not result in dramatic reductions in NAS PRs, a stabilization of rates was observed.

The Department of Health publishes and regularly updates a State Health Improvement Plan (SHIP) that highlights a number of major concerns and issues, including many that are directly related to the MCH population. One of the strategies employed by the Department focuses on raising awareness among providers and consumers on the importance and benefits of being healthy prior to pregnancy. The goal is to increase the percentage of women who receive preconception education and counseling regarding lifestyle behaviors and prevention strategies prior to pregnancy. Other strategies include raising awareness among potentially eligible women of the Medicaid Family Planning Waiver services for all women who lost full Medicaid services within the last two years. There is also a goal to reduce teen sexual activity through the use of positive youth development sponsored programs to promote abstinence. Another strategy involves partnering with DCF to initiate an educational health care provider and consumer campaign on safe sleep. Title V program staff devote considerable time and effort to these and other strategies to help ensure mothers and babies have the best possible chance of a healthy life.

Reducing racial disparities continues to be a major focus of the Department. The Office of Minority Health (OMH) serves as the Department’s coordinating office for consultative services and training in the areas of cultural and linguistic competency, coordination, partnership building, program development and implementation, and other related comprehensive efforts to address the heath needs of Florida's minority and underrepresented populations. OMH promotes the integration of culturally and linguistically appropriate services within health-related programs across the state to ensure that the needs of the state’s racial and ethnic minority communities are addressed. The Office coordinates its efforts with minority health liaisons located at each of the 67 local health departments across the state.

Successful transitioning from pediatric to adult care is a priority of CMS. Florida Health and Transition Services (FloridaHATS) is a collaborative initiative of CMS and the University of South Florida, established to ensure the successful transition from pediatric to adult health care for all youth and young adults in Florida, including those with disabilities, chronic health conditions, or other special health care needs. FloridaHATS activities include health care financing, education and training, and service models of care. FloridaHATS also provides oversight to four regional health care transition coalitions.

Another priority objective of CMS is providing a patient centered medical home. CMS currently supports and promotes a medical home model through the CMS Medical Home Program. Several participating providers were part of the Children’s Health Insurance Reauthorization Program Act (CHIPRA) grant to work on improving patient centered medical home capacity for pediatric providers in the state. The current needs assessment identified

strategies to strengthen and build on the patient centered medical home framework. This initiative will include engaging both public and private partners, as well as family advocates. The main objective will be to increase awareness and use of the patient centered medical home model.

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. The SMMC Managed Medical Assistance (MMA) program was created as a subset of the SMMC. Children with Special Health Care Needs (CSHCN) are served through the CMS Managed Care Plan within the Department's CMS program. The CSMN provides a broad range of medical, therapeutic and supportive services for eligible children with special health care needs and their families. The statewide network includes over 5,000 doctors, hospitals, university medical centers and other healthcare providers. Services are coordinated through one of the 22 CMS Area Offices or 15 Local Early Steps (early intervention) Offices around the state. The CMS Area Offices offer nurses and social workers to families who would like help with organizing their child's care.

AHCA successfully completed the implementation of the SSMC in 2014. The SMMC has two components, 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.

Children's Medical Services (CMS) recently became a Managed Medical Assistance Plan through Florida's SMMC Program for clinically eligible children with special health care needs. Medicaid enrollees that meet eligibility requirements may choose the Children's Medical Services Managed Care Plan. Mental health is a covered service in the benefit package, as it is a covered service for all SMMC MMA Plans. Children's Medical Services also partners with KidCare to administer the CMS portion of the program for children with special health care needs through age 18. Children served through CMS KidCare are able to receive the Medicaid mental health services benefit package. Based on availability and eligibility, there are also additional behavioral health services available through the Behavioral Health Specialty Network.

Health care reform efforts have impacted both MCH and CSHCN populations and the delivery of Title V-supported services in a number of ways. Funding through health care reform has enabled the implementation of programs, such as the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, in high need communities for families with children ages 0–4. The Florida Association of Healthy Start Coalitions is the lead agency for implementing the federal MIECHV program through a public-private partnership that includes local Healthy Start Coalitions, hospitals, federally-qualified health centers and other community-based organizations. The program provides parents and other caregivers with the knowledge, skills, and tools they need to assist their children in being healthy, safe, and ready to succeed in school. Training provided through the program has created additional workforce for the delivery of home visiting and other early childhood services.

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 (ASO) called the Healthy Start MomCare Network (HSMN) representing all of the 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 will be part of Florida's Managed Medical Assistance (MMA) Program. Each plan's programs and procedures include agreements with each local Healthy Start Coalition in the region to provide risk-appropriate care coordination for pregnant women and infants, consistent with AHCA policies and the MomCare Network. The plans must establish specific programs and procedures to improve pregnancy outcomes and infant health, including, but not limited to, coordination with the Healthy Start program, immunization programs, and referral to WIC, and the CMS program for CSHCN.

When the Affordable Care Act (ACA) was first enacted, the Florida Legislature chose not to set-up an ACA-

compliant health insurance exchange and did not accept federal funding for the expansion of Medicaid. Florida's uninsured population has instead taken advantage of the availability of insurance offered through the federal exchange. According to federal health officials, during the 2015 open enrollment period, Florida had the highest enrollment among states using the federal exchange, with 1.6 million people signing up for coverage under the ACA. While it is too early to measure the effect on the MCH and CSHCN population, reducing the number of uninsured people in Florida should clearly have a positive impact on health status.

The Florida Division of Consumer Services maintains a website that provides comprehensive information on the ACA such as: available health plans, obtaining affordable insurance, how to enroll, and resources on where to learn more about the ACA. The site also provides contact information for community health centers, hospitals, medical centers, and other places across the state where consumers can go to get hands-on help with ACA enrollment.

The basic statutory authority for MCH is Section 383.011, Florida Statutes, 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, Florida Statutes, 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, Florida Administrative Code, establishes rules governing Healthy Start care coordination and services.

Section 383.014, Florida Statutes, authorizes screening and identification of all pregnant women entering into 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, Florida Administrative Code, establishes rules governing prenatal and infant screening for risk factors associated with poor outcomes, rules related to metabolic, hereditary, and congenital disorders.

The basic statutory authority for CSHCN and their families is Chapter 391, Florida Statutes, known as the Children's Medical Services Act. Section 391.016, Florida Statutes, establishes the Children's Medical Services Program, and defines two primary functions: provide to children 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, in order to prevent or reduce long-term disabilities.

II.B. Five Year Needs Assessment Summary

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 and men, preconception care and counseling, prenatal care, infant health services, ICC and counseling, and c

preventive health services. The Department, maternal and child health practitioners, and community partners realize confronting inequities in health 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 outco 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.

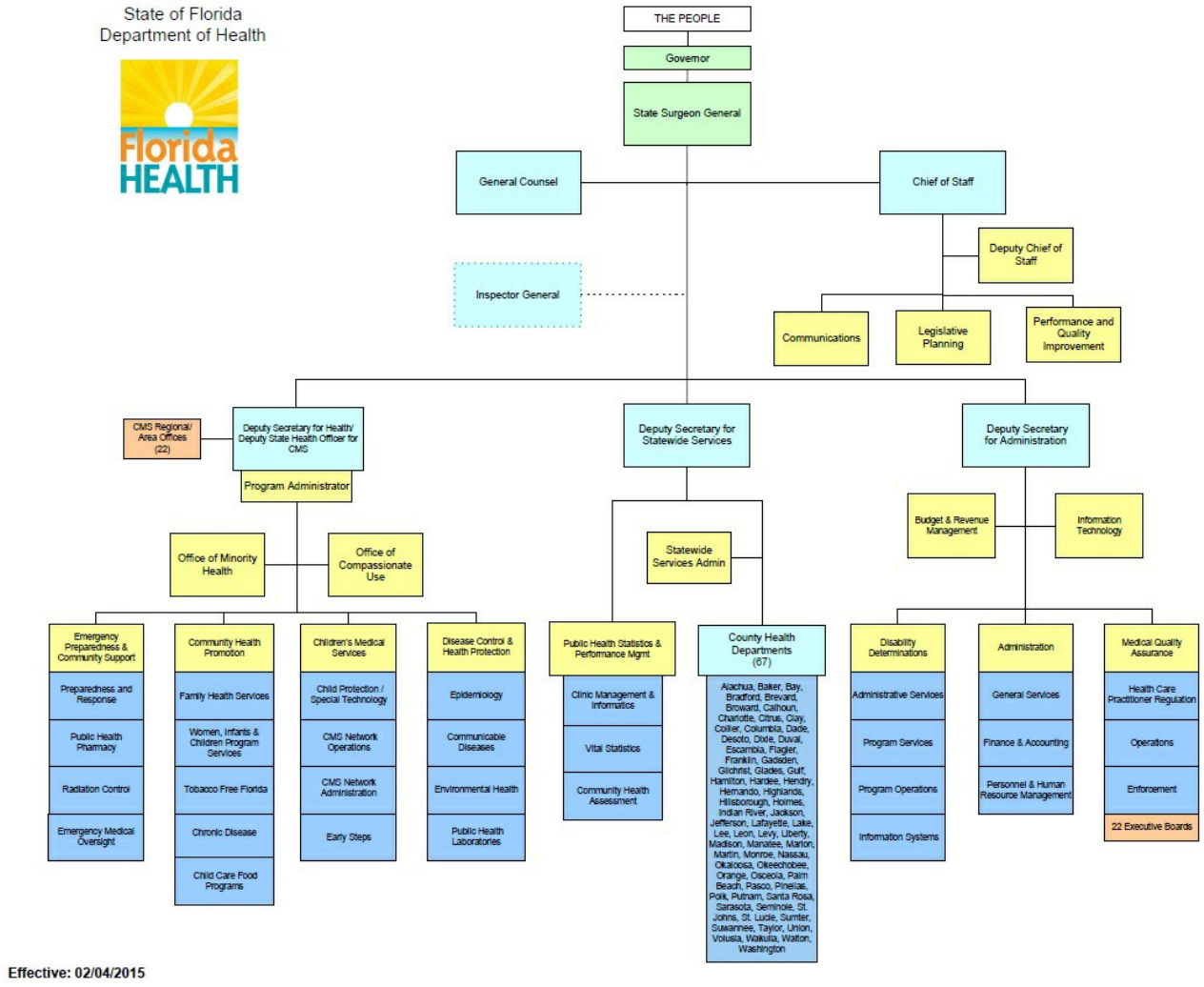
The Division Director of Community Health Promotion provides leadership, policy, and procedural direction for the Division, which includes the Bureaus of Child Care Food Programs, Chronic Disease Prevention, Family Health Services, Tobacco Free Florida, and WIC Program Services.

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.

II.C. State Selected Priorities

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	

The priorities were identified through the needs assessment process, and cover each of the six health domains and each of the three defined MCH population groups. Priorities were determined through the formation of and discussion amongst the MCH and the CSHCN Needs Assessment Advisory Workgroups; and a survey of MCH stakeholders, professionals, and partners. The workgroups took the list of priorities identified through the survey process and determined which of the priorities the Department could focus on to have the greatest impact on the

state's maternal and child health population, including CSHCN, while being mindful of the need to address each of the population domains, as well as, the relationship of the priorities to the national performance measures.

There were several priorities identified and strongly considered, but not selected. They included adequate health insurance coverage and substance exposed newborns. Although insurance coverage is an important need in Florida, it was not selected because the workgroup felt that increasing the number of women and families who had adequate insurance coverage could not be sufficiently addressed through the Title V program. However, the Department does provide Title V funding to Healthy Start Coalitions to address unfunded prenatal care. The same holds true for substance exposed newborns.

Racial disparity in infant mortality was not selected as a priority through the needs assessment process; however, the Department considers racial disparity and social determinants of health a priority issue across all program areas, particularly within our MCH program, as black infants in Florida are more than twice as likely as white infants to die in their first year of life. Although the term disparity is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist, particularly in health. The MCH program also selected social determinants of health as one of three priority areas to address through the CoIIN and to address racial disparities. The MCH program allocates Title V funding to the local health departments to address social determinants of health Florida's 67 local health departments are required to engage in a project that will address social determinants of health to improve the health of all.

In the previous five-year cycle, Florida listed a priority for the prevention of unintended and unwanted pregnancies and another for the prevention of teen pregnancies. These two issues will continue to be areas that both the Department's MCH and Adolescent Health programs focus on with assistance of Title V and X funding.

Following is a brief discussion of each of the seven listed state priorities:

Promoting safe sleep behaviors was a priority issue in the previous five-year cycle. Promoting safe sleep behaviors remains a priority because of the significant impact safe sleep has on reducing infant mortality, and because of the state's capacity to impact behaviors to increase the number of infants in safe sleep environments.

Promoting physical activity was selected because of an increased recognition of the importance of physical activity to improve lifelong overall health, the increasing obesity rates among the general population and children in particular, recent success exhibited by Healthiest Weight Florida initiatives, and the Department's overall emphasis on reducing weight and increasing physical activity.

Promoting tobacco cessation was added based on survey responses, workgroup input, and the Department's ability to partner with the Bureau of Tobacco Free Florida to have collective impact on this priority as well as recognizing this as a life course objective.

Promoting breastfeeding is a new priority added based on survey responses, workgroup input, and recent reports which further emphasize the importance of breastfeeding, especially as it relates to infant brain development and reducing future obesity.

Improving access to care for women is a new measure, but similar to one from the previous five-year cycle that focused on promoting preconception health screening and education.

Increasing access to medical homes and improving transition for adolescents and young adults with special health care needs to adult life continue to be priorities for the Division of CMS, and are identical to their priorities for the previous five-year cycle.

Medical home continues to be an important priority for CMS. Local CMS area offices work closely with providers who strive to provide a patient centered medical home for its patients. CMS provides care coordination to and works closely with these providers to assist with the needs of the children enrolled in the CMS Managed Care Plan. Additionally, CMS was a part of Florida's Children's Health Insurance Reauthorization Program Act (CHIPRA) grant.

CMS contracted providers for the CMS Medical Home Program participated in this project to build PCMH capacity in Florida. Now that the grant has concluded, the next five years will focus on continuing to leverage resources and build PCMH capacity throughout Florida.

Transition also continues to be a priority of key importance to CMS. A major strength associated with transition in Florida is the CMS memorandum of agreement with the Federally Qualified Health Centers to promote coordinated transition services between organizations. Implementation of such a strategy will require continued effort and collaboration at the local level. Recently, FloridaHATS developed a training course that incorporates the six elements of health care transition from *Got Transition*. While major training efforts have been underway, there continues to be a need for additional education efforts with the goal of promoting and raising awareness of transition efforts and services that benefit children with special health care needs. Additionally, family and patient engagement will play a critical role in transition activities.

The Department identified three additional priorities; however, the Title V Information System would not allow the addition of priorities that were not currently addressed by performance measures. These priorities will be added to the state priority list and addressed more thoroughly in next year's application when state performance measures can be developed. These priorities are currently priority issues in Florida that are being addressed through existing programs and services.

8. Improve dental care access for children and pregnant women.

Improving dental access for children was a priority identified in the previous five-year needs assessment and pregnant women was added during the current five-year needs assessment. The Department will establish a state performance measure next year, as well as strategies and objectives to enhance current efforts described elsewhere in this year's application.

9. Improve access to appropriate mental health services to all children.

Mental health will be a focus for Florida's Title V efforts over the next five years. CMS has the technological resources, such as an electronic health record and a customized care coordination module that can serve as a key component for an infrastructure which supports efficiency and quality management. Additionally, CMS has an established partnership with Florida's DCF Substance Abuse and Mental Health Program, which will be a crucial partnership while building CMS' initiative to address mental health needs in Florida's children and youth. Continued efforts to establish additional partnerships will play a major role in ensuring a successful implementation of objectives and strategies related to mental health efforts.

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

Addressing social determinants of health is a major focus of the Department, particularly as it relates to maternal and child health and as a cross-cutting life course approach through all aspects of the Department's programs and culture. The MCH program will establish further strategies and objectives in next year's application to enhance and supplement current efforts described in this year's application, which include community education activities that promote: access to care; health literacy; community engagement; and establishment of policies that positively influence social and economic conditions and support changes in individual behavior.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	68.0	69.0	70.0	71.0	72.0

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	81.3	82.3	83.2	84.0	84.7

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	27.7	29.4	31.1	32.8	34.5

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	78.3	80.0	81.6	83.1	84.5

NPM 8-Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	42.7	43.3	43.8	44.3	44.7

Annual Objectives					
	2016	2017	2018	2019	2020

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	20.2	19.9	19.6	19.3	19.0

NPM 11-Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	41.0	42.0	43.0	44.0	45.0

NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	42.0	44.0	46.0	48.0	50.0

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	6.5	6.4	6.3	6.2	6.1

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	22.5	22.0	21.5	21.0	20.5

Priority needs identified by the state's needs assessment process helped the Department select the eight national performance measures chosen for programmatic focus by the Title V program. Following is a discussion of the measures, why they were selected, and their linkage to the selected state priorities.

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

This measure was chosen because of the clear link to the state's priority to improve access to health care for women to improve preconception health. The Title V program has focused on both preconception and interconception health for a number of years, fully recognizing the importance of improving the health of all women of reproductive age to ensure better birth outcomes and healthier babies. Women's health at all ages of the lifespan is important and contributes to the well-being of Florida families as too often women are the primary caregiver for the families children, elderly parents and other family members, spouses or partners.

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

This measure was chosen because of the clear link to the state's priority to promote breastfeeding to ensure better health for infants and children. Promoting breastfeeding has been an important focus of the Title V program. It has also been recognized as a major health benefit to both infant and mother, as well as an enhancement of maternal/child bonding. The Department provides breastfeeding promotion and support activities through a number of different programs, including WIC, the Child Care Food Program, Healthy Start, and the Bureau of Chronic Disease Prevention. The Bureau of Chronic Disease Prevention utilizes funding from the Preventive Health and Health Services Block Grant to support hospitals in counties that have prioritized breastfeeding in their Community Health Improvement Plan and women living in counties with low breastfeeding initiation rates. The Title V program also has a long history of coordinating with the Department's WIC program on many of their breastfeeding initiatives, such as breastfeeding peer counseling and establishing local health department policies to protect, promote, and support breastfeeding as the preferred, normal method of infant feeding. The Florida SSDI project has published and presented data on the benefits of breastfeeding practices.

NPM 5: Percent of infants placed to sleep on their backs

This measure was chosen because of the clear link to the state's priority to promote safe and healthy infant sleep behaviors and environments. The MCH program is significantly involved with the CoIIN, and safe sleep for infants is one of the selected priority strategies for CoIIN. The Department formed a Statewide SUID Workgroup that provides input on the state work plan to reduce sleep-related infant deaths, and also created a logic model for conducting training efforts on Safe Sleep practices for health care providers, the Florida Hospital Association and other birthing centers, parents, caretakers, and the general public. Our Florida SSDI project has presented data on the benefits of safe sleep practices. The Title V program has assisted with the development of training for WIC staff to encourage discussion of safe sleep practices with their clients and continued training for Healthy Start and local health department staff on how to deliver SUID risk reduction education at the local level. These activities, along with data

showing that safe sleep initiatives have a significant impact on reducing infant mortality, made the selection of this measure a valid choice for the Title V program.

NPM 8: Percent of children ages 6-11 and adolescents ages 12-17 who are physically active at least 60 minutes per day

This measure was chosen because of the clear link to the state's priority to promote activities to improve the health of children and adolescents. The importance of physical activity to reduce obesity and improve health is a major focus within the Department. Studies have shown that for many children, a decline in physical activity begins in middle school, and those children who continue to be physically active through middle school and 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 life span, by reducing obesity and the risk of many chronic diseases.

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

This measure was selected based on data showing that 33 percent of Florida high school students experienced some form of bullying in 2011. Bullying is defined as: 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. 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 for the Title V program however, this focus can have a tremendous impact on improving health throughout the life span, by looking at adverse childhood experiences and the long term impact and risk factors associated with many chronic diseases.

NPM 11: Percent of children with and without special health care needs having a medical home

This measure was chosen because of the clear link to the state's priority to increase access to medical homes and primary care for all children, including children with special health care needs. A patient-centered medical home (PCMH) provides accessible, continuous, comprehensive, family-centered, coordinated, and compassionate medical care. All children should have a PCMH, but the PCMH is especially advantageous for children with special health care needs as they typically require coordination of care between primary care specialists. As an example, children with attention deficit hyperactivity disorder (ADHD) plus other co-occurring conditions are less likely to have an unmet health care need and fewer missed school days when they have a PCMH.

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

This measure was chosen because of the clear link to the state's priority to improve health care transition for adolescents and young adults with special health care needs to all aspects of adult life. Transition from pediatric to adult health care has become a priority nationwide and effective health care transition is especially important for children with special health care needs as they are less likely to finish school, go to college, or secure employment. When transition is successful, it can maximize lifelong functioning and well-being. Proactive coordination of patient, family, and provider responsibilities prior to becoming an adult, better equips youth to take ownership of their health care as adults.

NPM 14: A) Percent of women who smoke during pregnancy and B) Percent of children who live in households

where someone smokes

This measure was chosen because of the clear link to the state's priority to promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke (SHS) exposure to children. Smoking during pregnancy increases the risk of miscarriage and certain birth defects such as cleft lip or cleft palate. It can cause premature birth and low birth weight. Smoking during pregnancy is a risk factor for SIDS, and SHS doubles an infant's risk of SIDS. Exposure to SHS increases a child's risk of respiratory infections and common ear infections. Children with asthma who are exposed to SHS are likely to experience more frequent and more severe attacks, which can put their lives in danger.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

States are not required to provide a narrative discussion on the State Performance Measures (SPMs) until the FY2017 application

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Improve access to health care for women, specifically women who face significant barriers to better health, to improve preconception health.	1. Increase access to interconception care for women with prior adverse pregnancy outcomes. 2. Promote practices and increase awareness of preconception health. 3. Increase awareness of the Department's healthy weight initiative. 4. Improve access to healthcare for women of childbearing age before, during, and/or after a pregnancy. 5. Women of childbearing age	1. Provide interconception care and counseling up to 18 months to Healthy Start women. 2. Promote participation in learning collaboratives at the local, state and national level. 3. Engage in a public awareness campaign to promote healthy weight prior to pregnancy. 4a. Ensure access to prenatal, family planning and other health services. 4b. Encourage women to obtain preventative	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks)	Percent of women with a past year preventive medical visit		

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	receive an annual physical and gynecology exam yearly. 6. Department of Health and Local Health Departments provide community outreach and education. 7. Determine what educational material, models, and curriculums are currently being used by the Healthy Start Program to educate participants on Interconception Education and Counseling. 8. Implement uniform postpartum discharge procedures and ensure access to comprehensive post-delivery follow up care and offer post-delivery services to all women.	care. 4c. Provide translation services for women who speak a language other than English. 5a. Ensure all Healthy Start and local health department clients have a Reproductive Life Plan in their chart. 5b. Encourage all clients capable of reproduction receive and complete a Preconception and Counseling Checklist. 6. Participate in health fairs and community events, collaboration with local universities. 7a. Survey Healthy Start coalitions to determine current practices and curriculums	Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births			

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	9. Increase the number of eligible women age 14-55 who receive the family planning waiver.	used to provide interconception education and counseling to clients. 7b. Update Healthy Start Standards and Guidelines to reflect current process for Interconception Education and Counseling. 8a. Work with various providers to ensure women and families receive timely and appropriate follow up. 8b. Implement an effective postpartum discharge process so women are connected to appropriate follow up. 8c. Work with health care providers and partners to improve the number of women who				

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
		return for their postpartum visit. 9a. Encourage eligible clients to apply for the Family Planning (FP) Waiver. 9b Ensure clients complete the FP Waiver applications. 9c. Ensure staff awareness of how the FP application can be completed. 9d. Educate women on covered family planning services. 9e. Refer clients to the Family Health Line, if applicable. 9f. Ensure clients receiving the FP Waiver reapply for coverage during their last two months of eligibility.				

Women/Maternal Health

Women/Maternal Health - Plan for the 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 health, which was identified as one of the state's priority issues. The national performance measure selected for this priority was NPM 1: Percent of women with a past year preventive medical visit. Florida has identified a number of objectives and strategies to improve the health of women.

The Department is using Title V funding to help make available interconception/preconception care (ICC/PCC) through the Healthy Start program, neither of which is reimbursable by Medicaid. ICC/PCC services are offered 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.

The goal for Florida is that by 2018, 28 percent of women having a live birth will receive preconception counseling about healthy lifestyle behaviors and prevention strategies from a health care practitioner prior to pregnancy.

Three of the Healthy Start Coalitions in Florida received funding through the Strong Start for Mothers and Newborns Initiative Grant, which is a federally funded project of the Center for Medicare and Medicaid Innovation and the Centers for Medicare and Medicaid Services. The aim of the initiative is to:

- Reduce preterm births and improve outcomes for newborns and pregnant women
- Reduce early elective deliveries
- Enhance prenatal care models

Although well-woman care is not directly addressed by the Strong Start grant, many of the strategies that influence the outcomes listed above are also associated with improving women's health.

The MCH Section provides oversight of the maternal and child health system of care, the Healthy Start Program and the oversight and monitoring of 32 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.

Services include:

- Universal prenatal and infant risk screening
- Interconception education and care
- Breastfeeding education and support
- Care coordination, child birth and reproductive health planning education
- Smoking cessation
- Health and parenting education for at risk women and their children up to age three
- Education, counseling and referrals for access to care
- Nutrition and physical activity education

In addition to contracting with the 32 Healthy Start Coalitions, the MCH Section provides 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, in order to learn more about why infants die and to propose recommendations for change.
- Contract with the Hillsborough Healthy Start Coalition to provide for the implementation of FIMR services and also provide statewide awareness, education, and training forums to encourage dialogue regarding the development of community strategies and project development in order to address infant mortality.
- 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.

- 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 the Text4baby campaign throughout the state, with a focus on television and radio advertisements.
- Contract with the Florida Pregnancy Care Network to establish, implement, and monitor a comprehensive system of care through subcontracts that provide pregnancy support services which solely promote and encourage childbirth to women who suspect or are experiencing unplanned pregnancies
- 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.
- Contracts with the Miami-Dade Healthy Start Coalition and Pasco Healthy Start Coalition to implement the Nurse-Family Partnership evidence-based 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.

Reduction of maternal death is a national and state priority. Florida's Pregnancy Associated Mortality Review (PAMR) is an ongoing system of surveillance that collects and analyzes information related to maternal deaths in order 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 to obtain knowledge of 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 2003 and 2012, the pregnancy-related mortality ratio for non-Hispanic black women was significantly higher than non-Hispanic white and Hispanic women.

In response to this issue, the Department submitted an application and received funding from the AMCHP Every Mother Initiative. The Department along with its partner, ReachUp, Inc. (a Federal Healthy Start program and a not-for-profit organization whose mission is to advocate for and mobilize resources to help communities achieve equality in healthcare and positive health for families), will implement a community driven program to emphasize the development of community capacity and community connections as the means to producing better health outcomes. The emphasis is on local leadership development, promotion of collaborations, strengthening the capacity of community based organizations, and strengthening of social capital. The project is using community based approaches to health disparities that align with the literature on neighborhood or area effects on health. Perceptions of racial discrimination, for example, have been linked across a large body of studies to health behavior, physical health, and mental health, though the precise mechanisms for how stress created by discrimination translates into physical or behavioral outcomes is unclear.

Preconception peer educators will train lay leaders with backgrounds and, in some cases, health problems similar to those of the participants. The scope of work will be to provide coordination for prevention, education, nutrition, and awareness activities for eligible minorities for the purpose of increasing knowledge and understanding of maternal and infant mortality, and the impact of nutrition, preconception health, obesity, physical activity, and HIV on maternal and infant health. The purpose of the project is to promote improvement in minority health outcomes and the elimination of health disparities. The population to be served will be of childbearing age with a particular focus on historically black colleges and universities.

Another PAMR recommendation has led to the development of a statewide webinar on the associations between perinatal/child health outcomes and obesity. Briefs of the following Florida-specific epidemiological studies conducted by Department staff will be provided during the webinar:

- Obesity and Pregnancy-related Deaths: Florida, 2009- 2012
- Maternal Obesity and Infant Mortality
- Obesity & Overweight at Age 2: Risk factors among Florida WIC participants, 2011-2013
- Characteristics Associated with Gestational Weight Gain: Results from the Florida Pregnancy Risk Assessment Monitoring System, 2010-2011

Dr. Washington Hill, an emeritus PAMR member, will provide clinical overviews and summaries on the topics presented. Dr. Hill is a board-certified obstetrician/gynecologist who specializes in high-risk maternal and fetal medicine.

The Department provides a number of 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 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.

Currently, only 35 percent of adults in Florida are at a healthy weight. By 2030, 60 percent of Floridians could be obese. This increase will lead to lives cut short by preventable chronic disease and result in nearly $34 billion in related health care costs. More concerning is that if this trend continues, six out of 10 children born today could be overweight or obese by the time they graduate high school. In 2013, the Department launched Healthiest Weight Florida. The initiative partners with businesses, schools, non-governmental organizations, non-profit agencies, volunteer coalitions, hospitals, other state agencies and local government. This effort is reshaping communities around the state through five priority strategies: activity, nutrition, worksite wellness, schools, and messaging.

To further address healthy weight, the Department's Birth Defects Registry and the MCH program partnered and developed a public service campaign, Baby Steps to a Healthy Pregnancy, addressing men and women of reproductive age. The campaign has a multi-pronged approach focusing on healthy weight, preconception health, and physical activity. The campaign rolled out in 2014 and will be repeated in 2015 with downloadable flyers and video clips in English, Spanish, and Creole.

Notable Health Outcomes:
Overall, infant mortality has decreased from a rate of 7.5 per 1,000 live births in 2003 to 6.1 per 1,000 live births in 2013. Black infant mortality has decreased from a rate of 13.7 per 1,000 live births in 2003 to 10.6 per 1,000 live births in 2013.

Areas of Need/Improvement:
Racial disparities continue to exist in rates of infant mortality, with black infants being 2.3 times more likely to die within the first year of life than white infants in 2013. Continued work is needed to address the black/white disparity in infant mortality.

Women/Maternal Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	68	69	70	71	72

Following is a discussion of the strategies and objectives included in the state action plan in greater detail.

The first objective is to increase access to interconception care for women with prior adverse pregnancy outcomes. The strategies to accomplish this are: to incorporate Title V funding into Healthy Start contracts to support

interconception care and counseling up to 18 months to Healthy Start women who have risk factors that may lead to a poor pregnancy outcome. The second objective is to promote evidence-based and research-informed practices and increase awareness of preconception health to the public, healthcare providers, partners and stakeholders. The strategy for this objective is to participate in learning collaboratives at the local, state and national level, and share information learned in the collaboratives with those mentioned in the objective. A third objective is to increase awareness of the healthy weight initiative through a public awareness campaign to promote healthy weight prior to pregnancy.

The fourth objective is to improve access to healthcare for women of childbearing age before, during, and or after a pregnancy. Strategies include ensuring prenatal, family/reproductive health planning and other health services are accessible to all women, particularly women living in underserved areas, and encouraging women to visit local health departments, health clinics, and or private providers to obtain preventative care. Another strategy is to ensure translation services are provided for women who speak a language other than English, and that staff know the process for accessing translation services.

The fifth objective is to ensure that all women of childbearing age receive an annual physical and gynecology exam. Strategies to accomplish this objective are to ensure all Healthy Start and local health department clients have a Reproductive Life Plan in their chart, to be updated annually, and that all clients capable of reproduction receive and complete a Preconception and Counseling Checklist.

The sixth objective is for staff at the Department's central office and in the local health departments to provide community outreach and education. This will be accomplished through staff participation in health fairs and community events, and collaboration with local universities to educate the public on sexually transmitted infections, unplanned pregnancies, and how to properly use contraceptives.

As the seventh objective, staff will determine what educational material, models, and curriculums are currently being used by the Healthy Start Program to educate participants on interconception education and counseling. Staff will survey Healthy Start providers to determine current practices and curriculums used to provide interconception education and counseling to clients, and will also update the Healthy Start Standards and Guidelines to reflect the current process for providing interconception education and counseling to program participants and meeting contract requirements.

The eighth objective in the plan is to implement uniform postpartum discharge procedures and ensure access to comprehensive post-delivery follow up care and offer post-delivery services to all women. Staff will work with hospitals, providers, local health departments, home visitation programs and other community groups, to ensure women and families receive timely and appropriate follow up for safe sleep instruction, breastfeeding support, prevention of abusive head trauma, mental health, substance abuse services, domestic violence support, smoking cessation services, family planning, and other services. The Department will encourage the use of the postpartum discharge process as an opportunity to ensure women are connected with family planning services and primary care to promote appropriate interpregnancy intervals, facilitate access to a medical home, and specialty care referrals as needed. Staff will work with the Florida Hospital Association, American College of Obstetricians and Gynecologists, the Association of Nurse Midwives, the Agency for Health Care Administration, health care providers, Managed Care Plans and other partners to improve the number of women who return for their postpartum visit.

The ninth and final objective is to increase the number of eligible women age 14-55 who receive the Family Planning (FP) Waiver. Healthy Start, local health departments, and WIC staff will encourage eligible clients they serve to apply for the FP Waiver if they don't have insurance coverage, and ensure clients complete their FP Waiver Applications. The Department will ensure staff at the local level knows how the FP Application can be completed. Staff will educate women on family planning services covered, such as annual family planning physical exam, birth control, pregnancy test if needed, sexually transmitted infections and HIV counseling and testing, and sterilization services if desired. Staff will refer clients to the Family Health Line if applicable, and ensure clients receiving the FP Waiver reapply for coverage during their last two months of eligibility.

Last year's block grant included one national performance measure and two state measures that fit within the maternal domain: the percentage of infants born to pregnant women receiving prenatal care beginning in the first

trimester; the percentage of births with interpregnancy interval less than 18 months; and the percentage of women having a live birth who received preconception counseling about healthy lifestyle behaviors and prevention strategies from a health care provider prior to pregnancy. Following is a brief discussion of activities that are continuing for those measures.

Florida continues to address the percentage of infants born to pregnant women receiving prenatal care beginning in the first trimester. The Department: contracts and partners with Healthy Start Coalitions statewide to ensure an adequate infrastructure for the provision of first trimester prenatal care and continuous care for all pregnant women; develops policies that promote wellness among women of childbearing age; helps educate women on the importance of first trimester entry; works with the Healthy Start Coalitions to implement strategies to remove barriers and improve access to care; provides special technical assistance to counties with first trimester entry levels below the state average; and develops and implements strategies to improve access to early prenatal care, focusing on areas that have access to care barriers and low continuation of prenatal care. The aim is to increase community awareness of the importance of prenatal care as well as assist women in developing a support network within their community.

The Department continues to address the percentage of births with interpregnancy interval less than 18 months. The Maternal and Child Health Section develops and implements policies that promote wellness among women of childbearing age and help educate women on the importance of spacing pregnancies to have an interval of 18 months or longer between pregnancies. The Healthy Start population of pregnant women and mothers of infants, up to age 3 are provided information about available family planning services and where to obtain reproductive health care, including contraceptive methods. Birth intervals of 18 months or longer are encouraged during counseling and education as part of interconception counseling. We focus these efforts in counties that have higher than the state percentage of births with interpregnancy intervals less than 18 months.

The Department also continues to address the percentage of women having a live birth who received preconception counseling about healthy lifestyle behaviors and prevention strategies from a health care provider prior to pregnancy. The Department promotes reproductive life planning for all women of childbearing age as a component of primary care and promotes access to reproductive health services through the Family Planning Program. Staff continues to incorporate and monitor the provision of preconception health education and counseling services to family planning clients during local health department clinic visits. The Department contracted with Text4baby to create and implement customized text messages with Florida specific resources for Florida participants on various topics including preconception health resources in the state.

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Promote breastfeeding to ensure better health for infants and children and reduce low food security.	1. Increase the number of Florida hospitals implementing Baby-Friendly policies and practices. 2. Establish a	1a. Develop a work plan to encourage hospitals to establish policies and protocols in support of breastfeeding and becoming a Baby-Friendly hospital. 1b. Ensure Healthy	Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months		

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	breastfeeding room at the state office. 3. Conduct, participate, or support a public awareness campaign on breastfeeding benefits and resources. 4. Designation of Breastfeeding Friendly Child Care Facilities.	Start contracts include requirements and incentives to engage hospitals to become Baby-Friendly. 2. Develop a breastfeeding/pumping in the workplace department policy. 3. Partner with the Ounce of Prevention on a public awareness campaign to promote breastfeeding awareness. 4. Continue the promotion of child care facilities becoming breastfeeding friendly.	per 100,000 live births			
Promote safe and healthy infant sleep behaviors and environments including improving support systems, and daily living conditions that make safe sleep practices challenging.	1. Conduct a survey of pediatricians and family practice physicians and hospitals to assess their safe sleep education to parents. 2. Conduct, participate in, or support a public awareness campaign on SUID	1. Develop a questionnaire to be sent to pediatricians, family practice physicians and birthing hospitals in Florida. 2. Partner with the Ounce of Prevention on a public awareness campaign on the risks of bed sharing and promotion of breastfeeding.	Infant mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	Percent of infants placed to sleep on their backs		

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	prevention and infant safe sleep environments.					

Perinatal/Infant Health

Perinatal/Infant Health - Plan for the Application Year

The Florida Healthy Start Coalitions and the local health departments partner to provide needed services to pregnant women including prenatal care and breastfeeding education and support. The Florida Healthy Start program offers breastfeeding education and support services to all participants. Services provided to pregnant women encourage breastfeeding in the early postpartum period and provide anticipatory guidance and support in order to prevent breastfeeding problems and to 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 participates in the national CoIIN. The CoIIN aligns with the Department's State Health Improvement Plan (SHIP) 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.

There are multiple Safe Sleep programs in Florida communities that provide safe sleep information, cribs, and infant onesies with safe sleep messages. 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 safe sleep environment checklist was completed with each crib recipient.

The Department, DCF, and other Florida government agencies, state officials, non-profit 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 in an effort to promote safe sleep practices during routine calls and interactions with the public. The continuing campaign also encourages the public to donate new pack'n plays to designated locations, which are then distributed to needy families through the local Healthy Start Coalitions and participating home visiting programs.

The Department formed a Statewide Sudden Unexpected Infant Death (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 CoIIN and the Department's SHIP objectives. The workgroup is assisting in the development and implementation of evidence-based, culturally and linguistically competent 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. The workgroup is also assisting with the development of a survey to determine provider knowledge and beliefs of safe sleep practices and safe sleep environments.

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 were instrumental in the development of a state work plan to address SUID. The workgroup reviews and

provides input on the state work plan, advises on prioritization of plan objectives and outcomes, and assists with implementation of the state work plan strategies.

The Department is monitoring Florida's Maternal, Infant and Early Childhood Home Visiting (MIECHV) programs' activities related to breastfeeding and safe sleep. Florida's MIECHV is participating in the new Home Visiting CoIIN and has selected breastfeeding duration as its continuous quality improvement focus. There is potential synergy and collective impact connecting Title V activities with Florida's Healthy Start program and the MIECHV program.

The MCH Section is fortunate to have MCH Epi staff that conduct 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, this study, like other studies, 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.

Perinatal/Infant Health - Annual Report

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	81.3	82.3	83.2	84.0	84.7

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	27.7	29.4	31.1	32.8	34.5

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	78.3	80	81.6	83.1	84.5

We have selected two performance measures within the Perinatal/Infant Health Domain. The state priority for NPM 4: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months is to promote breastfeeding to ensure better health for infants and children in Florida. The state priority for NPM 5: Percent of infants placed to sleep on their backs is to support activities to promote safe and healthy infant sleep behaviors and environments.

The Department has developed a number of objectives and strategies to increase the percentage of infants who are ever breastfed and increase the percentage of infants who are breastfed exclusively through 6 months. The first objective is to increase the number of Florida hospitals implementing baby-friendly policies and practices. Strategies to accomplish this include developing a work plan to encourage hospitals to establish policies and

protocols in support of breastfeeding and becoming a baby-friendly hospital. The Department will also include incentives in the contracts with Healthy Start Coalitions to engage hospitals in becoming baby-friendly.

As a second objective, the Department will establish a pilot breastfeeding room in a building at the state central office. Strategies include developing a statewide department policy on breastfeeding and pumping in the workplace. A third objective is to conduct, participate, or support a public awareness campaign on breastfeeding benefits and resources. The Department will partner with the Ounce of Prevention on a public awareness campaign to promote breastfeeding awareness. The fourth objective for this measure is the designation of breastfeeding friendly child care facilities. The Department will continue to recognize and support the promotion of child care facilities becoming breastfeeding friendly.

The Department has developed two objectives and strategies to address the measure to increase the percentage of infants placed to sleep on their backs. The Department will conduct a survey of pediatricians, family practice physicians, and hospitals to assess their safe sleep education to parents. In partnership with the Ounce of Prevention, the Department will conduct, participate in, or support a public awareness campaign on SUID prevention and infant safe sleep environments.

Last year's block grant included one national performance measure and two state measures that fit within the Perinatal/Infant Domain. Two of the measures from last year were identical to this year's performance measures: infants breastfed at 6 months of age and infants placed to sleep on their backs. Activities for these measures were discussed above.

Activities that are continuing for the safe sleep measure include participation in CoIIN activities and engaging a multidisciplinary team to work on safe sleep practices and sleep environment. Information on the latest research findings and technical assistance is shared through statewide conference calls to Healthy Start and local health department staff. In partnership with Florida's DCF and the Ounce of Prevention Fund of Florida, the Department repeated the safe sleep PSAs and added a social media marketing campaign on SUID prevention and infant safe sleep environments. MCH staff continues to engage WIC staff to encourage discussion of safe sleep practices with WIC clients, and continue training for Healthy Start and local health department staff on how to deliver SUID risk reduction education at the local level.
In February 2015, the Department updated its "Brand Guide." The guide is the primary tool the Department uses for communicating with the public, partners and the legislature. The update included the requirement that "All media exposure of infant sleeping must portray these infants in a safe sleep environment. A safe sleep environment is described as infants sleeping on their backs, alone and in a crib. Soft objects, such as pillows and pillow-like toys, toys, bumper pads, quilts, comforters and sheepskins, should not be included in media." Media exposures including brochures and web sites with messages contrary to safe-sleep recommendations might create misinformation about safe sleep practices and affect individual behavior by influencing beliefs and attitudes. This policy change resulted from the CoIIN initiative, and was based on a recommendation from the MCH Section Administrator.

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Promote activities to improve the health of children	1. Ensure that schools are screening students for	1a. Monitor and assess school screening rates to assure that	Percent of children in excellent or very good health	Percent of children ages 6 through 11 and adolescents 12		

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment.	hearing, vision, scoliosis and growth and development with BMI. 2. Increase by 10% the number of targeted health care providers that provide counseling or education related to achieving or maintaining a healthy weight for their patients. 3. Increase the number of school health personnel that are trained to identify students with mental health needs. 4. Section 402.3026, F.S establishes Full Service Schools to serve high-risk students in need of medical and social services.	the standard of 95% is met each year. 1b. Ensure students receiving abnormal results are referred for follow-up medical care. 1c. Assess whether schools are providing healthcare interventions and case management in areas of low – referral resources or healthcare provider shortage areas. 2a. Promote the use of evidenced-based clinical guidelines to assess overweight and obesity. 2b. Establish principles of safe and effective weight loss, based on evidenced base practice.	Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	through 17 who are physically active at least 60 minutes per day		

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		2c. Encourage schools in other areas of the state to adopt or incorporate the FSU School of Medicine-Immokalee Obesity Prevention Toolkit "HealthyMe" for rural adolescents.				
		3a. Offer Department school health nurses Department of Education (DOE) approved training on identifying children with underlying mental health concerns.				
		3b. Encourage Department school health staff to participate in local and state councils, committees and workgroups that address mental health issues.				

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		3c. Provide training to Local School Health Advisory Councils to address the incidence of childhood obesity. 4a. School Health Program staff will conduct on-site monitoring, technical assistance and allocate funding for Full Service Schools. 4b. Full Service Schools will be designated in each county to address the needs of the medically underserved population.				

Child Health

Child Health - Plan for the Application Year

The School Health Program provides services to all children in Florida's public schools. Local health departments in cooperation with local education agencies and other partners are responsible for ensuring Florida's 2,651,421 kindergarten through 12th grade students have access to health services that assess, protect and promote their health and ability to learn. Basic school health services provided to all public school students include: nursing and nutritional assessments; record reviews ensuring physical exam and immunization requirements are in compliance, and appropriate services are provided for any chronic or complex health conditions; first aid; medication administration; screening for vision, hearing, growth and development, and scoliosis and referrals for additional care; preventive dental programs; obesity intervention services; emergency health services for injuries or acute illness;

health education classes; parent and staff consultations on student health issues and consultation for placement of students in exceptional education programs. During the 2013-2014 school year, there was a 3.5 percent increase in reported services compared to the 2012-2013 school year, and an 8 percent increase since 2010.

The School Health Program provides oversight and technical assistance to all local health departments, local education agencies and community partners relative to Florida Statutes and rules which affect the provision of school health services, best practices and program standards. Collaboration in regard to school health and wellness extends from the state to the local level.

The Department, and the DOE, have partnered for over 20 years to promote implementation of a Coordinated School Health approach in all Florida public schools. Coordinated School Health is an effective strategy to assist in the development and enhancement of state, district and school-based infrastructures that protect and maintain student and staff health and support academic achievement.

Community partners throughout the state contribute to the provision of health care to students in the school setting. The Blue Foundation; Central Florida Family Health Center; Children's Services Councils; Citizens' Commission for Children; County Commissions; Early Learning Coalitions; Health Care Taxing Districts (Broward, Palm Beach); Jackson Health System; Miami Children's Hospital; Nemours; Orlando Health; Rosen, Inc.; St. Vincent's Foundation; The Children's Trust (Miami-Dade); United Way; University of Miami; Winter Park Health Foundation represent the major partners, but there are many other collaborations in the smaller counties that work together for the benefit of children.

Florida's Coordinated School Health Partnership is a grassroots, volunteer organization whose mission is to create health literate and health practicing students and staff in all Florida schools. Members represent professional associations, foundations, not-for-profit organizations, businesses, insurers, health and education. The partnership is committed to working together to improve the health of children, adolescents, and staff in Florida schools. Goals focus on advocacy, policy, partnership, access to health care for all children and educating stakeholders about school health and wellness issues.

The Coordinated School Health Program within the Bureau of Chronic Disease works with DOE's Office of Healthy Schools to coordinate the Florida Healthy School District self-assessment and recognition program. The self-assessment is based on district infrastructure, policy, programs, and practices identified from national and state guidelines, best practices, and Florida statutes. The tool will help school districts assess existing policies and practices and guide them toward achieving the highest standards. Districts are encouraged to include school superintendents, school boards, school administrators, school health nurses, component area experts, parents, and the School Health Advisory Committee in the assessment process. The Coordinated School Health Program promotes the Coordinated School Health approach mentioned above, and the eight components of coordinated care that make up the approach are mandated by statute.

School health programs in all 67 counties screen children for vision, hearing, scoliosis and growth and development (BMI-weight and height for age and gender). As of the 2013-14 school year, 19.1 percent of Florida's first, third and six grade students were found to be in the obese category as defined by CDC guidelines, compared to 18.3 percent in 2012-2013. To address this issue, School Health Services programs throughout the state partner with the Department's Healthiest Weight Florida partners to provide schools with Prescriptions for Nature Play, linkages to Farm to School and Fresh from Florida Programs, guidance on 5-2-1-0 and similar programs, walking school bus programs, classroom gardens and much more. Developing and integrating a toolkit for obesity prevention and intervention for adolescents is a collaborative effort between Florida State University (FSU) School of Medicine-Immokalee campus, the Florida Department of Health School Health Services Program, and Healthiest Weight Florida.

Diabetes is an ever present condition that is treated on a daily basis in the school setting. A total of 7,249 school children were reported to have diabetes in 2013-14. The Department facilitated the updating of the Guidelines for the Care and Delegation of Care for Students with Diabetes in Florida Schools - 2015. This was a collaborative effort of the Department; DOE; the Florida Department of Agriculture and Consumer Affairs; local health departments in Brevard, Escambia, Leon, Manatee, and Pasco counties; Florida Center for Pediatric Endocrinology at the Florida

Hospital for Children; Tallahassee Memorial Hospital, Diabetes Center; University of Florida; and South University, College of Nursing and Public Health. This document is used daily to assist nurses and other personnel in the school setting with the day-to-day management of students with diabetes.

Asthma is a condition that impacts a reported 186,975 children in Florida. The Guidelines for the Care and Delegation of Care for Students with Asthma in Florida Schools were revised in 2013 and are scheduled to be updated in 2015. This revision of the guidelines was a collaborative effort of the Department; local departments of health; DOE; School Districts in Pasco, Pinellas and Suwannee Counties; the University of Florida Pulmonary Center and the Florida Asthma Coalition.

The growing number of children with mental health needs in Florida has been identified as a priority for DOE. The University of South Florida has received a grant from Substance Abuse and Mental Health Services Administration (SAMHSA), Project AWARE (Advancing Wellness and Resiliency through Education). The project has tapped the different disciplines that provide services in schools to be part of a state wide management team. The team is developing a definition of a basic skill set that those working with students should have in regard to identifying students that need mental health services. School nursing is represented on this management team by the State School Nurse Consultants from DOE, and the Department's central office School Health Program staff.

Linking Actions for Unmet Needs in Children's Health, known as Project LAUNCH, is a project funded by the SAMHSA focusing on the wellness of children from birth through 8 years of age in families living with or at risk of substance abuse. The lead agency for this project is the Florida Department of Children and Families working in collaboration with the Florida Department of Health, Florida Department of Education and local agencies such as, the Early Learning Coalition, Mid-County Community Council, Juvenile Welfare Board, Network for Students with Emotional/Behavioral Disabilities, Head Start/Early Start, Healthy Start, Community Health Centers of Pinellas, and others. The goal is for all children to reach social, emotional, behavioral, physical and cognitive milestones.

Project LAUNCH aims to prevent youth emotional and behavioral disorders by improving family function and the quality of the parent-child relationship. The project plans to broaden prevention through parent training, skill-building, and selective interventions for young children. Led by a partnership between the Florida Department of Children and Families and the Florida Department of Health, LAUNCH focuses on Lealman Corridor, an area consisting of four zip codes in Pinellas County.

The population of Lealman Corridor faces many early childhood developmental risk factors, such as limited services, high crime, substance use, domestic violence, and high rates of child maltreatment associated with substance use and unemployment. The population of this area also struggles with high rates of poverty, with 19 percent of individuals living at or below the poverty level. LAUNCH will use Lealman Corridor as a pilot site for enhanced provider collaboration, service supports, and family focused prevention and promotion of health and wellness. The state's Young Child Wellness Council will be using evaluation data from the LAUNCH project to measure outcomes and expand this community's success across the state.

Progress Made:

- The implementation of the School Health Annual Report Portal (SHARP) in 2013-14 for ease of data entry and report generation for the state. This will serve to facilitate the accuracy of reporting both statewide and on the local level.
- FSU School of Medicine-Immokalee (development of obesity toolkit) to address obesity in rural adolescents.
- The Department's presence at the Florida Association of School Nurses (FASN) and Florida School Health Association (FSHA) meeting that included a preconference provided by Healthy Weight and the Asthma Program for the FASN, and the Obesity Prevention/Intervention Toolkit at FSHA.
- Participation with DOE, the National Association of School Nurses (NASN) and the National Association of State School Nurse Consultants (NASSNC) on the nationwide data set in regard to chronic conditions.
- Partnership with NASN, and the USF Diabetes Center to apply for a Patient Centered Outcomes Research Initiative (PCORI) grant to determine how case management of diabetic children in the school setting impacts

the overall management of their diabetes.

- Healthy Schools/Tony Boselli influenza program is partnering with the Bureau of Immunizations, local health departments and school districts to offer influenza vaccinations in the school setting. The program has been expanding its reach each year with approximately 75,000 vaccinations provided to Florida's school children in 2014.
- The annual projected savings for Florida, at a rate of 20 percent childhood immunization, is $346 million indirect and $8.674 million in direct. The annual projected savings for Florida at a rate of 80 percent childhood immunization is $658 million in indirect and $165 million in direct. Dollar figures are adjusted for inflation from 2000 to 2013 dollars using the Bureau of Labor Statistics' Inflation Calculator. Human cost figures (illness, death and hospitalizations) are interpolated from national statistics.
- The Florida Vaccines for Children Program provides vaccines to children 0 through 18 years of age who meet program eligibility allowing providers to make routine immunizations available to eligible children without out-of-pocket expenses to the parent/guardian. The Immunization program has effectively raised awareness of the need for adolescent immunizations against human papillomavirus and meningococcal disease.

Challenges:

- Chronic conditions for students have seen a 121 percent increase since 1998.
- Florida has districts with high migrant student populations creating challenges in tracking health and immunization status.
- Florida school nurse to student ratio is 1 to 2,214. The school nurse to student ratio recommended by the American Academy of Pediatrics, NASN, and the U.S. Department of Health and Human Services is 1 to 750. For many students, the school nurse is the only form of healthcare they receive.
- Trouble referring students for follow-up health care in rural areas and healthcare provider shortage areas especially for mental, dental and primary care services.
- Changes in Medicaid eligibility requirements for children.
- Obesity rates continue to increase in Florida's children despite the many efforts at the state and local levels.

Plan for 2015-2016

The Department will develop definitions and clarifications for accurate reporting of student chronic health conditions. Major changes will include the separate reporting of Autism, Active Asthma, History of Asthma, Type 1 Diabetes and Type 2 Diabetes.

Additionally, the Department is considering consolidating the intent and requirements of three statutes into one, eliminating obsolete and duplicative requirements, promoting local autonomy to address student health needs and resource allocation and adding school based preventive oral health services. The goals are to implement prevention activities, reduce school absenteeism, and keep students healthy, out of the emergency room, in class and ready to learn. This is planned in conjunction with developing a reallocation methodology for school health funds to better align with changes in student demographics, student needs, chronic conditions management and better coordination of constantly shifting local resources.

The Department will create statewide, youth-led programs that are evidence-based and have measurable outcomes, as the HealthyMe Florida program that was funded by the Florida Legislature through the Department and developed FSU-Immokalee to specifically address the needs of overweight adolescents in rural or healthcare provider shortage areas. The toolkit has an electronic health record integration and aligns with the patient centered medical home strate the Affordable Care Act.

Student health screenings are supported by the School Health Program. In 2013-14, 104,759 students who were screened for BMI were in the obese range. The program standard is to refer students who screen in the underweight a obese ranges for follow-up services within 45 days of obtaining an abnormal result. School nurses also may provide obesity intervention services at their discretion. In addition, 141,282 students were referred for treatment from 2011-2 as a result of vision screening efforts in schools.

The Department will initiate training for School Health Advisory Committees from each county to raise awareness of obesity statistics on a local level. This training would serve to encourage the community to address the problem of childhood obesity in the biennial School Health Services Plan. Training would also address barriers to collaboration a effective strategies to overcome them; community involvement to prevent bullying, mental health awareness and build healthy school wellness teams.

NPM 8: Percent of children ages 6-11 and adolescents ages 12-17 who are physically active at least 60 minutes per day

The Department has many initiatives and programs in place to increase physical activity among children and adolesc Ongoing projects include efforts targeted towards working with early childhood education centers and schools to deve and implement policies relating to physical activity of the children and adolescents while they are in the centers/schoo Many other groups, including nonprofit organizations, 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 child and their parents about the importance of physical activity.

Let's Move! is a comprehensive initiative dedicated to solving the challenge of childhood obesity within a generation, so that children born today will grow up healthier and able to pursue their dreams. Combining comprehensive strategies with common sense, Let's Move! is about putting children on the path to a healthy future during their earliest months and years, and giving parents helpful information and fostering environments that support healthy choices. The initiative focuses on providing healthier foods in our schools; ensuring that every family has access to healthy, affordable food, and helping kids become more physically active.

Let's Go! is a nationally recognized childhood obesity prevention program partnering with schools, childcare and out of school programs, healthcare practices and community organizations to change environments where children and families live, learn work and play.

The 5-2-1-0 Program is being implemented in schools throughout the state as the foundation for changing social norms for children. The program has as its foundation the promotion of:

5 – servings of fruits and veggies each day
2 – hours or less of recreational screen time per day
1 – hour or more of physical activity each day
0 – sugary drinks, more water

School nurses, teachers, coaches and guidance counselors with the support of school and district leadership implement these program in schools throughout the state.

The FSU School of Medicine-Immokalee campus has developed the HealthyMe Toolkit. It is a set of evidence-based behavioral interventions to address one major medical condition with a strong behavioral component – obesity, specifically in the rural adolescent population. The tool kit is designed to provide primary care providers and school nurses with the tools that are needed to address obesity with the adolescent population. It uses motivational interviewing and social media to empower youth to take ownership of their health and address the behaviors that will impact their future.

The Coordinated School Health Partnership, a collaborative initiative supported by the Department and DOE, is using the CDC model, which incorporates the eight components of coordinated school health model and functions as a statewide School Health Advisory Council. Members of the partnership include: the Department of Agriculture, the Florida Dental Association, the Florida Hospital Association, the Florida Alliance for Healthy Kids, the Florida Dental Hygienists Association, the Alliance for a Healthier Generation, the Florida Association of School Nurses, and the Florida Parent –Teachers Association (PTA). This group meets biennially to discuss accomplishments and initiatives that promote the health of the children that attend Florida's schools.

Child Health - Annual Report

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	42.7	43.3	43.8	44.3	44.7

The state priority need for the Child Health Domain is to promote activities to improve the health of children and adolescents, which was identified as one of our state priority issues. The national performance measure selected for priority is NPM 8: Percent of children ages 6-11 and adolescents ages 12-17 who are physically active at least 60 mi per day. Florida has identified a number of objectives and strategies to improve the health of children and adolescent

Objectives:

- Ensure that schools are screening students for hearing, vision, scoliosis and growth and development with BMI.
- Increase the number of targeted health care providers that provide counseling or education related to achieving or maintaining a healthy weight for their patients.
- Increase the number of school health personnel that are trained to identify students with mental health needs.
- Maintain and or increase the number of children that are screened for height and weight for age and gender (BMI screening). Promote the Healthiest Weight Initiative, which has as its goal increasing the number of Floridians that are at a healthy weight inclusive of children and adolescents.
- Create statewide, youth-led programs with measurable outcomes, such as the HealthyMe Florida program that has been developed by the FSU School of Medicine-Immokalee to specifically address the needs of overweight adolescents and aligns with the patient centered medical home (PCMH) strategy.
- Increase the number of school nurses that have been trained in the delivery and reporting of interventions for children and adolescents that are over the 95th percentile when screened for height and weight for age and gender (BMI screening).
- Continue to fund and provide oversight for the Comprehensive School Health Services program. In 2013-14, 381,857 students attended Comprehensive School Health schools staffed by the local departments of health. Students in this program have lower birth rates (5.56 per thousand) than non-comprehensive students (7.44 per thousand) and 81.05 percent of comprehensive students return to school after giving birth.
- Continue to fund and provide oversight for Full Service Schools. In 2013-14, 302,703 students attended Full Services Schools. Staff coordinate in-kind donated services for their students who are at high-risk and in need of medical and social services.
- Increase the number of children and adolescents statewide that participate in 60 minutes of physical activity on a daily basis. Currently, children in elementary and middle school are required to participate in a physical education class once daily. This changes when adolescents leave middle school and enter high school. High

school students are only required to have one physical education class to graduate. If a student does not participate in sports, there is no guarantee that they will be physically active.

Strategies:

- School Health Program staff will monitor and assess school screening rates to assure that the standard of 95 percent is met each year. Staff will ensure that students receiving abnormal results are referred for follow-up medical care. Staff will assess whether schools are providing healthcare interventions and case management in areas of low-referral resources or healthcare provider shortage areas.

- School Health Program staff will promote the use of evidenced-based clinical guidelines to assess the number of students who are overweight or obese. Staff will establish and share with schools principles of safe and effective weight loss, based on evidenced base practice. Staff will encourage schools in other areas of the state to adopt or incorporate for rural adolescents the FSU School of Medicine-Immokalee Obesity Prevention Toolkit *HealthyMe*.

- The Department will offer school health nurses across the state the opportunity to take DOE approved training on identifying children with underlying mental health concerns. The Department will encourage school health staff to participate in local and state councils, committees and workgroups that address mental health issues.

- School Health Program staff will provide training to Local School Health Advisory Councils to address the incidence of childhood obesity. In collaboration with the DOE and local departments of health, staff will update and revise the School Health Administrative Guidelines, the Guidelines for the Care and Delegation of Care of Students with Asthma in Florida Schools, and the Nursing Delegation Guidelines.

- School Health Program staff will conduct on-site monitoring, provide technical assistance and allocate funding for Full Service Schools. Full Service Schools will be designated in each county to address the needs of the medically underserved population.

Last year's block grant included two national performance measures and one state measure that fit within the adolescent domain. Following is a brief discussion of activities that are continuing for those measures.

The Department continues to address the percentage of children between 19 to 35 months old who meet the 2-year-old immunization requirement. In 2014, the percentage of children who met the 2-year-old immunization requirement was 85.7 percent, which is a 1 percent decrease from 2013 and is below the national performance objective of 90 percent and the state performance measure of 95 percent. Activities are ongoing to meet and surpass the state and national goal of 90 percent for all 2-year-old children who are appropriately immunized. Specific activities include parent education; involvement of Healthy Start, immunization coalitions, and community partnerships; linkage with WIC, CMS and managed care organizations; identification of pockets of need for under-immunization; tracking immunizations in the health department; implementation of recall systems; public and private provider site reviews to assess coverage levels and promote the Standards of Pediatric Immunization Practices; increased enrollment of the registry in the private sector; continued implementation of the Vaccines for Children Program; and a statewide initiative to improve collaboration with stakeholders/partners to increase coverage levels in the target population.

The Department continues to monitor and address the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes. The Department's Injury Prevention Program is the lead agency for Safe Kids Florida, part of the Safe Kids Worldwide Campaign, a global effort to prevent unintentional injuries to children 14 and under. Currently there are 13 Safe Kids Coalitions in Florida, which were active in child passenger safety by distributing child safety seats, training Child Passenger Safety Technicians, and launching public awareness campaigns. In 2013, the childhood unintentional injury fatality rate in Safe Kids counties was 20.3 percent lower than the rate in non-Safe Kids counties, which corresponds to 142 fewer deaths than expected had the fatality rates been the same.

The Department also continues to monitor the percentage of children, ages 2 to 5 years, receiving WIC services with a body mass index at or above the 85th percentile. The Department's WIC program continues to expand its efforts to address obesity in young children. Data from Federal Fiscal Year (FFY) 2014 indicate that 26.3 percent of children ages 2-5 who receive WIC services had a BMI at or above the 85th percentile. This was below the objective of 27.7 and below last year's indicator of 27.8 percent. The WIC Program conducted a number of activities during FFY 2014 to continue to help reduce the number of children deemed overweight based on body mass index. WIC routinely reports on the healthy weight objective for WIC children as part of the Florida Surgeon General's Healthiest Weight initiative.

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
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.	1. Decrease the number of adolescents who are bullied or who bully others. 2. Increase the percentage of youth making healthy and positive choices. 3. Increase the number of youth receiving positive youth development programs by 5 percent.	1a. Partner with community agencies and organizations with bullying initiatives. 1b. Coordinate with the DOE Safe Schools Program to help promote the anti-bullying and violence message. 2. Increase the number of youth with exposure to resources and hotlines relative to violence and bullying. 3a. Promote the use of evidence based curriculum. 3b. Ensure that youth are receiving STD/HIV	Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000	Percent of adolescents, ages 12 through 17, who are bullied or who bully others		

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		information, sexual risk avoidance strategies. 3c. Provide information promoting positive youth development to encourage healthy behaviors and the reduction of risky behaviors.				
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.			Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day		

Adolescent Health

Adolescent Health - Plan for the Application Year

The Adolescent Health Program located in the School, Adolescent and Reproductive Health (SARH) Section 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 Adolescent Health Program continues with two initiatives that began in 2010, the Abstinence Education Program and the Teen Pregnancy Prevention Program.

The Title V Abstinence Education Grant, from the Administration of Children and Families, provided $2,738,485.00 per year which was used to fund local health departments, community and faith based organizations. The funded

providers used evidence-based abstinence education curriculums such as Choosing the Best, Making A Difference, Promoting Health Among Teens, and Heritage Keepers to deliver the program. Also, during the past year, to encourage parent and guardian involvement, positive youth development programs were provided for the parents and guardians. These parent programs endeavored to reinforce healthy behaviors, 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. The Abstinence Education Program was successfully delivered to 10,125 youth and to 2,154 parents and guardians.

The Teen Pregnancy Prevention Program Tier I Grant, through the U.S. Department of Health and Human Services (HHS) and Office of Adolescent Health (OAH) provided funding of $3,565,351.00 per year. This grant is in the fifth year of a five-year grant. The project was to replicate and evaluate the Teen Outreach Program (TOP). The TOP has been implemented under a rigorous, experimentally designed evaluation by the University of South Florida, College of Health during the entire grant period. The TOP, as an evidence-based program, has been shown to reduce birth rates, school suspensions, and school drop-out rates among participants. Through the Teen Pregnancy Prevention Project, TOP was facilitated in the public school system to 9th grade students in a health or health related class. The TOP curriculum consists of 25 weekly sessions and 20 hours of community service learning projects. Monitoring of each facilitator was done three times yearly by curriculum certified regional coordinators to ensure fidelity to the curriculum and as an evaluation process for the program. The TOP was delivered to 7,546 students in 23 non-metropolitan counties.

The Adolescent Health Program's current initiatives, the Abstinence Education Program and the Teen Pregnancy Prevention Program, will complete their fifth year of five years of funding in early fall, 2015. Both of the above projects will continue as listed above. The Abstinence Education Program currently has 17 providers, 10 local health departments and seven community or faith-based providers in middle school, high school, and community settings. The Teen Pregnancy Prevention Project is currently facilitating TOP in high schools in 23 counties.

Plans are to continue to enhance skills and improve the health of Florida's adolescents by continuing to provide the Abstinence Education Program in schools and community settings by funding providers from both local departments of health and community based organizations. The Abstinence Education Program plans to start a new funding cycle in October 2015 with $3,772,364 in federal funding for the upcoming year. A Request for Applications has been issued and work is underway for selection of providers. The Abstinence Education Program seeks to reach adolescents 11 to 19 years of age that reside in geographical areas which contain high-risk factors such as high rates of teen pregnancy, teen births, teen sexually transmitted diseases and high school drop-outs. The Teen Pregnancy Prevention Program has submitted an application for Pregnancy Prevention - Tier 1B grant through the Office of Adolescent Health. The program will also focus on adolescents ages 11 to 19, using evidence-based curriculums.

Collaborations and partnerships with local health departments, schools, school districts, community and faith-based organizations and Juvenile Justice Centers are critical to these 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 these programs. Settings where services are provided include schools, after-school programs, community and faith-based programs.

Accomplishments:

- Successfully building strong relationships with schools, school districts, teachers and staff. Schools embracing the positive youth development message incorporated in the evidence-based curriculum taught by the teen pregnancy prevention and abstinence education programs. Plans are to continue advocating for community leaders, local organizations and parents interest in programs that address adolescent health issues, encouraging outreach and sustainability of programs locally.
- Community service learning (CSL) projects - 264 youth selected projects will be completed this year. The CSL projects engage youth in planning activities that help others and encourages involvement in their communities.
- This year, the TOP was able to deliver curriculum to 30 percent more sites (43 settings are being served in the 2014-2015 school year compared to 33 settings served in 2013-2014) because the Program is able to include

schools and community settings previously limited by the grant evaluation. The majority of these settings provide TOP to multiple classes.

- Delivery of annual recertification/curriculum training and technical assistance prior to start of the new school year for providers facilitating teen pregnancy and abstinence education programs. Training is provided to ensure accurate information and fidelity to program curriculum, discussion of adolescent health issues such as STD/HIV, pregnancy prevention, life goals and choices and will continue yearly.
- Participation in the Coordinated School Health Council.

Challenges:

Class attendance/youth retention in programs can be challenging because of the specific timeframes required to complete the entire curriculum. Working with school staff to establish schedules is important to ensuring optimal attendance and complete exposure for the programs. Program staff proactively plan to have facilitators and providers establish schedules with principals and schools prior to the beginning of the school year to limit conflicts with class time.

Facilitator staffing changes mid-school year present another challenge because of the need for trained program staff to deliver teen pregnancy prevention or abstinence education curriculum with fidelity. The remedy for this involved having regional coordinators and contract managers for each program trained as certified curriculum instructors. This enabled newly hired facilitators to receive quality training in a timely fashion, thus minimizing curriculum class interruptions.

In developing the strong relationships with the schools, teachers and local health departments many providers and facilitators have received positive feedback about the program which initially struggled for a place in the busy school day. Providers have been advised sites noticed increased school performance, scores and graduation rates. The positive relationships have increased provider school access which increases productivity and their success in meeting grant goals. Plans have been made for varied provider funding levels, for the next grant period, to allow for an opportunity for potential increase in youth served by the Abstinence Education Program.

Another challenge is onsite monitoring to ensure fidelity to program subject matter. Each provider site is visited yearly to observe classroom lessons and review of office procedures and required documentation is performed. In order to make the most of the funds spent on monitoring visits, improvements have been made to the monitoring visit tools and expectations of observing multiple classes taught by each facilitator to thoroughly evaluate teaching skills and adherence to curriculum. Plans for this system will continue to be used.

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

The state priority need for the Adolescent Health Domain is to promote activities to improve the health of children and adolescents, which was identified as one of the state priority issues. NPM 9 was selected for this priority: Percent of adolescents, ages 12-17, who are bullied or who bully others. The Department has identified several objectives and strategies to improve the health of children and adolescents.

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. In 2011, data shows that 256,600 Florida public school students (33 percent) experienced some form of bullying. 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 2011 Youth Risk Behavior Survey (YRBS) indicates that a significantly higher number of students experiencing bullying described their grades as D's and F's in school during the past 12 months. The number of ninth grade students reporting being bullied is significantly higher than for students in 11th and 12th grades. Female students are significantly more likely than males to have experienced some form of bullying, name calling or teasing in the past year.

Programs and Initiatives:

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 that is accessed through school computer systems or networks. The DOE, Office of Safe Schools, has created a model policy against bullying and harassment that can be used by school districts to craft their individual policies.

The Teen Outreach Program, operated by the Department's Adolescent Health Program, provides public high school ninth grade students with education regarding healthy living, including: value setting, self-discipline, personal responsibility, managing life pressures, forming positive relationships, self-respect, commitment to others, refusal skills, effective communication, and skill/asset building. TOP also utilizes education peer group meetings, positive adult guidance and support and community service learning to achieve positive outcomes in youth.

The Department's Sexual Violence Prevention Program (SVPP) provides primary prevention education focusing on preventing sexual violence. The SVPP funds sites throughout the state to provide presentations on the prevention of sexual violence. Education is based on addressing the underlying attitudes, knowledge, and behavior that result in rape and sexual violence. Topics include bullying and sexual violence, consent and coercion, dating violence, drug facilitated rape, gender roles, healthy relationships, masculinity and sexual violence, media advocacy, oppression, primary prevention of sexual violence, role of bystanders, sexual harassment, and the law as it relates to sexual assault.

Adolescent Health - Annual Report

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	42.7	43.3	43.8	44.3	44.7

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	20.2	19.9	19.6	19.3	19

The state priority for this domain is to promote activities to improve the health of children and adolescents. The NPM 9 selected is the percent of adolescents, ages 12-17, who are bullied or who bully others. Following is a discussion of the strategies and objectives included in the state action plan in greater detail.

The first objective is to decrease the number of adolescents that report being bullied on the YRBS. Strategies to help decrease the number of adolescents being bullied include partnering with community agencies and organizations with bullying initiatives, including working with DOE's Safe Schools program to promote the anti-bullying and violence message.

The second objective is to increase the percentage of youth making healthy and positive choices. The associated strategy is to increase access to resources and hotlines so more adolescents can obtain information and guidance on making healthy and positive choices.

The third objective is to increase the number of youth receiving positive youth development programs by 5 percent. Strategies include encouraging and promoting the use of evidence-based positive youth development information by providing youth with accurate information on STD/HIV, pregnancy, violence and risky behaviors, and encouraging the development of skills used by youth to avoid risky behavior and to make healthy choices.

Last year's block grant included two national performance measures and one state measure that fit within the adolescent health domain. Following is a brief discussion of activities that are continuing for those measures.

Florida continues to address the rate of birth (per 1,000) for teenagers ages 15 through 17. Initiatives to address teen pregnancy include TOP, the Teen Pregnancy Prevention Tier 1 Grant, the Abstinence Education Program, the Comprehensive School Health Services Program, and the Family Planning Program. Florida has achieved a remarkable reduction in teen births, going from a rate of 22.6 births per 1,000 for teenagers 15-17 in 2007 to a rate of 10.5 births per 1,000 in 2013. The same programs and initiatives have helped create significant reductions in subsequent births for teens 15-17 as well, going from 9.4 percent in 2007 to 7.4 percent in 2013.

Suicide deaths among youths 15-19 continues to be a concern, and can be positively impacted by efforts to reduce bullying. Provisional data for 2014 shows a rate of 7.1 per 100,000 for this age group. Registered school nurses in the state's 46 county-level Comprehensive School Health Service Programs will continue to coordinate with school staff and assess and refer students for community-based mental health services. School nurses will also provide prevention interventions and classes in mental health, suicide prevention, violence prevention, conflict resolution, alcohol prevention, and drug prevention. The Florida Suicide Prevention Coalition continues to work on ways to identify and link youth at risk of suicide with appropriate prevention intervention services, and provide state agency and lawmakers with current information on youth suicide prevention.

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Increase access to medical homes and primary care for children with special health care needs.	1. Increase the number of pediatric providers in the state who identify with a level of medical homeness, as outlined by one of the current models. 2. Increase the	1. Convene a stakeholder group that will define levels of medical homeness and method(s) for assessing pediatric providers along that continuum. 2. CMS will partner with other leaders in the state to promote and improve CSHCN being assigned to	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health	Percent of children with and without special health care needs having a medical home		

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	number of CSHCN in the state assigned to a provider who is practicing at a higher level of medical homeness. 3. Increase the number of CMS Managed Care Plan enrollees who are assigned to a CMS provider who is practicing at the highest level of medical homeness. 4. Increase the number of higher acuity CMS Managed Care Plan enrollees assigned to highest level medical home.	primary care providers who achieve some level of medical homeness and provide support and education to pediatric providers in achieving higher levels of medical homeness from baseline. 3a. CMS will ensure that all CMS-credentialed primary care providers identify with some level of medical homeness. 3b. CMS to provide Care Coordination support to CMS-credentialed primary care providers who have CMS Managed Care Plan-enrolled children assigned to them as a standard resource to achieving a higher level of medical homeness.Care coordination includes but is not limited to:• Family needs assessment• Proactive care plan	Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine			

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		development• Facilitating care transitions• Education, support and coaching to families on disease-specific and general wellness topics• Coordination and tracking of referrals and test results• Use of health information technology to deliver and monitor care coordination and effectiveness of service delivery 3c. CMS will create an infrastructure to provide leadership in promoting and sustaining medical home for CYSHCN, including:• Improving access to pediatric providers who identify with some level of medical homeness.• Sustaining and improving those providers who wish to move to higher levels of medical homeness. 4. CMS to utilize acuity score as one criterion for promoting the assignment of children to practices at higher level of medical homeness.	Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Improve health care transition for adolescents and young adults with special health care needs to all aspects of adult life.	1. Increase the percentage of CMS Care Coordinators who receive transition-specific education and training annually. 2. Increase the percentage of providers and educators who receive information on how to access transition-specific education and training annually. 3. Increase the percentage of patients and families who receive transition-specific education and training annually. 4. Youth, families, and providers will have access to community-based	1. CMSN Care Coordinators will receive transition education and training. 2a. Providers are equipped with resources and education related to transition services and incorporating transition education as part of the annual well-child checkup. 2b. Educators are provided with resources and education related to health care transition and incorporate health care self-management skills in Transition IEPs. 3. Youth with and without special health care needs and their families will receive transition-specific, age-appropriate education related to the following aspects of their lives:• Work• Health care• Self-determination and self-management ability (power of attorney/guardianship)• Secondary and post-secondary education	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health	Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care		

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	resources necessary to facilitate and achieve successful health care transition. 5. Transition is recognized as a priority for the Department's Title V Program.	4. Transition support will be provided for youth, families, and providers. 5. CMS implements a transition program within the CMS organizational structure that includes specific programmatic outcomes related to quality improvement, measurable performance expectations, maintaining a transition registry and ensuring provider adequacy.				

Children with Special Health Care Needs

Children with Special Health Care Needs - Plan for the Application Year

In accordance with Section 501 [42 U.S.C. 701] (a)(1)(D), the Department's CMS Division provides family-centered, community-based, coordinated care for children with special health care needs participates in activities that promote and develop community-based systems of services for children with special health care needs and their families.

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2014 Efforts

On August 1, 2014, the CMS Managed Care Plan became a specialty plan through the Statewide Medicaid Managed Care (SMMC) Managed Medicaid Assistance (MMA) Program. April 2015 enrollment is over 63,000 children. CMS continues to be a choice through Florida KidCare. April 2015 CMS KidCare enrollment was over 13,500 children. In 2014, CMS also fully implemented its third party administrator; electronic health record and a module designed for CMS care coordinators and staff to document all coordination activities.

The Florida Healthy Kids Corporation instituted an administrative renewal process to reduce cancellations due to noncompliance with Title XXI renewal requirements. The process checks electronic databases for renewal information, which has significantly reduced the amount of paperwork parents need to submit. As a result, only a small portion of children whose parents have self-employment income that cannot be checked electronically need to submit paperwork. This has resulted in a decline in cancellations for renewal noncompliance.

CMS performs well in Healthcare Effectiveness Data and Information Set (HEDIS) Measures. For example, children's access to primary care practitioners exceeded 97 percent for CMS Title XXI funded enrollees in all age

groups during FY 2013-2014. CMS also scores well on measures of customer satisfaction. CMS exceeded 85 percent in several categories, including, health plan customer service, getting needed care quickly, experience with doctor's communication skills, getting prescription medications, and getting needed information on the Consumer Assessment of Health Care Providers and Systems (CAHPS) for CMS Title XXI funded enrollees during FY 2013-2014. Additionally, the University of Florida's Institute for Child Health Policy continues to conduct satisfaction surveys for CMS. Surveys are aimed at describing and quantifying satisfaction and health-related quality of life for children enrolled in the CMS Managed Care Plan. In the 2013-2014 report, 74 percent of Title XIX non-reform and 76 percent of Title XIX reform CMS Managed Care Plan enrollees rated the overall CMS program as excellent or very good.

Children's Medical Services Managed Care Plan enrollees ages 12 to 21 continue to receive information and resources related to transition. The Jacksonville Health and Transition Services program (JaxHATS) continues to provide clinic services and skill-building strategies to transitioning youths. FloridaHATS continues to collaborate with CMS to provide transition education and awareness to Florida's communities. In 2014, FloridaHATS completed several comprehensive training modules that are available through their website. All CMS staff and partners were made aware of this training opportunity. Additionally, FloridaHATS continued to have oversight and direction of the healthcare transition coalitions in Florida; adding a fourth one in Miami-Dade. Transition collaborative partners include the Federally Qualified Health Centers, the DOE, the Division of Vocational Rehabilitation, the Agency for Persons with Disabilities, the Department of Juvenile Justice, and AHCA.

Telemedicine technology continues to be explored as a health care delivery system within the CMS Managed Care Plan. CMS now has eight sites providing telemedicine services through eighteen subspecialty clinics.

Children's Medical Services continued to partner with the American Academy of Pediatrics (AAP) and Florida's AHCA for the Pediatric Medical Home Demonstration Project under Florida's Children's Health Insurance Program Reauthorization Act (CHIPRA) grant. CMS continued to expand the Medical Home program into physicians' practices and worked towards providing comprehensive medical home initiatives for all CMS Managed Care Plan enrollees. Physicians continued to partner with CMS in the medical home program and incorporated medical home care coordination, care management, and quality improvement teams in their practices.

The 11 designated RPICCs continue to provide direct health care services, including inpatient services and outpatient services. Two of the RPICCs provide obstetrical satellite clinics in rural locations. Many centers continue to participate in the FPQC, as does the CMS Nursing Consultant for the program.

Both the newborn screening data system and the newborn screening specimen cards were modified to include the pulse oximetry fields for Critical Congenital Heart Disease screening. Those fields included the date of screening, right hand oxygen saturation, lower extremity oxygen saturation, and indication whether the newborn's screening results were pass/fail.

The Florida Newborn Screening Program was reviewed by the national review team organized by NewSTEPs – a HRSA funded organization that provides technical assistance to state newborn screening programs. Florida was previously reviewed in 1992 and 2003. Recommendations were provided to the Department for incorporation into the screening program, such as eliminating the protein feed requirement. This will be presented to the Genetics and Newborn Screening Program Advisory Council for consideration.

Florida has 15 Early Steps offices that identify, evaluate, and provide services to eligible infants and toddlers. Early Steps offices also provide technical assistance and training to early intervention staff and providers; as well as provide training and support services for families.

Partnerships

The Florida Newborn Screening Program, Early Steps and the Child Protection Teams are all within the Department's Division of CMS. CMS also works closely with other Florida agencies including, the AHCA, DCF, DOE, the Department of Juvenile Justice, the Agency for Persons with Disabilities, and the Office of Early Learning. Additionally, CMS has several critical partnerships, including a partnership with the University of Florida's Pediatric Pulmonary Center, the Family Café and Family Network on Disabilities of Florida, the Foundation for Sickle Cell

Disease Research. These partnerships are reinforced by and supported through Sec. 505 [42 U.S.C. 701](a)(5)(F)(iii).

Children with Special Health Care Needs - Annual Report

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	41	42	43	44	45

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	42	44	46	48	50

Through Florida's CSHCN Needs Assessment, the following State Priority Needs were identified: Medical Home and Transition. For the Application year, 2016, Children's Medical Services will focus on several activities to address the identified strategies for improving the Medical Home and Transition initiatives in Florida.

National Performance Measure 11: Percent of children with and without special health care needs having a medical home.

The first objective that will address the medical home initiative in Florida is to increase the number of pediatric providers in the state who identify with a level of medical homeness, as outlined by one of the current models. Medical homeness is described as a provider or practice where medical care is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective The strategy for year one that will focus on this objective is to create a stakeholder group. The activities of this stakeholder group will include defining, for Florida (via a homegrown approach or by adopting an already published approach), Levels 1, 2 and 3 of a patient-centered medical home and developing a process and tools to assess participating providers.

Another objective that CMS will focus on is to increase the number of CSHCN in the state assigned to a provider who is practicing at a higher level of medical homeness. The strategies for this objective are to promote and improve CSHCN assignments to primary care providers who identify with a level of medical homeness and to provide support and education to pediatric providers in achieving higher levels of medical homeness from baseline. The year one activity associated with this strategy will be for CMS to explore collaboration opportunities with the Florida Pediatric Medical Home Leadership (FPMHL) group and to encourage the FPMHL and its existing mission.

CMS will also work towards the objective of increasing the number of CMS Managed Care Plan enrollees who are assigned to a CMS provider who is practicing at the highest level of medical "homeness." Strategies that are associated with this objective include having CMS ensure that all CMS-credentialed primary care providers identify with a level of medical "homeness." CMS will provide care coordination support to these providers, and CMS will create an infrastructure to provide leadership in promoting and sustaining medical home for CSHCN. Activities that CMS plans to accomplish in year 1 include: creating an internal Medical Home Focus Group (MHFG) of CMS-credentialed pediatric providers to seek understanding of the education and training needs of providers in medical home and encouraging coordinators to incorporate letters of introduction, provider office visits, and family visits during appointments.

The fourth medical home objective is to increase the number of higher acuity CMS Managed Care Plan enrollees assigned to highest level medical home. CMS will utilize the CMS acuity tool as a strategy to identify CSHCN who have the most complex needs. The first activity associated with this objective will be to assess the acuity of the children enrolled in the Network in order to appropriately assess their medical home needs.

Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care.

Health Care Transition will also continue as an important initiative for Florida's CSHCN Program. This first objective and strategy will focus on transition activities is to increase the percentage of CMS care coordinators who receive transition-specific education and training annually. During the first year, the CMS program office will ensure transition education is added to the Department's online education system.

Another transition related objective will be to increase the percentage of providers and educators who receive information on access transition-specific education annually. The strategy associated with objective is equipping providers and educators with resources and education related to transition services. The initial activity associated with this objective will be to develop school-based transition education modules for teachers and support staff.

Increasing the percentage of patients and families who receive transition-specific education and training annually is the third transition objective and strategy. Several activities that will address this will be to include appropriate links on organizational and partner websites, update materials for care coordinators to provide to families, and develop a youth ambassador program to promote and provide support for self-determination and self-management skills to youth in transition.

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. This objective will be accomplished by the strategy to provide transition support to youth, families, and providers. First year activities will include identifying CMS transition navigators, promoting the FloridaHATS web-based health services directory for young adults in Florida, and continuing to build regional transition coalitions throughout the state.

The fifth transition objective that CMS will work towards is to establish transition as a priority in CMS. The strategy for this objective will be to implement a CMS transition program that will focus on quality improvement, performance expectations, maintaining a training registry, and ensuring provider education and adequacy. Activities associated with this objective will include identifying a transition program consultant, exploring more robust reporting options in the CMS data system, incorporating FloridaHATS as a component of the CMS transition program, and identifying necessary resources for transition navigators, youth ambassadors, and programmatic operations.

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Promote tobacco cessation to reduce adverse birth outcomes	1. Increase patient awareness and knowledge of the negative effects	1a. Encourage providers to discuss the dangers of smoking while	Rate of severe maternal morbidity per 10,000 delivery hospitalizations	A) Percent of women who smoke during pregnancy and B) Percent of		

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
and secondhand smoke exposure to children.	of smoking during pregnancy through provider education and training. 2. Healthy Start Coalitions will incorporate evidence based smoking cessation programs into their curriculum and train Family Health Line staff on the SCRIPT program to increase referrals to Healthy Start and SCRIPT. 3. Increase public awareness surrounding the dangers of E-Cigarettes. 4. Increase the number of preconception women who quit smoking. 5. Increase awareness on the dangers of secondhand smoke.	pregnant with their patients. 1b. Increase public awareness of the dangers of smoking while pregnant. 1c. Implementing the Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) program for Healthy Start and other home visiting programs for pregnant women. 2a. Rewrite the Healthy Start Standards and Guidelines to clearly define SCRIPT as the approved, evidence-based intervention for smoking cessation services during pregnancy. 2b. Ensure each Healthy Start	Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality	children who live in households where someone smokes		

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		Coalition has at least one staff member trained and certified to deliver the SCRIPT program. 3a. Issue a press release from the Department addressing the dangers of E-Cigarettes. 3b. Ban the use of E-Cigarettes in local health departments. 3c. Create and disseminate materials on the dangers of E-Cigarettes. 4a. Increase the number of health care providers who address the dangers of smoking and tobacco use in the preconception visit. 4b. Develop/update trainings on preconception health to include	rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births Percent of children in excellent or very good health			

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
		information about the dangers of tobacco. 4c. Increase the number of healthcare providers who utilize preconception health screening tools and resources to identify smokers. 5. Implement a statewide public awareness campaign on the dangers of secondhand smoke on children and families.				

Cross-Cutting/Life Course

Cross-Cutting/Life Course - Plan for the Application Year

As the performance measure for the Cross-cutting/Life Course Domain, Florida chose NPM 14: A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes. 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. Second hand smoke exposure actually 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 second hand smoke are likely to experience more frequent and more severe attacks, which can put their lives in danger.

Tobacco Free Florida provides "3 Free Ways To Quit – call, click, or come in." The Florida Quitline is available 24 hours a day, 7 days a week, offering telephone counseling in English and 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, may receive a two-week starter kit of nicotine replacement therapy (NRT). Self-help materials are also provided by mail. The Florida Quitline is one of the nation's busiest, serving just

over 77,000 Florida tobacco users in FY2013-2014. Over 58,000 accessed counseling services over the telephone, and over 18,000 more received counseling through the online option.

Tobacco users may also access resources to help them quit through Florida's WebCoach online service. They can plan their quit date and even receive NRT through this free online service. Both the telephone and online services provide another feature to help tobacco users quit. Text2Quit is a new digital service that texts positive messages to tobacco users before, during, and after they quit. In its second year of operation, WebCoach served 18,890 users.

If callers prefer an in-person option, they are referred to one of the Area Health Education Centers (AHEC), which provide free cessation services in a group environment. In FY 2013-2014, the AHECs provided over 10,000 tobacco users with smoking cessation through two different courses; Quit Smoking Now and the Tools to Quit course. The Quit Smoking Now is taught in six one-hour sessions over a six-week period and the Tools to Quit is a two-hour course. AHECs also provide training for health care professionals and students based on the Clinical Practice Guidelines for Treating Tobacco Use and Dependence. The AHECs train health care practitioners and students to identify tobacco users and refer them for treatment each time they are seen in a clinical setting.

The Tobacco Free Florida campaign continues to educate residents on the negative effects of tobacco through a media campaign utilizing proven messages to encourage tobacco cessation. Because Tobacco Free Florida uses media housed in the CDC's resource center the campaign's $21 million budget is used mainly to place media. The Tobacco Free Florida brand has over 90 percent brand recognition.

Local health departments, Healthy Start Coalitions, and Department staff monitored 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. In 2012, a total of 13,949 pregnant women received 29,200 Healthy Start smoking cessation services during the prenatal period. In addition, 6,745 mothers, family members, or caregivers received 16,745 Healthy Start smoking cessation services postpartum. A new webpage was developed on the Tobacco Free Florida website targeting obstetric provider practitioners with information on smoking cessation reduction strategies for pregnant women.

Florida has been an active participant in the CoIIN smoking cessation strategy team. The CoIIN was instrumental in forging a stronger collaboration between Department programs and stakeholders. The collaboration resulted in a partnership with the Florida March of Dimes and the Florida Association of Healthy Start Coalitions to plan for the statewide implementation of the Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) curriculum. SCRIPT is an evidence-based program shown to be effective in helping thousands of pregnant women quit smoking. It is designed to be a component of a patient education program for prenatal care providers, and is cited by the Agency for Healthcare Research and Quality's Smoking Cessation Clinical Practice Guidelines.

The Florida Association of Healthy Start Coalitions (FAHSC) was awarded grant funding from the March of Dimes to implement train-the-trainer workshops on the SCRIPT program. In partnership with FAHSC, the March of Dimes, and the SCRIPT developers, Florida will have trained, at a minimum, 100 SCRIPT Implementation Coordinators through five regional workshops by June 2015. A minimum of 500 direct service staff working with pregnant women and their families through Healthy Start, public health, and other community programs will be trained on SCRIPT by June 2015. It is anticipated this effort will increase the number of smoking cessation services provided through the Healthy Start program by at least 20 percent by June 2015 (baseline: 11,940 pregnant women received 25,354 units of service in 2013 through Healthy Start).

Participants who complete the training will serve as SCRIPT Implementation Coordinators for their organizations or regions. The coordinators will apply the skills from the training to: plan SCRIPT implementation, train direct care providers, order SCRIPT materials, and plan SCRIPT tracking and evaluation. They will be qualified to train front-line clinical and case management staff in using SCRIPT to counsel pregnant women and their families. Training will be provided by the Society for Public Health Education. The Department will provide SCRIPT materials for sustained implementation.

FAHSC is working with the SCRIPT developers to create a Florida-specific training and implementation guide to ensure program quality and effectiveness. The guide will integrate requirements of the Healthy Start Standards and

Guidelines for delivery of smoking cessation services.

The AHEC contracts will continue to encourage systems change activities in large obstetric practices. These activities advocate for systems change including identification and referral for tobacco users during each visit, practitioner and staff training, and information regarding free and available cessation services for their patients.

Healthy Start Coalitions and local health departments will continue to encourage pregnant women and new mothers to sign up for Text4baby. The Department is currently working with Text4baby to create customized text messages specifically for Florida participants. The messages focus on various topics including resources in Florida and the effects of secondhand smoke.

Family Planning providers across the state will screen their clients for the extent of tobacco use, and provide information on the Florida's 3 Free Ways To Quit. 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 Healthy Start Standards and Guidelines for tobacco cessation.

The SWOT analysis conducted by the MCH Needs Assessment Advisory Group revealed several strengths of the Department's capacity to address tobacco cessation such as: (1) having community based grants in all 67 counties that offer different partnerships that include chronic disease, national partners, the Tobacco Advisory Council, DCF, Healthy Families Florida, the American College of Obstetrics and Gynecology, and home visiting programs; (2) integrating electronic referrals into the electronic medical records, (3) having data available from various surveys to monitor trends and other changes (e.g. PRAMS Report and BRFSS); (4) having data on pregnant women through Healthy Start screening and births; (5) having a referral source with the Florida Quit Line; (6) ensuring the SCRIPT Programs have one-on-one visitation through Healthy Start; and (7) having policies enforced to assist with being a smoke free community such as Smoke Free multi-unit housing.

Challenges include: (1) having unreliable smoking data; (2) the lack of standardization and difference in funding across health departments and counties; (3) misconceptions and lack of data on E-Cigarettes; (4) demographic and cultural disparities; (5) reluctance of individuals to admit smoking; (6) smoking may be a low priority when many co-morbidities are present; (7) getting all healthcare providers to screen, counsel and refer pregnant women who smoke; and (8) a substantial percentage of mothers relapse within six months after delivery.

These challenges present opportunities to address and improve tobacco cessation in Florida including: (1) increasing partnerships with tobacco cessation providers regarding referrals; (2) investigating the feasibility of implementing a low cost medication program for cessation (not among pregnant women); (3) expanding SCRIPT through Healthy Start; (4) having more education on E-Cigarettes; (5) adding E-Cigarette questions to surveillance surveys; and (6) adding behavioral health screenings on tobacco use for middle and high schools.

Florida is conducting additional activities to enhance the life course approach across all population groups. The Department applied to a request for applications from the AMCHP and was selected as one of seven state working group teams to contribute to the development of standardized life course indicators that could be used to measure states' progress in improving the health and well-being of their maternal and child populations using the Life Course Theory. AMCHP defines the life course approach as a theoretical model that takes into consideration the full spectrum of factors that impact an individuals' health, not just at one stage of life, but through all stages of life. The Florida team was multi-disciplinary and included MCH program and epidemiology staff, representatives from community partners (e.g. Healthy Start Coalitions), as well as members from CMS, Medicaid, chronic disease programs, home visiting programs, and academic programs.

The project was modeled after the Core State Preconception Health Indicators project. As part of the life course project, state teams used conceptual frameworks identified by the National Expert Panel to search the literature and propose initial life course indicators. They developed and wrote descriptions of proposed indicators, and screened proposed indicators for usability, data availability, and other criteria identified by the expert panel. Teams participated in acquiring expert and public input on the proposed indicators, and fully researched and described each of the selected indicators based on the final criteria. They rated and voted on each of the selected indicators,

and discussed and selected final proposed indicators. Teams considered the solicited expert and public input on selected indicators and finalized recommended indicators. The project has concluded and 59 (of 413) indicators have been identified to represent key issues that impact MCH populations across sensitive and critical periods along the life span. This collaborative effort was accomplished despite limited resources.

The Department's CDC/Council for State and Territorial Epidemiologists (CSTE) Fellow has been leading efforts to create an indicator report for all 59 final indicators, where data is available. The resulting document is intended to be a mechanism to further cross-cutting collaboration within and outside of the Department. The Florida Life Course Metrics Report will be made available to staff, stakeholders, and the general public. This report will include statistics and figures for the indicators and comparisons of Florida data to the national average will be included as well as recommendations for the state of Florida. Detailed CDC/CSTE Fellow activities entail: (1) Reviewing the current literature on the life course approach to public health, including information on the Life Course Metrics project provided by AMCHP; (2) Completing a spreadsheet to identify data sources and availability of required data; (3) Obtaining necessary statistics from various data sources including, but not limited to, vital records, Medicaid claims data, the Pregnancy Risk Assessment Monitoring System, and the National Survey of Children's Health; (4) Comparing Florida data to national rankings on life course indicators. These specific activities are necessary for creating a comprehensive data report and developing recommendations for Florida.

Building on the work of the Florida Life Course Metrics Report, a county-level cluster analysis will be conducted within the next year to assess the health status of Florida counties based on the life course indicators. The life course indicators include a variety of topics such as diabetes, repeat teen pregnancy, social capital, incarceration rate, and adverse childhood experiences. The indicators chosen for the analysis will depend on data availability at the county level, data quality, and calculation feasibility. This analysis will provide a baseline status for the entire state with respect to how counties rank on the various life course indicators. The results are intended to help programs differentiate counties with and without good outcomes and then guide decisions to provide resources to counties with the greatest need. Additionally, counties will be able to compare their status with neighboring counties or with counties who share similar demographics. This real life application of the Life Course Theory will allow partners across the state to become familiar with the theory and begin to understand how the life course indicators intersect to influence health. We anticipate that a workgroup will be established that will include several partners at the state and federal levels. This workgroup will advise the direction of the project. Once complete, the results will be shared statewide in hopes of starting conversations at both the state and local level regarding a life course approach to public health.

Cross-Cutting/Life Course - Annual Report

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	6.5	6.4	6.3	6.2	6.1

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	22.5	22.0	21.5	21.0	20.5

The state priority need for the Life Course Domain is promoting tobacco cessation to reduce adverse birth

outcomes and secondhand smoke exposure to children. Florida has identified a number of objectives and strategies to reduce the percentage of women who smoke during pregnancy and the percentage of children who live in households where someone smokes.

The first objective is to increase patient awareness and knowledge of the negative effects of smoking during pregnancy through provider education and training. Strategies include: encouraging providers to discuss the dangers of smoking while pregnant with their patients; increasing the public awareness of the dangers of smoking while pregnant; and implementing the SCRIPT program for Healthy Start and other home visiting programs for pregnant women. To evaluate, the following measures will be assessed: the number of healthcare professionals providing smoking cessation education will be examined using PRAMS data; the number of clients who have increased knowledge of the negative effects of tobacco use using service data; and the number of women who quit smoking using data from BRFSS and vital statistics.

The second objective is for Healthy Start Coalitions to incorporate evidence-based smoking cessation programs into their curriculum by training Family Health Line staff on the SCRIPT program to increase referrals to Healthy Start and SCRIPT. Strategies to accomplish this objective include rewriting the Healthy Start Standards and Guidelines to clearly define SCRIPT as the approved, evidence-based intervention for smoking cessation services during pregnancy. Each Healthy Start coalition will have at least one staff member trained and certified to deliver the SCRIPT program. Markers of success will be a significant increase in the state's capacity to provide smoking cessation services, an increase in the awareness of the state's smoking cessation services through the Family Health Line, and the standardization of smoking cessation services provided in Florida.

The third objective is to increase public awareness surrounding the dangers of E-Cigarettes by issuing a press release from the Department addressing the dangers of E-Cigarettes, banning the use of E-Cigarettes in local health departments, and creating and disseminating materials on the dangers of E-Cigarettes. Markers of success will be the implementation of policies that prevent the use of E-Cigarettes and a significant increase in the public awareness of E-Cigarette dangers, measured by the number of people who were exposed to advertisements.

The fourth objective is to increase the number of preconception women who quit smoking. Strategies include: increase the number of health care providers who address the dangers of smoking and tobacco use in the preconception visit; develop/update trainings on preconception health to include information about the dangers of tobacco; and increase the number of healthcare providers who utilize preconception health screening tools and resources to identify smokers. To evaluate, the state will measure changes in the number of healthcare providers who have increased knowledge and awareness of the dangers of tobacco and changes in the number of providers who utilize preconception screening tools.

The fifth objective is to increase awareness on the dangers of secondhand smoke by implementing a statewide public awareness campaign on the dangers of secondhand smoke on children and families. To evaluate, the program will use WIC data to determine whether statistically significant reductions in the number of children who experience secondhand smoke in their home exist.

Last year's block grant included a national performance measure on the percentage of women who smoke in the last three months of pregnancy. Since Florida's birth certificate does not ask about smoking during the third trimester PRAMS data is used to determine performance on this indicator. The most recent available PRAMS data was 2011, when 8.6 percent of pregnant women smoked during the last three months of pregnancy. Data for 2000 indicated that 9.4 percent of pregnant women smoked during the last three months of pregnancy. While fewer numbers of pregnant women are reporting tobacco use in the third trimester, it is becoming even more challenging to reach and impact those that do as the percentage decreases.

Other Programmatic Activities

Title V MCHBG funding is being used to help support the Department's Bureau of Epidemiology in conducting and collecting information for a Women and Infants Survey for Health (WISH). The WISH project is a random population-based surveillance system of maternal behaviors and experiences before, during, and shortly after pregnancy. Data collected includes information on maternal health and behaviors, prenatal and postpartum care, and infant health.

The survey is conducted statewide and results are tabulated down to the county level. While greatly assisting the state Title V program in their planning and evaluation of MCH services, WISH will also enable local health departments and Healthy Start Coalitions to use survey findings for planning and evaluating prenatal health programs at the local level. WISH targets women that were not sampled by PRAMS. Unlike PRAMS, WISH questions can be developed and added to address emergent issues in Florida, and WISH focuses on rural areas and small counties.

Title V funding is also allocated directly to local health departments for SFY 2015-2016 to address three MCH priority areas based on local needs: 1). Well woman preventive health visits: provision of prenatal care and education for chronic disease management and prevention for pregnant women; preconception health counseling; and provision of reproductive health services, supplies, education, and counseling that must include a discussion of a reproductive life plan; 2) Dental/oral health care for pregnant women and for children ages 1 to 6: primary dental care services, both preventative (to include oral health education) and other treatment; and 3) Social determinants of health community education activities that promote: access to care; health literacy; community engagement; or establishment of policies that positively influence social and economic conditions, and support changes in individual behavior.

Title V funding was used in SFY 2014-2015 to support the expansion of dental sealant programs in a five county area of high unmet needs due to a lack of dental providers, transportation barriers, and low social economic factors influencing access to care. The School-based Sealant Pilot Project was carried out in five rural counties, providing preventive services to children in second, third, and fifth grades. Preliminary data reveal that over 3,000 children were screened, 2,312 children received 6,418 sealants, and 2,960 children received oral health instructions.

In SFY 2013/2014, Title V funding was allocated to 28 county level dental clinics to provide primary dental care services focusing on women of child bearing age and children. Services included preventive, restorative, surgical care, or other needed treatment, for uninsured or underinsured pregnant or postpartum women at or below 200 percent of the federal poverty level who were referred by WIC or Healthy Start. The program also provided oral health education to promote optimal well-being for both mother and child, especially as it relates to improving birth outcomes and preventing early childhood caries.

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. Working with local health department dental programs, FQHCs, and local oral health coalitions across the state, preventive services are provided 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 programs are supported by Title V funding and make possible reaching high risk children in need of dental services and improving dental outcomes for all children in the state.

During 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 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 MCHB funding support for the start-up costs of multiple new programs.

In FY 2014-15, MCH 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.

During 2014, Adolescent Health Program staff participated in the Comprehensive Adolescent Health Systems (CAHS) – CoIIN as initiated by the AMCHP and the State Adolescent Health Resource Center (SAHRC). The

CAHS-CoIIN included Adolescent program staff from Colorado, Minnesota, Iowa, Florida, New Jersey, Puerto Rico, and Ohio. The purpose of the network was to share resources and learn best practices around adolescent health systems building – integrating adolescent health messages, education and awareness into all areas of public health. SAHRC provided many tools and resources including training on the Technology of Participation (TOP). TOP encompassed best practices for group facilitation and meeting productivity. Members met face to face during the summer of 2013 and the summer of 2014. Conference calls were held each month. The end result was a great toolbox for expanding adolescent health, awareness of efforts, successes, and challenges in other states around adolescent health, and a structured plan for each state to continue adolescent health systems building.

The MCH Section is collaborating with the REACHUP, Inc., a Federal Healthy Start site and community partner in Tampa, to receive the translation project sub-award for the Every Mother Initiative and implement enhancements to the Preconception Peer Educator (PPE) program at the community level. The PPE Program originated in the Department of Health and Human Services, Office of Minority Health, and works with the college age population, enlisting college students who serve as peer educators on college campuses and in the community. They help disseminate essential preconception health messages that may seem too foreign for a population that may not be actively seeking to start a family. Because over 50 percent of all pregnancies are unplanned, it is imperative to provide all women, and in particular sexually active women and their partners, with information to make timely, informed decisions about their reproductive futures. PPE training was originally designed to emphasize reduction in infant mortality by education of women and men on the importance of preconception health. REACHUP, Inc. for the EMI included additional training information which highlights the relationship between a woman's health status and health behaviors now and eventual pregnancy/maternal outcome in the future. The project is directed at Historically Black Colleges and Universities (HBCUs) in an effort to promote preconception health to a population impacted by higher rates of infant mortality. The project activities include plans for PPE training at the University of South Florida, Bethune-Cookman University and Florida Agricultural and Mechanical University.

Other MCH projects include the Pregnancy Associated Mortality Review (PAMR) project and the Fetal and Infant Mortality Review (FIMR) project. The PAMR project is a population-based surveillance and selective state level case review process aimed at reducing the maternal mortality rate. The FIMR project is a community-based collaborative effort to establish a continuous quality improvement mechanism for communities that focuses not only on the medical aspects of prenatal and infant health care delivery systems, but also on the psychosocial, environmental and structural processes that contribute to fetal and infant deaths, and simultaneously complement the community-based nature of the Healthy Start Coalitions.

II.F.2 MCH Workforce Development and Capacity

The Department's Leadership Institute provides a leadership development opportunity for staff seeking to enhance their leadership skills. The Leadership Institute is a seven-month leadership development course for new and mid-career supervisors and managers from throughout the agency. The curriculum offers a unique blend of online training, external projects, and monthly regional face-to-face application/discussion seminars. During each monthly seminar, the regional groups network with the "statewide classroom" using video-teleconferencing technology. The session topics have been: 1) Leadership, People, and Tasks, 2) Supervisor Roles and Responsibilities, 3) Developing Employees, 4) Communication, 5) Motivation, 6) Coaching and Delegation, and 7) Quality Improvement. The 2015 Florida Department of Health Leadership Institute is structured around the newly developed Department of Health Leadership Competencies and is strategically designed to advance the competencies of leaders from one level to the next. The 2015 session topics will be: 1) Leadership: An Overview, 2) The Importance of Insight (addresses personal integrity and self-awareness), 3) Communication and Influence, 4) Building Productive Relationships, 5) Shaping and Managing Strategy, and 6) Achieving Results.

In January 2015, Cassandra Pasley and Kelli Stannard began participating in AMCHP's Leadership Institute for State CSHCN Directors and AMCHP's New Director Mentor Program. AMCHP's Leadership Institute is a 16-month program focusing on developing leadership skills at the state and national level. AMCHP's New Director Mentor Program is an 18-month commitment, utilizing learning, mentoring, and peer-to-peer interaction to increase effectiveness and performance of the CSHCN Director.

Staff within the Department has also been encouraged 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.

The Department partners with Florida State University (FSU) to allow nursing students to intern with a Department nurse for 60 hours over a six week period. The students are in their senior year of undergraduate school and are enrolled in a Nursing Leadership class. Through their studies at the Department's central office, they are paired with a preceptor that has a nursing degree and shows leadership skills. The FSU nursing student is able to observe the workings of the Department by attending staff meetings, webinars, and trainings. They have opportunities to ask questions and learn about different public health nursing roles.

The Department has a partnership with Florida Agricultural and Mechanical University (FAMU) to assist students working towards their Masters of Public Health degree to participate in a summer rotation between their first and second years. Students participate in three 40-hour rotations through different divisions within the agency to see public health in action. The Division of Community Health Promotion provides mentors for students each summer. The FAMU students are assigned to specific projects within the division based on their skills and areas of interest. This unique program is one strategy in the agency's workforce development plan.

Each year CDC contracts with the University of Illinois at Chicago (UIC) to provide a distance learning course in Public Health Epidemiology for practicing MCH epidemiology professionals in state health departments. There are currently nine people participating in this class in Florida. The purpose of this year's course is to build data capacity in states with respect to working with claims-based, administrative data systems, such as hospital discharge data, Medicaid claims data, and various linked data, for the purpose of monitoring and analyzing indicators relevant to MCH practice and policy.

Another way in which the Title V Program has engaged with public health professional educational programs is through the CDC/CSTE Applied Epidemiology Fellowship Program. This two-year fellowship program matches recent graduates of epidemiology with a host site (state or local level health department) based on interest area and skill set. The fellow is given on-the-job training and mentoring by two highly trained and experienced epidemiologists. Currently the Division of Community Health Promotion is hosting a CDC/CSTE Applied Epidemiology Fellow whose subject area is maternal and child health. This fellow will support Title V programmatic efforts by enhancing data capacity and completing major projects on Title V related topics such as life course theory.

Title V plays an important role in allowing the Department to maintain capacity within the Title V workforce. Florida has the lowest number of state employees per capita than any state in the nation, and budgets in recent years have called for further reductions in state positions. In addition, salary limits placed on new hires make it difficult to attract new workers, particularly in nursing positions. Title V funding helps ensure the Department is able to maintain an adequate workforce in the central office in order to preserve, enhance, and expand services for the Title V population.

II.F.3. Family Consumer Partnership

The Department has a number of ways it builds and strengthens family/consumer partnerships for the state's MCH population, including CSHCN. 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 that 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.

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 component to the success of a Healthy Start Coalition. Such involvement requires coalition leadership to be knowledgeable of and understand the communities 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 requires 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 website to provide information for parents and families on Down syndrome and other prenatally diagnosed developmental disabilities.

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 parents 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 is currently working with the Department's Office of Communications providing feedback in the development of materials, postcards, and posters to be used to promote the website.

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- 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.

Phone interviews lasted approximately 20 minutes, were digitally recorded, and professionally transcribed verbatim. The recordings and transcripts were simultaneously reviewed by evaluation staff to ensure accuracy. As a team, the MIECHV Evaluators then performed a preliminary content analysis of interview data, producing a thematic review and short summary of preliminary findings. Self-reported demographic information was also recorded and entered into Qualtrics survey software. Qualitative analytic methods were used to compile the results.

The information gained through the family participants are used to drive quality improvement initiatives in areas including: (1) the types of referrals they receive, (2) what parts of the home visits are most helpful to them, (3) what their relationship is like with their home visitor, and (4) how home visiting lessons and activities are utilized in their daily life.

The Department's Office of Performance and Quality Improvement (OPQI), Workforce Development Unit, has developed a branded PowerPoint presentation, brochure, fact sheet and poster for use by Department employees, designed to help staff deliver an integrated consistent message about public health. Most people don't understand what public health is, much less how it impacts their daily lives. The materials provide an overview, *Public Health 101*, which is used with consumers and the general public. The program is designed to foster leadership development; expand public health knowledge, skills, and abilities; and broaden an understanding of the Department and its mission and programs. The materials are also designed to be used at colleges and universities.

Title V provides funding to support the annual Family Café conference. The Family Café serves as a source of information for individuals with disabilities on an ongoing basis in a number of ways. It produces an annual publication every fall called *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. The Family Café also 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 children with special health care needs year-round, while representing commitment to fostering community leadership.

Consumers played an important role in the MCH block grant development. During the 2015 Needs Assessment, CMS identified several family representatives to participate on the CSHCN Needs Assessment Advisory Group. Workgroups were created for each of the CMS priorities selected, and the workgroups also had family representation. Additionally, a family survey was conducted during the Needs Assessment to gather information related to families perceived health care needs.

Consumers also play an important role in health advocacy. Students across the state play an important role in advocating for reductions in the use of tobacco products. Students Working Against Tobacco (SWAT) is Florida's statewide youth organization working to mobilize, educate, and equip Florida youth to revolt against and deglamorize the efforts of tobacco companies to lure new smokers.

Additionally, each Early Steps Office has a Family Resource Specialist. The Family Resource Specialist is typically a family member of a child who received early intervention services. The Family Resource Specialist is a resource for families and serves as a community link to support family centered efforts and activities within the local Early Steps, advocates for families served, and solicits feedback from families receiving early intervention services to ensure diverse input regarding programs, policies and the delivery of early intervention services.

In 2014 and 2015, a family representative accompanied 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.

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.

The Florida School-Based Health Alliance promotes school-based and school-linked health clinics to provide a safety net for children and adolescents. The goal of the Alliance is to increase access to comprehensive health care, resulting in improved health and learning for children and adolescents throughout Florida. There are currently over 50 school-based or school-linked clinics in Florida.

II.F.4. Health Reform

Today, maternity care is a covered benefit in all plans sold on the new health insurance marketplaces as well as most job-based plans. Despite this, gaps in maternity coverage still persist. Women covered under grandfathered and

transitional health plans, as a dependent on a parent's employer-sponsored plan, or on self-funded student health plans still may not have maternity coverage. Some of these women may be able to enroll in pregnancy-related Medicaid and get access to maternity coverage if they meet the state's income-eligibility requirements. However, women who do not qualify for pregnancy-related Medicaid may not be able to get an insurance plan that covers maternity care while they are pregnant. As a result, women may have to pay for maternity care out of- pocket and/or forgo needed prenatal care – putting both their health and economic well-being at risk.

To address this need, the Department provides Title V funding to help support Florida's Healthy Start Coalitions. Based on the funding allocation used to distribute the funds, a total of $664,514 was allocated during state fiscal year 2014-15 for unfunded prenatal care providing gap-filling health care services to the maternal population. In addition, Florida's Healthy Start Coalitions provide consumer assistance to pregnant women with managed care organizations and through the Presumptive Eligibility for Pregnant Women (PEPW) application process.

Efforts to assure cultural and linguistic competence and to promote health equity were integrated into the Department's Agency Strategic Plan objectives. The Department is actively working to promote and implement the Culturally and Linguistically Appropriate Services (CLAS) Standards using the self-assessment tool.

The CMS Managed Care Plan serves children with special health care needs through a statewide managed system of care. The CMS Managed Care Plan provides the full Medicaid benefit package to enrollees, which includes medical, dental, behavioral health, pharmacy and transportation services. The CMS Managed Care Plan is a specialty plan choice under Florida's Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA). The CMS Managed Care Plan is for Medicaid recipients under the age of 21 who meet the CMS clinical screening criteria. Additionally, Title XXI enrollees under the age of 19 may choose the CMS Managed Care Plan if clinical eligibility criteria are met.

For children who are not eligible for Title XIX Medicaid or Title XXI KidCare, the CMS Safety Net Program serves children with chronic and serious special health care needs from birth to 21 years of age who are unable to access 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 Program provides a limited health services package for the enrollee's primary and secondary qualifying conditions, based on the availability of funds.

II.F.5. Emerging Issues

A number of issues confront the state in meeting the health needs of its residents and visitors. These include the growth and diversity of Florida's population; the ongoing threat of infectious diseases, such as influenza, HIV/AIDS, and measles; the large number of substance abusers, including children and adults who use tobacco and consume alcohol; and the ever-present threat of natural or man-made disasters.

Also of critical importance is addressing the wide disparities in health status, with minority populations bearing a disproportionate burden of disease. The Department uses community-focused strategies to provide the tools, planning support and policy direction communities need in order to address the challenges presented by a broad spectrum of public health issues.

The economic environment continues to affect public health in Florida. One ongoing challenge is the ever-increasing demand for public health services in the face of limited resources. Because of rapid changes in the environment– including demands for increased accountability for public agencies, rapid technological and medical advances, rising health care costs, and managed care—the Department must continually evolve to protect, promote and improve the health of Floridians. To meet the challenge, the Department has designed a performance management system to focus and unify our efforts internally and with our public health system partners. This statewide performance management system is the cornerstone of the Department's organizational culture of accountability and performance excellence.

The Department has applied for and is currently seeking accreditation through the Public Health Accreditation Board (PHAB). As an integrated public health agency, Florida is seeking a single accreditation decision for the state office and all 67 local health departments. If successful, the Department will be the first state agency to have received an integrated public health accreditation status. This national accreditation for public health departments has been developed to promote service, value, and accountability to people, the communities in which they live, and the organizations supporting those communities. The goal of the voluntary national accreditation program is to improve and protect the health of the public by advancing the quality and performance of tribal, state, local, and territorial public health departments.

II.F.6. 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, social media, working with parent organizations, and our own Online Newsroom.

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. 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.

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 the state action plan. The CSHCN 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 local health departments complete a Community Health Assessment and Community Health Improvement Plan (CHIP) 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 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 to 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, the University Health Systems, hospitals, and regional and local programs that support children with special health care needs. CMS has continuous communications with these groups to ensure continued understanding of the needs of children with special health care needs 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.

The Maternal and Child Health Block Grant, Needs Assessment and documents are available over the internet on the Department's website. http://www.floridahealth.gov/healthy-people-and-families/womens-health/pregnancy/mch-block-grant.html

II.F.7. 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 not expanding their programs is quite limited: the median income limit for parents in 2014 is just 50 percent of poverty, or an annual income of $9,893 a year for a family of three. In states that do not expand their programs, many adults will fall 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 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. In Florida, it is estimated that 669,000 fall within the coverage gap, 50 percent are female and 64 percent are in a working family. (Kaiser Family Foundation, Nov. 2014)

Technical assistance is requested in developing strategies to address the coverage gap, disparities in health coverage, access and outcomes among people of color through Title V funding.

III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 18,672,124	$ 18,672,124	$ 18,904,025	$ 18,904,025
Unobligated Balance	$ 0	$ 0	$ 0	$ 0
State Funds	$ 169,216,415	$ 169,216,415	$ 169,390,341	$ 169,390,341
Local Funds	$ 0	$ 0	$ 0	$ 0
Other Funds	$ 0	$ 0	$ 0	$ 0
Program Funds	$ 0	$ 0	$ 0	$ 0
SubTotal	$ 187,888,539	$ 187,888,539	$ 188,294,366	$ 188,294,366
Other Federal Funds	$ 468,939,035	$ 291,513,375	$ 362,324,908	$ 362,324,908
Total	$ 656,827,574	$ 479,401,914	$ 550,619,274	$ 550,619,274

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 18,920,363	$ 18,920,363	$ 18,996,748	$
Unobligated Balance	$ 0	$ 0	$ 0	$
State Funds	$ 169,402,594	$ 169,402,594	$ 169,459,883	$
Local Funds	$ 0	$ 0	$ 0	$
Other Funds	$ 0	$ 0	$ 0	$
Program Funds	$ 0	$ 0	$ 0	$
SubTotal	$ 188,322,957	$ 188,322,957	$ 188,456,631	$
Other Federal Funds	$ 415,342,314		$ 378,242,185	$
Total	$ 603,665,271	$ 188,322,957	$ 566,698,816	$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
Federal Allocation	$ 18,996,748	$
Unobligated Balance	$ 0	$
State Funds	$ 169,459,883	$
Local Funds	$ 0	$
Other Funds	$ 0	$
Program Funds	$ 0	$
SubTotal	$ 188,456,631	$
Other Federal Funds	$ 631,011,471	$
Total	$ 819,468,102	$

III.A. Expenditures

Expenditure amounts for the FY2014 annual report are included in forms 2, 3a and 3b. There were no significant variations in expenditures for the federal MCH Block Grant funds. Variations in the non-federal MCH Block Grant funds for the FY2016 budgeted amounts and the FY2014 expenditures is a result of a change in methodology used to calculate the amount of funds spent by the Department for the types of individuals and services specified on the forms.

III.B. Budget

Federal funding through the Title V MCH Block Grant provides needed support to our statewide efforts. Of the $18,996,748 budgeted as the expected federal allotment for FY2016, a total of $5,779,133 is budgeted for preventive and primary care for children (30.4 percent) and $8,539,800 for children with special health care needs (45 percent), which meet the 30 percent requirements. In addition, $1,818,087 (9.6 percent) is budgeted towards Title V administrative costs. Total state match for FY2016 is $169,459,883, which exceeds the state's FY1989 maintenance of effort amount of $155,212,322. Budgeted amounts for FY2016 are contained on Forms 2, 3a and 3b.

A complete list of other federal funds with funding amounts is included on Form 2, line 9. Other federal funds include the Health Resources and Services Administration (HRSA) State Systems Development Initiative grant; Women, Infants, and Children (WIC) funding; the Department of Health and Human Services (DHHS) State Abstinence Education Grant Program; the U.S. Department of Agriculture Child and Adult Care Food Program; the DHHS Title X Family Planning grant; the Centers for Disease Control and Prevention (CDC) Preventive Health Services Block Grant; various other CDC grants; the HRSA Emergency Medical Services for Children grant; and the Centers for Medicare & Medicaid Services School Health grant.

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 (EOCC), or to perform other

emergency duties, including but not limited to response to or threats involving any disaster or threat of disaster, man-made or natural.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Title V Medicaid IAA MOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - FL DOH Org Chart.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Florida

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION	$ 18,996,748	$ 18,920,363
(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)		
A. Preventive and Primary Care for Children	$ 5,779,133	$ 5,881,183
B. Children with Special Health Care Needs	$ 8,539,800	$ 8,539,800
C. Title V Administrative Costs	$ 1,818,087	$ 1,741,377
2. UNOBLIGATED BALANCE	$ 0	$ 0
(Item 18b of SF-424)		
3. STATE MCH FUNDS	$ 169,459,883	$ 169,402,594
(Item 18c of SF-424)		
4. LOCAL MCH FUNDS	$ 0	$ 0
(Item 18d of SF-424)		
5. OTHER FUNDS	$ 0	$ 0
(Item 18e of SF-424)		
6. PROGRAM INCOME	$ 0	$ 0
(Item 18f of SF-424)		
7. TOTAL STATE MATCH	$ 169,459,883	$ 169,402,594
(Lines 3 through 6)		
A. Your State's FY 1989 Maintenance of Effort Amount	$ 155,212,322	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL	$ 188,456,631	$ 188,322,957
(Same as item 18g of SF-424)		
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	$ 631,011,471	
(Subtotal of all funds under item 9)		
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL	$ 819,468,102	$ 188,322,957
(Partnership Subtotal + Other Federal MCH Funds Subtotal)		

	FY14 Annual Report Budgeted
1. FEDERAL ALLOCATION	$ 18,920,363
A. Preventive and Primary Care for Children	$ 5,881,183
B. Children with Special Health Care Needs	$ 8,539,800
C. Title V Administrative Costs	$ 1,741,377
2. UNOBLIGATED BALANCE	$ 0
3. STATE MCH FUNDS	$ 169,402,594
4. LOCAL MCH FUNDS	$ 0
5. OTHER FUNDS	$ 0
6. PROGRAM INCOME	$ 0
7. TOTAL STATE MATCH	$ 169,402,594

	FY16 Application Budgeted
9. OTHER FEDERAL FUNDS	
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI);	$ 95,374
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC);	$ 363,338,668
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program;	$ 2,738,485
US Department of Agriculture (USDA) > Food and Nutrition Services > Child and Adult Care Food Program (CACFP);	$ 224,746,165
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning;	$ 10,125,800
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant;	$ 4,599,330
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > various;	$ 13,611,803
Department of Health and Human Services (DHHS) > Health Resources and Services	$ 130,000

Administration (HRSA) > EMS ;	
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > School Health;	$ 11,625,846

Form Notes For Form 2:

Various CDC Programs - Tobacco, Diabetes, Rape Prevention, Cancer, Cardiovascular.

Field Level Notes for Form 2:

None

Data Alerts:

None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Florida

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF INDIVIDUALS SERVED		
IA. Federal MCH Block Grant		
1. Pregnant Women	$ 2,047,630	$ 2,758,003
2. Infants < 1 year	$ 812,098	$ 1,135,008
3. Children 1-22 years	$ 5,779,133	$ 4,746,175
4. CSHCN	$ 8,539,800	$ 8,539,800
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 17,178,661	$ 17,178,986
IB. Non Federal MCH Block Grant		
1. Pregnant Women	$ 36,722,454	$ 33,023,359
2. Infants < 1 year	$ 14,564,268	$ 4,514,681
3. Children 1-22 years	$ 103,643,706	$ 61,166,860
4. CSHCN	$ 14,529,455	$ 53,606,775
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 169,459,883	$ 152,311,675
Federal State MCH Block Grant Partnership Total	$ 186,638,544	$ 169,490,661

Form Notes For Form 3a:

Form 2a line 1A includes infants and children. Last year the Federal and Non Federal were combined.

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Form 2 1A includes infants. Form 3a 1A 3 has infants and children separated.	

Data Alerts:

None

Form 3b
Budget and Expenditure Details by Types of Services

State: Florida

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
1. Direct Services	$ 1,539,800	$ 1,711,783
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	$ 1,539,800	$ 1,711,783
2. Enabling Services	$ 15,638,861	$ 15,467,203
3. Public Health Services and Systems	$ 1,818,087	$ 1,741,377
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		$ 1,373,414
Physician/Office Services		$ 338,369
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		
Laboratory Services		
Direct Services Total		$ 1,711,783
Federal Total	$ 18,996,748	$ 18,920,363

IIB. Non-Federal MCH Block Grant

1. Direct Services	$ 1,069,455	$ 1,069,455
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	$ 1,069,455	$ 1,069,455
2. Enabling Services	$ 168,390,428	$ 151,242,220
3. Public Health Services and Systems	$ 0	$ 17,090,919
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		
Physician/Office Services		$ 1,069,455
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		
Laboratory Services		
Direct Services Total		$ 1,069,455
Non-Federal Total	$ 169,459,883	$ 169,402,594

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 215,770

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Holocarboxylase synthase deficiency	213,612 (99.0%)	31	0	0 (0%)
Homocystinuria	213,612 (99.0%)	5	1	1 (100.0%)
Classic phenylketonuria	213,612 (99.0%)	11	5	5 (100.0%)
Primary congenital hypothyroidism	213,612 (99.0%)	176	77	77 (100.0%)
Classic galactosemia	213,612 (99.0%)	124	4	4 (100.0%)
Congenital adrenal hyperplasia	213,612 (99.0%)	25	9	9 (100.0%)
Biotinidase deficiency	213,612 (99.0%)	35	3	3 (100.0%)
Cystic fibrosis	213,612 (99.0%)	514	36	36 (100.0%)
Severe combined immunodeficiences	213,612 (99.0%)	29	4	4 (100.0%)
S,S disease (Sickle cell anemia)	213,612 (99.0%)	259	219	219 (100.0%)

1b. Secondary RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Hypermethioninemia	213,612	5	0	0

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
	(99.0%)			(0%)

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
Newborn Hearing	207,782 (96.3%)	8,033	268	268 (100.0%)

3. Screening Programs for Older Children & Women

4. Long-Term Follow-Up

Florida newborn screening process stops at diagnosis and the Newborn Screening Program does not follow the child after the final diagnosis is confirmed. No information is gathered and the infants are not monitored after diagnosis.

Form Notes For Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Holocarboxylase synthase deficiency - Receiving At Lease One Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: The analyte markers (C5-OH and C3) that are used to identify MCD are also used to identify babies with 3-MCC, MMA, MUT and PA.	
2.	**Field Name:**	**S,S disease (Sickle cell anemia) - Receiving At Lease One Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: These numbers encompass all sickle cell screening types in the state.	
3.	**Field Name:**	**Hypermethioninemia - Receiving At Lease One Screen**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: The analyte marker (Met) is used to identify both homocystinuria and hypermethionemia so the number of presumptive positives is the same for both and represents the same babies.	

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Florida

Reporting Year 2014

		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	139,999	96.6	0.9	2.5	0.0	0.0
2. Infants < 1 Year of Age	80,432	96.9	0.7	2.4	0.0	0.0
3. Children 1 to 22 Years of Age	215,346	97.3	0.7	2.0	0.0	0.0
4. Children with Special Health Care Needs	122,049	75.2	23.0	1.8	0.0	0.0
5. Others	0	0.0	0.0	0.0	0.0	100.0
Total	557,826					

Form Notes For Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2014**
	Field Note: Note: 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.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2014**
	Field Note: Note: 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.	
3.	**Field Name:**	**Children 1 to 22 Years of Age**
	Fiscal Year:	**2014**
	Field Note: Note: 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.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2014**
	Field Note: Note: 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.	

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Florida

Reporting Year 2014

Types Of Individuals Served	Total Served
1. Pregnant Women	155,181
2. Infants < 1 Year of Age	213,612
3. Children 1 to 22 Years of Age	2,957,229
4. Children with Special Health Care Needs	146,458
5. Others	0
Total	3,472,480

Form Notes For Form 5b:

None

Field Level Notes for Form 5b:

None

Form 6

Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Florida

Reporting Year 2014

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	219,905	156,999	49,059	281	6,307	333	3,298	3,628
Title V Served	139,999	99,951	31,233	179	4,015	212	2,100	2,309
Eligible for Title XIX	135,239	96,553	30,171	173	3,879	205	2,028	2,230
2. Total Infants in State	215,194	153,278	48,737	282	6,138	276	3,267	3,216
Title V Served	80,432	57,291	18,216	105	2,294	103	1,221	1,202
Eligible for Title XIX	77,940	55,515	17,652	102	2,223	100	1,183	1,165

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	157,385	61,784	736	219,905
Title V Served	100,197	39,334	468	139,999
Eligible for Title XIX	96,790	37,996	453	135,239
2. Total Infants in State	154,693	59,083	1,418	215,194
Title V Served	57,819	22,083	530	80,432
Eligible for Title XIX	56,027	21,399	514	77,940

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

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 451-2229	(800) 451-2229
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) 245-4444 x2957	(850) 245-4444 x2957
5. Number of Calls Received on the State MCH "Hotline"		19,641
B. Other Appropriate Methods		
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

Application Year 2016

1. Title V Maternal and Child Health (MCH) Director

Name	Kris-Tena Albers, CNM, ARNP
Title	Chief, Bureau of Family Health Services
Address 1	4052 Bald Cypress Way, Bin A-13
Address 2	
City / State / Zip Code	Tallahassee / FL / 32399-1723
Telephone	(850) 245-4467
Email	Kris-Tena.Albers@flhealth.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Cassandra Pasley, BSN, JD
Title	Director, Children's Medical Services
Address 1	4052 Bald Cypress Way
Address 2	
City / State / Zip Code	Tallahassee / FL / 32399-1723
Telephone	(850) 245-4218
Email	Cassandra.Pasley@flhealth.gov

3. State Family or Youth Leader (Optional)

Name	Lori Fahey
Title	President and CEO, The Family Café, Inc
Address 1	519 North Gadsden Street
Address 2	
City / State / Zip Code	Tallahassee / FL / 32301
Telephone	(850) 224-4670
Email	lfahey@familycafe.net

Form Notes For Form 8:

None

Form 9
List of MCH Priority Needs

State: Florida

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 and NOMs:

Objectives are for children ages 6-11.

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
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: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

2012	166.2	2.9 %	3,384	203,557
2011	164.2	2.8 %	3,352	204,118
2010	158.5	2.8 %	3,265	205,959
2009	150.7	2.7 %	3,183	211,276
2008	140.7	2.5 %	3,121	221,901

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
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-4.1 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
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-4.1 Notes:

None

Data Alerts:

None

NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.5 %	0.0 %	3,266	215,338
2012	1.6 %	0.0 %	3,370	213,076

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	1.6 %	0.0 %	3,388	213,363
2010	1.6 %	0.0 %	3,478	214,525
2009	1.6 %	0.0 %	3,498	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-4.2 Notes:

None

Data Alerts:

None

NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	7.0 %	0.1 %	15,080	215,338
2012	7.0 %	0.1 %	14,890	213,076
2011	7.1 %	0.1 %	15,139	213,363
2010	7.1 %	0.1 %	15,203	214,525
2009	7.1 %	0.1 %	15,749	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-4.3 Notes:

None

Data Alerts:

None

NOM-5.1 Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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-5.1 Notes:

None

Data Alerts:

None

NOM-5.2 Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	3.0 %	0.0 %	6,395	215,168
2012	3.0 %	0.0 %	6,464	212,925

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	3.0 %	0.0 %	6,373	213,054
2010	3.1 %	0.0 %	6,537	214,301
2009	3.0 %	0.0 %	6,655	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-5.2 Notes:

None

Data Alerts:

None

NOM-5.3 Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	7.1 %	0.1 %	15,199	215,168
2012	7.2 %	0.1 %	15,346	212,925
2011	7.3 %	0.1 %	15,645	213,054
2010	7.4 %	0.1 %	15,899	214,301
2009	7.6 %	0.1 %	16,689	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-5.3 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
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
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
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
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
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
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
2013	227.5	10.3 %	490	215,407
2012	229.9	10.4 %	490	213,148

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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.

NOM-10 Notes:

None

Data Alerts:

None

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	10.0	0.2 %	2,030	203,558
2011	9.9	0.2 %	2,016	204,118
2010	8.1	0.2 %	1,671	205,959
2009	5.8	0.2 %	1,218	211,276
2008	3.7	0.1 %	827	221,901

Legends:
🏴 Indicator has a numerator ≤10 and is not reportable
ϟ 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 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.0 %	1.4 %	706,086	3,724,708

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% 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
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
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
2011_2013	13.0	0.6 %	459	3,542,990
2010_2012	14.1	12.9 %	509	3,600,735
2009_2011	14.7	13.5 %	539	3,661,955
2008_2010	16.8	15.5 %	624	3,707,519
2007_2009	20.2	18.7 %	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
2011_2013	7.5	6.6 %	264	3,542,990

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010_2012	6.7	5.9 %	242	3,600,735
2009_2011	6.0	5.2 %	221	3,661,955
2008_2010	5.6	4.9 %	209	3,707,519
2007_2009	6.0	5.2 %	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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.6 %	1.4 %	779,531	3,984,726
2007	19.0 %	1.8 %	762,335	4,017,889
2003	18.1 %	1.1 %	708,059	3,907,632

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% 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) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	11.6 %	1.3 %	63,247	546,411

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.2 Notes:

None

Data Alerts:

None

NOM-17.3 Percent of children 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
2011_2012	1.8 %	0.5 %	60,056	3,362,789
2007	1.4 %	0.7 %	45,971	3,320,821

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-17.3 Notes:

None

Data Alerts:

None

NOM-17.4 Percent of children 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
2011_2012	8.4 %	1.0 %	282,811	3,356,177
2007	8.4 %	1.4 %	278,087	3,311,906

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-17.4 Notes:

None

Data Alerts:

None

NOM-18 Percent of children 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
2011_2012	57.6 %	6.2 %	184,642	320,339
2007	52.0 %	8.4 %	149,783	288,175
2003	54.1 %	5.3 %	153,034	282,969

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-18 Notes:

None

Data Alerts:

None

NOM-19 Percent of children 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
2011_2012	83.5 %	1.3 %	3,328,052	3,984,726
2007	88.9 %	1.3 %	3,571,983	4,017,492
2003	86.1 %	1.0 %	3,365,485	3,907,632

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-19 Notes:

None

Data Alerts:

None

NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	27.5 %	2.3 %	470,715	1,711,443
2007	33.1 %	3.1 %	576,403	1,739,310
2003	32.5 %	1.9 %	552,699	1,702,013

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	28.4 %	0.1 %	48,745	171,960

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
2013	26.3 %	0.9 %	190,477	724,609
2011	25.1 %	0.8 %	170,531	678,193
2009	25.0 %	0.6 %	164,195	657,645
2007	26.4 %	1.0 %	179,687	681,417
2005	25.1 %	0.9 %	174,228	694,616

Legends:
Indicator has an unweighted denominator <100 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-20 Notes:

None

Data Alerts:

None

NOM-21 Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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

Year	Annual Indicator	Standard Error	Numerator	Denominator
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

Form 10a
National Performance Measures (NPMs)

State: Florida

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	68.0	69.0	70.0	71.0	72.0

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	81.3	82.3	83.2	84.0	84.7

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	27.7	29.4	31.1	32.8	34.5

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	78.3	80.0	81.6	83.1	84.5

NPM-8 Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	42.7	43.3	43.8	44.3	44.7

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	20.2	19.9	19.6	19.3	19.0

NPM-11 Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	41.0	42.0	43.0	44.0	45.0

NPM-12 Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	42.0	44.0	46.0	48.0	50.0

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	6.5	6.4	6.3	6.2	6.1

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	22.5	22.0	21.5	21.0	20.5

Form 10b

State Performance/Outcome Measure Detail Sheet

State: Florida

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c

Evidence-Based or Informed Strategy Measure Detail Sheet

State: Florida

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Florida

Form Notes for Form 10d NPMs and SPMs

None

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	1,218	1,175	1,314	1,224	
Denominator	1,218	1,175	1,314	1,224	
Data Source	Florida Newborn Screening Program	Florida Newborn Screening Program	Florida Newborn Screening Program	Florida Newborn Screening Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts:

None

NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

	2011	2012	2013	2014	2015
Annual Objective	55.0	69.0	70.0	71.0	72.0
Annual Indicator	68.2	68.2	68.2	68.2	
Numerator					
Denominator					
Data Source	National Survey of	Florida State	Florida State	Florida State	

	2011	2012	2013	2014	2015
	Children with Special Health Ca	Profile data for CSHCN survey.	Profile data for CSHCN survey.	Profile data for CSHCN survey.	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease

Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	46.0	38.0	38.0	39.0	40.0
Annual Indicator	36.2	36.2	36.2	36.2	
Numerator					
Denominator					
Data Source	Florida State Profile Data for CSHCN Survey	Florida State Profile data for CSHCN survey	Florida State Profile data for CSHCN survey	Florida State Profile data for CSHCN survey	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs

(CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	62.0	60.0	67.0	68.0	69.0
Annual Indicator	56.5	64.3	64.3	64.3	
Numerator		435,089	431,822	431,822	

	2011	2012	2013	2014	2015
Denominator		676,655	671,574	671,574	
Data Source	Florida State Profile data for CSHCN survey	CSHCN survey and American Community Survey	CSHCN survey and American Community Survey	CSHCN survey and American Community Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2012**

Field Note:
2012 percentage increased in part due to change in methodology using American Community Survey for the population estimate in conjunction with the HRSA national survey of CSHCN.

4. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	90.0	65.0	67.0	69.0	71.0
Annual Indicator	63.2	63.2	63.2	63.2	
Numerator					
Denominator					
Data Source	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey	Florida State Profile data for CSHCN survey	Florida State Profile data for CSHCN survey	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

	2011	2012	2013	2014	2015
Annual Objective	36.0	38.0	40.0	40.0	42.0
Annual Indicator	37.0	37.0	37.0	37.0	
Numerator					
Denominator					
Data Source	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore,

the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

	2011	2012	2013	2014	2015
Annual Objective	90.0	90.0	90.0	90.0	90.0
Annual Indicator	86.1	83.0	86.7	85.7	
Numerator	190,618	178,050	184,876	182,501	
Denominator	221,391	214,519	213,237	212,954	
Data Source	DOH Survey of Immunization in 2-Year-Old Children	DOH Survey of Immunization in 2-Year-Old Children	DOH Survey of Immunization in 2-Year-Old Children	DOH Survey of Immunization in 2-Year-Old Children	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

None

Data Alerts:

None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	15.0	13.4	11.9	10.2	10.0
Annual Indicator	13.4	12.0	10.5	9.1	
Numerator	4,723	4,219	3,698	3,206	
Denominator	353,110	352,066	352,403	351,029	

	2011	2012	2013	2014	2015
Data Source	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts:

None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	14.0	14.1	14.2	17.9	18.8
Annual Indicator	14.6	15.6	17.6	18.9	
Numerator	13,516	16,531	19,615	23,399	
Denominator	92,889	106,218	111,259	123,673	
Data Source	Agency for Health Care Administration/DOH	Agency for Health Care Administration/DOH	Agency for Health Care Administration/DOH	Agency for Health Care Administration/DOH	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2011**
	Field Note: 2011 data is an estimate based on 2010 data because data for 2011 is not yet available to the Public Health Dental Program from the Florida Medicaid Program.	

Data Alerts:

None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	1.6	2.0	2.0	1.8	1.7
Annual Indicator	2.1	1.8	1.9	2.4	
Numerator	69	60	62	80	
Denominator	3,274,059	3,303,959	3,344,701	3,382,656	
Data Source	DOH Office of Vital Statistics	DOH Office of Vital Statistics	DOH Office of Vital Statistics	DOH Office of Vital Statistics	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts:

None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	39.5	40.0	46.5	41.0	41.2
Annual Indicator	39.0	46.2	40.9	48.7	
Numerator					
Denominator					
Data Source	CDC National Immunization Survey	CDC National Immunization Survey	CDC National Immunization Survey	CDC National Immunization Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**
	Field Note:	

The Department of Health does not track breastfeeding data in the general population. The Department uses data provided by CDC. The data above is from the CDC Breastfeeding Report Cards which reports provisional data from the National Immunization Survey (NIS).

Breastfeeding Report Card date Provisional data from National Immunization Survey
2009 2006 births
2010 2007 births
2011 2008 births
2012 2009 births
2013 2010 births

2.	**Field Name:**	**2012**

Field Note:
The Department uses data provided by the CDC based on the National Immunization Survey.

3.	**Field Name:**	**2011**

Field Note:
The Department uses data provided by the CDC based on the National Immunization Survey. The CDC data is based on children born in 2008 and interviewed through November 2011. The latest provisional data currently available on the CDC website is for 2008 births. Final data becomes available in August 2012.

Data Alerts:

None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	99.0	99.0	99.0	99.0	99.0
Annual Indicator	95.8	96.5	96.4	86.4	
Numerator	204,721	205,860	207,821	190,141	
Denominator	213,722	213,403	215,658	220,140	
Data Source	CMS Newborn Screening Database	CMS Newborn Screening Database	CMS Newborn Screening Database	CMS Newborn Screening Database	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts:

None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	16.3	14.0	12.5	10.6	10.3
Annual Indicator	14.3	11.8	10.9	11.7	
Numerator	576,000	529,450	488,010	504,907	
Denominator	4,042,000	4,486,862	4,477,159	4,297,777	
Data Source	US Census	US Census	US Census	US Census	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**
	Field Note: : US Census Bureau Estimates. 2012 and 2013 data adjusted to include 18-year-olds. Prior years did not include 18-year-olds.	
2.	**Field Name:**	**2012**
	Field Note: : US Census Bureau Estimates. 2012 and 2013 data adjusted to include 18-year-olds. Prior years did not include 18-year-olds.	

Data Alerts:

None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	28.7	28.5	28.2	27.7	26.0
Annual Indicator	28.8	28.3	27.8	26.3	
Numerator	51,346	49,118	51,146	45,791	

	2011	2012	2013	2014	2015
Denominator	178,223	173,603	183,974	174,172	
Data Source	Office of WIC and Nutrition Services	Office of WIC and Nutrition Services	Office of WIC and Nutrition Services	Office of WIC and Nutrition Services	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

None

Data Alerts:

None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	8.5	9.2	7.9	7.8	7.7
Annual Indicator	8.1	8.1	8.6	8.6	
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS 2011	PRAMS 2011	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Since Florida's birth certificate does not ask about smoking during the third trimester, PRAMS data is used to determine performance on this indicator. Data come from the 2011 PRAMS, the last year available. For the PRAMS data, the numerator and the denominator are weighted to be representative of the state.	
2.	**Field Name:**	**2013**
	Field Note: Since Florida's birth certificate does not ask about smoking during the third trimester, PRAMS data is used to determine performance on this indicator. Data come from the 2011 PRAMS, the last year available. For the PRAMS data, the numerator and the denominator are weighted to be representative of the state.	

3.	**Field Name:**	**2012**

Field Note:
Since Florida's birth certificate does not ask about smoking during the third trimester, PRAMS data is used to determine performance on this indicator. Data come from the 2010 PRAMS, the last year available. For the PRAMS data, the numerator and the denominator are weighted to be representative of the state.

4.	**Field Name:**	**2011**

Field Note:
Since Florida's birth certificate does not ask about smoking during the third trimester, PRAMS data is used to determine performance on this indicator. Data come from the 2010 PRAMS, the last year available. For the PRAMS data, the numerator and the denominator are weighted to be representative of the state.

Data Alerts:

None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	5.8	6.0	7.4	6.2	6.0
Annual Indicator	6.9	8.4	6.5	7.1	
Numerator	83	101	78	85	
Denominator	1,207,467	1,201,681	1,200,272	1,192,611	
Data Source	DOH Vital Statistics	DOH Vital Statistics	DOH Vital Statistics	DOH Vital Statistics	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts:

None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015

	2011	2012	2013	2014	2015
Annual Objective	90.0	90.0	91.6	92.4	92.6
Annual Indicator	88.8	92.2	91.2	91.6	
Numerator	3,099	3,133	3,063	3,025	
Denominator	3,488	3,398	3,360	3,302	
Data Source	Florida DOH CHARTS	Florida DOH CHARTS	DOH CHARTS	DOH CHARTS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts:

None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	81.0	81.5	82.0	82.5	83.0
Annual Indicator	80.3	80.0	79.9	79.4	
Numerator	154,294	159,307	159,880	160,186	
Denominator	192,194	199,097	199,996	201,802	
Data Source	Florida DOH CHARTS	Florida DOH CHARTS	DOH CHARTS	DOH CHARTS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts:

None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Florida

SPM 1 - The percentage of Part C eligible children receiving service

	2011	2012	2013	2014	2015
Annual Objective	98.0	98.0	98.0	98.0	98.0
Annual Indicator	94.3	97.6	83.2	85.2	
Numerator	35,079	34,637	24,947	14,541	
Denominator	37,189	35,490	29,982	17,071	
Data Source	Early Steps Data System Annual Report.	Early Steps Data System Annual Report	Early Steps Data System Annual Report	Early Steps Data System Annual Report	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2013**

Field Note:
These data include 12 months for 7 programs 3 months for 2 programs 4 months for 2 programs 1 month for 1 program and exclude 3 programs. Five local programs converted from the CMS Early Steps Data System to the CMS-KIDS data system which does not collect all service encounter data. A total of 8 programs have now converted to CMS-KIDS data system. Conversion to CMS-KIDS for the remaining programs was completed during 2013-2014.

2. **Field Name:** **2012**

Field Note:
These data include 7 months for one local program 10 months for two local programs and 12 months for the 12 remaining programs. Three local programs converted from the CMS Early Steps Data System to the CMS-KIDS data system which does not collect all service encounter data. Conversion to CMS-KIDS for the remaining programs will be phased in during 2012-2014.

Data Alerts:

None

SPM 2 - The percentage of births with inter pregnancy interval less than 18 months.

	2011	2012	2013	2014	2015

Annual Objective	36.6	35.2	34.9	34.0	33.8
Annual Indicator	35.7	35.3	34.3	34.6	
Numerator	41,496	42,911	42,172	43,318	
Denominator	116,089	121,453	123,080	125,267	
Data Source	Florida CHARTS	Florida CHARTS	Florida CHARTS	Florida CHARTS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

None

Data Alerts:

None

SPM 3 - The percentage of women having a live birth who received preconception counseling about healthy lifestyle behaviors and prevention strategies from a health care provider prior to pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	21.0	22.0	23.0	24.0	25.0
Annual Indicator	16.7	16.7	16.7	16.7	
Numerator					
Denominator					
Data Source	PRAMS 2011	PRAMS 2011	PRAMS 2011	PRAMS 2011	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**
	Field Note: Data Source: PRAMS 2011 16.7 percent of all women received at least five preconception health topics before they got pregnant. Most recent data available.	
2.	**Field Name:**	**2012**
	Field Note:	

Data Source: PRAMS 2011 16.7 percent of all women received at least five preconception health topics before they got pregnant. Most recent data available.

3.	**Field Name:**	**2011**

Field Note:
Data Source: PRAMS 2011 16.7 percent of all women received at least five preconception health topics before they got pregnant.

Data Alerts:

None

SPM 4 - The percentage of infants not bed sharing.

	2011	2012	2013	2014	2015
Annual Objective	78.0	79.0	80.0	42.0	43.4
Annual Indicator	39.4	39.4	39.4	39.4	
Numerator					
Denominator					
Data Source	PRAMS 2011	PRAMS 2011	PRAMS 2011	PRAMS 2011	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**

Field Note:
2011Florida PRAMS Report

2.	**Field Name:**	**2012**

Field Note:
2011 Florida PRAMS Report.

3.	**Field Name:**	**2011**

Field Note:
2011 Florida PRAMS Report. PRAMS question: How often does your new baby sleep in the same bed with you or anyone else? Note: data prior to 2011 came from national CDC report which counts always and often as yes to bed sharing; and seldom rarely and never as not bed sharing. Florida PRAMS only counts never answers as not bed sharing which is why the percentage appeared to drop substantially between 2010 and 2011. Data for 2012 and 2013 is not available yet. We used the same information for 2012 and 2013 that we found in 2011. For the

PRAMS data the numerator and the denominator are weighted to be representative of the state.

Data Alerts:

None

SPM 5 - The percentage of infants back sleeping.

	2011	2012	2013	2014	2015
Annual Objective	65.0	66.0	67.0	68.0	69.0
Annual Indicator	67.2	67.2	67.2	67.2	
Numerator					
Denominator					
Data Source	PRAMS 2011	PRAMS 2011	PRAMS 2011	PRAMS 2011	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**
	Field Note: 2011 PRAMS report.	
2.	**Field Name:**	**2012**
	Field Note: 2011 PRAMS report.	
3.	**Field Name:**	**2011**
	Field Note: 2010 PRAMS report.	

Data Alerts:

None

SPM 6 - The percentage of teen births, ages 15-17, that are subsequent (repeat) births.

	2011	2012	2013	2014	2015

	2011	2012	2013	2014	2015
Annual Objective	8.8	8.1	7.3	6.7	6.3
Annual Indicator	8.3	7.4	7.4	8.1	
Numerator	391	314	274	257	
Denominator	4,723	4,219	3,698	3,191	
Data Source	Florida CHARTS	Florida CHARTS	Florida CHARTS	Florida CHARTS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

None

Data Alerts:

None

SPM 7 - The percentage of low-income children who access dental care

	2011	2012	2013	2014	2015
Annual Objective	30.3	38.4	38.6	29.6	31.4
Annual Indicator	26.3	27.8	29.0	30.1	
Numerator	594,914	670,173	745,342	793,504	
Denominator	2,261,437	2,414,583	2,567,729	2,640,145	
Data Source	Agency for Health Care Administration	Agency for Health Care Administration	Agency for Health Care Administration	Agency for Health Care Administration	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**

Field Note:
Annual Performance Objectives Modified to better reflect trend in data source for this measure. From 2011 forward, the data source is the CMS-416 Report which is furnished by the Agency for Health Care Administration. Prior to 2011, approximations using data from several different sources were used to obtain estimates. This

change in data source reflects an effort to measure the objective in a consistent way from one decision support system.

2.	**Field Name:**	**2011**

Field Note:
Annual Performance Objectives Modified to better reflect trend in data source for this measure. From 2011 forward, the data source is the CMS-416 Report which is furnished by the Agency for Health Care Administration. Prior to 2011, approximations using data from several different sources were used to obtain estimates. This change in data source reflects an effort to measure the objective in a consistent way from one decision support system.

Data Alerts:

None

Form 11

Other State Data

State: Florida

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: Florida

Please click the link below to download a PDF of the State Action Plan Table.
State Action Plan Table