Maternal and Child Health Services Title V Block Grant

Florida

FY 2018 Application/ FY 2016 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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

Florida HEALTH

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

Rick Scott
Governor

Celeste Philip, MD, MPH
Surgeon General and Secretary

July 13, 2017

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

Dear Sir or Madam:

Enclosed is Florida's Maternal and Child Health Services Title V Block Grant for FY2018. 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 FY2018.

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

Sincerely,

Kelli T. Wells, MD, MPH
Deputy Secretary for Health

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

Florida Department of Health
Office of the State Surgeon General
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PHAB Accredited Health Department
Public Health Accreditation Board

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 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 (Department) is responsible for administering the Title V Maternal and Child Health (MCH) Block Grant, encompassing the MCH and Children with Special Health Care Needs (CSHCN) programs. These programs fall within the auspices of the Division of Community Health Promotion and the Office of the Children's Medical Services (CMS) Plan and Specialty Programs.

While Florida has experienced declining morbidity and mortality rates (success), disparities persist (challenge). Although infant mortality inequalities, disparities, and poor health outcomes are known, the contributing factors require greater understanding and research because they are major drivers of the black-white infant mortality gap. The Department is committed to achieving health equity and eliminating these differences with action that goes beyond health care.

- Overall infant mortality rate has gone from 7.2 deaths per 1,000 live births in 2006 to 6.2 in 2015, with a low of 6.0 deaths per 1,000 live births in 2012 and 2014.
- The black infant mortality rate has gone from 12.9 deaths per 1,000 live births in 2006 to 11.4 deaths per 1,000 live births in 2015, with a low of 10.6 deaths per 1,000 live births in 2013

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. Each of the state priorities includes specific language directed at addressing and eliminating disparities. These priorities also determined the eight national performance measures (NPM) chosen for programmatic focus.

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

Domain: Women/Maternal Health

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

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

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

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

Domain: Perinatal/Infant Health

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

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

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

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

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

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

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

The decline in the incidence of sudden infant death syndrome (SIDS) has plateaued in recent years. Concurrently, sleep-related deaths, including suffocation, asphyxia, and entrapment; and ill-defined or unspecified causes of death have increased in incidence. It is important to address these other causes of sleep-related infant death. Many of the modifiable and non-modifiable risk factors for SIDS and suffocation are strikingly similar. Focusing on a safe sleep environment can reduce the risk of all sleep-related infant deaths, including SIDS.

Domain: Child Health

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

ESM 8.1: The number of county School Health Programs who are utilizing the evidence-based Comprehensive School Physical Activity Program (CSPAP) for the reduction of childhood obesity

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

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

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

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

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

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

State Priority: Address the social determinants of health that influence the relationship between health status and

biology, individual behavior, health services, social factors, and policies

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

Domain: Adolescent Health

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

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

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. Students experiencing bullying describe their grades as D's and F's in school at a significantly higher rate than those who are not bullied. 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 and provides the opportunity for the Department to improve health throughout the life span by reducing the percentage of adolescents who are bullied and increasing the proportion of students who graduate.

Domain: Children with Special Health Care Needs

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

ESM 11.1: Number of pediatric providers in Florida who have received information related to the Patient Centered Medical Home (PCMH) and who have completed a Medical Home Assessment Tool for their practice

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, compassionate, and culturally effective medical care. It is especially advantageous for CSHCN as they require coordination of care between providers.

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

ESM 12.1: Number of pediatric providers in Florida who have practices that have a Health Care Transition (HCT) policy or youth with readiness assessment (with physicals) and plans of care

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

Health care transition continues to be an important initiative and priority for the CSHCN Program. 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.

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

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

Mental health has been identified to be of extreme importance. Without early diagnosis and treatment, children with mental health conditions may have problems at home, in school, and socially.

Domain: Cross-Cutting or Life Course

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

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

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

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

Block Grant Accomplishments in 2016

Although not comprehensive, the following list provides several highlights of work that was accomplished and that supports the state's MCH priorities and national performance measures:

Hypertension in Pregnancy (HIP) Initiative

In 2015 hypertensive disorders caused 7.9 percent of pregnancy-related deaths. The focus of the HIP initiative is to improve proper screening, diagnosis, and management of hypertensive disorders related to pregnancy. The project emphasizes timely recognition, a quick and organized response to severe hypertension cases, and proper patient education and discharge. The HIP Initiative kicked off in the fall of 2015 and will end in the summer 2017.

Perinatal Quality Indicator System

A new statewide Perinatal Indicators System was developed to provide more timely and accurate indicators for all hospitals. This system has rolling enrollment.

Mother's Own Milk (MOM) in the Neonatal Intensive Care Unit (NICU)

The aim of this project is to increase the number of very low birth weight (VLBW) infants in Florida who receive mothers own milk at NICU discharge by focusing on intent to provide breast milk, establishing and maintaining

mothers' supply, and transitioning to the breast.

Birth Certificate Accuracy Initiative (BCI)

Inaccurate or incomplete birth certificate data impacts surveillance, research, and public health prevention and intervention strategies. The BCI Pilot aims to improve the accuracy of 22 key birth certificate variables to at least 95 percent by providing training, support, and data reporting.

Promoting Primary Vaginal Deliveries (PROVIDE)

About one-fifth of Florida hospitals meet the Healthy People 2020 national goal for Nulliparous Term Singleton Transverse (NTSV) cesarean section deliveries of 23.9 percent or less. The purpose of this project is to work with Florida stakeholders and hospitals to improve readiness, recognition, response, and reporting with the ultimate goal of promoting intended primary vaginal deliveries.

Long-Acting Reversible Contraception (LARC) at Delivery

This initiative aims to increase the use of LARC immediately postpartum to reduce the number of unintended pregnancies and improve maternal and child health. As a result of this initiative, the Agency for Health Care Administration (AHCA), Florida's Medicaid Agency, has instituted a Medicaid policy enabling hospitals and providers to receive full reimbursement for a LARC device and physician insertion procedure fee prior to hospital discharge.

Obstetric Hemorrhage Initiative (OHI)

Hemorrhage is one of the state's most preventable maternal mortality issues and is one of the top causes of maternal mortality in Florida. From 1999-2012 hypertensive disorders were the leading cause of pregnancy-related deaths, accounting for 15.5 percent of such deaths in Florida. The initiative developed a set of protocols and tools using evidence-based elements. Hospitals are asked to spend 18 months implementing the recommended changes and six months institutionalizing them in their facilities.

March of Dimes

A strong partnership has been developed between the Department and the March of Dimes. A temporary position has been established to work directly in the March of Dimes office to carry out the Department's priorities in partnership with AHCA, PAMR, and the FPQC. All these organizations are tightly interwoven to advance evidence-based return on investment initiatives.

Florida's Pregnancy-Associated Mortality Review (PAMR)

In addition to monitoring annual data and trends, select topics are chosen for further analysis to obtain more complete understanding of particular issues or conditions. An action subcommittee was established to move PAMR recommendations to action. Two infographics have been produced with Urgent Maternal Mortality Messages to providers on hemorrhage-placental disorders and peripartum cardiomyopathy. A third message is currently in production on maternal morbidity.

Florida Healthy Babies Initiative

The Department invested $1.5 million in Maternal and Child Health Block Grant funding to the county health departments to conduct enhanced data analysis on infant mortality (including an environmental scan of existing pertinent programs) and to host a community action-planning meeting to examine disparities in infant deaths, the role of social determinants of health, and propose local action.

II. Components of the Application/Annual Report

II.A. Overview of the State

The mission of the Florida Department of Health is to protect, promote and improve the health of all people in Florida through integrated state, county, and community efforts. The Department's goal is to be the healthiest state in the nation. To effectively plan for improving health, it is imperative to understand that where residents and visitors live, learn, work and play contributes to their health. Health is shaped by the social, economic, and environmental conditions in which we live, and the available, accessible community resources. It is necessary to address the conditions that produce our health rather than only treating medical conditions after they occur. This section discusses the principal characteristics important to understanding the health status and needs of not only Florida's population but more specifically Florida's MCH and CSHCN population.

According to U.S. Census estimates for July 1, 2016, Florida has a total population of more than 20.6 million citizens, following only California and Texas as the third most populous state. Between April 2010 and July 2016, Florida's population increased by 9.6 percent. The most recent demographic US Census data as of July 1, 2015 show 76.0 percent of Florida's population is white,16.1 percent black, and 7.9 percent other races, mixed race, or unknown. Of the total population by ethnicity, 23.7 percent are Hispanic and 76.3 percent non-Hispanic. More than half of the state's population (51.9 percent) is between the ages of 25-64 and 29.6 percent are between the ages of 0-24. Florida's population 65 and older comprise 18.5 percent of the state's population compared to just 14.1 percent in this age group nationally. A greater percentage of health care resources are expended on the elderly population in Florida compared to other states.

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

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

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

Florida is a temporary home to well over 100 million tourists and visitors each year, which presents challenges to the state's public health system. In 2016, Florida hosted nearly 113 million tourists, a record compared to any previous

year. Migrant farm workers and unauthorized immigrants also have a significant impact on the state's public health services and resources. Florida was home to 850,000 unauthorized immigrants in 2014, compared to 925,000 in 2012 and a peak of 1,050,000 in 2007. California and Texas are the only states with greater numbers of unauthorized immigrants.

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

The Title V program, along with private and public health providers, contributes to meeting the challenges that come with the state's diverse group of residents, immigrants (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 a health care 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.

The health of the economy plays a major role in the health status of the state's MCH population. The economy in Florida has been recovering since the economic downturn suffered during the most recent nationwide recession. The average annual wage in Florida currently stands at 87.6 percent of the national average. Florida's economy is heavily reliant upon the service-related industry, where minimum wage jobs with little or no benefits are more the norm than the exception. A lack of well-paying jobs makes it difficult for many individuals and families to meet their basic needs. Those households most disproportionately affected are female-headed households, blacks, Hispanics, people living with a disability, and unskilled recent immigrants. According to the latest final numbers from the U.S. Bureau of Labor and Statistics, Florida's unemployment rate was 4.8 percent in March 2017, compared to 4.5 percent for the nation. Florida had a high school graduation rate of 77.9 percent in the 2014-15 school year, rising to 80.7 percent for 2015-16. In comparison, the national rate was 83.2 percent during the 2014-15 school year.

With a total area of 58,560 square miles, Florida ranks 22nd among states in total area and 8th in the nation in population density. Driving from Pensacola in the western panhandle of Florida to Key West at the southernmost point is nearly an 800 mile journey. The 1,200 miles of coastline become a target during hurricane season, and 2,276 miles of tidal shoreline are subject to concerns regarding water quality and fish and wildlife habitat degradation. A recent study by a private data analysis firm ranked Florida as the state with the highest level of risk from natural hazards.

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

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.

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

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

The Department is leading a diverse group of stakeholders to build Florida's State Health Improvement Plan (SHIP) for 2017-2021. The SHIP is a statewide plan for public health system partners and stakeholders to improve the health of Floridians. The partnership has already conducted a comprehensive state health assessment (SHA) to identify the most important health issues affecting Floridians. The SHIP Steering Committee is currently setting five-year priorities based upon the health issues and strategic opportunities identified in the SHA. Workgroups will identify goals, strategies and measurable objectives around each priority issue. The SHIP highlights major concerns and issues, including many that are directly related to the MCH and CSHCN population.

Comprehensive community health assessment and health improvement planning are the foundations for improving and promoting healthier Florida communities. Florida's 67 counties use a common process for collecting, analyzing, and using data to educate and mobilize communities, develop priorities, gather resources, and plan and implement actions to improve public health.

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

area's needs and priorities.

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

1. Childhood Vaccines – Increase vaccination of children to prevent disease and keep all of Florida's children protected from health threats. High immunization levels contribute positively to the state's economy by lowering disease incidence, lowering health care costs, and protecting travelers from vaccine-preventable diseases. Increasing access to and availability of vaccines will help keep Florida's families and communities protected from emerging health threats and improve overall school attendance.

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

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

4. HIV Infections – Reduce the incidence of HIV infections to allow more Floridians to live longer healthier lives. Florida has a comprehensive program for preventing the transmission of HIV and for providing care and treatment to those already infected. By reducing the incidence of HIV, more Floridians will live longer, healthier lives.

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

6. Inhaled Nicotine – Decrease inhaled nicotine use to provide a longer and healthier life for more Floridians. Cigarette smoking remains a major cause of cancer deaths in the United States. E-cigarette use among youth is on the rise with a 539 percent increase since 2011. The FDA deems all tobacco products are illegal for anyone under the age of 18. Florida has led the nation with innovative strategies to teach young people about the dangers of smoking and to help current smokers have the resources and support they need to quit. By decreasing inhaled nicotine use through outreach and education, Floridians will experience longer, healthier lives.

7. Licensure Time – Decrease time to issue licenses to health care professionals so they may serve the medical needs of Floridians more quickly. By decreasing the licensure processing time, health care professionals will be able to get to work in a timelier manner.

The Department has also adopted the National Association of City and County Health Officials' Protocol for Assessing Community Excellence in Environmental Health - PACE EH. For several years, the Bureau of Environment Health has supported county health departments to work with their communities and address environmental health concerns. Collectively, the county health departments across Florida who have implemented

PACE EH in communities have become a national model and provided evidence that communities can identify environment and urban planning issues as environmental health issues and address the social determinants of health. All projects are designed to open the lines of communication between the Department's county health departments and their affected communities.

During the 2016 Legislative Session, HB 941 specified that the Office of Minority Health be renamed as the Office of Minority Health and Health Equity, to be led by the Senior Health Equity Officer, a newly created position. The bill was enacted as section 20.53(9), Florida Statutes. The Office serves as the Department's coordinating office for consultative services and training in the areas of cultural and linguistic competency, partnership building, program development and implementation, and other related comprehensive efforts to address the heath needs of Florida's minority and underrepresented populations. The Office promotes the integration of culturally and linguistically appropriate services within health-related programs across the state to ensure the needs of the state's racial and ethnic minority communities are addressed, including people who are lesbian, bisexual, gay, and transgendered (LGBT).

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

The first project of the Health Equity Program Council was Florida's Healthy Babies Initiative, the Department's direct response to focus on the black-white infant mortality gap. During phase one of the initiative, the Department invested $1.5 million in Maternal and Child Health Block Grant funding. Funding was provided to the county health departments to conduct an enhanced data analysis on infant mortality, including an environmental scan of existing pertinent programs, and to host a community action-planning meeting to examine disparities in infant deaths, the role of social determinants of health, and propose local action.

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

Encouraging physical activity and healthier food choices has a positive impact on birth outcomes and child health. Women who are healthier before and during pregnancy lessen the risk of maternal and infant morbidity and mortality.

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

Following the Centers for Disease Control and Prevention (CDC) declaration of a national opioid epidemic, Florida's Governor signed Executive Order 17-146 on May 3, 2017 directing the State Health Officer and Surgeon General to declare a statewide public health emergency. Signing the Emergency Order allowed the state to immediately draw down more than $27 million in federal grant funding from the United States Department of Health and Human Services (HHS) Opioid State Targeted Response Grant, which was awarded to Florida in April 2017 to provide prevention, treatment, and recovery support services to address this epidemic. Without the order, the state

would have had to wait until July 2017 to distribute these federal grant funds to local communities. In addition to declaring a Public Health Emergency, the State Surgeon General issued a standing order for Naloxone, an emergency treatment for opioid overdose. This will ensure first responders have immediate access to this lifesaving drug to respond to opioid overdoses.

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

On July 1, 2014, the operation of the Healthy Start Medicaid-funded Waiver and SOBRA (MomCare) components were moved from the Department to AHCA. AHCA now contracts with an administrative services organization (ASO) called the Healthy Start MomCare Network (HSMN) representing all 32 state Healthy Start Coalitions. The HSMN contracts with the coalitions to provide counseling, education, risk-reduction and case management services, and quality assurance for all enrollees of the Waiver and SOBRA services. Medicaid-eligible clients will be part of Florida's Managed Medical Assistance 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.

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 program was created as a subset of the SMMC. The CMS Managed Care plan (CMS Plan) is a specialty plan option for clinically eligible children with special health care needs. The CMS Plan provides a broad range of medical, therapeutic, and supportive services for eligible children with special health care needs. The CMS Plan's statewide provider network includes over 39,000 primary care providers, specialists, hospitals, university medical centers, and other health care providers. Services are coordinated through one of the 19 CMS Area Offices around the state. Every child enrolled in CMS is assigned a nurse care coordinator and possibly a social worker, depending on the child's needs.

AHCA successfully completed the implementation of the SMMC 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.

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, Florida had the highest enrollment among states using the federal exchange during the 2015 open enrollment period 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.

Health care reform efforts have impacted both MCH and CSHCN populations and the delivery of Title V-supported services in several ways. Funding through health care reform 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 MIECHV program provides parents and other caregivers with the knowledge, skills, and tools needed 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.

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 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 and Updates

FY 2018 Application/FY 2016 Annual Report Update

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

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

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

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

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

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

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

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

and infants receive high quality, evidence-based perinatal care to help ensure the best health outcomes possible.

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

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

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

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

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

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

The *Florida Life Course Indicator Report* was published online and can be found at: www.flhealth.gov/floridalifecourse. This comprehensive state-level report provides baseline measures of the 59 life course indicators selected in a project led by AMCHP and participating partners. The goal of the report is to establish a knowledge base about the Life Course Theory and to promote the use of the life course indicators by

public health practitioners. The report is available to download in subsections based on topics such as *Community Well-Being* and *Reproductive Life Experiences*. The Executive Summary provides a high-level overview of all the indicators and identifies cohesion between the Life Course Theory and current Department priority areas, including the social determinants of health. This work is a wonderful addition to the needs assessment and State Work Plans to more adequately drive and improve the strategies developed to address the MCH and CSHCN priorities and performance measures.

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

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

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

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

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

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

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

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

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

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

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

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

FY 2017 Application/FY 2015 Annual Report Update

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II.B.1. Process

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

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

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

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

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

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

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

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

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

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

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

II.B.2. Findings

II.B.2.a. MCH Population Needs

Women/Maternal Health

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

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

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

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

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

Perinatal/Infant Health

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

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

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

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

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

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

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

outpatient services.

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

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

Child Health and Adolescent Health

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

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

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

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

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

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

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

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

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

Children with Special Health Care Needs

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

Other Findings/Strengths/Needs

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

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

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

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

II.B.2.b Title V Program Capacity

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

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

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

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

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

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

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

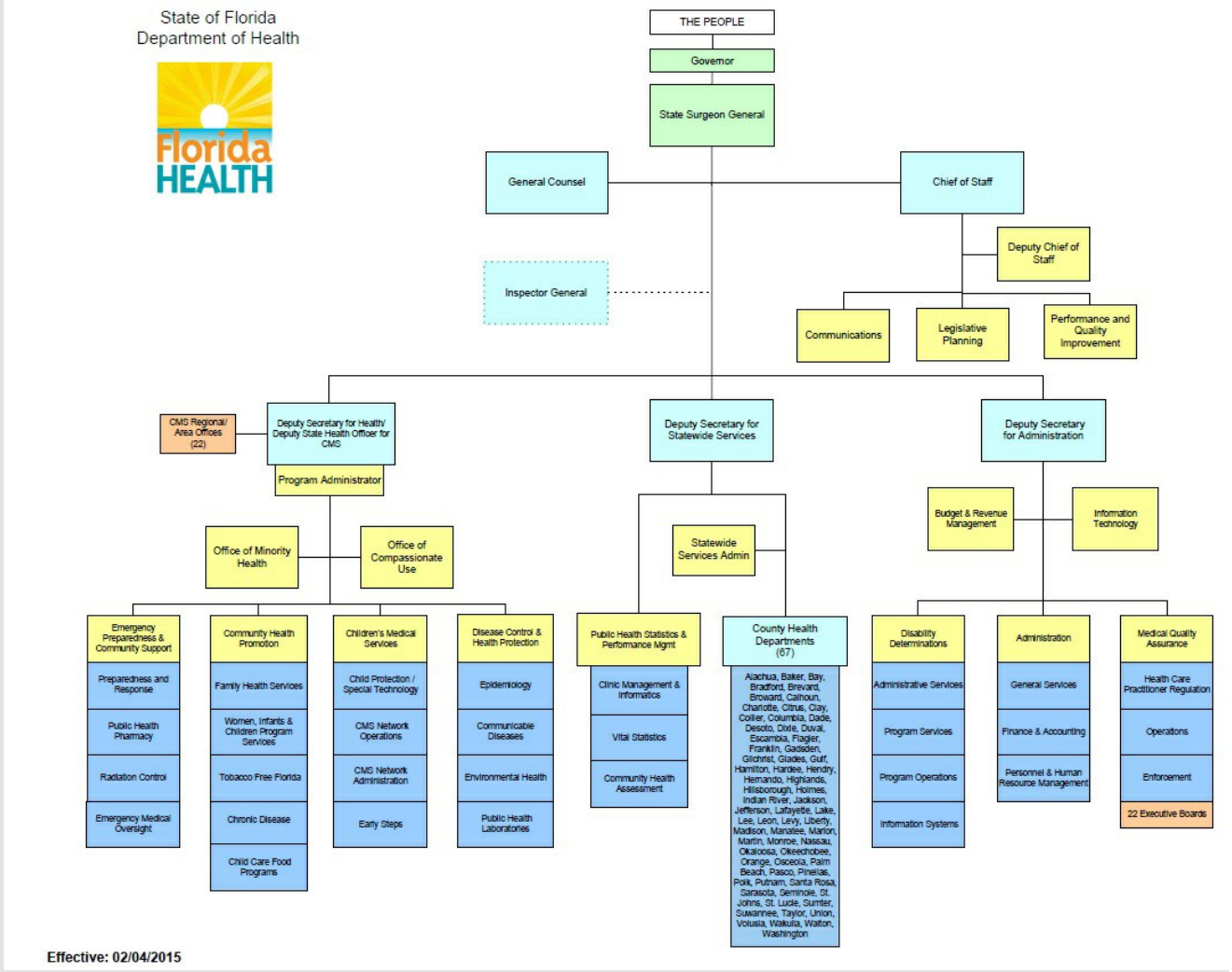
The Division Director of Community Health Promotion provides leadership, policy, and procedural direction for the Division, which includes the Bureaus of Child Care Food Programs, Chronic Disease Prevention, Family Health Services, Tobacco Free Florida, and WIC Program Services.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II.C. State Selected Priorities

No.	Priority Need
1	Promote safe and healthy infant sleep behaviors and environments, including improving support systems and the daily living conditions that make safe sleep practices challenging.
2	Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment.
3	Promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children.
4	Promote breastfeeding to ensure better health for infants and children and reduce low food security.
5	Improve access to health care for women to improve preconception and interconception health, specifically women who face significant barriers to better health.
6	Increase access to medical homes and primary care for children with special health care needs.
7	Improve health care transition to all aspects of adult life for adolescents and young adults with special health care needs.
8	Improve dental care access for children and pregnant women.
9	Improve access to appropriate mental health services to all children.
10	Address the social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies.

Following is a list of the state priorities for Florida:

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

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

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

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

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

6. Increase access to medical homes and primary care for children with special health care needs.

7. Improve health care transition to all aspects of adult life for adolescents and young adults with special health care needs.

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

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

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

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 MCH 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 state 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 a priority issue as black infants in Florida are more than twice as likely as white infants to die in their first year of life. The Department is committed to achieving health equity and eliminating these differences.

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 10 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; the 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 based on survey responses, workgroup input, and recent reports that further emphasize the importance of breastfeeding, especially as it relates to infant brain development and reducing future obesity. Additionally, racial and ethnic minority women continue to have lower breastfeeding rates than white women. The inclusion of this priority offers a unique opportunity to promote and support breastfeeding through public policy and these efforts can have a meaningful impact on the future health of the mother and the child.

Improving access to care for women is a new measure, 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 CMS, and are identical to the priorities for the previous five-year cycle.

The Patient Centered Medical Home (PCMH) continues to be a priority for CMS. Local CMS area offices work closely with providers who strive to provide PCMHs for their patients. CMS provides care coordination to and works closely with providers to assist with the needs of the children enrolled in the CMS Managed Care Plan. Additionally, CMS has collaborated with HealthARCH at the University of Central Florida, the state's only designated NCQA Partner in Quality for PCMH transformation, to identify pediatric physicians and practices that are ready for transformation to continue to leverage resources and build PCMH capacity in Florida.

Another priority of key importance for CMS is transition. 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 this strategy will require continued effort and collaboration at the local level. Recently, FloridaHATS developed a training course for educators that provides resources and education related to health care transition and incorporates health care self-management skills in Transition IEPs. 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 all children, including children with special health care needs. Additionally, family and patient engagement will play a critical role in transition activities.

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

Mental health continues to be a focus for Florida's Title V efforts with the MCH population and with CSHCN population. CMS is working with Florida's DCF Substance Abuse and Mental Health Program and other key partners on integrating primary care and behavioral health. In January 2017, CMS was accepted to participate in the National MCH Workforce Development Center's 2017 cohort. This opportunity will allow CMS and all the partners working on this state performance measure to gain practical skills and knowledge to help plan and implement evidence-based and evidence-informed strategies to accomplish our goals.

The MCH program is implementing the Moms and Babies evidenced-based program into Florida's Healthy Start Program. The program promotes healthy mood, bonding with one's baby, and strategies for pregnant women and new moms to cope with stress in their lives. The program is also being implemented through Florida's MIECHV program. The Department partnered with the MIECHV program and Northwestern University and received a grant from the Robert Wood Johnson Foundation to evaluate the implementation of the program using trained paraprofessionals in a one-on-one home visiting setting.

Continued efforts to establish additional partnerships, including those with families and family leaders in the state, will play a major role in ensuring a successful implementation of objectives and strategies related to mental health efforts.

Addressing social determinants of health is a priority issue and a major focus, 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. Additionally, the MCH program selected social determinants of health as one of three priority areas to address through the Collaborative Improvement and Innovation Network (CoIIN).

The MCH program allocates Title V funding to Florida's 67 county health departments to address four priority areas, one of which is social determinants of health.

The Department's Bureau of Environmental Health has adopted the National Association of City and County Health Officials' Protocol for Assessing Community Excellence in Environmental Health - PACE EH. County health departments across Florida have implemented PACE EH to identify and address environmental health issues within their communities.

An excellent example of this effort is Indian River County, where MCH block grant funds helped pay for a PACE EH Coordinator, an individual from the community who is also the local NAACP President. The project addressed health equity issues, resulting in improvements in some of their most impoverished communities. An assessment of local needs was conducted and empowered residents with the tools needed to address their county commission, resulting in approval for a new potable water line and plans to make streets more pedestrian and bike friendly and improve access to a key recreation area adjacent to low-income housing complexes. Interaction with the community led to working with non-government organizations to provide safe sleep education. After learning that many residents needed a safe place for their infant to sleep, a grant was written to assist mothers upon hospital discharge with crib needs.

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
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 5 - Percent of infants placed to sleep on their backs
- NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
- NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
- NPM 11 - Percent of children with and without special health care needs having a medical home
- NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

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 and improve preconception health, specifically women who face significant barriers to better health. The Title V program has focused on both preconception and interconception health for several 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 because women are often 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 and reduce low food security 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 support 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 State Systems Development Initiative (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, including improving support systems and the daily living conditions that make safe sleep practices challenging, such as the lack of an infant's own sleep surface or overcrowding. Safe sleep for infants is one of the Department's 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 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 county 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 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 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 because 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. A special emphasis will be placed on the young lesbian, gay, bisexual, and transgendered (LGBT) community due to the high reported rates of bullying towards this population. A 2015 CDC national report states that lesbian, gay, and bisexual students were bullied online at twice the rate of heterosexual students, and were bullied at school at a 75 percent greater rate than heterosexual students.

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 children with special health care needs. A patient-centered medical home (PCMH) provides accessible, continuous, comprehensive, family-centered, coordinated, compassionate, culturally effective 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 providers and 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 to all aspects of adult life for adolescents and young adults with special health care needs. 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 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 secondhand smoke 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 secondhand smoke 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

- SPM 1 - The percentage of children that need mental health services that actually receive mental health services.
- SPM 2 - The percentage of low-income children under age 21 who access dental care.
- SPM 3 - The percentage of parents who read to their young child age 0-5 years

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

This measure was chosen because of the clear link to the state's priority to improve access to appropriate mental health services to all children. Increasing the number of children who have mental health and behavioral health conditions and are referred to timely and appropriate treatment will improve health outcomes and the child's ability to function optimally at home, at school, and in society.

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

This measure was chosen because of the clear link to the state's priority to improve dental care access for children and pregnant women. Oral health is vitally important to overall health and well-being. Oral health is a state of being free from chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects, periodontal disease, tooth decay and tooth loss, and other disease and disorders that affect the oral cavity. Good oral health habits and access to routine dental care should be established early in life. Poor oral health can affect a child's ability to learn and school attendance. Research has shown a link to diabetes, heart and lung disease, stroke, respiratory illnesses, and other conditions for pregnant women, including the delivery of preterm and low birth weight infants. In addition, a child's oral health can have lasting impact on their life course and ability to thrive. Children with poor oral health are three times more likely to miss school due to oral health problems, and pain and infection from tooth decay can affect a child's ability to focus in school.

SPM 3: Increase the percentage of parents who read to their young children

This measure was chosen because of the clear link to the state's priority to address the social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies. Encouraging parents to read to their children has a positive impact, including but not limited to improvement in the parent-child bond, improved language development in children, and increased positive parenting.

II.F. Five Year State Action Plan

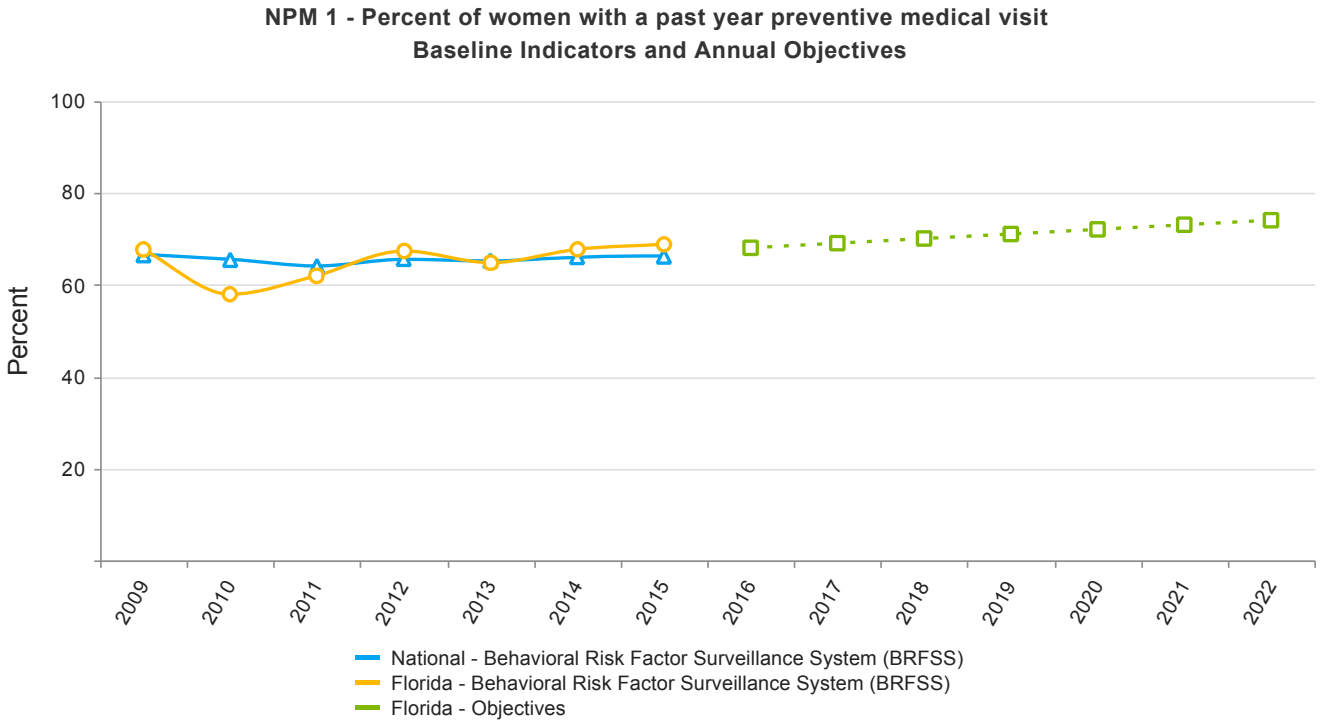
II.F.1 State Action Plan and Strategies by MCH Population Domain

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2014	183.1	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2011_2015	23.8	NPM 1
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	8.6 %	NPM 1
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.5 %	NPM 1
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	7.1 %	NPM 1
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	10.0 %	NPM 1
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	3.1 %	NPM 1
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	6.9 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	25.7 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	6.5	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	6.1	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	4.2	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	2.0	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	234.6	NPM 1

National Performance Measures



Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	68
Annual Indicator	68.8
Numerator	2,287,771
Denominator	3,324,933
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	69.0	70.0	71.0	72.0	73.0	74.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	27,000.0	27,500.0	28,000.0	28,500.0	29,000.0	29,500.0

State Action Plan Table

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

Priority Need

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

NPM

Percent of women with a past year preventive medical visit

Objectives

1. Increase the number of preventative health services for women of reproductive age.

2. Increase the number of eligible women age 14-55 years who utilize the family planning waiver to receive family planning services.

3. Increase client awareness of the importance of interconception health for improving perinatal outcomes through consistency of messaging on interconception care health issues.

Strategies
1a. Collaborate with the Bureau of Chronic Disease Prevention to measure the number of women receiving preventative health screens.
1b. Collaborate with the Bureau of Chronic Disease Prevention to raise awareness of and offer the preventative health services available for women of reproductive age.
1c. Include a provision in the Florida Pregnancy Care Network (FPCN) contract that supports a partnership with the Healthy Start Coalitions and the provision of preventative health care services (interconception) for women at risk for a subsequent poor birth outcome.
1d. Work with the Healthy Start Coalitions to increase the number of women who are being provided interconception care as coded under program components 22 and 32.
1e. Create a process for secure text appointment reminders/ confirmation (example: STD Texting Project).
2a. The Department's Title V program will coordinate with the Title X program and AHCA's Bureau of Medicaid Services to provide a Family Planning Waiver training to state Healthy Start care coordinators and county health department (CHD) staff.
2b. Revise Healthy Start contracts and county health department agreements to require yearly mandatory training for all Healthy Start staff on the Family Planning Waiver.
3a. Conduct an assessment to determine what educational materials, models, and curriculums are currently being used by the Healthy Start program to educate and counsel participants on interconception health.
3b. Develop and/or identify an evidence-based interconception health curriculum for statewide implementation in the Healthy Start program.
3c. Implement one interconception health curriculum for statewide use in the Healthy Start program.
3d. Revise Healthy Start contracts to require the Healthy Start Coalitions to provide trainings on interconception care services and eligibility to community providers, such as: maternal health care providers, pediatric providers, community health centers, federally qualified health centers, and managed care plans.
3e. Research innovative ideas, such as the feasibility of cellphone applications that will provide education for Healthy Start clients on maternal and infant topics and provide Healthy Start appointment reminders.

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

NOMs

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

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

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

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

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

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

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

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

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

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

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

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

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

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

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, specifically women who face significant barriers to better health, and to improve preconception health, which was identified as one of the state's priority issues. The goal for Florida is that by 2018, at least 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 national performance measure selected for this priority was NPM 1: Percent of women with a past year preventive medical visit. The Department has identified objectives and strategies to improve the health of Florida's women.

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

Services include:

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

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

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

In partnership with the March of Dimes, the Department is using Title V funds to co-fund the Healthy Start Coalition of Hillsborough County (Tampa), to develop a statewide ICC curriculum to be implemented July 1, 2017 through all 32 Healthy Start Coalitions. The curriculum will include topics on accessing health care, baby spacing, body mass index, healthy weight, chronic health conditions, contraceptive use, environmental risk factors, folic acid intake, infections, establishing a medical home, mental health, nutrition, oral health, physical activity, the relationship of poor pregnancy outcomes and future pregnancy outcomes, and substance use including the effects of opioids. The curriculum works to educate women on ways to improve their health for themselves while highlighting how improving their health may

help improve future pregnancy outcomes.

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

Training on the Healthy Start Interconception Curriculum will take place during the first quarter of the 2017/2018 contract year. The Healthy Start coalitions will implement a train-the-trainer approach to ensure every Healthy Start care coordinator receives the required training.

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

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

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

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

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

- Technical assistance to states
- New materials documenting state experiences

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

These projects will continue until 2019. Florida will implement system-wide changes to eliminate barriers to accessing reproductive health care, while also addressing health disparities. Addressing all women of reproductive age, with a focus on the underinsured and Medicaid populations, Florida will accomplish these activities through two goals:

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

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

As part of the ASTHO Learning Community, a pilot project, funded with Title V funds, was initiated in Duval County through the Northeast Florida Healthy Start Coalition. The pilot project is working with AHCA to unbundle postpartum LARC and delivery fees, develop billing procedures with insurance carriers, and provide education for providers and patients.

Building on the pilot project, the Department contracted with the FPQC to implement a hospital-based quality improvement initiative for Florida birthing hospitals to roll out and institute the practice of providing access to postpartum LARC statewide and provide best practices for the state.

The Department's MCH Section contracts with the Florida Pregnancy Care Network to implement the Department's Florida Pregnancy Support Services Program. The program is a network of nonprofit pregnancy support centers that provide support and assistance to women, men, and their families faced with difficult pregnancy decisions. Services include free pregnancy tests, peer counseling, and referrals; and most of the centers offer classes on pregnancy, childbirth, parenting, and personal finance management. Funding is provided through the General Appropriations Act. During the 2016 state legislative session, funding was increased by $2,000,000 and proviso language was added to include wellness services. The funding and proviso was included again during the 2017 legislative session. The program is currently piloting wellness services, such as well woman exams for non-pregnant women 18 and older (available to uninsured women who have a state-issued photo ID).

An STI testing pilot project is also taking place. The project serves men and women, minors, and adults.

The Department's MCH Section staff will continue to promote the availability of the services to the Florida Association of Healthy Start Coalitions and to the county health departments as a referral source.

Reduction of maternal death is a national and state priority. Florida's Pregnancy-Associated Mortality Review is an ongoing system of surveillance that collects and analyzes information related to maternal deaths to promote system

improvements through evidence-based actions aimed at preventing future untimely deaths. Florida's PAMR team is a public-private partnership. Actions of the team include reports covering multiple years of review, which are beneficial for evaluating trends and proposing recommendations for change. In addition to monitoring annual data and trends, select topics are chosen for further analysis to obtain a more complete understanding of a particular issue or condition and promote the development of targeted actions that may prevent future deaths. The FPQC is one method that is used for moving recommendations to action through quality improvement projects.

A recurring recommendation from the PAMR team is to stress the importance of a woman receiving education on preconception health and the need to have a medical home to manage chronic disease processes and to maintain optimal weight. Florida's PAMR data also notes that non-Hispanic black women are significantly more likely to die from pregnancy complications compared to non-Hispanic white and Hispanic women. Between 2003 and 2014, the pregnancy-related mortality ratio for non-Hispanic black women was significantly higher than non-Hispanic white and Hispanic women. In response to issues determined by PAMR, the MCH Section will collaborate with the Bureau of Chronic Disease prevention to analyze data that will enable the Department to identify strategies to increase the number of preventative services for women of reproductive age.

The Department's MCH Section will continue to collaborate with the Bureau of Communicable Diseases to create a process for secure text appointment reminders/confirmations. According to an article in the American Family Physician, text message reminders increase attendance at health care appointments compared with no reminders or postal reminders. They are as effective as telephone call reminders but are less expensive. Low income populations have access to unlimited text messaging through government phone assistance programs making this mode of communication very accessible. In addition, the Department will continue to work with Florida's Medicaid agency to incorporate innovative texting services into the managed care plan contracts.

The Department's MCH Section will continue to partner with the March of Dimes and Florida's Prematurity Prevention Partnership project using Title V to co-fund 11 community teams in a project with the Healthy Start Coalitions as the community leads. The purpose of the project is to reduce preterm births and reduce racial and ethnic disparities in preterm births. The community projects must create meaningful, cross-sector, multidisciplinary approaches designed to address one or more of the following elements: preconception health; ensuring appropriate preventative treatment for women at-risk of preterm birth; discouraging early elective deliveries and preventing unintended pregnancies; and promoting optimal birth spacing. The implemented projects must be evidence-based or research-informed. In addition, Title V funding will be provided to establish a position at the March of Dimes to expand, enhance, track, and evaluate the community team's projects and ensure they are aligned with proven interventions to reduce preterm birth. This position will also assist with the statewide Florida Prematurity Prevention Partnership and provide assistance to the Chair of the Prematurity Prevention Workgroup. The Chair is held by the Department's Bureau Chief of Family Health Services for a two-year commitment.

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

- Contracts with 11 Fetal Infant Mortality Review (FIMR) projects through the Healthy Start program to provide for the implementation of FIMR services to address the behavioral, environmental, and structural processes that may impact fetal and infant deaths, to learn more about why infants die and to propose recommendations for change.
- 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 maternal and child health initiatives such as Text4baby, Healthiest Weight, safe sleep, and Reach Out and Read campaigns throughout the state, with a focus on television and radio advertisements.

- 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. Services will include employability skill training to clients through the *Win at Work* program, a program that addresses work equity.
- 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 Florida Association of Healthy Start Coalitions to implement the evidence-based Nurse-Family Partnership home visiting model, with the intent to strengthen and improve the coordination of client support services and provide model-specific services to improve benefits for at risk populations.

Three of the Healthy Start Coalitions in Florida received funding through the Strong Start for the 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. A study on initiating Strong Start in the Florida Healthy Start Program is underway and results are pending.

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

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

- *Pregnancy-related Deaths due to Infection, Florida 2005-2014*
- *Florida's Pregnancy-Associated Mortality Review 2014 update*
- *Pregnancy-Related Deaths due to Hypertensive Disorders, Florida 1999-2012*
- *Pregnancy-Related Deaths due to Hemorrhage, 1999-2012*
- *Assessing Preventability of Maternal Deaths in Florida in 2013*

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

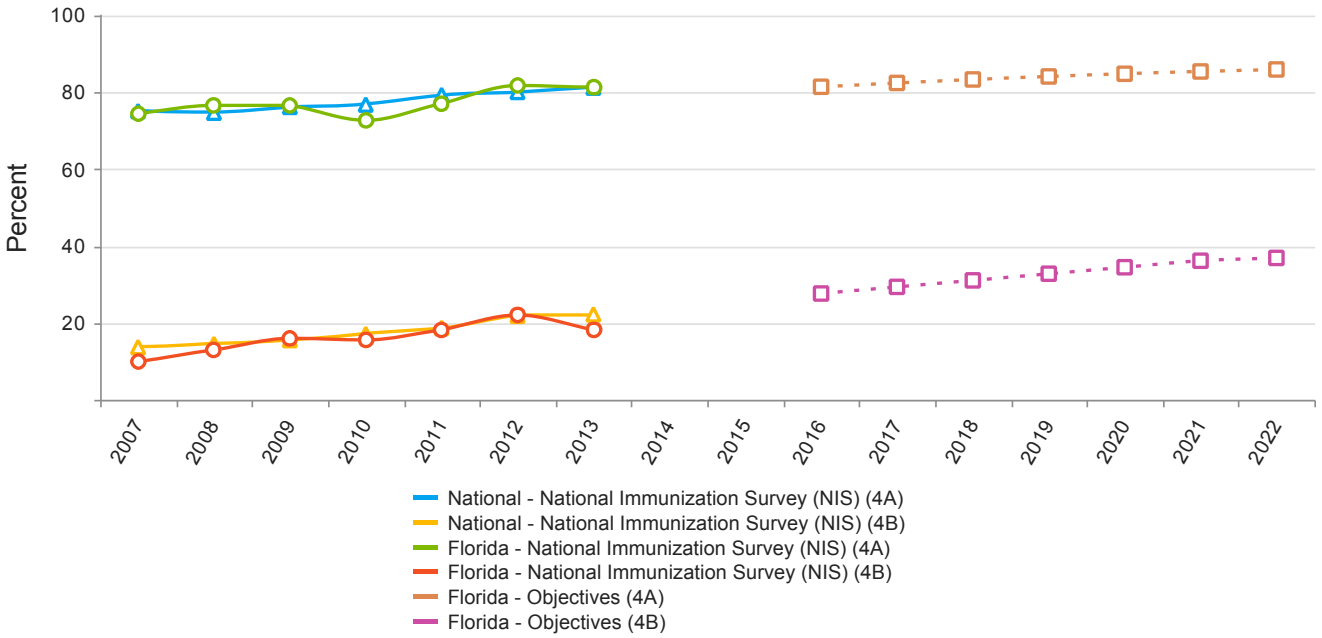
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	6.1	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	2.0	NPM 4 NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	87.7	NPM 4 NPM 5

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
Baseline Indicators and Annual Objectives



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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	81.3
Annual Indicator	81.1
Numerator	171,099
Denominator	210,888
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	82.3	83.2	84.0	84.7	85.3	85.8

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	27.7
Annual Indicator	18.4
Numerator	37,940
Denominator	206,047
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	29.4	31.1	32.8	34.5	36.2	36.9

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	42.0	42.0	42.0	42.0	42.0	42.0

NPM 5 - Percent of infants placed to sleep on their backs
Baseline Indicators and Annual Objectives

FAD for this measure is not available for the State.

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

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	73.3	74.4	75.4	76.3	77.1	77.9

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	15.0	20.0	25.0	30.0	35.0	40.0

State Action Plan Table

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

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

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

Objectives
1. Increase the number of Florida hospitals implementing Baby Steps to Baby Friendly policies and practices or taking steps to become baby friendly.
2. Establish a breastfeeding room at the state health office.
3. Enhance access to breastfeeding support.
4. Increase the number of Very Low Birth Weight (VLBW) infants receiving breast milk.

Strategies
1 Using the Florida Healthy Babies Initiative, develop a plan to encourage hospitals to establish policies and protocols in support of breastfeeding and becoming a Baby Steps to Baby Friendly hospital or becoming a Florida Breastfeeding Coalition’s Quest for Quality Maternity Care Award recipient.
2.Support the breastfeeding/pumping in the department’s workplace policy.
3a. Improve access to breastfeeding support for Healthy Start clients not eligible for WIC.
3b. Promote continuing breastfeeding education for Healthy Start Care Coordinators.
4. Support a Hospital-Based Quality Improvement Initiative to promote evidence-based interventions to increase the use of breast milk for VLBW infants in the NICU.

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

NOMs

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

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

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

Priority Need

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

NPM

Percent of infants placed to sleep on their backs

Objectives

1. Increase public awareness through consistent safe sleep messages from various entities invested in the wellbeing of infants.

2. Increase community stakeholder and partner involvement in the development of statewide strategies and policies to prevent sudden unexpected infant death.

3. Determine the scope of safe sleep activities in Florida.

Strategies

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

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

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

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

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

NOMs

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

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

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

Perinatal/Infant Health - Plan for the Application Year

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

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

Florida counties without a birthing hospital recording more than 10 births a year are not eligible for Baby Steps to Baby Friendly Title V funding. Of those counties not eligible, four (Calhoun, Liberty, Hamilton, and Madison) have been identified to participate in the Rural Breastfeeding Pilot Project. This pilot project will provide Title V funding to these four county health departments to promote evidence-based practices and carry out strategies related to breastfeeding education, support, and protection.

Title V funding will be provided to the Florida Breastfeeding Coalition to enhance current efforts and expand capacity for projects related to breastfeeding promotion. Funding will include a program evaluation that would recognize future and existing problems associated with the Florida Breastfeeding Coalition's website and application process, and provide technical assistance that will aid in the relief of the established programmatic issues.

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

MCH staff are in the process of standardizing an evidenced-based Healthy Start breastfeeding curriculum that can be used statewide as a broader approach to improving the quality of breastfeeding education provided to Healthy Start clients. It is essential to provide an evidence-based, current curriculum to guide Healthy Start care coordinators and to provide all clients appropriate and culturally relevant information. A standardized continuing breastfeeding education requirement will be implemented statewide.

The Department will continue efforts to target the most vulnerable infants in our state by aiming to increase the number of VLBW infants who receive breast milk. Title V funds will continue to support the FPQC's hospital-based quality improvement project, the Mother's Own Milk (MOM) Initiative, by promoting-evidence-based interventions to increase the use of breast milk for VLBW infants in Florida's NICUs.

The Department will continue to participate in the national Infant Mortality CoIIN Safe Sleep Learning Collaborative. Participation includes collaboration with local health departments and community partners in tailoring projects specific to the needs of the community. The Department encourages access to all CoIIN activities to any interested partners to participate on a national level. This has greatly engaged our partners' desire to be a part of a national

effort.

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

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

Perinatal/Infant Health - Annual Report

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

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

In 2016, Florida developed the Florida Safe Sleep Hospital Certification project, a partnership with birthing hospitals to train health care professionals, who may not always provide current information or model correct safe sleep practices. The activities of the project are to: train hospital staff and provide materials for distribution to patients, encourage each hospital to develop a Safe Sleep policy and submit an annual report on educational activities and staff compliance, and assess whether proposed activities address disparities.

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

The Department continues to facilitate a SUID Workgroup. The purpose of the workgroup is to create a coordinated, integrated system of policies and practices, and align Title V activities with the CoIIN and the Department's State Health Improvement Plan objectives. The workgroup assists in the development and implementation of evidence-based, culturally, and linguistically appropriate strategies to promote safe sleep behaviors and safe sleeping environments. Membership includes representatives from several state agencies, Healthy Start Coalitions, medical personnel, the Florida Breastfeeding Coalition, the Florida SIDS Alliance, the Florida Hospital Association, and parents.

As a component of Florida's Healthy Babies Initiative, in 2016, all 67 county health departments were given a base amount of Title V funding and required to conduct or enhance a data analysis project on infant mortality (including an environmental scan of existing pertinent programs) and to host one or more community meetings to increase awareness of disparities in infant deaths and the role of social determinants of health. Based on discussions and outcomes of community meetings, each county health department was required to submit an action plan to address disparities in infant mortality. Action plans were reviewed by subject matter experts in the program offices through a lens of identifying proposed strategies and best practices that could be applied and have statewide impact and feedback was provided to each county on their action plan. The most commonly proposed strategies and themes identified in the counties' local plans were: breastfeeding, smoking reduction among pregnant women, safe sleep, and increased WIC access and utilization.

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

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

The Department, the Department of Children and Families, and other Florida government agencies, state officials, nonprofit organizations, and first responders came together to launch the Safe Sleep Campaign. The campaign included public outreach as well as free online training and materials for Florida's first responders 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 (portable cribs) to designated locations, which are then distributed to needy families through the local Healthy Start Coalitions and participating home visiting programs.

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

The Department participated with the Florida's MIECHV program on activities related to breastfeeding and safe sleep. Florida's MIECHV participates in the 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 Department contracted with the Florida Perinatal Quality Collaborative to develop and implement a breastfeeding project, Mother's Own Milk (MOM), in Florida's NICUs. The project is a hospital-based quality improvement initiative designed to promote best practices related to providing breast milk especially to Florida's most vulnerable VLBW infants.

The MOM project provided three regional trainings for NICU nurses in Gainesville, Miami, and Orlando during August and September of 2016. The Breastfeeding Resource Nurse Master training provided 120 Florida NICU nurses instruction on the 10 Steps for Promoting and Protecting Human Milk and Breastfeeding in Vulnerable Infants. Resources were provided to the trained nurses to return to their institutions and train their colleagues to become breastfeeding resource nurses. The breastfeeding resources for mothers and health care providers are available on the FPQC website at: http://health.usf.edu/publichealth/chiles/fpqc/momresources. The enhancement to the MOM project for the Breastfeeding Resource Nurse Master training and development of the resource Web page was funded through Title V. All deliverables associated with the initiative have been completed.

The Baby Steps to Baby Friendly project, a component of Florida's Healthy Babies Initiative, has motivated and incentivized hospitals in Florida to improve maternity care breastfeeding practices and policies and achieve recognition. Of the original 41 hospitals participating, 10 are in the dissemination phase and three are in the final designation phase of the 4-D Pathway. There are currently 60 hospitals taking steps towards their baby friendly designation.

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

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

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

Data from the 2013 Florida Pregnancy Risk Assessment Monitoring System (PRAMS) show that the percent of Florida women who initiate breastfeeding is higher, at 87.9 percent, than the Healthy People 2020 goal of 81.9 percent. However, duration drops quickly to 72.5 percent at 4+ weeks and to 52.4 percent at 12+ weeks. This survey is a valuable tool for recognizing trends and identifying a focus for breastfeeding promotion efforts. Survey data can be found at:
http://www.floridahealth.gov/%5C/statistics-and-data/survey-data/pregnancy-risk-assessment-monitoring-system/_documents/reports/prams2013.pdf

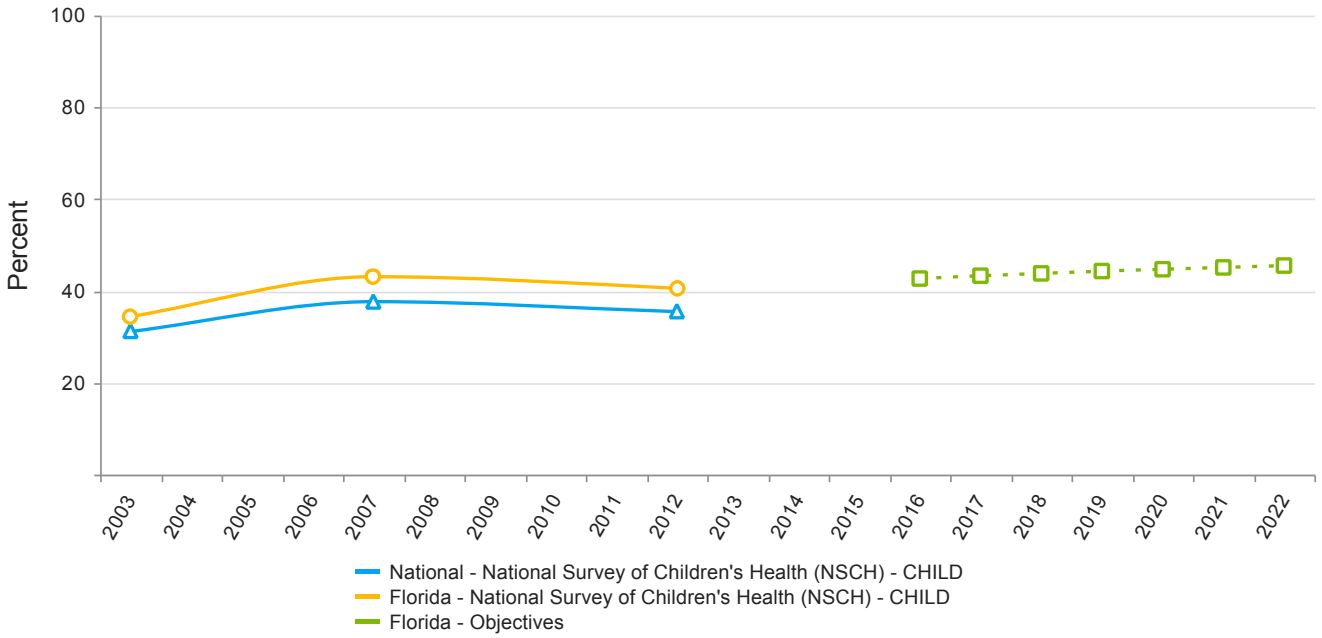
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	83.5 %	NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	NSCH-2011_2012	27.5 %	NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	WIC-2014	26.8 %	NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	YRBSS-2015	26.8 %	NPM 8

National Performance Measures

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



NPM 8 - Child Health

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CHILD	
	2016
Annual Objective	42.7
Annual Indicator	40.7
Numerator	521,434
Denominator	1,282,761
Data Source	NSCH-CHILD
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	43.3	43.8	44.3	44.7	45.1	45.5

Evidence-Based or –Informed Strategy Measures

ESM 8.1 - The number of county School Health Programs who are utilizing the evidence-based Comprehensive School Physical Activity Program (CSPAP) for the reduction of childhood obesity

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	20
Numerator	
Denominator	
Data Source	School Health Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	25.0	30.0	34.0	38.0	42.0	45.0

State Performance Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	35.9
Numerator	986,425
Denominator	2,745,598
Data Source	Florida Agency for Health Care Administration (AHC
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	37.4	38.9	40.4	41.9	43.4	44.9

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	42.6
Numerator	545,146
Denominator	1,279,782
Data Source	2011/12 National Survey of Children's Health
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	45.1	47.6	50.1	52.6	55.1	55.6

State Action Plan Table

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

Priority Need

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

NPM

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

Objectives

1. Increase the number of Florida counties where registered school nurses are implementing Healthy Lifestyle Interventions.

2. Increase the number of schools that implement Comprehensive School Physical Activity Program (CSPAP) efforts aligned with the Healthier U.S. Schools Challenge (HUSSC).

3. Increase the availability of adaptive CSPAP and the HUSSC resources to parents with children with a disability.

Strategies

1a. Promote the implementation of proven model programs for the reduction of childhood obesity.

1b. Promote the use of the Healthy Lifestyle Intervention Individualized Healthcare Plan template.

1c. Ensure county staff collect and enter Healthy Lifestyle Intervention data in the Department’s Health Management System.

2a. Support the Coordinated School Health Partnership, the Healthy District Collaborative, and the Interagency Collaborative.

2b. Maintain partnerships to obtain access to data on other recognition opportunities through the Healthier U.S. School Challenge, Alliance for a Healthier Generation, or Let’s Move Active Schools.

2c. Add CSPAP resources on the Department's website.

3a. Promote parent involvement in school district committees such as: School Health Advisory Committees, Parent Teacher Organizations, and Special Education Advisory Teams.

3b. Increase health equity in the school environment by promoting access to adaptive physical activity equipment.

ESMs	Status
ESM 8.1 - The number of county School Health Programs who are utilizing the evidence-based Comprehensive School Physical Activity Program (CSPAP) for the reduction of childhood obesity	Active

NOMs
NOM 19 - Percent of children in excellent or very good health
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

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

Priority Need

Improve dental care access for children and pregnant women.

SPM

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

Objectives

1. Increase the number of low-income children under age 21 receiving a preventive dental service.

Strategies

1a. Partner with community agencies and organizations to implement oral health initiatives.

1b. Increase the number of School-Based Sealant Programs.

1c. Increase the capacity of existing School-Based Sealant Programs.

1d. Increase the number of children participating in existing School-Based Sealant Programs.

1e. Monitor, assess, and provide continued technical assistance and training to County Health Department Dental Programs.

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

Priority Need

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

SPM

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

Objectives

1. Increase the number of partners and local county health departments participating in the Reach Out and Read program.

2. Increase the number of books distributed to parents and children.

Strategies

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

2. Partner with Federally Qualified Health Centers to implement the Reach Out and Read program during well-child visits.

Child Health - Plan for the Application Year

The School Health Program will provide services to all children in Florida's public schools. County health departments, in cooperation with local education agencies and other partners, will be responsible for ensuring that Florida's 2.7 million pre-kindergarten through 12th grade students have access to health services that assess, protect, and promote their health and ability to learn. School health services provided to all public school students include: nursing assessments; health record reviews to ensure physical exam and immunization requirements are compliant with statutory requirements; health services for chronic or complex health conditions requiring school-day management; first aid; medication administration; screening, referral and follow-up for vision, hearing, scoliosis and growth and development; preventive oral health programs; healthy lifestyle intervention services; emergency health services; health education classes; parent and staff consultations on student health issues; and consultation for placement of students in exceptional student education programs.

The Department and the Department of Education (DOE) will continue to partner and promote implementation of the Whole School, Whole Community, Whole Child (WSCC) approach in Florida public schools. This approach is an effective strategy to assist in the development and enhancement of state, district, and school-based infrastructures that promote and maintain student and staff health and support academic achievement.

The Department's Bureau of Chronic Disease Prevention will work with DOE's Office of Healthy Schools to support the Coordinated School Health Partnership's 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 helps school districts assess existing policies and practices, and guides them toward achieving the highest standards. Districts are encouraged to include school superintendents, school boards, school administrators, school nurses, component area experts, parents, and the School Health Advisory Committee in the assessment process. The WSCC approach represents an expansion of the Coordinated School Health model with 10 components that comprise an ecological framework directed at the whole school, with the school in turn drawing its resources and influences from the whole community and serving to address the needs of the whole child. This includes promotion of Comprehensive School Physical Activity Programs (CSPAP) and participation in the Healthier U.S. Schools Challenge. CSPAP is a multi-component approach by which school districts and schools use all opportunities (before, during, and after school) for students to be physically active; meet the nationally-recommended 60 minutes of physical activity each day; and develop the knowledge, skills, and confidence to be physically active for a lifetime.

Challenges:

- Florida's school nurse to student ratio is 1 to 2,364. The school nurse to student ratio recommended by the National Association of School Nurses (NASN) is 1 to 750, and the American Academy of Pediatrics recommends one school nurse for every school. For many students, the school nurse is the only form of health care they receive.
- Since 2010, reported chronic and complex conditions in students have increased 25 percent (from 562,085 to 743,442).
- Changes in Florida's Medicaid eligibility requirements for children is resulting in more uninsured students.
- The shift in primary care services from county health departments to community-based health care providers, such as federally qualified health centers, is making it more difficult to refer students for follow-up health care services.
- The focus on academics and test preparation sometimes makes it difficult to prioritize physical activity for children.

The PHDP will partner with other state agencies and not-for-profit organizations to plan and implement programs to

benefit the oral health needs of children and families.

Beginning in August 2017, the PHDP has been accepted to lead Florida through the State Oral Health Leadership Institute, which includes a collaborative project between the AHCA and the Center for Health Care Strategies. This quality improvement project aims to increase the number of positive consent forms obtained so more children can receive preventive dental services through the Department's School-Based Sealant Program.

The PHDP also plans to participate in dental health initiatives planned by the Oral Health Florida Coalition. The Coalition 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 various action teams (committees) and the leadership council, to support initiatives to increase oral health services for children and families in Florida.

The PHDP, in coordination with the Oral Health Florida Sealant Action Team, will continue to promote the use of a cost efficient dental hygienist workforce model for School-Based Sealant Program (S-BSP) service delivery. Working with county health department dental programs, FQHCs, and local oral health coalitions across the state, preventive services will continue to be provided to low income children in Title I Schools. Providing services to children in school settings eliminates many barriers that impact access to dental care. S-BSPs are supported by Title V funding and make it possible to reach high-risk children in need of dental services and improve dental outcomes for children in the state.

During the coming year, the PHDP will continue to increase statewide data capacity and serve as the state's S-BSP data warehouse across all agencies through the FLOSS Database.

The PHDP will continue to provide Florida S-BSPs with quality improvement and assurance guidance, technical assistance, and training to ensure local program efficiencies and increased capacity of children are served through these programs.

To increase the percentage of parents who read to their young children, Title V funding will continue to be available to county health departments through Schedule C and a statement of work. Beginning with the 17/18 state fiscal year, the statement of work provides an option for county health departments to use Title V funding to create a reading rich environment in waiting room areas such as a child's reading table and chairs, a bookshelf, children's books, etc. Funds may also be used to establish a Reach Out and Read (ROAR) program. ROAR is an evidence-based early intervention model that encourages literacy and school readiness. ROAR gives young children a foundation for success by incorporating books into pediatric care and encourages families to read aloud together. ROAR medical providers encourage families to read aloud and engage with their infants, toddlers and preschoolers every day. Additionally, medical providers give books to children at more than 10 well-child visits from infancy until they start school.

Literacy is a known factor impacting the social determinants of health. Healthy People 2020 includes school readiness and literacy in the Early and Middle Childhood domains and objectives.

As recommended by the American Academy of Pediatrics, ROAR incorporates early literacy into pediatric practice, equipping parents with tools and knowledge to ensure that their children are prepared to learn when they start school. Through this evidence-based intervention, parents learn new ways to stimulate their children's literacy development, have more books in their home, and read to their children more. Parents are supported as their children's first and most important teachers, and children are given a foundation for success.

Child Health - Annual Report

The Department's School Health Program provided health and health education services to all children in Florida's public schools. Local county health departments, in cooperation with local education agencies and other partners, worked to ensure that Florida's 2.7 million pre-kindergarten through 12th grade students had access to health services that assess, protect, and promote their health and ability to learn.

The School Health Program continued to provide oversight and technical assistance to all local health departments, local education agencies, and community partners pursuant to Florida Statutes and the Administrative Code, which delineate the provision of school health services, best practices, and program standards. During the past year, the School Health Program performed 28 onsite program monitoring visits, two contract monitoring visits, and hosted five statewide technical assistance conference calls.

The central office School Health Program worked in partnership with the Florida School Health Association (FSHA) and the Florida Association of School Nurses (FASN) and provided school health program updates at their annual conferences. The School Health Program provided 2015-2016 data for the NASN initiative, Stand Up and Be Counted, to collect state-level data for a national standardized minimum dataset of key school health indicators.

The Department and DOE partnered and promoted implementation of the Coordinated School Health approach in Florida public schools. This included collaboration in the provision of five regional trainings entitled *School Health Partners Workshop 2015: Enhancing the Work of School Health Advisory Committees, School Health and Wellness Advisory Committees*, and Wellness Task Force Committees in Florida School Districts.

The Coordinated School Health program within the Bureau of Chronic Disease Prevention worked with DOE's Office of Healthy Schools to support the Coordinated School Health Partnership's Florida Healthy School District self-assessment and recognition program. As part of these assessments, the School Health Program provided information on the completion of corrective actions by school districts that are monitored for compliance with federal and state laws and rules, and compliance with program standards.

Title V supported the development of the PHDP's two new modules and added enhancements to existing modules in the FLOSS Database. The two new modules designed, developed, and implemented include the School-Based Sealant Program Module and the Oral Health Surveillance Module. The School-Based Sealant Program Module is being used by all agencies and programs in Florida to enter aggregate data and information regarding their local programs. The system is accessible by both internal and external partners and serves as the true statewide data warehouse for this important public health dental measure for children. The data and information collected show oral health needs and services across agencies, programs, schools, and children. The Oral Health Surveillance Module is used for all populations the PHDP routinely collects data for using the Basic Screening Survey Methodology, including preschool and school age children. This is the first system in the nation developed by a state oral health program to electronically collect real-time statewide screening data across various high need populations. The data collection for oral health indicators and consent form questions is conducted by external screeners in the field and has the ability to be verified immediately by PHDP staff.

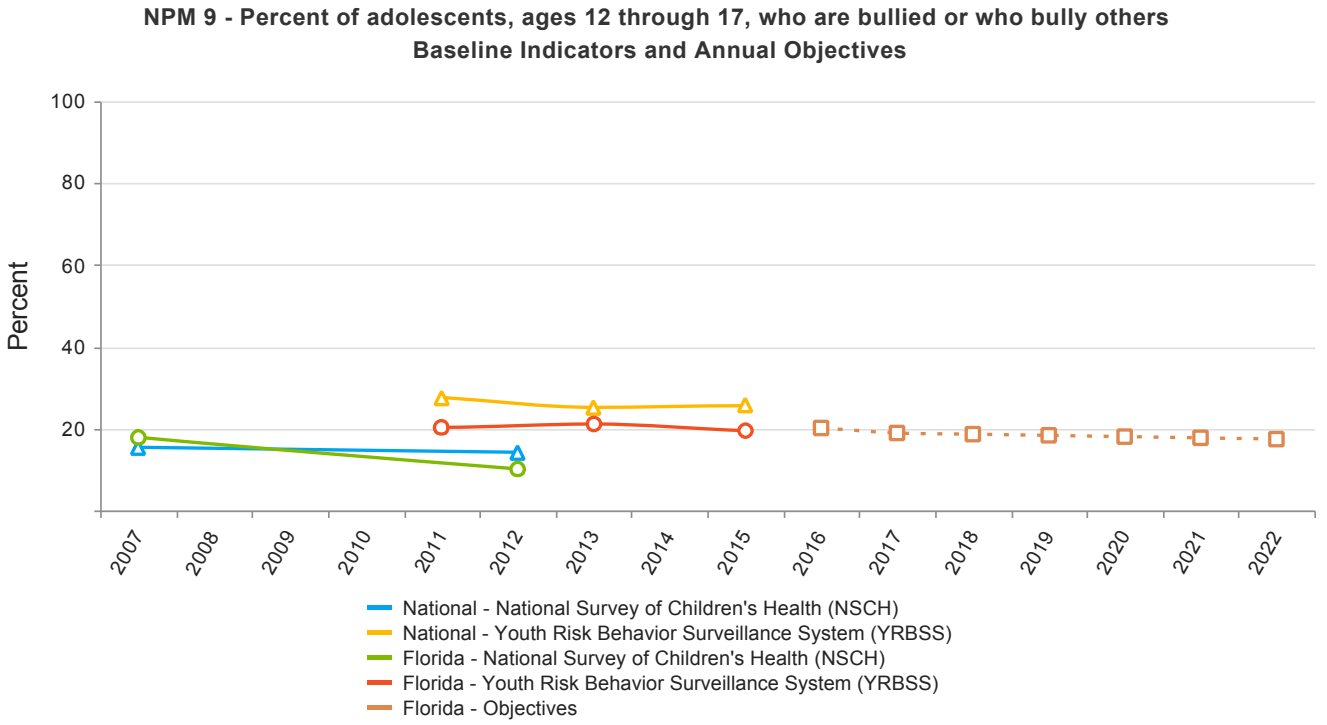
Since 2000, Florida has seen a 12 percent increase in the population with access to fluoridated water. However, not all communities have access to community water fluoridation (CWF) nationally or in Florida. Currently, estimates show almost 75 percent have access to CWF nationally and 77 percent have access in Florida. Since CWF is not mandated in Florida, local level advocating, approving, and implementation is key to increasing the percentage of citizens with access to fluoridated water.

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	32.4	NPM 9
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	7.4	NPM 9

National Performance Measures



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	20.2
Annual Indicator	10.1
Numerator	138,029
Denominator	1,370,209
Data Source	NSCH
Data Source Year	2011_2012

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

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	19.0	18.7	18.4	18.1	17.8	17.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	6.0	6.0	6.0	6.0	6.0	6.0

State Action Plan Table

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

Priority Need

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

NPM

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

Objectives

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.

Strategies

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 related to violence and bullying.

3a. Promote the use of an evidence-based curriculum.

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

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

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

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Adolescent Health - Plan for the Application Year

The Adolescent Health Program (AHP) works to promote, protect, and improve the health of all Florida youth. As a means of working toward health equity, the AHP ensures inclusion of sexual minority populations including youth in the LGBT community. All providers funded by the AHP participate in annual, mandatory training that builds upon inclusivity. Training includes:

- Value-neutrality best practices
- Facilitation skills that create a safe space
- Mandatory Reporting guidelines
- State-specific sexually transmitted disease updates
- Anti-bullying resources, education, and promotional materials
- Curriculum adaptation that includes gender neutral or LGBT-specific couple references (as permitted by each school district)
- Linkages to services that serve and support LGBT youth

The AHP continues to work to increase the percentage of youth making positive and healthy choices with the intention of improving the health of adolescents and young adults by decreasing the percentage of youth engaging in risky behaviors that lead to teen pregnancy, sexually transmitted diseases, substance abuse, and violence.

The AHP also continues to work with the Sexual Risk Avoidance Program that began in 2010, from the Administration of Children and Families. This program provides $3,772,364 per year to fund county health departments and community-based organizations. The funded providers use evidence-based, effective sexual risk avoidance education curriculums including Choosing the Best, Making A Difference, Promoting Health Among Teens, and Real Essentials to deliver the program. The curricula encourage parent and guardian involvement and endeavor to reinforce healthy behaviors, positive attitudes, and reduce risk-taking behaviors. All classes are delivered in school or community-based settings. Providers are monitored regularly to ensure fidelity to the curricula and adherence to grant guidelines. The monitoring, conducted by program contract managers, includes observation of the educator conducting classes with youth and or parents/significant adults.

The AHP is currently funding 18 providers for the 2016-2017 grant year. These providers include 14 local health departments and four community-based providers in middle school, high school, and community settings. Funding is expected to continue through September 2019. Providers were selected through a Request for Applications process. Applications were reviewed for need, capacity, and thorough plans to reach adolescents ages 11-19 with high rates of teen birth, repeat teen births, and sexually transmitted diseases. Through contracts with providers, the AHP will continue to improve the health of Florida adolescents through skill building, goal-setting, and providing sexual risk avoidance education.

Collaborations and partnerships with local health departments, schools, school districts, community-based organizations, and Juvenile Justice Centers are critical to the projects. Schools and school districts agreeing to allow facilitators and instructors to provide the curriculum in their educational facilities are imperative to the success of the programs.

The MCH Section will host a student from the Graduate Student Epidemiology Program to examine the association between bullying and the use of tobacco, drugs, and alcohol among high school students in Florida, using 2011-2015 data from the Florida Youth Risk Behavior Survey.

The 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.

Additionally, SVPP has received a grant and will continue to facilitate the evidence-based Green Dot strategy in local high schools. The Green Dot strategy is a comprehensive approach to violence prevention that capitalizes on the power of peer and cultural influence across all levels of the socioecological model. Green Dot is built on the premise that a cultural shift is necessary in order to measurably reduce the perpetration of power-based personal violence. In order to create a cultural shift, a critical mass of people will need to engage in a new behavior or set of behaviors that will make violence less sustainable within any given community. The new behavior is a Green Dot.

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

The Sexual Risk Avoidance Program had 17 providers, 10 local health departments, and seven community or faith-based providers in middle school, high school, and community settings. In the 2015-2016 grant year, the Sexual Risk Avoidance Program was successfully delivered to 11,975 youth and to 2,500 parents and guardians.

The Title V Abstinence Education Grant, from the Administration of Children and Families, funded local health departments and community and faith-based organizations to implement evidence-based sexual risk avoidance education curriculums including Choosing the Best, Making A Difference, Promoting Health Among Teens, and Heritage Keepers. The curriculums encourage parent and guardian involvement. The parent programs endeavor to reinforce healthy behaviors and 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.

Section 1006.147, Florida Statutes, was signed into law in 2008. The statute requires Florida school districts to adopt a policy prohibiting bullying and harassment of students and staff on school grounds or school transportation, at school-sponsored events, and through the use of data or computer software accessed through school computer systems or networks. The DOE Office of Safe Schools, has created a model policy against bullying and harassment that school districts can use to craft their individual policies.

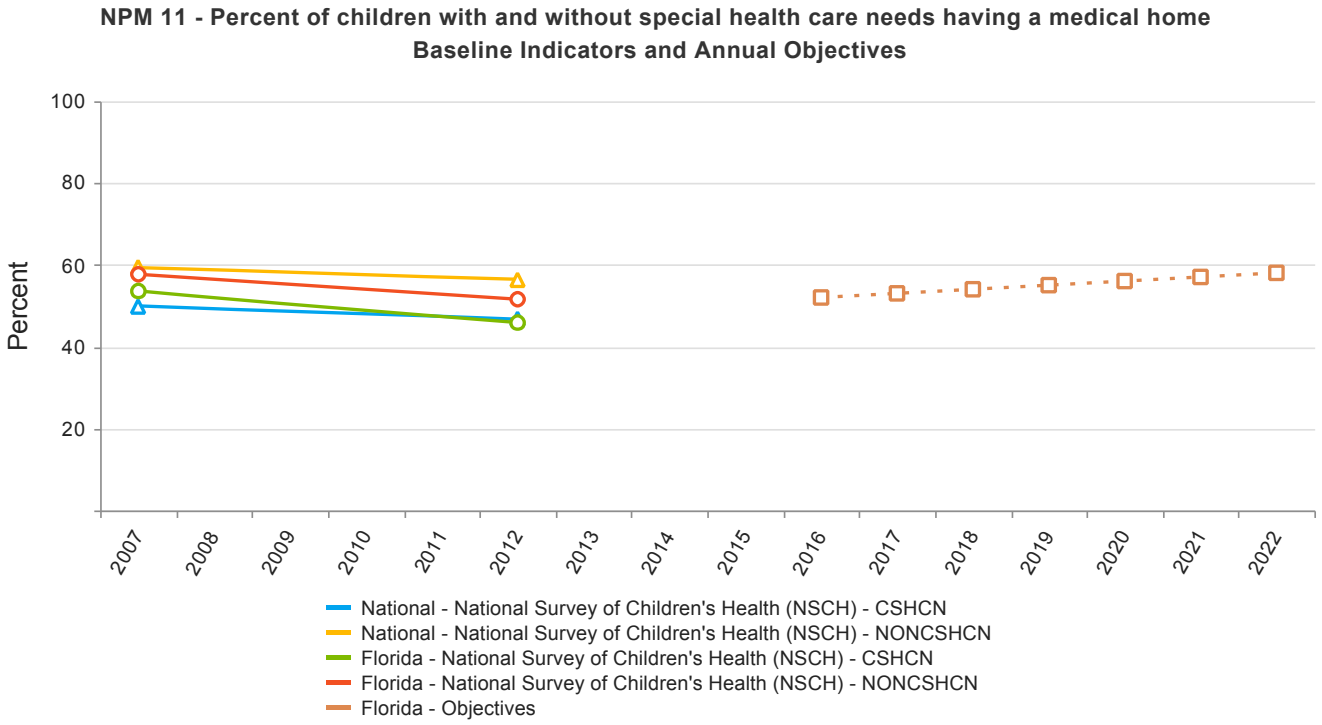
Bullying is a serious detriment to a child's health, sense of well-being, safety, education, and emotional development, and greatly increases the risk of self-injury and suicide. According to the 2015 CDC YRBS survey, 15 percent of Florida students were bullied on school property and 11.6 percent were bullied electronically. Bullying is defined as an attack or intimidation with the intention to cause fear, distress, or harm that is either physical (hitting, punching), verbal (name calling, teasing), or psychological/relational (rumors, social exclusion); a real or perceived imbalance of power between the bully and the victim; and repeated attacks or intimidation between the same children over time. Data from the 2015 Youth Risk Behavior Survey indicate that a significantly higher number of students experiencing bullying described their grades as Ds and Fs in school during the past 12 months. The number of ninth grade students reporting being bullied is significantly higher than for students in 10^{th}, 11^{th}, and 12^{th} grade. Female students are significantly more likely than males to have experienced some form of bullying, name calling, or teasing in the past year.

Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	NS-CSHCN-2009_2010	11.6 %	NPM 11 NPM 12
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	83.5 %	NPM 11 NPM 12
NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)	NIS-2015	66.7 %	NPM 11
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	47.9 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	62.5 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	45.3 %	NPM 11
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	87.3 %	NPM 11
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	70.4 %	NPM 11

National Performance Measures



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	52
Annual Indicator	45.7
Numerator	343,845
Denominator	751,777
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	53.0	54.0	55.0	56.0	57.0	58.0

Evidence-Based or –Informed Strategy Measures

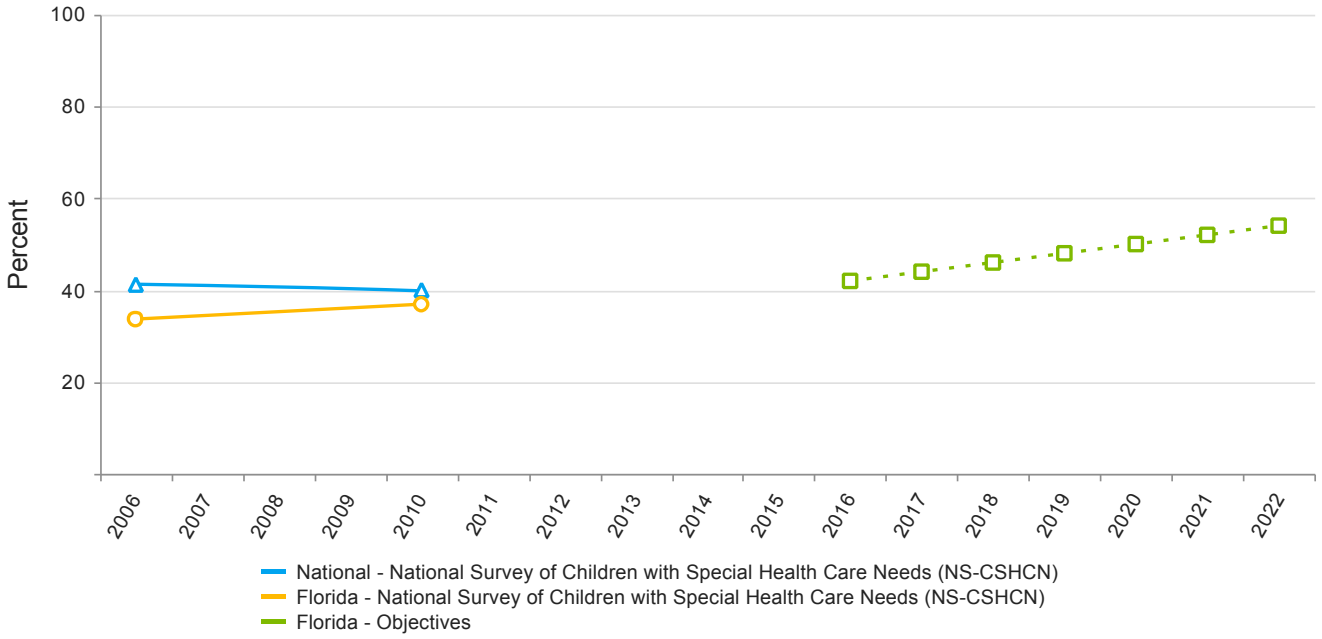
ESM 11.1 - Number of pediatric providers in Florida who have received information related to the Patient Centered Medical Home (PCMH) and who have completed a Medical Home Assessment Tool for their practice.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Florida Children's Medical Services
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	500.0	1,000.0	2,000.0	3,000.0	4,000.0	5,000.0

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



Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	42
Annual Indicator	37.0
Numerator	89,064
Denominator	240,468
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	44.0	46.0	48.0	50.0	52.0	54.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Number of pediatric providers in Florida who have practices that have a Health Care Transition (HCT) policy or youth with readiness assessment (with physicals) and plans of care.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Florida Children's Medical Services
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	500.0	1,000.0	2,000.0	3,000.0	4,000.0	5,000.0

State Performance Measures

SPM 1 - The percentage of children that need mental health services that actually receive mental health services.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	57.7
Numerator	
Denominator	
Data Source	National Survey of Children's Health
Data Source Year	2011/2012
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	58.0	59.0	60.0	61.0	62.0	63.0

State Action Plan Table

State Action Plan Table (Florida) - Children with Special Health Care Needs - Entry 1

Priority Need

Increase access to medical homes and primary care for children with special health care needs.

NPM

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

Objectives

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 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 a highest level medical home.

Strategies

1. Convene a stakeholder group that will define methods for assessing pediatric providers along the continuum. Methods will include health and wellness outcomes for children, specifically children with special health care needs.

2. CMS will partner with other leaders in the state to promote and improve CSHCN being assigned to 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 encourage primary care providers to identify with some level of medical homeness.

3b. CMS will provide care coordination support to CMS-credentialed primary care providers who have CMS Managed Care Plan-enrolled children assigned to them. Care coordination includes but is not limited to: family needs assessment; proactive care plan 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; and the 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 CSHCN, including: improving access to pediatric providers who identify with some level of medical homeness, and supporting through technical assistance and training, providers who wish to move to higher levels of medical homeness.

4. CMS will utilize acuity score as one criterion for promoting the assignment of children to practices at higher level of medical homeness.

ESMs	Status
ESM 11.1 - Number of pediatric providers in Florida who have received information related to the Patient Centered Medical Home (PCMH) and who have completed a Medical Home Assessment Tool for their practice.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
NOM 19 - Percent of children in excellent or very good health
NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

State Action Plan Table (Florida) - Children with Special Health Care Needs - Entry 2

Priority Need

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

NPM

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

Objectives

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 resources necessary to facilitate and achieve successful health care transition.

5. Transition is recognized as a priority for the Department’s Title V Program.

Strategies

1. CMS 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 Individualized Education Programs (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, elf-determination and self-management ability (power of attorney/guardianship), and secondary and post-secondary education.

4. Transition support will be provided for youth, families, and providers.

5. CMS will implement 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.

ESMs	Status
ESM 12.1 - Number of pediatric providers in Florida who have practices that have a Health Care Transition (HCT) policy or youth with readiness assessment (with physicals) and plans of care.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (Florida) - Children with Special Health Care Needs - Entry 3

Priority Need

Improve access to appropriate mental health services to all children.

SPM

The percentage of children that need mental health services that actually receive mental health services.

Objectives

1. Increase the number of CMS Plan enrollees with a diagnosed behavioral health condition who receive treatment in an integrated primary and behavioral health model of care.

2. Increase the percentage of CMS enrollees with a diagnosed behavioral health condition who received evidence-based treatment consistent with their diagnoses and provided by an appropriately credentialed provider.

3. 100 Percent of CMS care coordinators will be trained annually in issues related to behavioral health care. Required topics to include infant mental health diagnosis and intervention, autism spectrum disorder (ASD) diagnosis and intervention, and other issues identified by staff and stakeholders.

4. Increase by 5 percent annually the number of primary care and specialty care providers who are trained annually in issues related to behavioral health care. Required topics to include infant mental health diagnosis and intervention, ASD diagnosis and intervention, and others identified by stakeholders.

5. Increase awareness among providers, staff, partners, and parents of behavioral health resources available at the national, state, and local levels.

6. Increase efficiency among providers and partners in delivering evidence-based, non-duplicative care and services to children with behavioral health conditions.

7. Increase the number of culturally and linguistically diverse families who receive affordable diagnostic evaluation and/or treatment for ASD within two months of initial contact and within a 40-mile radius of their home.

Strategies

1. Convene an Integrated Primary and Behavioral Health Care Task Force that will identify models of care that could be implemented by the CMS Plan.

2. The Integrated Primary and Behavioral Health Care Task Force will identify models of care that could be implemented by the CMS Plan.

3. CMS Care Coordinators will receive education and training for identified behavioral health care needs including infant mental health and autism spectrum disorder (ASD).

4. Providers are equipped with resources and education/training for identified behavioral health care needs including infant mental health and ASD.

5. All CMS Plan providers, staff, and parents will have access to educational materials and resources pertinent to children's behavioral health care, including infant mental health and ASD.

6. CMS will encourage efficient local and state coordination with behavioral health partner organizations.

7. CMS will partner with other entities in the state to provide support and services to culturally and linguistically diverse individuals that are at risk for or have an ASD.

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

Florida will focus activities and strategies to meet four main objectives related to the Patient Centered Medical Home (PCMH). 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. Medical homeness refers to the degree to which a provider or practice aligns themselves with the medical home principles. CMS created an internal workgroup that focused on strategies and activities to enhance medical home participation in Florida. This workgroup was helpful in implementing and promoting several best practices for our two regions that operate Medical Home Programs through the CMS Plan. This workgroup will expand in 2018 to include external partners and stakeholders. The activities of this stakeholder group will include identifying the process and tools to assess participating medical home providers and performance outcome measures as it relates to medical home. This will include identifying health and wellness outcomes for children, specifically children with special health care needs.

Another objective that CMS is focusing on is to increase the number of children with special health care needs 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. Beginning in 2017, CMS will provide educational materials and education opportunities to providers and practices through electronic and in-person communications.

CMS will also work towards the objective of increasing the number of CMS Managed Care Plan (CMS 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 work with Florida providers to identify with a level of medical homeness. CMS will work to create an infrastructure to provide leadership and support in promoting and sustaining medical home for CSHCN. In 2017, CMS began collaborating with HealthARCH at the University of Central Florida, the state's only designated NCQA Partner in Quality for PCMH practice transformation, to identify pediatric physicians and practices that are ready for patient-centered medical home transformation. CMS has established several communication strategies to increase information sharing to providers and activities to promote and support the PCMH that will be incorporated into these communication channels. Activities of the Stakeholder Workgroup, collaboration with a NCQA Partner in Quality and activities of the CMS care coordinators will also be vital in achieving this objective.

The fourth medical home objective is to increase the number of higher acuity CMS Plan enrollees assigned to the highest level medical home. CMS will utilize the CMS acuity tool as a strategy to identify CSHCN who have the most complex needs. CMS Plan policy outlines that the CMS acuity tool will be completed annually. CMS will continue to engage the internal workgroup to identify steps necessary to assist the CMS Plan in matching enrollees with providers based on acuity scores where applicable.

CMS is implementing Regional Title V Nursing Consultant positions in each of its eight regions (statewide). The consultants will survey staff and providers (primary and specialty) to identify education and training needs related to medical home, transition, and behavioral health; create a medical home policy; assist with revisions to the transition policy for required annual CMS staff training and recommended transition provider training; facilitate and collaborate with the four regional transition coalitions within the state; and provide outreach and support services to CSHCN and their families, providers, and community and state agencies throughout the state.

Health Care Transition will also continue as an important initiative for Florida's CSHCN Program. Florida will focus on activities and strategies to successfully meet five objectives related to transition activities in Florida. The first objective and strategy focusing on transition activities is to increase the percentage of CMS care coordinators who

receive transition-specific education and training annually. CMS has included transition education in both orientation materials and annual training materials for care coordinators. All care coordinators are required to complete the transition modules for care coordinators as part of this annual training and is tracked by CMS at the State Health Office.

Another transition-related objective is to increase the percentage of providers and educators who receive information on transition-specific education annually. The strategy associated with this objective is equipping providers and educators with resources and education related to transition services. The initial activity associated with this objective was to develop school-based transition education modules for teachers and support staff. Development of these modules began in 2015 and was completed in 2016. CMS will work with the Florida Department of Education to incorporate the modules in their online training system. CMS will continue to work to promote and increase awareness regarding several educational modules related to health care transition available at the FloridaHATS website.

Increasing the percentage of patients and families who receive transition-specific education and training annually is the third transition objective and strategy. CMS has transition information available to members and providers, both electronically and in paper form. CMS care coordinators have access to the American Academy of Pediatrics' evidence-based anticipatory guidance handouts through our Care Coordination Portal. An additional activity that will address this objective will be the development of a youth ambassador program that will 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. In 2017, CMS will implement transition navigators by utilizing the Title V Regional Consultants. Transition navigators will promote the FloridaHATS web-based health services directory for young adults in Florida, assist providers in developing transition policies, conduct activities that will promote the concepts found in the Six Core Elements of Healthcare Transition, and continue to build regional transition coalitions throughout the state. CMS will also work to improve upon transition-related activities for CMS Plan enrollees including incorporating transition related conversations into the multi-disciplinary team staffing when appropriate, exploring the use of telehealth in transition planning and education, and building upon the memorandum of agreement in place between CMS and the Florida Association of Community Health Centers to identify opportunities to collaborate on activities and initiatives related to transition.

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 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. This year, the six core elements of transition will be incorporated into the CMS electronic health record.

The CMS Plan is working towards increasing the number of CMS Plan enrollees with a behavioral health condition who receive behavioral health treatment. The CMS Plan has partnered with Concordia Behavioral Health to manage inpatient and outpatient mental health as well as substance abuse services. CMS will continue performance improvement reviews of the provider credentialing processes and evaluate recruitment of physicians, specialist, and adult providers to provide behavioral health services for CMS enrolled clients, improve efficiency, and focus on expanding the CMS provider network. Staff will continue outreach, education, and recruitment of CMS pediatricians to participate in the statewide integrated primary and behavioral health model of care. The PCMH readiness

assessment being conducted by HealthARCH, includes behavioral health indicators that will be used for baseline data to build and/or scale up existing effective practices and competencies towards behavioral health.

An integrated Behavioral Health Task Force has been formed with key agency partners including the Department of Children and Families, Office of Substance Abuse and Mental Health, the Agency for Health Care Administration, and the Family Network on Disabilities. This task force was accepted in the National MCH Workforce Development Center's 2017 cohort and its activities will be critical to the implementation of the activities of this state performance measure. In addition to the alignment of statewide efforts, the purpose and goal is to work with CMS to collect data on top diagnosis, review utilization patterns of behavioral health resources, study existing models of integrated and collaborative care models, explore funding sources for implementing integrated care at the state and local levels, identify one to three pilot locations, and write an evaluation plan. The adopted models of integrated primary and behavioral health care will address disparities related to provider expertise and training, geography, timeliness of treatment, and service coordination. The task force will communicate regularly with the Medical Home Stakeholder Group to ensure both groups' goals and plans align, including primary care practices that implement an integrated model that will also pursue the highest level of medical homeness.

Children's Medical Services has identified a need to provide care coordinators and providers with access to training and education related to behavioral health issues such as infant mental health diagnosis and intervention, autism spectrum disorder (ASD) diagnosis and intervention, and other conditions. National guidelines to train staff and providers on evidenced-based practices and activities to increase the workforce skills in change management and systems integration will be explored by the Behavioral Health Task Force. CMS has care coordinators to manage the special needs of the CMS enrollee Statewide Inpatient Psychiatric Program Services (SIPP) population. The care coordination performance measure strategies and quality improvement program have been revised to incorporate behavioral health measures.

Children's Medical Services has formed a Behavioral Health Consultant position. The consultant will survey staff and providers (primary and specialty) to identify and prioritize training needs; create a behavioral health policy for required annual CMS staff training on behavioral health issues and recommend provider training; and continue to explore evidence-based trainings that are available from national and or state resources.

Children with Special Health Care Needs - Annual Report

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

2016 Efforts

Children's Medical Services (CMS) is a specialty plan option through the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance Program. March 2017 enrollment is over 50,000 children. CMS also continues to be a choice through Florida KidCare. March 2017 CMS KidCare enrollment was over 9,000 children. The CMS care coordinators utilize an electronic health record and a care coordination module to document all care coordination activities and relevant health and psychosocial information.

The CMS Plan receives annual reports for both the Title XIX and Title XXI components of the Plan. The reports include information related to Healthcare Effectiveness Data and Information Set (HEDIS) Measures and Consumer Assessment of Health Care Providers and Systems (CAHPS). While CMS has always strived to meet and exceed national benchmarks related to customer service and quality health care delivery, in 2016, the CMS Plan implemented a new care coordination curriculum with performance measures and associated tools to help enhance and support the care coordinator's ability to communicate with and assist the family in meeting the needs of the child. Year 2015 Calendar data was released in 2016 for the CMS Plan. While the CMS Plan received a four-star (out of five) rating on treating Mental Illness and three-star ratings in the areas of Keeping Kids Healthy and Children's Dental Care, the Plan did receive a one-star rating in the area of pregnancy-related care. As a result, the CMS Plan created and implemented a prenatal pregnancy program for CMS enrollees in 2016. Members who are pregnant are identified and enrolled in the program upon learning of their pregnancy. This program is maintained by a single care coordinator who assists the member and family throughout the pregnancy and postpartum. Care coordination for this population includes education and linkages to community resources, including Healthy Start and WIC.

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. FloridaHATS has available, several comprehensive training modules for providers and care coordinators. In 2016, FloridaHATS completed a training module for educators. All CMS staff are required to complete the FloridaHATS transition modules as part of their orientation training. As of March 2017, a total of 337 CMS care coordinators had completed this training. Additionally, FloridaHATS continued to have oversight and direction of the health care transition coalitions in Florida. Transition collaborative partners include the Federally Qualified Health Centers, the DOE, the Division of Vocational Rehabilitation, the Agency for Persons with Disabilities, the Department of Juvenile Justice, and the Agency for Health Care Administration.

Telemedicine technology continues to be explored as a health care delivery system within the CMS Managed Care Plan. CMS has eight sites providing telemedicine services through 18 subspecialty clinics.

The 11 designated Regional Perinatal Intensive Care Centers (RPICC) continue to provide direct health care services, including inpatient services and outpatient services. Two of the RPICCs provide RPICC obstetrical satellite clinics in rural locations. Many centers continue to participate in the Florida Perinatal Quality Collaborative quality

improvement projects, as does the CMS Nursing Consultant for the program.

The Child Protection Teams Program continues to work with an epidemiologist to analyze the impact of social determinates of health on child deaths. This analysis will inform our prevention strategies for state and local Child Abuse Death Review committees.

The State System Development Initiative (SSDI) grant provided technical assistance to counties involved in the Florida Healthy Babies Initiative's data analysis activities. The purpose of this statewide initiative is to positively influence the social determinants of health and reduce racial disparity in infant mortality.

Children's Medical Services continues to focus on improving social/emotional development of infants and toddlers served by Early Steps. The Bureau of Early Steps and Newborn Screening is the state lead agency for Part C of the Individuals with Disabilities Education Act (IDEA). Early Steps provides services statewide to infants and toddlers, birth through age 3, with developmental delays or disabilities. The Office of Special Education Programs has required all Part C Programs to develop a State Systemic Improvement Plan (SSIP). The SSIP is a multi-year plan that began in federal fiscal year (FFY) 2013/2014 and will continue through FFY 2018/2019. The plan has three phases. Phase I occurred in FFY 2013/2014 and included a data and root cause analysis. Phase II occurred during FFY 2014/2015 and included the development of a strategies and activities plan to be implemented during Phase III. Phase III is a multi-year phase. Year 1 of Phase III occurred during FFY 2015/2016.

During Year 1 of Phase III, Early Steps focused on developing the infrastructure necessary to implement the planned strategies and activities. Phase III activities included: drafting a statewide fiscal plan; developing a new Individualized Family Support Plan with embedded functional outcomes; contracting with three local demonstration sites to test evidence-based practices for suitability for future statewide implementation; hiring implementation staff and identifying implementation cohorts at demonstration sites; contracting with subject matter experts to develop a training plan for demonstration sites; contracting with a market research firm to assist with procurement of a more robust data system to improve data reliability. The Department of Health also requested budget authority for an additional seven full-time positions for the Early Steps State Office to further develop the necessary infrastructure. The strategies and activities that were originally planned during Phase II have been refined and restructured to allow for data informed decision making and to provide a greater focus on the activities expected impact on social-emotional development. The ultimate focus of the SSIP is to improve social and emotional development of infants and toddlers served through the Early Steps.

In 2016, Florida's Newborn Screening Program (NBS) and Florida's electronic birth registration information were successfully linked to ensure accurate data. Additionally, the Genetics and NBS advisory Council recommended adding X-linked adrenaleukodystrophy to the screening panel.

Partnerships

In 2015, the CMS Plan was transitioned from the Division of CMS to the Office of the CMS Managed Care Plan. This helped to establish the CMS Plan as an entity that could be structured and subsequently operated much like the other Managed Medical Assistance plans. Both the Office of the CMS Plan and the Division of CMS work closely together on Department programs and priorities. The Florida Newborn Screening Program, Early Steps, and the Child Protection Programs are all within the Department's Division of CMS. CMS also works closely with other Florida agencies including 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, the Family Network on Disabilities of Florida, and 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).

In 2016, CMS began working with the University of Florida's Pediatric Pulmonary Center on a series of training opportunities for family leaders employed by organizations with family partnership roles. The group has been trained in compassion fatigue and there are plans to continue this series through 2017 and beyond.

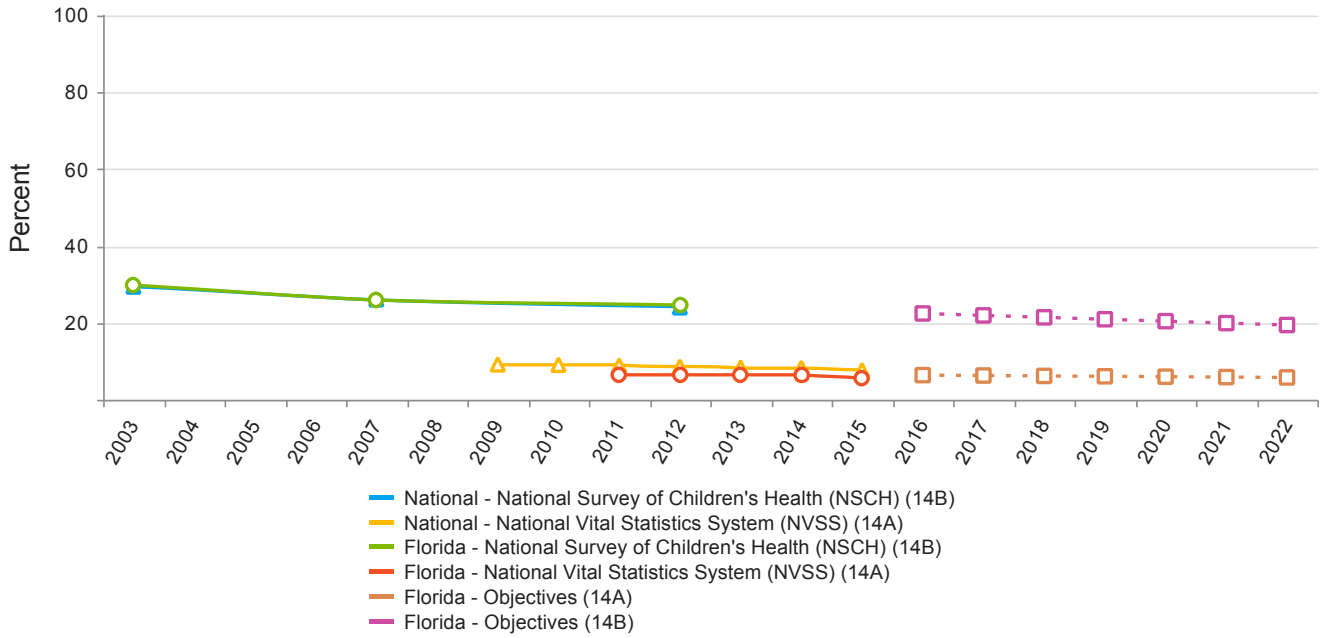
Cross-Cutting/Life Course

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2014	183.1	NPM 14
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2011_2015	23.8	NPM 14
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	8.6 %	NPM 14
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.5 %	NPM 14
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	7.1 %	NPM 14
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	10.0 %	NPM 14
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	3.1 %	NPM 14
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	6.9 %	NPM 14
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	25.7 %	NPM 14
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	6.5	NPM 14
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	6.1	NPM 14
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	4.2	NPM 14
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	2.0	NPM 14
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	234.6	NPM 14
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	87.7	NPM 14
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	83.5 %	NPM 14

National Performance Measures

NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes
Baseline Indicators and Annual Objectives



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

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	6.5
Annual Indicator	5.8
Numerator	12,970
Denominator	223,231
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	6.4	6.3	6.2	6.1	6.0	5.9

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	22.5
Annual Indicator	24.6
Numerator	967,635
Denominator	3,932,309
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	22.0	21.5	21.0	20.5	20.0	19.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	7,976
Numerator	
Denominator	
Data Source	Well Family System
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	9,250.0	9,500.0	9,750.0	10,000.0	10,250.0	10,500.0

State Action Plan Table

State Action Plan Table (Florida) - Cross-Cutting/Life Course - Entry 1

Priority Need

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

NPM

A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Objectives

1. Increase patient awareness and knowledge of the negative effects 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.

Strategies
1a. Encourage providers to discuss the dangers of smoking while pregnant with their patients.
1b. Increase public awareness of the dangers of smoking while pregnant.
1c. Implement the 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 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 information about the dangers of tobacco.
4c. Increase the number of health care 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.

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

NOMs

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

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

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

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

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

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

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

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

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

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

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

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

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

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

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

NOM 19 - Percent of children in excellent or very good health

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 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.

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

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

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

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

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

Florida continues to be 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, the MIECHV, the Bureau of Tobacco Free Florida, and the MCH Title V program to plan for the statewide implementation of the 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 Area Health Education Centers (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 patients.

Healthy Start Coalitions and county health departments will continue to encourage pregnant women and new mothers to sign up for Text4baby. The Department is exploring ways to strengthen Text4baby's presence in Florida and increase the number of enrollees. The MCH staff continues to promote Text4baby on statewide calls with partners that provide MCH services.

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

Cross-Cutting/Life Course - Annual Report

The Department participated in the national Infant Mortality CollN smoking cessation strategy team. The Florida team engaged community partners in the national initiative. In 2016, a grant was awarded to the Florida Association of Healthy Start Coalitions to support follow-up, continuous process and quality improvement, and tailored enhancements to the initial training based on an analysis of the evaluation completed in year one. The Department contributed Title V funds to ensure the success of the ongoing effort.

The Florida Association of Healthy Start Coalitions stakeholder group reviewed and revised the SCRIPT training program, and tested the new training package in two pilot communities. A webinar was recorded and archived on a learning management system for community partners to access. The expectation is that these efforts will support ongoing training and strengthen capacity. The Healthy Start Standards and Guidelines are currently under revision to include the SCRIPT intervention and coding procedures.

The MCH Section continued to collaborate with the Bureau of Tobacco Free Florida on the promotion of program services. The Department implemented new services through the Florida Quitline. The Individual Services option provides the tobacco user with a two-week nicotine replacement starter kit, Text2Quit, motivational e-mails, and a Quit Guide. The tobacco user can select any or all of the four services and they are available with a limited registration. For individual services, the tobacco user does not have to be enrolled in the Phone Quit, Web Quit, or Group Quit option to participate.

In FY 2015-2016, Florida's statewide fully integrated e-referral system to the Florida Quitline through the county health departments had 7,869 referrals or 39 percent of the total tobacco cessation referrals. The total number of referrals to the Florida Quitline for this fiscal year was 20,231. The Florida Quitline served a total of 59,553 tobacco users. This represents a six percent increase following two years of declining enrollment. The Phone Quit option had 38,120 enrolled in counseling, 12,852 in WebCoach, and 8,858 n the Individual Services option, which began January 2016.

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.

If callers prefer an in-person option, they are referred to one of the Area Health Education Centers (AHEC), which provides free cessation services in a group environment. During FY 2015-2016, a total of 76,629 Floridians received cessation services from Tobacco Free Florida. The AHECs saw a record setting 20,316 clients through their single and multi-session in-person programs provided in a group environment. Additionally, the AHECs trained health care practitioners and students to identify tobacco users and refer them for treatment.

Other Programmatic Activities

The Department is participating in the Policy Academy, an initiative of the Department of Health and Human Services jointly funded by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment and the Administration of Children, Youth and Families, Children's Bureau's Office on Child Abuse and Neglect. The aim is to improve outcomes for pregnant and postpartum women with opioid use disorders and their infants and families who are involved or at risk of being involved with child welfare services. The Policy Academy is supporting teams to create a state-specific policy agenda and action plan and strengthen collaboration across systems to address the multiple and complex needs of this population.

Title V funding was allocated to county health departments for SFY 2016-2017 to address four 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 all children ages 1 to 21, with a focus on children ages 1 to 6: primary dental care services, both preventative (to include oral health education) and other treatment; (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: and (4) prevention of unintended or unwanted pregnancy (male or female) and teen pregnancy prevention (male or female) and provision of reproductive health services, supplies, education, and counseling that must include discussion of a reproductive life plan (male or female).

Title V funding was allocated to county health departments for SFY 2015-2016 and SFY 2016-2017 to address four MCH priority areas based on local needs, including using these funds to increase the number of pregnant women who had a dental visit during pregnancy and increase the number of children (ages 1-21) served. During SFY 2015-2016, a total of 29 county health departments chose the dental priority area. During SFY 2016-2017, a total of 29 county health departments chose the dental priority area.

Dental sealants are the most effective way of preventing caries in permanent molars, where more than 80 percent of decay occurs in the children's permanent teeth. The deep grooves and fissures of the molars allow decay to occur deep within the tooth structure where fluoride is less effective. Thin plastic coatings applied to the tooth surface stop this decay from happening. Dental sealants are cost effective. Every $1 invested in dental sealants applied by county health department dental programs yields $1.88 in dental treatment savings. The cost savings over three years for 54,607 children receiving one dental sealant by a county health department during calendar year 2016 is over $3.5 million. School-Based Sealant Programs (S-BSPs) are a cost-effective, evidence-based way to reduce barriers to accessing preventive dental care among children.

Title V Funding has been consistently used to establish new S-BSPs in Florida. During SFY 2015-2016, Title V funding was used to support the expansion of dental sealant programs in six county areas of high unmet needs due to a lack of dental providers, transportation barriers, and low social economic factors influencing access to care. These dental sealant programs provided preventive services to school-aged children. Final data reveal that 595 children were screened, and 1,817 dental sealants, 825 fluoride varnish applications, and 1,058 oral health instructions were provided at these six counties during SFY 2015-2016.

Seven county health departments received MCHBG funding in September 2016 to initiate new S-BSP programs during SFY 2016-2017 to increase access while reducing barriers to receiving oral health care. To date, all S-BSP programs have implemented a cost-effective workforce model (dental hygienists) and purchased portable equipment. Collaborative agreements between the school districts and the county health departments have been

completed and five programs currently provide services. As of March 1, 2017, a total of 1,237 children have been served with at least one dental sealant and 4,439 sealants have been placed in these new S-BSPs. There have also been 1,209 children screened and assessed, 1,893 fluoride varnish applications provided, and 1,904 oral health instructions given.

To promote these S-BSPs to children and increase positive consent rates from parents, a postcard explaining dental sealants and their effectiveness in preventing tooth decay was produced and disseminated to each of the new programs, utilizing Title V funding. The postcards incorporate best practices for health literacy and implementation of healthy oral health behaviors in second and third grade children, the target population of the S-BSPs. The postcard encourages discussion of improved oral hygiene, specifically the benefits of dental sealants, between teachers, children, and their parents or guardians.

Community water fluoridation has been demonstrated to be the most cost-effective method for preventing dental caries. The positive effects of fluoridation benefit all citizens regardless of age or socioeconomic status. The level of understanding of water fluoridation and its benefits is extremely low in Florida, including among dental providers. Thus, programs and materials to teach and provide relevant scientific support for water fluoridation are needed to effectively promote water fluoridation at the community level. In SFY 2015-2016, Title V funding assisted the PHDP to support water fluoridation promotional activities implemented by the *Oral Health Florida Coalition* in local communities. Funding supported training programs and education activities for local communities involved in water fluoridation campaigns. These trainings included educating citizens and local authorities about the benefits of community water fluoridation and helped local communities to organize grassroots activities in support of local campaigns.

These efforts were continued during SFY 2016-2017 when Title V funding was provided to the PHDP to purchase the implementation of a modified and updated community water fluoridation training curriculum and technical assistance services for health and dental professionals to promote water fluoridation in Florida. In addition, a step-by-step check list and technical assistance guide was purchased to assist local communities in either initiating or supporting the continuation of community water fluoridation. The PHDP contracted with the *Oral Health Florida Coalition* to purchase the provision of training, educational materials and other items required to increase the oral health literacy of health and water professionals, dentists, dental hygienists, and public health professionals on the topic area of community water fluoridation. In Florida, the increase in oral health literacy regarding community water fluoridation often leads to greater access to water fluoridation for the general public. This usually occurs when an individual learns of the benefit of fluoridation and then approaches his/her local city or county leaders on whether a public health measure can be initiated for the community.

During fall 2016, the PHDP developed and deployed a community water fluoridation knowledge survey to licensed dentists and dental hygienists across the state. Results from the N=799 respondents reveal that 50.3 percent of dental practitioners in Florida know the optimal fluoride concentration and 57.1 percent can correctly recognize that Florida does not mandate community water fluoridation. Despite the lack of knowledge shown in this survey, 82.8 percent of dental practitioners are confident in discussing the dental benefits of fluoridation with patients and 93.2 percent believe that community water fluoridation is safe and effective in the prevention of tooth decay. Results also reveal that the vast majority of respondents did not have any experience with participating in or leading a local fluoridation campaign. These results show that growth in community water fluoridation knowledge is needed among Florida's dental practitioners. Respondents showed interest in receiving training and the PHDP will use these results to guide future programmatic activities, including the continued dissemination of training and technical assistance guides purchased through Title V Funds. The results of the PHDP's dental practitioner community water fluoridation knowledge survey will be used to tailor fluoridation training programs and initiatives for oral health providers to bolster support for increasing community water fluoridation statewide.

Title V funding is currently being utilized to implement a Teledentistry Pilot Project in three regions of the state that have the highest urgent dental care needs among school-aged children, as identified by local Department's S-BSP data collection efforts. Three counties (Leon, Polk, and Jackson) were selected as these county health department dental programs utilize a complete electronic oral health record and deploy a dental hygiene model for the provision of preventive dental services. These programs purchased electronic equipment and developed a mechanism for real-time, live communication between the hygienist in the field and the dentist in the fixed clinic to address urgent care (emergency) dental needs of children in Title I schools. The intent of the pilot is to increase the presence of a dental home while addressing urgent care needs immediately by electronically reducing transportation and other barriers to care. FDOH- Polk's S-BSP has purchased a full set of video equipment and will be starting in schools on May 26, 2017. Jackson and Leon Counties are in the process of ordering equipment and expect to provide services at the start of the fall 2017 school semester. The pilot project will continue through September 2017.

During SFY 2016-2017 Title V funding supported the PHDP's FLOSS Database that serves as a data warehouse for several oral health related initiatives and builds oral health data capacity and infrastructure for the state of Florida. Using SFY 2016-2017 Title V funds, FLOSS automated two new business processes regarding statewide oral health data collection for (1) School-Based Sealant Programs and (2) Oral Health Surveillance projects across vulnerable MCH populations. Development of the two new modules is scheduled for completion in May 2017. Training for statewide external and internal partners will be conducted through September 2017.

Florida conducted activities to enhance the life course approach across all population groups. The Department applied to a request for applications from the Association of Maternal and Child Health Programs (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. The team 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. The teams 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 led the efforts to create an indicator report for all 59 final indicators. The resulting document is intended to be a mechanism to further cross-cutting collaboration within and outside the Department. The Florida Life Course Metrics Report is now available to staff, stakeholders, and the general public on the Department's website at: www.flhealth.gov/floridalifecourse. The report includes statistics and figures for the indicators, and comparisons of Florida data to the national average as well as recommendations for Florida. Detailed CDC/CSTE Fellow activities to create the report included: (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; and (4) comparing Florida data to national rankings on life course indicators. These specific activities were necessary for creating a comprehensive data report and developing recommendations for Florida.

II.F.2 MCH Workforce Development and Capacity

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.

In March 2016, the Florida Department of Health received first-in-the-nation national accreditation as an integrated department of health through the Public Health Accreditation Board. The national accreditation program, jointly supported by the Centers for Disease Control and Prevention and the Robert Wood Johnson Foundation, sets standards against which the nation's more than 3,000 governmental public health departments can continuously improve the quality of their services and performance. To receive accreditation, a health department must undergo a rigorous, multi-faceted, peer-reviewed assessment process to ensure it meets or exceeds a set of quality standards and measures. This accreditation signified that the unified Florida Department of Health, including the state health office and all 67 county health departments, was rigorously examined and met or exceeded national standards for public health performance management and continuous quality improvement.

The Department is currently developing health equity employee performance expectations to require every staff member to demonstrate engagement and move them past the learning and training phase and into action – empowering, requiring decision makers to begin to apply what they have learned to their programs, whether it is clinic flow, contracts, creation and monitoring, partner meetings, and agency activities.

In 2017, two CMS staff members began participating in a mentor program with the National MCH Workforce Development Center. They both participate in one-on-one coaching sessions for leadership skills building. They are both also part of a local toastmasters club.

CMS is also working with the University of Florida's Pediatric Pulmonary Center on efforts to implement a statewide training effort to support and increase the skills of family leaders across many organizations.

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

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. Additionally, the Department partners with Florida State University to provide internships for Masters of Public Health students over the course of 13 weeks that total 200 hours.

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. The purpose of the most recent course was 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.

The Title V Program has engaged with public health professional educational programs including the CDC/CSTE Applied Epidemiology Fellowship Program, the Graduate Student Epidemiology Program (GSEP), the CDC/Harvard School of Public Health Practicum, and other experiences through partnerships with local universities. During the summer of 2017, the Bureau of Family Health Services will host a GSEP summer intern who will conduct epidemiologic analyses on bullying, which is a MCH Title V Block Grant priority area, in relation to smoking and use of alcohol and drugs among high school students in Florida. For our Florida Safe Sleep Hospital Project, two Harvard students completed a comprehensive plan to evaluate this program and one Florida State University student has been working with us to revise a survey that will administered to clinicians throughout the state.

A previous CSTE Fellow was later hired as the oral health epidemiologist for the Public Health Dental Program, a program within the Bureau of Family Services. Through this hire, the Department is supporting the core goals of the CSTE Fellowship, which include securing permanent employment at a state or local health department and enhancing epidemiology workforce capacity. This staff member also serves as Chair of the Association of Maternal and Child Health Programs Workforce and Leadership Development Committee. Having a Bureau staff member serving on this committee keeps Florida abreast of emerging MCH workforce issues and connects us to national workforce development materials and professional development training opportunities.

The Department implemented a Research/Investigations Workgroup at the state office to assist local and state epidemiologists and fellows/trainees through the conception, design, analysis, and interpretation of studies/investigations that are more complex than what is handled on a day-to-day basis. The type and degree of assistance provided by the workgroup is dependent on the request, but would consider several aspects such as disease of concern, data and analysis required, skill level of the requestor, and alignment with the Department's strategic plan and research agenda.

A Research/Investigations Workgroup can streamline the investigation process for local and state epidemiologists, while providing valuable input throughout the process to ensure appropriate methods and interpretation of results. Being aware of and tracking research produced within the Department will allow for a more efficient use of resources by eliminating duplication of efforts; promoting collaboration across programs; ensuring appropriate use of datasets and products; and continually moving the research forward by building on findings

The Department recently launched the Research Excellence Initiative, a year-long education program for Department of Health professionals. The goals of this program are to promote high quality innovative research, foster collaborations, and educate and recognize Department researchers. Two Bureau of Family Health Services epidemiologists completed this program during the last fiscal year and Title V funding sponsored their travel to the associated in-person training/networking events. The end-product of this initiative included a poster presentation entitled *Relationship Between Hospital Breastfeeding Experiences and Breastfeeding Duration among New Mothers in Florida, Pregnancy Risk Assessment Monitoring System, 2012-2013*, which was presented at the 2017 AMCHP Conference. An additional bureau staff member was accepted to participate in the April 2017 cohort of the Research Excellence Initiative, which will focus on children's oral health status.

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

Employee wellness is a major focus within the Department. On Friday mornings, many gather for an organized weekly walk around the office complex campus. Employees are encouraged to walk on their break time, or to conduct “walking meetings” rather than simple one-on-one time to discuss issues. On campus PiYo workouts are offered during lunch times twice a week. This year, the Department organized a Spring Into Action 10,000 Step a Day Challenge, challenging employees to accumulate enough collective steps to walk us from Tallahassee to Seattle. There are regular reminders and presentations on healthy eating, and encouragement to participate in Healthy Weight Florida initiatives. The Department’s worksite wellness program, Florida Health at Work, recently received an award from the Working Well Leon Program for our efforts to create a culture of wellness and a positive, healthy working environment.

II.F.3. Family Consumer Partnership

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

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

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

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

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

Consumers are also valuable contributors in various advisory roles. With the support of the legislature, the Department was authorized in section 383.141, Florida Statutes, to create an information clearinghouse 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 parent's perspective in information gathered and made available to health care providers for use in counseling pregnant women whose unborn children have been prenatally diagnosed with developmental disabilities. The Council 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: the types of referrals they receive, what parts of the home visits are most helpful to them, what their relationship is like with their home visitor, and how home visiting lessons and activities are utilized in their daily life.

The Department 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.

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. This year, CMS, along with the University of Florida's Pediatric Pulmonary Center, will present at the Family Café on recent training efforts for family leaders.

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 essential 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.

The Family Network on Disabilities is Florida's Family to Family Health Information Center. Children's Medical Services works with this organization to promote family involvement in health care decision-making. In 2017, CMS will be exploring ways to coordinate with the Family Network on Disabilities on several projects.

Each year, a family representative accompanies CMS at 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.

In 2015, Children's Medical Services established a technical advisory panel for the CMS Managed Care Plan. A family representative sits on this advisory panel and brings a unique perspective to the panel's discussions and priorities.

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.

CMS is currently working with families, CMS leadership, and CMS family support workers to develop a Person and Family Engagement Strategic Plan. Activities and objectives will begin in July 2017. Objectives and strategies are based on the Centers for Medicare and Medicaid's 2016 *Person and Family Engagement Strategy* and on the *Standards for Systems of Care for Children and Youth with Special Health Care Needs.* CMS will continue to seek input from families and family leaders for the strategies and objectives within the strategic plan. Some key activities will include establishing family partners in all CMS regions, exploring and implementing activities that will promote family involvement at all levels of decision-making including at the personal level and policy level, a continuous review of all CMS policies by a newly established statewide family leader position and the establishment of a family partner curriculum.

In 2017, CMS held a series of public meetings and family forums to gather feedback related to the Plan's health care delivery model. CMS has received input from families, stakeholders, advocates, and providers. The family forums created a space for families to have a voice and to be open and honest regarding the health care services they receive. CMS will be doing a qualitative review and analysis of the information gathered at each family forum to provide recommendations to leadership regarding key values for families in their health care.

II.F.4. Health Reform

Today, maternity care is a covered benefit in all plans sold on the new health insurance marketplace 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 $1,326,028 was allocated during state fiscal year 2016-17 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.

It remains unclear whether the current administration will make changes to the marketplace that affect whether maternity and newborn care will remain as mandatory services health plans are required to provide. It is also possible that more people will be uninsured if changes are made, and that more women and families may need assistance in with their prenatal care.

The federal government has agreed to restore $1.5 billion to a state program that repays hospitals that care for the uninsured. Called the Low Income Pool, these funds were set to expire this year, but the funding has been reinstated, though at a lesser amount than it was three years ago. Federal officials said they were restoring a portion of the LIP program in an effort to give the state more autonomy in its Medicaid program.

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 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.

Following the Centers for Disease Control and Prevention (CDC) declaring a national opioid epidemic, Florida's Governor signed Executive Order 17-146 directing a Public Health Emergency across the state. Signing the Emergency Order allows the state to immediately draw down more than $27 million in federal grant funding from the United States Department of Health and Human Services (HHS) Opioid State Targeted Response Grant, which was awarded to Florida in April 2017 to provide prevention, treatment, and recovery support services. Without the order, it would have taken months for the state to distribute these funds to local communities. In addition to declaring a Public Health Emergency, the State Surgeon General issued a standing order for Naloxone, an emergency treatment for opioid overdose. This will ensure first responders have immediate access to this lifesaving drug to respond to opioid overdoses.

Transmission of the Zika virus, and the possible effect on babies born in Florida, is a major concern of the Department. Florida has a high volume of international travelers between Florida and affected locations, and has experienced local transmission of other exotic mosquito-borne diseases in the recent past. Between 2015 to April 2017, of the 5,197 reported confirmed or probable Zika virus disease cases in the US, Florida had the most with 1,116 cases. Florida has mosquito vectors that are known or suspected to be competent of transmitting Zika virus if infected. Additionally, the virus is now being transmitted locally in American territories (Puerto Rico, the Virgin Islands, and American Samoa) where interstate travel to Florida is common. The number of Hispanics of Puerto Rican origin alone living in Florida has surpassed one million for the first time, more than doubling the state's Puerto Rican population over the past 14 years. The trend comes as the island's economic recession has led many residents of the U.S. territory to look for opportunities on the U.S. mainland, and as more Puerto Ricans move to Florida from other states. Concurrently, during 2014, there were 12,500 live births in Florida to Puerto Rican women. This combination makes Florida high-risk for local transmission of the Zika virus.

The Department is addressing the Zika virus in a number of ways. Department personnel and partners investigate and report Zika virus infections of clinical and public health importance (e.g. pregnant women, in utero or intrapartum transmission, sexual transmission, transfusion, and transplant associated transmission, and local mosquito-borne

transmission). Ongoing Zika preparedness, surveillance, and response is a concerted effort among the Department's state office and county health departments, local mosquito control, and key partners throughout the state. Internal partnerships within the Department included individuals from our laboratory, birth defects, maternal and child health, sexually transmitted diseases, emergency preparedness, and communications groups. The Department provides impacted counties with maps that highlight populations that may have gaps in communication access or are targeted groups for Zika prevention information (low income, non-English speaking, non-white, women of reproductive age). In addition, county health departments for affected counties have developed additional outreach programs for local medical professionals to increase awareness and access to diagnostic tools. A Zika information hotline answers questions from the public, and calls are monitored to identify possible cases.

Outreach materials and guidance are provided to hospitals, physicians, obstetricians, nurses, and midwives. A Zika syndromic surveillance query was developed to identify travel-related cases. A plan to report local Zika activity to blood banks in Florida has also been developed. Florida has requested funding for two more epidemiologists to support Zika epidemiology (one located in Miami-Dade County and another in Orange County, the counties with the highest number of impacted pregnant women and testing requests). These positions will work regionally and support outreach projects statewide including involvement with active surveillance, follow-up of pregnant women potentially exposed to Zika, response to any local introductions, as well as assist with development and distribution of Zika and mosquito bite prevention outreach to targeted audiences.

If a local Zika introduction were to occur, cluster investigations would be performed to identify any additional cases. In addition, increased outreach and messaging would occur. In the event of widespread transmission, Zika kits modeled after the CDC kits used in Puerto Rico including repellent, mosquito larvicide, mosquito netting as appropriate, condoms, and prevention information would be distributed to pregnant women in affected areas. In addition, mosquito repellant would be provided to homeless individuals in affected areas.

The Department received grant funding through the Centers for Medicare & Medicaid Services to combat Zika in areas where the virus is most prevalent. Activities include: education on the availability of long-acting reversible contraception to reduce unplanned pregnancies impacted by the Zika virus; education and information regarding the availability of free Zika virus testing for pregnant women in Florida's county health departments; identifying appropriate referral sources to specialized services, including obstetricians, pediatricians, high-risk hospitals and birthing facilities, Early Steps, infant mental health providers, and child protection resources/strategies (i.e. Coping with Crying); and designating two hospitals as resource and referral centers for practitioners to assist in providing care in accordance with the CDC guidelines.

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, our own Online Newsroom, and social media; and working with parent organizations.

During the 2015 Needs Assessment process, the MCH Section developed a web-based electronic survey that was sent to 55 MCH stakeholders, professionals, and partners who were then asked to complete the survey and distribute the survey to consumers, other members of the community, and community partners; some of whom posted the survey on Facebook pages. The purpose of the survey was to obtain feedback on which MCH topics should be identified as priorities for the state and thus become the basis for the 2016 MCHBG application. 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 county health departments complete a Community Health Assessment and a 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 develop an understanding of the issues they feel are important, then prioritizes issues related to the community's health and quality of life.

As recipients of Title X funding, local health departments are required to establish an advisory committee of five to nine members who are broadly representative of the community to review and approve all informational and educational materials prior to distribution 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. In addition, the Department created an MCH Block Grant inbox dedicated to comments and suggestions regarding the block grant application. The block grant documents and the link to the inbox can be found at: http://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/mch-block-grant.html

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 the federal poverty level or an annual income of $9,893 a year for a family of three. In states that do not expand their programs, many adults 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 Medicaid programs disproportionately affect people of color, particularly blacks. This disproportionate effect occurs because the racial and ethnic composition of states not expanding their programs differs from the ones that are expanding. In Florida, it is estimated that 669,000 fall within the coverage gap, 50 percent are female and 64 percent are in working families. (Kaiser Family Foundation, Nov. 2014)

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

III. Budget Narrative

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$18,920,363	$18,920,363	$18,996,748	$18,996,748
Unobligated Balance	$0	$0	$0	$0
State Funds	$169,402,594	$169,402,594	$169,459,883	$169,459,883
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$188,322,957	$188,322,957	$188,456,631	$188,456,631
Other Federal Funds	$415,342,314		$378,242,185	$378,242,185
Total	$603,665,271	$188,322,957	$566,698,816	$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		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$18,996,748	$18,996,748	$18,984,911	
Unobligated Balance	$0	$0	$0	
State Funds	$169,459,883	$169,459,883	$155,212,322	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$188,456,631	$188,456,631	$174,197,233	
Other Federal Funds	$631,011,471	$608,138,617	$14,466,727	
Total	$819,468,102	$796,595,248	$188,663,960	

	2018	
	Budgeted	Expended
Federal Allocation	$19,243,069	
Unobligated Balance	$0	
State Funds	$155,212,322	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$174,455,391	
Other Federal Funds	$28,194,845	
Total	$202,650,236	

III.A. Expenditures

Expenditure amounts for the FY2016 annual report are included in forms 2, 3a and 3b. There were no significant variations in expenditures for the federal MCH Block Grant funds.

III.B. Budget

Federal funding through the Title V MCH Block Grant provides needed support to our statewide efforts. Of the $19,243,069 budgeted as the expected federal allotment for FY2018, a total of $5,929,780 is budgeted for preventive and primary care for children (30.8 percent) and $8,789,800 for children with special health care needs (45.6 percent), which meet the 30 percent requirements. In addition, $1,816,299 (9.5 percent) is budgeted towards Title V administrative costs. Total state match for FY2018 is $155,212,322. Budgeted amounts for FY2018 are contained on Forms 2, 3a and 3b.

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 - Cooperative agreement DOH-Healthy Start-AHCA.pdf

V. Supporting Documents

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

Supporting Document #01 - Glossary.pdf

Supporting Document #02 - DOH-DETAILED-ORG-CHART.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Florida

	FY18 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 19,243,069	
A. Preventive and Primary Care for Children	$ 5,929,780	(30.8%)
B. Children with Special Health Care Needs	$ 8,789,800	(45.6%)
C. Title V Administrative Costs	$ 1,816,299	(9.5%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 155,212,322	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 155,212,322	
A. Your State's FY 1989 Maintenance of Effort Amount $ 155,212,322		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 174,455,391	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 28,194,845	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 202,650,236	

OTHER FEDERAL FUNDS	FY18 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 4,435,757
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 1,602,442
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 10,530,800
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > School Health	$ 11,625,846

	FY16 Annual Report Budgeted		FY16 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 18,996,748		$ 18,996,748	
A. Preventive and Primary Care for Children	$ 5,779,133	(30.4%)	$ 5,779,133	(30.4%)
B. Children with Special Health Care Needs	$ 8,539,800	(45%)	$ 8,539,800	(44.9%)
C. Title V Administrative Costs	$ 1,818,087	(9.6%)	$ 1,818,087	(9.6%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 169,459,883		$ 169,459,883	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 169,459,883		$ 169,459,883	
A. Your State's FY 1989 Maintenance of Effort Amount $ 155,212,322				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 188,456,631		$ 188,456,631	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 631,011,471		$ 608,138,617	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 819,468,102		$ 796,595,248	

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 95,374	$ 49,029
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 363,338,668	$ 341,153,055
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 2,738,485	$ 2,738,485
US Department of Agriculture (USDA) > Food and Nutrition Services > Child and Adult Care Food Program (CACFP)	$ 224,746,165	$ 224,746,165
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 10,125,800	$ 9,697,416
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 4,599,330	$ 4,404,677
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > various	$ 13,611,803	$ 13,611,803
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > EMS	$ 130,000	$ 112,141
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > School Health	$ 11,625,846	$ 11,625,846

Form Notes for Form 2:

There are a smaller number of federal funds reported on Form 2 than in previous years. Currently, the Title V MCH Director is a Bureau Chief. The previous director was a Division Director, who had more federally-funded programs under her control and direction.

Field Level Notes for Form 2:

None

Data Alerts: None

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

State: Florida

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 1,865,060	$ 2,047,630
2. Infants < 1 year	$ 842,130	$ 812,098
3. Children 1-22 years	$ 5,929,780	$ 5,779,133
4. CSHCN	$ 8,789,800	$ 8,539,800
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 17,426,770	$ 17,178,661

IB. Non Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 30,450,092	$ 36,722,454
2. Infants < 1 year	$ 13,262,707	$ 14,564,268
3. Children 1-22 years	$ 97,259,847	$ 103,643,706
4. CSHCN	$ 14,239,676	$ 14,529,455
5. All Others	$ 0	$ 0
Non Federal Total of Individuals Served	$ 155,212,322	$ 169,459,883
Federal State MCH Block Grant Partnership Total	$ 172,639,092	$ 186,638,544

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Form 3b
Budget and Expenditure Details by Types of Services

State: Florida

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 3,000,000	$ 1,984,498
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	$ 3,000,000	$ 1,984,498
2. Enabling Services	$ 14,426,770	$ 15,194,163
3. Public Health Services and Systems	$ 1,816,299	$ 1,818,087
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		$ 153,309
Physician/Office Services		$ 1,814,007
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 17,182
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 1,984,498
Federal Total	$ 19,243,069	$ 18,996,748

IIB. Non-Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 6,800,000	$ 7,702,023
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	$ 6,800,000	$ 7,702,023
2. Enabling Services	$ 148,412,322	$ 161,757,860
3. Public Health Services and Systems	$ 0	$ 0
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		$ 0
Physician/Office Services		$ 7,673,239
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 28,784
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 7,702,023
Non-Federal Total	$ 155,212,322	$ 169,459,883

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: 224,273

1. 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
Core RUSP Conditions	222,167 (99.1%)	1,259	459	459 (100.0%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency
3-Hydroxy-3-methyglutaric aciduria	Holocarboxylase synthase deficiency	ß-Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect
Very long-chain acyl-CoA dehydrogenase deficiency	Medium-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria
Citrullinemia, type I	Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I
Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S, βeta-thalassemia	S,C disease
Biotinidase deficiency	Critical congenital heart disease	Cystic fibrosis	Hearing loss	Severe combined immunodeficiences
Classic galactosemia				

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Hearing loss	216,681 (96.6%)	8,343	285	285 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The Florida Newborn Screening process follows the child from the point of identification through confirmatory testing.

Form Notes for Form 4:

Hearing loss is included under Other Newborn Screening Tests due to the difference in the number of newborns screened, related to a difference in the testing methodologies, however it is on RUSP as a core condition.

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Florida

Reporting Year 2016

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	138,313	95.2	1.2	3.6	0.0	0.0
2. Infants < 1 Year of Age	76,688	98.0	0.4	1.6	0.0	0.0
3. Children 1 to 22 Years of Age	248,282	97.0	0.8	2.2	0.0	0.0
4. Children with Special Health Care Needs	86,321	77.6	16.1	6.3	0.0	0.0
5. Others	0					
Total	549,604					

Form Notes for Form 5a:

Florida data on source of coverage does not distinguish between other, none, and unknown. All numbers for columns D, E, and F are included in column D.

Field Level Notes for Form 5a:

None

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

State: Florida

Reporting Year 2016

Types Of Individuals Served	Total Served
1. Pregnant Women	170,384
2. Infants < 1 Year of Age	209,615
3. Children 1 to 22 Years of Age	2,878,038
4. Children with Special Health Care Needs	143,047
5. Others	0
Total	3,401,084

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 2016

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	224,418	159,877	49,310	244	6,858	211	3,650	4,268
Title V Served	138,313	98,535	30,391	151	4,226	130	2,250	2,630
Eligible for Title XIX	131,812	93,904	28,962	143	4,028	124	2,144	2,507
2. Total Infants in State	224,273	160,830	49,109	289	6,371	272	3,543	3,859
Title V Served	76,688	54,994	16,792	99	2,179	93	1,211	1,320
Eligible for Title XIX	75,154	53,894	16,457	97	2,135	91	1,187	1,293

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	157,414	65,323	1,681	224,418
Title V Served	97,017	40,260	1,036	138,313
Eligible for Title XIX	92,457	38,368	987	131,812
2. Total Infants in State	159,599	63,978	696	224,273
Title V Served	54,573	21,877	238	76,688
Eligible for Title XIX	53,482	21,439	233	75,154

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Florida

A. State MCH Toll-Free Telephone Lines	2018 Application Year	2016 Reporting Year
1. State MCH Toll-Free "Hotline" Telephone Number	(850) 451-2229	(850) 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"		10,911

B. Other Appropriate Methods	2018 Application Year	2016 Reporting Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Florida

1. Title V Maternal and Child Health (MCH) Director	
Name	Shay Chapman, BSN, MBA
Title	Chief, Bureau of Family Health Services
Address 1	4052 Bald Cypress Way, Bin A-13
Address 2	
City/State/Zip	Tallahassee / FL / 32399-1723
Telephone	(850) 245-4464
Extension	
Email	Shay.Chapman@flhealth.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Jeffrey Brosco, MD, PhD
Title	Deputy Secretary for Children's Medical Services
Address 1	4052 Bald Cypress Way, Bin A-06
Address 2	
City/State/Zip	Tallahassee / FL / 32399-1723
Telephone	(850) 245-4213
Extension	
Email	Jeffrey.Brosco@flhealth.gov

3. State Family or Youth Leader (Optional)	
Name	Joane White
Title	Family Support Worker
Address 1	13101 Bruce B. Downs Blvd.
Address 2	
City/State/Zip	Tampa / FL / 33612
Telephone	(813) 396-9772
Extension	
Email	Joane.White@flhealth.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Florida

Application Year 2018

No.	Priority Need
1.	Promote safe and healthy infant sleep behaviors and environments, including improving support systems and the daily living conditions that make safe sleep practices challenging.
2.	Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment.
3.	Promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children.
4.	Promote breastfeeding to ensure better health for infants and children and reduce low food security.
5.	Improve access to health care for women to improve preconception and interconception health, specifically women who face significant barriers to better health.
6.	Increase access to medical homes and primary care for children with special health care needs.
7.	Improve health care transition to all aspects of adult life for adolescents and young adults with special health care needs.
8.	Improve dental care access for children and pregnant women.
9.	Improve access to appropriate mental health services to all children.
10.	Address the social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies.

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Promote safe and healthy infant sleep behaviors and environments including improving support systems, and daily living conditions that make safe sleep practices challenging.	Continued	
2.	Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment.	New	
3.	Promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children.	New	
4.	Promote breastfeeding to ensure better health for infants and children and reduce low food security.	New	
5.	Improve access to health care for women, specifically women who face significant barriers to better health, to improve preconception health.	New	
6.	Increase access to medical homes and primary care for children with special health care needs.	Continued	
7.	Improve health care transition for adolescents and young adults with special health care needs to all aspects of adult life.	Continued	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Florida

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

Florida set objectives based on the YRBSS data, not the NSCH data that was used to come up with an indicator in the TVIS system. We feel that the YRBSS data is a more accurate indicator of the current situation

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
2015	75.7 %	0.1 %	161,407	213,229
2014	75.7 %	0.1 %	159,417	210,735
2013	73.2 %	0.1 %	152,189	207,988
2012	73.1 %	0.1 %	150,595	205,947
2011	73.8 %	0.1 %	150,478	203,797
2010	72.7 %	0.1 %	144,841	199,326
2009	71.7 %	0.1 %	149,827	209,106

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	183.1	3.0 %	3,822	208,694
2013	170.6	2.9 %	3,501	205,222
2012	166.0	2.9 %	3,379	203,557
2011	163.7	2.9 %	3,342	204,118
2010	158.3	2.8 %	3,261	205,959
2009	150.3	2.7 %	3,176	211,276
2008	140.0	2.5 %	3,107	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
2011_2015	23.8	1.5 %	259	1,086,229
2010_2014	23.6	1.5 %	254	1,076,550
2009_2013	25.3	1.5 %	273	1,077,953
2008_2012	21.5	1.4 %	235	1,093,991
2007_2011	20.8	1.4 %	233	1,120,008
2006_2010	19.3	1.3 %	221	1,143,396
2005_2009	20.0	1.3 %	231	1,155,046

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4.1 - 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
2015	8.6 %	0.1 %	19,306	224,193
2014	8.7 %	0.1 %	19,065	219,927
2013	8.5 %	0.1 %	18,346	215,338
2012	8.6 %	0.1 %	18,260	213,076
2011	8.7 %	0.1 %	18,527	213,363
2010	8.7 %	0.1 %	18,681	214,525
2009	8.7 %	0.1 %	19,247	221,319

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.1 - 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
2015	1.5 %	0.0 %	3,433	224,193
2014	1.6 %	0.0 %	3,501	219,927
2013	1.5 %	0.0 %	3,266	215,338
2012	1.6 %	0.0 %	3,370	213,076
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
2015	7.1 %	0.1 %	15,873	224,193
2014	7.1 %	0.1 %	15,564	219,927
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
2015	10.0 %	0.1 %	22,407	224,173
2014	9.9 %	0.1 %	21,846	219,909
2013	10.0 %	0.1 %	21,594	215,168
2012	10.2 %	0.1 %	21,810	212,925
2011	10.3 %	0.1 %	22,018	213,054
2010	10.5 %	0.1 %	22,436	214,301
2009	10.6 %	0.1 %	23,344	221,161

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.1 - 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
2015	3.1 %	0.0 %	6,857	224,173
2014	3.1 %	0.0 %	6,784	219,909
2013	3.0 %	0.0 %	6,395	215,168
2012	3.0 %	0.0 %	6,464	212,925
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
2015	6.9 %	0.1 %	15,550	224,173
2014	6.9 %	0.1 %	15,062	219,909
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
2015	25.7 %	0.1 %	57,676	224,173
2014	25.7 %	0.1 %	56,543	219,909
2013	26.4 %	0.1 %	56,704	215,168
2012	27.1 %	0.1 %	57,640	212,925
2011	27.8 %	0.1 %	59,291	213,054
2010	30.2 %	0.1 %	64,627	214,301
2009	32.1 %	0.1 %	70,945	221,161

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	4.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	6.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.5	0.2 %	1,425	220,685
2013	6.6	0.2 %	1,417	216,119
2012	6.6	0.2 %	1,419	213,877
2011	6.9	0.2 %	1,473	214,141
2010	6.8	0.2 %	1,459	215,306
2009	6.8	0.2 %	1,520	222,137

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.1	0.2 %	1,344	219,991
2013	6.1	0.2 %	1,322	215,407
2012	6.1	0.2 %	1,306	213,148
2011	6.5	0.2 %	1,379	213,414
2010	6.5	0.2 %	1,397	214,590
2009	6.9	0.2 %	1,527	221,394

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	4.2	0.1 %	913	219,991
2013	4.0	0.1 %	868	215,407
2012	4.0	0.1 %	847	213,148
2011	4.3	0.1 %	920	213,414
2010	4.4	0.1 %	937	214,590
2009	4.5	0.1 %	994	221,394

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	2.0	0.1 %	431	219,991
2013	2.1	0.1 %	454	215,407
2012	2.2	0.1 %	459	213,148
2011	2.2	0.1 %	459	213,414
2010	2.1	0.1 %	460	214,590
2009	2.4	0.1 %	533	221,394

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	234.6	10.3 %	516	219,991
2013	227.5	10.3 %	490	215,407
2012	229.9	10.4 %	490	213,148
2011	245.5	10.7 %	524	213,414
2010	251.2	10.8 %	539	214,590
2009	257.9	10.8 %	571	221,394

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	87.7	6.3 %	193	219,991
2013	93.8	6.6 %	202	215,407
2012	83.0	6.2 %	177	213,148
2011	82.0	6.2 %	175	213,414
2010	85.3	6.3 %	183	214,590
2009	86.3	6.3 %	191	221,394

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

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: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	11.4	0.2 %	2,368	208,695
2013	10.8	0.2 %	2,211	205,225
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

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
2015	20.3	1.0 %	410	2,015,646
2014	20.1	1.0 %	401	1,995,207
2013	19.5	1.0 %	385	1,975,876
2012	19.2	1.0 %	375	1,954,997
2011	20.7	1.0 %	402	1,941,084
2010	20.9	1.0 %	407	1,945,037
2009	21.3	1.1 %	412	1,936,378

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	32.4	1.2 %	755	2,330,369
2014	31.6	1.2 %	730	2,309,604
2013	29.4	1.1 %	676	2,303,428
2012	31.8	1.2 %	734	2,309,847
2011	33.0	1.2 %	768	2,327,390
2010	32.2	1.2 %	759	2,359,229
2009	35.6	1.2 %	841	2,365,899

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2015	13.2	0.6 %	465	3,525,120
2012_2014	12.7	0.6 %	445	3,518,703
2011_2013	13.0	0.6 %	459	3,542,990
2010_2012	14.1	0.6 %	509	3,600,735
2009_2011	14.7	0.6 %	539	3,661,955
2008_2010	16.8	0.7 %	624	3,707,519
2007_2009	20.2	0.7 %	748	3,712,629

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2015	7.4	0.5 %	262	3,525,120
2012_2014	7.6	0.5 %	269	3,518,703
2011_2013	7.5	0.5 %	264	3,542,990
2010_2012	6.7	0.4 %	242	3,600,735
2009_2011	6.0	0.4 %	221	3,661,955
2008_2010	5.6	0.4 %	209	3,707,519
2007_2009	6.0	0.4 %	224	3,712,629

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs

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
2014	26.8 %	0.1 %	48,896	182,567
2012	28.3 %	0.1 %	48,702	171,832
2010	29.8 %	0.1 %	58,019	194,924
2008	30.7 %	0.1 %	46,051	150,046

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

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

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	26.8 %	0.8 %	184,561	688,764
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
2015	6.9 %	0.2 %	281,867	4,102,077
2014	9.2 %	0.3 %	372,586	4,052,007
2013	11.0 %	0.3 %	443,880	4,025,110
2012	10.8 %	0.3 %	431,221	3,997,922
2011	11.9 %	0.3 %	474,740	3,992,737
2010	12.8 %	0.3 %	513,357	3,999,244
2009	14.8 %	0.3 %	600,227	4,056,356

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	66.7 %	3.7 %	209,945	315,014
2014	72.7 %	4.4 %	227,360	312,870
2013	70.0 %	4.4 %	217,207	310,138
2012	68.6 %	3.8 %	213,601	311,516
2011	66.7 %	3.5 %	214,657	321,764
2010	68.2 %	3.5 %	231,322	339,366
2009	49.0 %	3.4 %	174,338	355,765

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2016	47.9 %	1.8 %	1,777,685	3,712,793
2014_2015	48.0 %	1.9 %	1,780,234	3,712,688
2013_2014	50.3 %	1.9 %	1,867,932	3,714,239
2012_2013	46.9 %	2.6 %	1,722,142	3,672,407
2011_2012	43.9 %	3.3 %	1,632,951	3,716,498
2010_2011	38.9 %	1.9 %	1,442,929	3,709,328
2009_2010	37.9 %	2.4 %	1,366,413	3,605,312

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	62.5 %	4.9 %	359,256	574,582
2014	57.2 %	5.3 %	327,470	572,114
2013	49.7 %	5.2 %	283,474	570,577
2012	39.4 %	5.2 %	222,784	565,651
2011	50.0 %	4.5 %	282,686	565,363
2010	41.1 %	5.2 %	221,673	539,914
2009	39.3 %	4.3 %	217,892	554,254

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	45.3 %	5.0 %	271,278	598,962
2014	41.0 %	5.1 %	244,885	597,836
2013	27.8 %	4.4 %	166,254	597,984
2012	21.4 %	4.8 %	127,078	594,763
2011	NR	NR	NR	NR

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	87.3 %	2.5 %	1,024,631	1,173,544
2014	90.7 %	2.1 %	1,061,277	1,169,950
2013	84.8 %	2.8 %	990,810	1,168,561
2012	86.8 %	2.6 %	1,006,684	1,160,414
2011	77.5 %	2.7 %	899,634	1,160,986
2010	61.9 %	3.3 %	688,244	1,111,347
2009	47.2 %	3.1 %	536,871	1,137,222

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	70.4 %	3.3 %	825,716	1,173,544
2014	72.2 %	3.4 %	844,322	1,169,950
2013	72.3 %	3.3 %	844,690	1,168,561
2012	68.6 %	3.5 %	796,377	1,160,414
2011	61.2 %	3.1 %	710,999	1,160,986
2010	55.1 %	3.4 %	612,809	1,111,347
2009	52.7 %	3.1 %	599,159	1,137,222

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: Florida

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

Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	68
Annual Indicator	68.8
Numerator	2,287,771
Denominator	3,324,933
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	69.0	70.0	71.0	72.0	73.0	74.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	81.3
Annual Indicator	81.1
Numerator	171,099
Denominator	210,888
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	82.3	83.2	84.0	84.7	85.3	85.8

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	27.7
Annual Indicator	18.4
Numerator	37,940
Denominator	206,047
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	29.4	31.1	32.8	34.5	36.2	36.9

Field Level Notes for Form 10a NPMs:

None

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

FAD for this measure is not available for the State.

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	73.3	74.4	75.4	76.3	77.1	77.9

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CHILD	
	2016
Annual Objective	42.7
Annual Indicator	40.7
Numerator	521,434
Denominator	1,282,761
Data Source	NSCH-CHILD
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	43.3	43.8	44.3	44.7	45.1	45.5

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	20.2
Annual Indicator	10.1
Numerator	138,029
Denominator	1,370,209
Data Source	NSCH
Data Source Year	2011_2012

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

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	19.0	18.7	18.4	18.1	17.8	17.5

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	52
Annual Indicator	45.7
Numerator	343,845
Denominator	751,777
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	53.0	54.0	55.0	56.0	57.0	58.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	42
Annual Indicator	37.0
Numerator	89,064
Denominator	240,468
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	44.0	46.0	48.0	50.0	52.0	54.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	6.5
Annual Indicator	5.8
Numerator	12,970
Denominator	223,231
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	6.4	6.3	6.2	6.1	6.0	5.9

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	22.5
Annual Indicator	24.6
Numerator	967,635
Denominator	3,932,309
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	22.0	21.5	21.0	20.5	20.0	19.5

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: Florida

SPM 1 - The percentage of children that need mental health services that actually receive mental health services.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	57.7
Numerator	
Denominator	
Data Source	National Survey of Children's Health
Data Source Year	2011/2012
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	58.0	59.0	60.0	61.0	62.0	63.0

Field Level Notes for Form 10a SPMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	35.9
Numerator	986,425
Denominator	2,745,598
Data Source	Florida Agency for Health Care Administration (AHC
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	37.4	38.9	40.4	41.9	43.4	44.9

Field Level Notes for Form 10a SPMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	42.6
Numerator	545,146
Denominator	1,279,782
Data Source	2011/12 National Survey of Children's Health
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	45.1	47.6	50.1	52.6	55.1	55.6

Field Level Notes for Form 10a SPMs:

None

Form 10a
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Florida

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	27,000.0	27,500.0	28,000.0	28,500.0	29,000.0	29,500.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	42.0	42.0	42.0	42.0	42.0	42.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	15.0	20.0	25.0	30.0	35.0	40.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.1 - The number of county School Health Programs who are utilizing the evidence-based Comprehensive School Physical Activity Program (CSPAP) for the reduction of childhood obesity

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	20
Numerator	
Denominator	
Data Source	School Health Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	25.0	30.0	34.0	38.0	42.0	45.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	6.0	6.0	6.0	6.0	6.0	6.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.1 - Number of pediatric providers in Florida who have received information related to the Patient Centered Medical Home (PCMH) and who have completed a Medical Home Assessment Tool for their practice.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Florida Children's Medical Services
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	500.0	1,000.0	2,000.0	3,000.0	4,000.0	5,000.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.1 - Number of pediatric providers in Florida who have practices that have a Health Care Transition (HCT) policy or youth with readiness assessment (with physicals) and plans of care.

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Florida Children's Medical Services
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	500.0	1,000.0	2,000.0	3,000.0	4,000.0	5,000.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	7,976
Numerator	
Denominator	
Data Source	Well Family System
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	9,250.0	9,500.0	9,750.0	10,000.0	10,250.0	10,500.0

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: Florida

SPM 1 - The percentage of children that need mental health services that actually receive mental health services.
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase the percentage of children with a mental/behavioral condition who receive treatment.
Definition:	**Numerator:** Number of children that needed mental health services that actually received mental health services. **Denominator:** Number of children that needed mental health services. **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MHMD-5: Increase the proportion of children with mental health problems who receive treatment.
Data Sources and Data Issues:	National Survey of Children's Health
Significance:	Linking children who have mental health and behavioral health conditions to timely and appropriate treatment will improve health outcomes and improve the child's ability to function optimally at home, at school, and in society

SPM 2 - The percentage of low-income children under age 21 who access dental care.
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To increase the number of eligible low-income children who receive dental care.
Definition:	**Numerator:** Number of Medicaid eligible children (unduplicated) age 0-20 receiving any dental or oral health service. **Denominator:** Total number of Medicaid eligible children age 0-20. **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	OH-8: Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year.
Data Sources and Data Issues:	Agency for Health Care Administration (Medicaid DSS)
Significance:	Oral health is vitally important to overall health and well-being. Oral health is much more than just healthy teeth. Oral health is a state of being free from chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects, periodontal disease, tooth decay and tooth loss, and other disease and disorders that affect the oral cavity. Good oral health also includes the ability to carry on basic human functions such as chewing, swallowing, speaking, smiling, and singing. These functions are critical in our communication with others and interaction with the world. Oral health is also firmly linked with overall health. Research has shown a link to diabetes, heart and lung disease, stroke, respiratory illnesses, and conditions of pregnant women including the delivery of pre-term and low birth weight infants. Changes in the mouth often are the first signs of problems elsewhere in the body, such as infectious diseases, immune disorders, nutritional deficiencies, and cancer. Maintaining good oral and physical health requires a multi-faceted approach including a healthy diet, proper exercise, access to health care professionals, and public health initiatives such as fluoridated community water and preventive dental services including dental sealants. Dental disease is largely preventable through effective health promotion and dental disease prevention programs. Collaborative partnerships among individuals, communities, health care providers and governing bodies are necessary to achieve optimal oral health in Florida.

SPM 3 - The percentage of parents who read to their young child age 0-5 years
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To increase the number of parents who read to their child age 0-5.
Definition:	**Numerator:** Number of children aged 0 to 5 years whose parents report that someone in their family read to the child every day in the past week. **Denominator:** Number of children aged 0 to 5 years. **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	EMC-2.3 Increase the proportion of parents who read to their young child.
Data Sources and Data Issues:	National Survey of Children's Health
Significance:	Encouraging parents to read to their child has a positive impact on children, including but not limited to, increased positive parenting, improvement in the parent-child bond, and improved language development in children.

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: Florida

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Florida

ESM 1.1 - The number of interconception services provided to Healthy Start clients
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Active
Goal:	To increase the number of interconception care services provided to clients in the Healthy Start Program
Definition:	**Numerator:** Number of interconception services provided to Healthy Start clients **Denominator:** N/A **Unit Type:** Count **Unit Number:** 80,000
Data Sources and Data Issues:	Department of Health, Health Management System
Significance:	Interconception care helps providers identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management. The goal to improve the woman's health and help reduce health risks to her future baby, resulting in improved outcomes for newborns and mothers.

ESM 4.1 - The number of birthing hospitals implementing steps to becoming a Baby Steps to Baby Friendly hospital or implementing steps to achieve a Florida Breastfeeding Coalition's Quest for Quality Maternity Care Award
NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the number of birthing hospitals in Florida that are implementing steps to become Baby Friendly Certified or implementing steps to achieve a Florida Breastfeeding Coalition's Quest for Quality Maternity Care Award.
Definition:	**Numerator:** Number of birthing hospitals in Florida that are implementing steps to becoming Baby Friendly or implementing steps to achieve a Florida Breastfeeding Coalition's Quest for Quality Maternity Care Award. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 60
Data Sources and Data Issues:	Internal documentation, numbers kept within the Maternal and Child Health Section. The number may decrease as hospitals reach certification.
Significance:	Baby Friendly birthing hospitals offer an optimal level of care for infant feeding and mother/baby bonding. They provide mothers with the information, confidence, and skills necessary to successfully initiate and continue breastfeeding their babies or feed formula safely. Breastfeeding provides the most complete nutrition possible, the optimal mix of nutrients and antibodies necessary for each baby to thrive. Studies have shown that breastfed children have far fewer and less serious illnesses than those who never receive breast milk, including a reduced risk of SIDS, childhood cancers, and diabetes. Recent studies show that women who breastfeed enjoy decreased risks of breast and ovarian cancer, anemia, and osteoporosis. Both mother and baby enjoy the emotional benefits of the very special and close relationship formed through breastfeeding.

ESM 5.1 - The number of birthing hospitals implementing steps to become Safe Sleep Certified
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Active
Goal:	To increase the number of birthing hospitals in Florida that are Safe Sleep Certified.
Definition:	**Numerator:** Number of birthing hospitals in Florida that are Safe Sleep Certified. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 50
Data Sources and Data Issues:	Internal documentation, numbers kept within the Maternal and Child Health Section.
Significance:	Safe sleep guidelines are endorsed by the American Academy of Pediatrics, the National Institute of Health, the CDC and by other nationally recognized programs. A hospital safe sleep certification process would ensure that participating hospitals develop a policy to support safe sleep efforts and that trusted hospital professionals provide consistent safe sleep messaging to parents.

ESM 8.1 - The number of county School Health Programs who are utilizing the evidence-based Comprehensive School Physical Activity Program (CSPAP) for the reduction of childhood obesity
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of School Health Programs who are implementing the evidence-based 5210 program to reduce the number of students who at or above the 95th percentile (obese).
Definition:	**Numerator:** The number of county School Health Programs who are implementing Healthy Lifestyle Interventions with students at or over the 95th percentile. These interventions utilize Individualized Healthcare Plans for nursing diagnosis Nutrition: More than Bod **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Data entered in the Department of Health – Health Management System by registered school nurses.
Significance:	Utilization of registered school nurses to implement Health Lifestyle Interventions using the 5210 program was initially piloted in Sarasota county. This county was selected as just one of ten teams in the nation to participate in phase 1 of the Healthy Weight Collaborative. A federal initiative supported by the Health Resources and Services Administration (HRSA) and guided by the National Initiative for Children's Healthcare Quality (NICHQ) the aim of the Healthy Weight Collaborative (HWC) is to enable multi-sector Teams (consisting of primary care, public health and community sector participants) to implement selected evidence-based strategies to accelerate progress towards community-wide healthy weight and health equity. Sarasota county's registered school nurses have been able to assist students at or over the 95th percentile to make significant progress in reducing body weight.

ESM 9.1 - The number of high schools implementing the evidence-based Green Dot violence prevention and intervention strategy
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To increase the number of high schools implementing Green Dot, so more students receive instruction on how to practice violence prevention and reduce power-based personal violence.
Definition:	**Numerator:** The number of schools implementing the Green Dot initiative. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	The number may stay the same as the program takes three to five years to implement.
Significance:	Bullying is a serious detriment to a child's health, sense of well-being, safety, education, and emotional development, and greatly increases the risk of self-injury and suicide.

ESM 11.1 - Number of pediatric providers in Florida who have received information related to the Patient Centered Medical Home (PCMH) and who have completed a Medical Home Assessment Tool for their practice.
NPM 11 – Percent of children with and without special health care needs having a medical home

Measure Status:	Active
Goal:	Increase access to medical homes and primary care for children with special health care needs.
Definition:	**Numerator:** Number of pediatric providers in Florida who have received information related to PCMH and who have completed a Medical Home Assessment Tool for their practice. **Denominator:** Number of pediatric providers in Florida. **Unit Type:** Count **Unit Number:** 10,000
Data Sources and Data Issues:	Florida Children's Medical Services
Significance:	Children and youth with special health care needs have varying degrees of medical complexities. Linking them to services within a patient-centered medical home ensures the patient and their family are partners in the decision making and the child receives comprehensive, coordinated, quality health care across a continuum.

ESM 12.1 - Number of pediatric providers in Florida who have practices that have a Health Care Transition (HCT) policy or youth with readiness assessment (with physicals) and plans of care.
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	Increase the percent of youth with special health care needs who receive services necessary to transition to adult health care, work and independence.
Definition:	**Numerator:** Number of pediatric providers in Florida who have practices that have a HCT policy or youth with readiness assessment (with physicals) and plans of care. **Denominator:** Number of pediatric providers in Florida. **Unit Type:** Count **Unit Number:** 10,000
Data Sources and Data Issues:	Florida Children's Medical Services
Significance:	Linking youth who are transitioning from pediatric to adult health care services, school, and independence will improve health outcomes and improve the young adult's ability to function optimally at home, at school and in society.

ESM 14.1 - The number of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to Healthy Start clients
NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Measure Status:	Active
Goal:	To increase the number of pregnant women who receive Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services.
Definition:	**Numerator:** Number of SCIPT services provided to Healthy Start clients. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 50,000
Data Sources and Data Issues:	Internal documentation, numbers kept within the Maternal and Child Health Section.
Significance:	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. Increasing the number of pregnant women who receive SCRIPT services will benefit both the women and eventually her child.

Form 11
Other State Data

State: Florida

The Form 11 data are available for review via the link below.

Form 11 Data

State Action Plan Table

State: Florida

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

Abbreviated State Action Plan Table

State: Florida

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Improve access to health care for women to improve preconception and interconception health, specifically women who face significant barriers to better health.	NPM 1 - Well-Woman Visit	ESM 1.1	

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Promote breastfeeding to ensure better health for infants and children and reduce low food security.	NPM 4 - Breastfeeding	ESM 4.1	
Promote safe and healthy infant sleep behaviors and environments, including improving support systems and the daily living conditions that make safe sleep practices challenging.	NPM 5 - Safe Sleep	ESM 5.1	

Child Health

State Priority Needs	NPMs	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.	NPM 8 - Physical Activity	ESM 8.1	
Improve dental care access for children and pregnant women.			SPM 2
Address the social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies.			SPM 3

Adolescent Health

State Priority Needs	NPMs	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.	NPM 9 - Bullying	ESM 9.1	

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Increase access to medical homes and primary care for children with special health care needs.	NPM 11 - Medical Home	ESM 11.1	
Improve health care transition to all aspects of adult life for adolescents and young adults with special health care needs.	NPM 12 - Transition	ESM 12.1	
Improve access to appropriate mental health services to all children.			SPM 1

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children.	NPM 14 - Smoking	ESM 14.1	