Maternal and Child Health Services Title V Block Grant

Florida

FY 2017 Application/ FY 2015 Annual Report

Created on 9/28/2016 at 4:14 PM

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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

Rick Scott
Governor

Celeste Philip, MD, MPH
Surgeon General and Secretary

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

July 13, 2016

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 FY2017. 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 FY2017.

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

Sincerely,

Anna Likos, MD, MPH
Acting Deputy Secretary for Health

Robert Herron
Chief, Bureau of Finance and Accounting

Florida Department of Health
Office of the State Surgeon General
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PHONE: 850/245-4210 • FAX: 850/922-9453
FloridaHealth.gov

PHAB Accredited Health Department
Public Health Accreditation Board

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 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 programs. These programs fall within the auspices of the Divisions of Community Health Promotion and Children's Medical Services (CMS). The MCH and Children with Special Health Care Needs (CSHCN) programs are located within these two divisions.

In March 2016, the Department received first-in-the-nation national accreditation as an integrated department of health through the Public Health Accreditation Board. 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.

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

Although infant mortality is the lowest in Florida's history, the Department is working to eliminate racial and ethnic disparities. In early 2016, the Department announced $1.4 million in Title V funding to support Florida's Healthy Babies, a collaborative statewide initiative to positively influence social determinants of health and reduce racial disparity in infant mortality. The initiative engages the Department's 67 CHDs and numerous partners within each county to address disparities with evidence-based interventions.

The initiative is an effort of the Department's Health Equity Program Council, which focuses on helping all Floridians achieve health equity, or the highest level of health. Though Florida has experienced declining morbidity and mortality rates, disparities persist. The department is committed to eliminating these differences. The council is comprised of county health officers and leaders in the state health office and works to assist local efforts, monitor emerging research, and determine how to expand best practices statewide.

The initiative provides all 67 CHDs with funding 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. In addition, 26 counties received funding to work with 45 hospitals statewide on Baby Steps to Baby Friendly, 10 practices proven to enhance hospital maternity care to support and promote exclusive breastfeeding; and 29 counties received funding to work on Protective Factors, evidence-based curricula to enhance parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, and social and emotional competence of children that decreases the risk of child maltreatment.

The five-year needs assessment and continual assessment during interim years drive the state's Title V MCH program. State priorities were selected through the needs assessment process and cover each of the six health domains. These priorities also determined the eight national performance measures (NPM) chosen for programmatic focus.

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 have made them vulnerable to poor health, is important and contributes to the well-being of Florida's families. The Title V program focuses on 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. Florida's goal is that by 2018, 28 percent of women having a live birth will receive preconception counseling about healthy lifestyle behaviors and prevention strategies from a health care practitioner prior to pregnancy.

The Department is using Title V funds to help make available ICC/PCC through the state's Healthy Start program. Neither ICC nor PCC is reimbursable by Medicaid. ICC/PCC services are offered to Healthy Start clients who have had a pregnancy and are high-risk of having a poor birth outcome for a subsequent pregnancy.

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 in order to promote system improvements through evidence-based actions aimed at preventing future untimely deaths. The Florida Perinatal Quality Collaborative is contracted by the Department to engage perinatal stakeholders to improve maternal and infant health outcomes through design, implementation, and evaluation of processes, and to enhance quality improvement efforts.

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 Baby Friendly 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. The Department provides breastfeeding promotion and support activities through a number of different programs, including the Women, Infant and Children program (WIC), the Child Care Food Program, Healthy Start, and the Bureau of Chronic Disease Prevention in establishing policies to promote and support breastfeeding as the preferred method of infant feeding.

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

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 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 nonmodifiable 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.

Additionally, the Department updated its Brand Guide, the primary tool the Department uses for communicating with the public, partners, and the legislature, to include a requirement that all media exposure of infant sleeping must portray these infants in a safe sleep environment.

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 program 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

The importance of physical activity to reduce obesity and improve health is a major focus of the Department's Healthiest Weight Florida initiative. Studies show that for many children, a decline in physical activity begins in middle school, but children who continue to be physically active through 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. 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.

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 Green Dot evidence-based 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 providers 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

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 providers who have practices that have a HCT policy or youth with readiness assessment (with physicals) and plans of care

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

SPM 1: The percentage of children with a behavioral health condition who receive treatment consistent with their diagnosis

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

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.

CMS is working to increase the number of pediatric providers who identify with a level of medical homeness, the degree to which a provider or practice aligns themselves with the medical home principles. One objective is to increase the number of CSHCN assigned to a provider who is practicing at a higher level of medical homeness and to provide support and education to pediatric providers to higher levels of medical homeness.

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.

A Title V Registered Nursing Consultant is dedicated to the CSHCN programs, including transition. CMS Managed Care Plan enrollees ages 12 to 21 receive information and resources related to transition in collaboration with Florida Health and Transition Services (FloridaHATS). CMS also plans to explore more robust reporting options in the CMS data system, and identify necessary resources for transition navigators, youth ambassadors, and programmatic operations.

Mental health has also been identified through the needs assessment to be of extreme importance. Without early diagnosis and treatment, children with mental health conditions may have problems at home, in school, and socially. CMS is preparing to form a Behavioral Health Consultant position to survey staff and providers to identify training needs; create a behavioral health policy for required annual CMS staff training and recommend provider training; and explore evidence-based trainings that are available from other resources.

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. It is also a risk factor for SIDS, and 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.

II. Components of the Application/Annual Report

II.A. Overview of the State

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

According to U.S. Census estimates for July 1, 2015, Florida has a total population of more than 20.2 million citizens, following only California and Texas as the third most populous state. Between April 2010 and July 2015, Florida's population increased by 7.8 percent. According to estimates provided by the Florida Legislature's Office of Economic and Demographic Research (EDR) 2014 estimates, 78 percent of Florida's population is white, 16.8 percent black, and 5.2 percent other races, mixed race, or unknown. Of the total population, 24.3 percent are Hispanic and 75.7 percent non-Hispanic. More than half of the state's population (51 percent) is between the ages of 25-64 and 30 percent are between the ages of 0-24. Florida's population 65 and older comprise 18.7 percent of the state's population compared to just 13 percent in this age group nationally. This indicates that a greater percentage of health care resources are expended on the elderly population in Florida compared to other states.

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

The Title V program, along with private and public health providers, 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 the healthcare provider through a conference or three-way calling system. In order to translate health-related educational materials into multiple languages for use around the state, Language Line Services also provides written translation services in over 100 languages.

Florida is a temporary home to well over 100 million tourists and visitors each year, which presents challenges to the state's public health system. In the first quarter of 2016, Florida hosted 29.8 million tourists, a record for any previous three-month period. Migrant farm workers and unauthorized immigrants also have a significant impact on the state's public health services and resources. Florida was home to 925,000 unauthorized immigrants in 2012, compared to a peak of 1,050,000 unauthorized immigrants in 2007. California and Texas are the only states with greater numbers of unauthorized immigrants.

The health of the economy plays a major role in the health status of the state's MCH population. The economy in Florida has been recovering since the economic downturn suffered during the recent nationwide recession. The average annual wage in Florida currently stands at 87.6 percent of the national average. Florida's economy is heavily reliant upon the service-related industry, where minimum wage jobs with little or no benefits are more the norm than the exception. A lack of well-paying jobs makes it difficult for many individuals and families to meet their basic needs. Those households most disproportionately affected are female-headed households, blacks, Hispanics, people living with a disability, and unskilled recent immigrants. According to the latest final numbers from the U.S. Bureau of Labor and Statistics, Florida's unemployment rate was 4.9 percent in March 2016, compared to 5.0 percent for the nation. Florida had a high school graduation rate of 77.8 percent during the 2014-15 school year, compared to a national rate of 82.3 percent.

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

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

The Department has published a Florida Emergency Preparedness Guide for residents and visitors as a tool that includes tips on making an emergency plan, steps for making a disaster supply kit, information on community services, and contact information for emergency shelters. The guide is posted on the Department's Emergency Preparedness & Response website, and is available in English, Spanish, and Creole. It is important to note the website also includes helpful information for vulnerable populations. At-risk or vulnerable populations are often defined as those groups whose unique needs may not be fully integrated into planning for disaster response. These populations include, but are not limited to, persons with physical, cognitive, or developmental disabilities. Also included in this group are persons with limited English proficiency, the geographically or culturally isolated, medically or chemically dependent, homeless, frail elderly, children, and pregnant women. Meeting the needs of vulnerable populations during or following a disaster is a key component of public health and medical preparedness planning.

There are a number of current priorities and initiatives that provide direction and impact upon the state's Title V directives. The Title V MCH and CSHCN administrators, 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. The Title V program receives input and advice from statewide partnerships, stakeholders, and other agencies and organizations. Many of our policies and services originate through legislative bills, statutory regulations, administrative rules, and directives from the State Surgeon General. Priorities are discussed in the state priorities section, and initiatives are discussed throughout the document.

One key overarching initiative within the Department is Healthiest Weight Florida, a public-private collaboration bringing together state agencies, non-profit organizations, businesses, and entire communities to help children and adults make consistent, informed choices about healthy eating and active living. The initiative works closely with partners to leverage existing resources to maximize reach and impact. These partners include the business community; hospitals; non-governmental organizations; non-profit agencies; other federal, state, or local government agencies; and volunteer coalitions. Encouraging physical activity and healthier food choices has a positive impact on birth outcomes and child health. Women who are healthier before and during pregnancy lessen the risk of maternal and infant morbidity and mortality.

In October 2015, the Florida Perinatal Quality Collaborative released a report showing that the number of early elective deliveries in Florida has reduced significantly, falling to 3 percent in 2013. Increasing the number of full-term deliveries has a positive impact on birth outcomes and the health of the child.

Neonatal abstinence syndrome (NAS) continues to be a concern in Florida, particularly due to the widespread abuse of opioids such as prescription pain killers. NAS is a group of physiological and neurobehavioral symptoms experienced by newborns exposed to prescription or illicit drugs taken by a mother during pregnancy. Infants with NAS have prolonged hospital stays, experience serious medical complications, and place a tremendous strain on service systems. Between 2008 and 2011, data showed a dramatic increasing trend in NAS prevalence in Florida, with a 2.5 fold increase from 25.8 per 10,000 live births in 2008 to 66.7 per 10,000 live births in 2011. Data from 2011 through 2013 revealed that the previous increasing trend has leveled to prevalence rates between 66.7and 69.6 per 10,000 live births. Infants born to white non-Hispanic women continue to have the highest reported prevalence rate of NAS (131.5 per 10,000 live births). The 2014 NAS prevalence rate is 76.6 per 10,000 live births,

an increase of approximately 10 percent from the previous year. Racial and ethnic disparities still remain.

Based on county-level prevalence rates, three areas of high concern are North Central to Northeastern Florida, Northwest Florida, and Southwest Florida. To gather more accurate statewide data, Florida added NAS to the Practitioner List of Reportable Diseases/Conditions in 2014. The Department is continuing to assist with a coordinated public health approach to NAS by developing and distributing educational materials to health professionals and identifying existing resources for families.

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

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

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

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

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

Another priority objective of CMS is providing a patient-centered medical home (PCMH) to CSHCN. CMS currently supports and promotes a medical home model through the CMS Medical Home Program in two regions of the state. Many local area offices have also successfully implemented a model that promotes the PCMH by assigning care

coordinators based on the child's primary care provider. Several CMS-credentialed providers were part of the Children's Health Insurance Reauthorization Program Act grant to work on improving PCMH capacity for pediatric providers in the state. The current needs assessment identified strategies to strengthen and build on the PCMH framework. This initiative will include engaging both public and private partners, as well as family advocates. The main objective will be to increase awareness and use of the PCMH model.

In 2011, the Florida Legislature created Part IV of Chapter 409, Florida Statutes, directing the Agency for Health Care Administration (AHCA) to create the Statewide Medicaid Managed Care (SMMC) program. The SMMC Managed Medical Assistance 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 healthcare 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.

The Agency for Health Care Administration 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.

Children's Medical Services also partners with KidCare to administer the CMS portion of the program for clinically eligible children with special health care needs through age 18. Children served through CMS KidCare are able to receive a benefit package that mirrors Medicaid's benefit package, including mental health services. Based on availability and eligibility, there are also additional behavioral health services available through the Behavioral Health Specialty Network.

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

On July 1, 2014, the operation of the Healthy Start Medicaid funded Waiver and SOBRA (MomCare) components were moved from the Department to AHCA. AHCA now contracts with an administrative services organization (ASO) called the Healthy Start MomCare Network (HSMN) representing all of the state Healthy Start Coalitions. The HSMN contracts with the coalitions to provide counseling, education, risk-reduction and case management services, and quality assurance for all enrollees of the Waiver and SOBRA services. Medicaid-eligible clients will be part of Florida's Managed Medical Assistance Program. Each plan's programs and procedures include agreements with each local Healthy Start Coalition in the region to provide risk-appropriate care coordination for pregnant women and infants, consistent with AHCA policies and the MomCare Network. The plans must establish specific programs and procedures to improve pregnancy outcomes and infant health, including, but not limited to, coordination with the Healthy Start program, immunization programs, and referral to WIC, and the CMS program for CSHCN.

When the Affordable Care Act (ACA) was first enacted, the Florida Legislature chose not to set up an ACA-compliant health insurance exchange and did not accept federal funding for the expansion of Medicaid. Florida's uninsured population has instead taken advantage of the availability of insurance offered through the federal exchange. According to federal health officials, during the 2015 open enrollment period, Florida had the highest enrollment among states using the federal exchange, with 1.6 million people signing up for coverage under the ACA. While it is too early to measure the effect on the MCH and CSHCN population, reducing the number of uninsured

people in Florida should clearly have a positive impact on health status.

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

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

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

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

The basic statutory authority for CSHCN and their families is Chapter 391, Florida Statutes, known as the Children's Medical Services Act. Section 391.016, Florida Statutes, establishes the Children’s Medical Services Program, and defines two primary functions: provide to children with special health care needs a family-centered, comprehensive, and coordinated statewide managed system of care that links community-based health care with multidisciplinary, regional, and tertiary pediatric specialty care; and provide essential preventive, evaluative, and early intervention services for children at risk for or having special health care needs, in order to prevent or reduce long-term disabilities.

II.B. Five Year Needs Assessment Summary

Needs Assessment Update (as submitted with the FY 2017 Application/FY 2015 Annual Report)

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 and men, preconception care and counseling, prenatal care, infant health services, ICC and counseling, and other preventive health services. The Department, maternal and child health practitioners, and community partners realize confronting inequities in health access, interventions and outcomes requires examining care systems, individual risk factors, community resources and deficits, and cultural factors that interact to influence and/or determine health 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

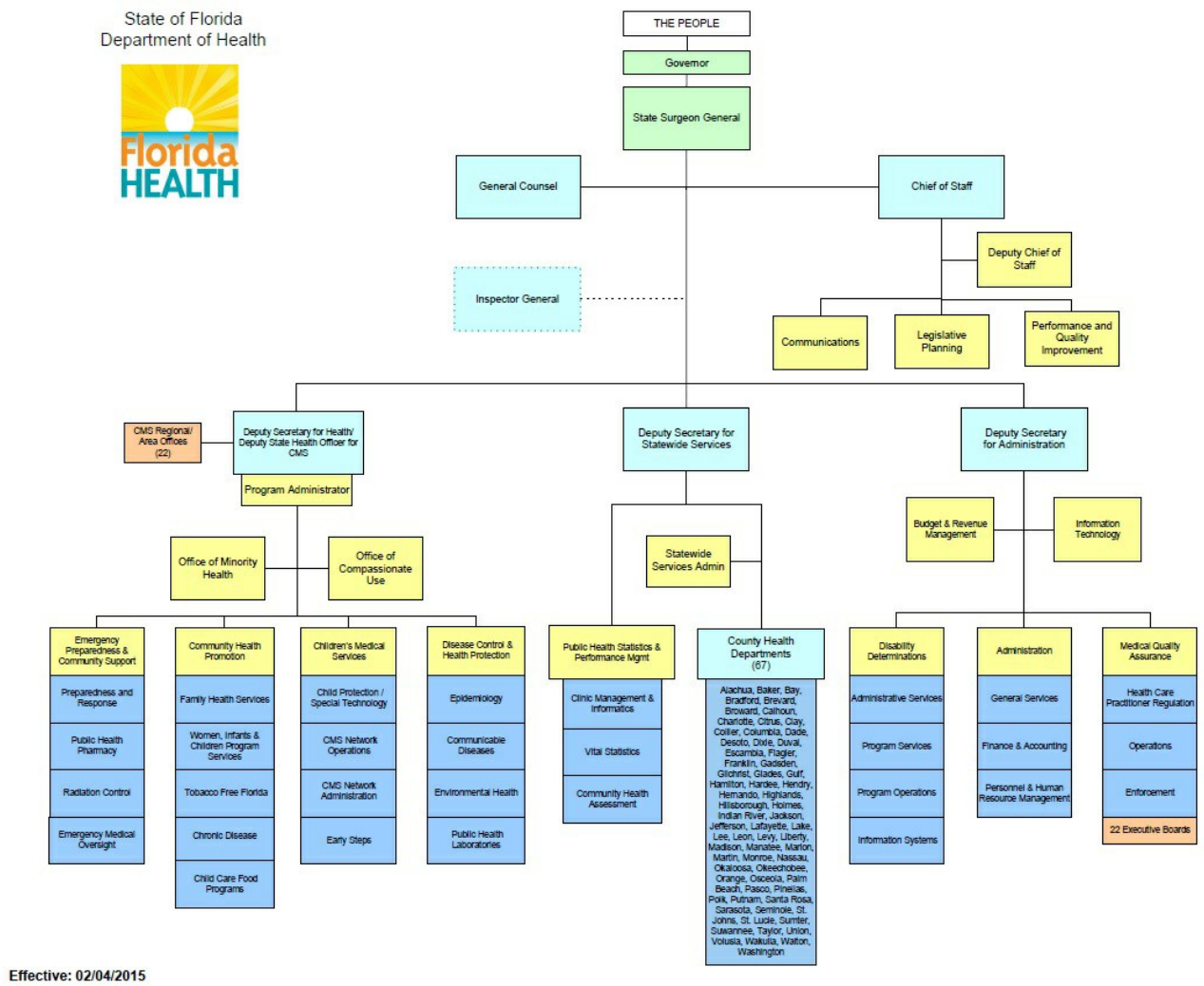
Division, which includes the Bureaus of Child Care Food Programs, Chronic Disease Prevention, Family Health Services, Tobacco Free Florida, and WIC Program Services.

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, 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 for adolescents and young adults with special health care needs to all aspects of adult life.
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 maternal and child health population, including CSHCN, while being mindful of the need to address each of the population domains, as well as, the relationship of the priorities to the national performance measures.

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

Racial disparity in infant mortality was not selected as a priority through the needs assessment process; however, the Department considers racial disparity a priority issue as black infants in Florida are more than twice as like as white infants to die in their first year of life.

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, 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 woman. 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, but similar to one from the previous five-year cycle that focused on promoting preconception health screening and education.

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

The Patient Centered Medical Home continues to be an important priority for CMS. Local CMS area offices work closely with providers who strive to provide a PCMH for its patients. CMS provides care coordination to and works closely with these providers to assist with the needs of the children enrolled in the CMS Managed Care Plan. Additionally, CMS was a part of Florida's Children's Health Insurance Reauthorization Program Act grant. CMS contracted providers for the CMS Medical Home Program participated in this project to build PCMH capacity in Florida. Now that the grant has concluded, the next five years will focus on continuing to leverage resources and build PCMH capacity throughout Florida.

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

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

efforts to establish additional partnerships will play a major role in ensuring a successful implementation of objectives and strategies related to mental health efforts.

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. 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 the local health departments to address social determinants of health. Florida's 67 local health departments are required to engage in a project that will address social determinants of health to improve the health of all. The MCH program will continue to establish further strategies and objectives in next year's application to enhance and supplement current efforts described in this year's application, which include community education activities that promote: access to care; health literacy; community engagement; and establishment of policies that positively influence social and economic conditions and support changes in individual behavior.

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

- NPM 1 - Percent of women with a past year preventive medical visit
- 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, specifically women who face significant barriers to better health, to improve preconception health. The Title V program has focused on both preconception and interconception health for a number of years, fully recognizing the importance of improving the health of all women of reproductive age to ensure better birth outcomes and healthier babies. Women's health at all ages of the lifespan is important and contributes to the well-being of Florida families as too often women are the primary caregiver for the families' children, elderly parents and other family members, spouses, or partners.

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

This measure was chosen because of the clear link to the state's priority to promote breastfeeding to ensure better health 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 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. The MCH program is significantly involved with the CoIIN, and safe sleep for infants is one of the selected priority strategies for CoIIN. The Department formed a Statewide SUID Workgroup that provides input on the state work plan to reduce sleep-related

infant deaths, and also created a logic model for conducting training efforts on Safe Sleep practices for health care providers, the Florida Hospital Association and other birthing centers, parents, caretakers, and the general public. Our Florida SSDI project has presented data on the benefits of safe sleep practices. The Title V program has assisted with the development of training for WIC staff to encourage discussion of safe sleep practices with their clients and continued training for Healthy Start and local health department staff on how to deliver SUID risk reduction education at the local level. These activities, along with data showing that safe sleep initiatives have a significant impact on reducing infant mortality, made the selection of this measure a valid choice for the Title V program.

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

This measure was chosen because of the clear link to the state's priority to promote activities to improve the health of children and adolescents 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 based on data showing that 33 percent of Florida high school students experienced some form of bullying in 2011. Bullying is defined as: attack or intimidation with the intention to cause fear, distress, or harm that is either physical (hitting, punching), verbal (name calling, teasing), or psychological/relational (rumors, social exclusion); a real or perceived imbalance of power between the bully and the victim; and repeated attacks or intimidation between the same children over time. Bullying is a serious detriment to a child's health, sense of well-being, safety, education, and emotional development, and greatly increases the risk of self-injury and suicide. Bullying is a new priority for the Title V program however, this focus can have a tremendous impact on improving health throughout the life span, by looking at adverse childhood experiences and the long-term impact and risk factors associated with many chronic diseases.

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

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

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

This measure was chosen because of the clear link to the state's priority to promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke 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 with a behavioral health condition who receive treatment consistent with their diagnosis.
- 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: Percent of children with a behavioral health condition who receive treatment consistent with their diagnosis

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. 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.

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 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

State Action Plan Table

State Action Plan Table - Women/Maternal Health - Entry 1

Priority Need

Improve access to health care for women, specifically women who face significant barriers to better health, to improve preconception 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 inter-conception 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. 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 healthcare providers • pediatric providers • community health centers • federally qualified health centers • managed care plans

3d. 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

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

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

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	68	69	70	71	72	73

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	67.7 %	1.6 %	2,205,303	3,257,052
2013	64.6 %	1.4 %	2,093,161	3,240,620
2012	67.4 %	2.0 %	2,184,556	3,241,114
2011	62.0 %	1.6 %	1,923,190	3,101,087
2010	57.9 %	1.5 %	1,477,625	2,553,334
2009	67.5 %	2.0 %	2,131,020	3,157,714

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	69,000.0	70,000.0	71,000.0	72,000.0	73,000.0

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, 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. Florida has identified a number of objectives and strategies to improve the health of women.

In the coming year, the Department will continue using Title V funding to make available interconception care (ICC) through the Healthy Start program, which is not reimbursable by Medicaid. 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 a poor birth outcome. Services should be offered in a cultural and linguistically appropriate manner.

As a result of ongoing discussions with Florida's Agency for Health Care Administration (AHCA), Florida Medicaid will be offering reimbursement for immediate postpartum insertion of long-acting reversible contraceptives (LARCs), in addition to but separate from labor and delivery reimbursement. 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. Through Title V funding and a partnership between the Department, AHCA, and the Florida Perinatal Quality Collaborative, a hospital-based quality improvement initiative will be implemented to smooth the transition for facilities and providers. Before statewide rollout of the initiative, a pilot project will be launched and evaluated in order to provide best practices for the state.

The 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 outcome.

Services include:

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

The Department is collaborating with the Florida Association of Healthy Start Coalitions to continue to adopt 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 has data systems (the Health Management System and the Well Family System) in place that enable the program to track the time and number of services provided to a participant for data collection purposes.

The Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) curriculum, an evidence-based program for smoking cessation, has been implemented into the Healthy Start program and coding specifications for smoking cessation have been revised to measure SCRIPT implementation. A quality improvement pilot project will continue to address training needs of SCRIPT implementers.

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, in order 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 the Text4baby and Healthiest Weight campaigns throughout the state, and the addition of a safe sleep campaign 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 Florida Perinatal Quality Collaborative (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.
- Contract with the Florida Association of Healthy Start Coalitions to implement a statewide training program on perinatal depression, child development services and other evidence-based interventions.

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

A recurring recommendation from the PAMR team is to stress the importance of a woman receiving education 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 2013, the pregnancy-related mortality ratio for non-Hispanic black women was significantly higher than non-Hispanic white and Hispanic women.

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

In response to issues brought up 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.

Another strategy is the MCH Section will 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. (Strength of Recommendation: C, based on consensus, disease-oriented evidence, usual practice, expert opinion, or case series.)" (Narasimhan, 2013). Low income populations have access to unlimited text messaging through government phone assistance programs making this mode of communication very accessible.
Narasimhan, K. (2013). Text message appointment reminders. *American Family Physician*, 88(1), 20-21.

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

Notable Health Outcomes:

Overall, infant mortality has decreased from a rate of 7.5 per 1,000 live births in 2003 to 6.0 per 1,000 live births in 2014. Black infant mortality has decreased from a rate of 13.7 per 1,000 live births in 2003 to 11.0 per 1,000 live births in 2014.

Areas of Need/Improvement:

Racial disparities continue to exist in rates of infant mortality, with black infants being 2.3 times more likely to die within the first year of life than white infants in 2014. Continued work is needed to address the black/white disparity in infant mortality.

Women/Maternal Health - Annual Report

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

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

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

The Department submitted an application and received funding from the AMCHP Every Mother Initiative. The Department along with its partner, ReachUp, Inc. (a Federal Healthy Start program and a not-for-profit organization whose mission is to advocate for and mobilize resources to help communities achieve equality in healthcare and positive health for families), implemented a community driven program to emphasize the development of community capacity and community connections as the means to producing better health outcomes. The emphasis was on local leadership development, promotion of collaborations, strengthening the capacity of community based organizations, and strengthening of social capital. The project used community based approaches to health disparities that aligned with the literature on neighborhood or area effects on health.

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

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

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

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

Perinatal/Infant Health

State Action Plan Table

State Action Plan Table - 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-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

1a. Develop a work plan to encourage hospitals to establish policies and protocols in support of breastfeeding and becoming a Baby-Friendly hospital or becoming a Florida Breastfeeding Coalition's Quest for Quality Maternity Care Award recipient.

1b. Ensure Healthy Start contracts include requirements to engage hospitals to become Baby-Friendly.

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. Standardize Healthy Start breastfeeding curriculum across the state.

3c. 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

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

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 - 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 (SUID).

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

Strategies

1a. Conduct a survey to be sent to pediatricians, family practice physicians, pediatric nurse practitioners, and birthing hospitals practicing and/or located in Florida.

1b. Participate on the DCF work group to create a Safe Sleep Course for child care centers to be used with all child care centers in Florida.

1c. Pilot a Safe Sleep Certification model in birthing hospitals located in Florida.

2. Convene and facilitate a statewide SUID work group.

3. Inventory and evaluate safe sleep activities currently implemented statewide.

ESMs

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

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

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	81.3	82.3	83.2	84.0	84.7	85.3

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	81.6 %	3.5 %	162,064	198,524
2011	77.0 %	3.6 %		
2010	72.5 %	3.8 %		
2009	76.5 %	2.8 %		
2008	76.6 %	2.8 %		
2007	74.4 %	2.6 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

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

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

Annual Objectives

	2016	2017	2018	2019	2020	2021
Annual Objective	27.7	29.4	31.1	32.8	34.5	36.2

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2012	22.3 %	3.7 %	42,582	191,068
2011	18.3 %	3.0 %		
2010	15.6 %	3.2 %		
2009	15.9 %	2.2 %		
2008	13.0 %	2.0 %		
2007	10.1 %	1.6 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

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

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

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

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

Annual Objectives						
	2016	**2017**	**2018**	**2019**	**2020**	**2021**
Annual Objective	78.3	80	81.6	83.1	84.5	85.8

FAD not available for this measure.

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

Annual Objectives					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	5.0	15.0	20.0	25.0	30.0

Perinatal/Infant Health - Plan for the Application Year

There are two state priorities within the Perinatal/Infant Health Domain. One is to promote breastfeeding to ensure better health for infants and children and reduce low food security. The national performance measure selected for this priority is NPM 4: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months. The second state priority within this domain is 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. The national performance measure selected for this priority is NPM 5: Percent of infants placed to sleep on their backs.

The Department has developed a number of objectives and strategies to increase the number of breastfed infants as well as the duration they are fed breast milk. Breastfeeding promotion strategies will be incorporated into several initiatives through various community settings such as hospitals and childcare facilities. This will be accomplished by cultivating the relationship between the local health departments and their unique communities. Local health departments, with support from Title V, will encourage and support hospitals in pursuing Baby-Friendly policies and practices.

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. The Department will continue public awareness efforts through a partnership with the Ounce of Prevention as part of the Healthiest Weight Initiative. These strategies will serve as an example to local health departments as well as public and private partners.

In the coming year, enhancing access to breastfeeding support will be a focus of MCH by engaging Florida's Healthy Start programs and clients. The Department will encourage improved access to breastfeeding support in the community for Healthy Start clients who are not eligible for WIC. A broader approach to improving the quality of breastfeeding education provided to Healthy Start clients will be initiated by standardizing the Healthy Start breastfeeding curriculum across the state. It is essential to provide an evidence-based and 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.

The Department will continue efforts to target the most vulnerable infants in our state by aiming to increase the number of very low birth weight (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 neonatal intensive care units (NICUs). This initiative will be expanded through additional funding to allow for targeted breastfeeding education to participating NICU health care providers in order to compensate for a scarcity of lactation specialists. This will enhance the breastfeeding support provided to vulnerable families through this initiative.

New evidence-based models to promote infant sleep behaviors and to support safe conditions are being pursued by the Department. MCH will focus on health care providers' knowledge and resources regarding safe sleep education provided to their patients. An assessment of provider knowledge will take place to determine barriers or knowledge deficits and to guide targeted provider education and resource development. Florida will also continue the Sudden Unexpected Infant Death (SUID) Workgroup as detailed in the following annual report. MCH continues to participate in the Safe Sleep Learning Collaborative CoIIN. Participation include includes collaboration with local health departments and community partners in tailoring projects specific to the needs of the community.

Perinatal/Infant Health - Annual Report

The Department has pursued 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 local health departments partner to provide needed services to all participating pregnant women including prenatal care, support

services, and breastfeeding education and support. Services provided to pregnant women encourage breastfeeding in the early postpartum period and provide anticipatory guidance and support in order to prevent breastfeeding problems and to address barriers to breastfeeding. Breastfeeding education and services provided to postpartum women promote the continuation and exclusivity of breastfeeding and enable women to overcome any perceived or actual breastfeeding problems.

The Department participates in the national Infant Mortality Collaborative Improvement and Innovation Network (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. Florida chose the Sarasota Safe Sleep Initiative as the pilot project for the Safe Sleep CoIIN. This initiative is working on training all child care centers in Sarasota County on safe sleep practices. Data collected from the Sarasota Safe Sleep Initiative is being shared with the CoIIN. Florida is also engaging community partners in statewide Safe Sleep CoIIN calls to share safe sleep efforts that are occurring across the state. Additionally, the Department has opened all CoIIN activities to any interested partners to participate on a national level. This has greatly engaged our partner's desire to participation and to be a part of a national effort.

The Department continues to facilitate a Statewide Sudden Unexpected Infant Death (SUID) Workgroup. The purpose of the workgroup is to create a coordinated, integrated system of policies and practices and align Title V activities with the CoIIN and the Department's State Health Improvement Plan objectives. The workgroup is assisting 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. The workgroup assisted with the development of a survey to determine provider knowledge and beliefs of safe sleep practices and safe sleep environments.

Through the Department's Florida Healthy Babies Initiative to reduce infant mortality statewide, local health departments were required to complete a data assessment that includes an examination of social determinants of health, primary causes of infant death, and an environmental scan of local initiatives that address safe sleep, breastfeeding, and protective factors. Communities are required to publicize the data and develop an action plan that incorporates the findings.

The Department is monitoring Florida's Maternal, Infant and Early Childhood Home Visiting (MIECHV) programs' activities related to breastfeeding and safe sleep. Florida's MIECHV is participating in the 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.

In October 2015, MCH partnered with the Florida Perinatal Quality Collaborative to develop and implement a breastfeeding initiative, the Mother's Own Milk (MOM) Initiative, in Florida's Neonatal Intensive Care Units (NICUs). It is a hospital-based quality improvement initiative designed to promote best practices related to providing breast milk especially to Florida's most vulnerable very low birth weight (VLBW) infants. Through the promotion of evidence-based practices and process improvements, volunteering hospitals aim to increase the number of infants receiving breast milk therefore improving neonatal outcomes. Hospitals participate on a voluntary basis. Efforts are being made towards recruitment with the intention to include all Florida Level II and Level III NICUs.

With Title V funding, the Florida's Healthy Babies Initiative included activities connecting local health departments with hospitals in their journey to Baby Friendly status. The Baby Steps to Baby Friendly project engages local health departments to assist hospitals in a self-assessment and drafting of a work-plan to take steps towards Baby Friendly Designation. The Department's priority initiative, the Healthiest Weight Initiative, through the Preventive Services block grant is promoting and supporting Baby Steps to Baby friendly for participating hospitals as well.

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. Florida's Medicaid is in the process of including coverage of electric breast pumps before the end of fiscal year (2015-2016) demonstrating a commitment to promote the best nutrition and the

best start for Florida's babies.

MCH Epi 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.

The Florida Pregnancy Risk Assessment Monitoring System (PRAMS) report *Prevalence of Breastfeeding among Florida Women, 2011* shows that the prevalence of breastfeeding among Florida women is higher, at 83.4 percent, than the Healthy People 2020 goal of 81.9 percent. However, duration drops quickly to 67.6 percent at 4+ weeks and to 46.7 percent at 12+ weeks. This survey is a valuable tool for recognizing trends and identifying a focus for breastfeeding promotion efforts.

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 safe sleep environment checklist was completed with each crib recipient.

The Department, DCF, and other Florida government agencies, state officials, non-profit organizations and first responders came together to launch the Safe Sleep Campaign. The campaign included public outreach as well as free online training and materials for Florida's first responders in an effort to promote safe sleep practices during routine calls and interactions with the public. The continuing campaign also encourages the public to donate new pack'n plays (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 SUID workgroup reviews and provides input on the state work plan, advises on prioritization of plan objectives and outcomes, and assists with implementation of the state work plan strategies.

The Department participated on a DCF led work group to create a Safe Sleep Course by offering changes based on the American Academy of Pediatrics recommendations. The Safe Sleep Course is designed to provide training to child care providers in an online format.

According to the American Academy of Pediatrics' Policy Statement, SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment from the Pediatrics journal Volume 128, Number 5, November 2011, the AAP recommends that all physicians, nurses, and other health care professionals should receive education on safe infant sleep and all child care providers should receive education on safe infant sleep and implement safe sleep practices.

Child Health

State Action Plan Table

State Action Plan Table - 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. Ensure that county school health staff are screening students for hearing, vision, scoliosis and growth and development with BMI.

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

3. Provide health services to Florida's pre-kindergarten through 12th grade public school students as mandated by Sections 381.0056, 381.0057, and 402.3026, Florida Statutes.

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

Strategies

1a. Monitor and assess county screening performance to ensure that 95% of students in the required grade levels are screened.

1b. Ensure that students with abnormal results are referred for follow-up medical care.

1c. Assess whether school health staff are providing screening referral follow-up and case management in areas of low referral resources or healthcare provider shortage areas.

2a. Promote the implementation of proven model programs for the reduction of childhood obesity.

2b. Promote the use of the Healthy Lifestyle Intervention Individualized Healthcare Plan template.

2c. Ensure that county staff collect and enter Healthy Lifestyle Intervention data in the Department of Health's Health Management System.

3a. The Department’s School Health Program will allocate funding for school health services, conduct on-site monitoring, and provide technical assistance.

3b. County school health programs will implement school health services according to sections 381.0056, 381.0057, and 402.3026, Florida Statutes, best-practice guidelines, programs standards and their county’s biennial school health services plan.

4a. Support the Coordinated School Health Partnership, the Healthy District Collaborative, and the Interagency Collaborative.

4b.Establish and maintain a CSPAP registration system or maintain partnership 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.

4c. Maintain CSPAP resources on the Department's website.

4d. Carry out a marketing plan to promote CSPAP and the Healthier U.S. Schools Challenge to superintendents, principals, PE teachers, nurses, community based organizations (YMCA / Parks and Rec/ Boys and Girls Clubs), and local health offices.

ESMs

ESM 8.1 - The number of county School Health Programs who are utilizing the evidence-based program for the reduction of childhood obesity

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 - 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 children under age 21 receiving a preventive dental service.

Strategies

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

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

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

1d. Increase children participation 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 - 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.

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 (Child Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	42.7	43.3	43.8	44.3	44.7	45.1

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	40.7 %	2.9 %	521,434	1,282,761
2007	43.3 %	3.8 %	557,105	1,288,248
2003	34.4 %	2.4 %	436,607	1,270,940

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

ESM 8.1 - The number of county School Health Programs who are utilizing the evidence-based program for the reduction of childhood obesity

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	7.0	14.0	21.0	28.0	35.0

Child Health - Plan for the Application Year

The School Health Program will provide services to all children in Florida's public schools. Local 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, and health services are provided 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 central office School Health Program will provide oversight and technical assistance to all local health departments, local education agencies, and community partners relative to statutes and rules that affect the provision of school health services, best practices, and program standards. Collaboration in regard to school health and wellness extends from the state to the local level. During the coming year, the School Health Program will perform 37 onsite program monitoring visits, two contract monitoring visits, and will host six statewide technical assistance conference calls. The central office School Health Program and other staff from the Bureau of Chronic Disease Prevention will promote and provide technical assistance related to increasing physical activity before, during, and after school.

School health programs in all 67 counties will screen children for vision, hearing, scoliosis, and growth and development with body mass index (BMI). As part of the central office School Health Program's effort to reduce the number of students whose results are in the obese range, county school health programs will partner with the Department's Healthiest Weight Florida partners to provide schools with linkages to Farm to School and Fresh from Florida Programs, guidance on 5-2-1-0 and similar proven programs, walking school bus programs, community

gardens, and other wellness programs as locally appropriate.

The central office School Health Program will continue to manage the two state funded vision contracts – Florida Heiken Children's Vision Program and Florida's Vision Quest. These programs make available to eligible (uninsured) public school students in grades pre-kindergarten through 12 who have failed school-based vision screening and are in need of comprehensive vision exams and possible corrective lenses. The total allocation for these two contracts is $2 million. The School Health Program will encourage local county health department and school district school health staff to utilize these providers for follow-up exams and eyeglasses for students in their school districts.

The recently updated Emergency Guidelines for Schools, 2016 Florida Edition, will be printed and distributed to county school health programs. These guidelines provide easy-to-follow algorithms for laypersons to respond to the health care needs of students in emergency situations. The printable file will be made available on the School Health Program website.

The School Health Administrative Guidelines, 2012 version is currently being updated. This is a collaborative process involving the Department, the Florida Department of Education (DOE), and county school health coordinators from county health departments and school districts. These guidelines provide policy guidance, program standards and references for the administration and implementation of school health services programs in Florida. The updated guidelines will be made available on the School Health Program website.

It is anticipated that community partners throughout the state will continue to contribute to the provision of health care to students in the school setting. The Blue Foundation, Central Florida Family Health Center, Children's Services Councils, Citizens' Commission for Children, County Commissions, Early Learning Coalitions, Health Care Taxing Districts (Broward, Palm Beach), Miami Children's Hospital, Nemours, Orlando Health, Rosen, Inc., St. Vincent's Foundation, The Children's Trust (Miami-Dade), United Way, University of Miami, Winter Park Health Foundation, and Naples Community Hospital Healthcare System represent the major partners, but there are many other community partners that contribute to the success of local school health programs.

The central office School Health Program will continue to work in partnership with the Florida School Health Association (FSHA) and the Florida Association of School Nurses (FASN) and provide school health program updates at their annual conferences. Additionally, the School Health Program will continue to provide annual data for the National Association of School Nurses' (NASN) initiative, Stand Up and Be Counted, to collect state-level data for a national standardized minimum dataset of key school health indicators, including those related to physical activity.

The Department and the 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 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 guide 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 ten 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.

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

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

Challenges:

- Florida's school nurse to student ratio is 1 to 2,197. The school nurse to student ratio recommended by the American Academy of Pediatrics, NASN, and the U.S. Department of Health and Human Services is 1 to 750. For many students, the school nurse is the only form of healthcare they receive.
- Since 2010, reported chronic and complex conditions in students have increased 29.6 percent (from 562,085 to 728,335).
- Florida has districts with high populations of students from migrant farmworker families who are difficult to track and ensure immunization compliance.
- Recent increases in the emigration of families with children from the Caribbean and South America are challenging Florida's school districts' ability to accommodate the high level of need for health and social services that these children present.
- 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 FQHCs, is making it more difficult to refer students for follow-up health care services in rural areas and healthcare provider shortage areas. This especially impacts mental health, oral health, and primary care services.
- The focus on academics and test preparation sometimes makes it difficult to prioritize physical activity for children.

As part of the objectives of the MCH Program, the Public Health Dental Program (PHDP) will collaborate with other state agencies and not-for-profit organizations to plan and implement programs to benefit the needs of children and families. The PHDP plans to collaborate with AHCA to develop oral health literacy campaigns to increase the number of children who receive dental services through higher utilization of Medicaid and CHIP programs. The PHDP also plans to participate 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 the 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.

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 (S-BSP) service delivery. Working with county health department dental programs, FQHCs, and local oral health coalitions across the state, preventive services are provided to low income children in Title I Schools. Providing services to the 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 improving dental outcomes for children in the state. Plans to promote the availability of existing services, improve existing school-based program efficiencies, and increase the number of children served through these programs will take place in the coming year. 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 served through these programs.

As part of the plan to increase the percentage of parents who read to their young child, the MCH Section will partner with local health departments in their childhood immunization and dental clinics to encourage reading using the Reach Out and Read model. Reach Out and Read is an evidence-based early literacy intervention model that encourages literacy and school readiness. 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.

The Reach Out and Read program builds on the unique relationship between parents and medical providers to develop critical early reading skills in children, beginning in infancy. As recommended by the American Academy of Pediatrics, Reach Out and Read 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.

As a result of 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 central office 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 have 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. During the 2014-2015 school year, there was a 4.34 percent increase in reported services compared to the 2013-2014 school year, and a 13.36 percent increase over the past five years.

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, three contract monitoring visits, and hosted six statewide technical assistance conference calls.

School health programs in all 67 counties screened 803,192 children for vision, 586,874 for hearing, 169,684 for scoliosis, and 557,540 for growth and development (BMI-weight and height for age and gender). As of the 2014-15 school year, 18.4 percent of Florida's first, third and six grade students were found to be in the obese range as defined by CDC clinical growth charts, compared to 19.1 percent in 2013-2014.

The School Health Program continued to manage the two state-funded vision contracts – Florida Heiken Children's Vision Program and Florida's Vision Quest – totaling $1.75 million. During 2014-2015, 71,469 students were referred to these two providers. Florida's Vision Quest provided 6,080 comprehensive eye exams resulting in the provision of 5,321 pairs of free eyeglasses to Florida students. During this same contract period, Florida Heiken Children's Vision Program provided 4,005 comprehensive eye exams resulting in the provision of 3,742 pairs of free eyeglasses.

The school district and county health department school nurses continued to collaborate with the DOH Immunization Program to provide vaccinations required for school entry and attendance. This is accomplished through immunizations given at county health departments, school-based vaccination clinics, and referral to community-based health providers. Vaccines are made available through the Centers for Disease Control and Prevention's Vaccines for Children Program.

In 2014-2015, in collaboration with DOE, DOH released Nursing Guidelines for the Care and Delegation of Care for Students with Diabetes in Florida Schools - (2015). These guidelines incorporated feedback from the public and private sector medical community and school health coordinators from county health departments and school districts.

Community partners contributed to school health services through the provision of both funding and clinical staff in schools. Community partner funding for school health services totaled $35,373,165 in 2014-2015.

The central office School Health Program worked in partnership with the FSHA and the FASN and provided school health program updates at their annual conferences. The School Health Program provided 2014-2015 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.

Adolescent Health

State Action Plan Table

State Action Plan Table - 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 relative 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

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

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

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	20.2	19.9	19.6	19.3	19	18.7

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	10.1 %	1.9 %	138,029	1,370,209
2007	17.8 %	3.1 %	246,089	1,385,335

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: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	21.1 %	0.6 %	168,274	798,216
2011	20.2 %	0.6 %	158,477	784,047

Legends:

Indicator has an unweighted denominator <100 and is not reportable

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

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

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

Adolescent Health - Plan for the Application Year

The Adolescent Health Program, located in the Adolescent and Reproductive Health Section, continues to work to increase the percentage of youth making positive and healthy choices with the intention of improving the health of adolescents and young adults by decreasing the percentage of youth engaging in risky behaviors that lead to teen pregnancy, sexually transmitted diseases, substance abuse and violence. The Adolescent Health Program continues with one initiative that began in 2010, the Sexual Risk Avoidance Program.

The Title V State Abstinence Education Grant, from the Administration of Children and Families, provides $3,772,364 per year to fund local health departments and community based organizations. The funded providers use evidence-based and effective abstinence education curriculums including Choosing the Best, Making A Difference, Promoting Health Among Teens, Real Essentials, and Heritage Keepers to deliver the program. The curriculums 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. Monitoring of all providers is performed to evaluate and ensure fidelity to the curriculums. The monitoring, conducted by program contract managers, includes classroom observation of the instructor providing education classes to assess adherence to the curriculum. In the 2014-2015 grant year, the Sexual Risk Avoidance Program was successfully delivered to 11,250 youth and to 2,465 parents and guardians.

The Adolescent Health Program's current initiative, the Sexual Risk Avoidance Program, completed the fifth year of five years of funding in early fall of 2015. The Sexual Risk Avoidance Program currently has 14 providers, 10 local health departments and four community based providers in middle school, high school, and community settings. A new grant cycle began in October 2015 and will 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 Adolescent Health Program 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.

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

The state priority identified for the Adolescent Health Domain is 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. NPM 9 was selected for this priority: Percent of adolescents, ages 12-17, who are bullied or who bully others.

Bullying is a serious detriment to a child's health, sense of well-being, safety, education, and emotional development, and greatly increases the risk of self-injury and suicide. In 2015, data show that 228,200 Florida public high school students (30 percent) experienced some form of bullying. Bullying is defined as an attack or intimidation with the intention to cause fear, distress, or harm that is either physical (hitting, punching), verbal (name calling, teasing), or psychological/relational (rumors, social exclusion); a real or perceived imbalance of power between the bully and the victim; and repeated attacks or intimidation between the same children over time. Data from the 2015 Youth Risk

Behavior Survey (YRBS) indicate that a significantly higher number of students experiencing bullying described their grades as D's and F's in school during the past 12 months. The number of ninth grade students reporting being bullied is significantly higher than for students in 10th, 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. From 2009 to 2015, the number of high school students who were bullied at school increased by 12 percent.

Programs and Initiatives:

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

The 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 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 in order to measurably reduce the perpetration of power-based personal violence, a cultural shift is necessary. 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.

Adolescent Health - Annual Report

The Adolescent Health Program continues work to increase the percentage of youth making positive and healthy choices with the intention of improving the health of adolescents and young adults by decreasing the percentage of youth engaging in risky behaviors that lead to teen pregnancy, sexually transmitted diseases, substance abuse, and violence. The Adolescent Health Program continues with two initiatives that began in 2010, the Sexual Risk Avoidance Program and the Teen Pregnancy Prevention Program.

The Adolescent Health Program's initiatives, the Abstinence Education Program and the Teen Pregnancy Prevention Program, completed their fifth year of five years of funding in early fall, 2015. 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. The Teen Pregnancy Prevention Project facilitated the evidence-based Teen Outreach Program in high schools in 23 counties in Florida. The Teen Pregnancy Prevention Project was not funded beyond October, 2015.

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 abstinence 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, positive attitudes and reduce risk-taking behaviors. All classes were delivered in school or community-based settings. Monitoring of all providers was carried out to evaluate and ensure fidelity to the curriculum. The monitoring, conducted by program contract managers, included classroom observation of the instructor providing education classes to assess adherence to the curriculum. The Sexual Risk Avoidance Program was successfully delivered to 10,125 youth and to 2,154 parents and guardians.

Children with Special Health Care Needs

State Action Plan Table

State Action Plan Table - 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.

2a. 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.

2b. 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. • 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 to provide care coordination support to CMS-credentialed primary care providers who have CMS Managed Care Plan-enrolled children assigned to them as a standard resource to achieving a higher level of medical homeness. Care coordination includes but is not limited to: • Family needs assessment • Proactive care plan development • Facilitating care transitions • Education, support and coaching to families on disease-specific and general wellness topics • Coordination and tracking of referrals and test results • Use of health information technology to deliver and monitor care coordination and effectiveness of service delivery

3c. CMS will create an infrastructure to provide leadership in promoting and sustaining medical home for CSHCN, including: • Improving access to pediatric providers who identify with some level of medical homeness. • Sustaining and improving those providers who wish to move to higher levels of medical homeness.

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

ESMs

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

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 - Children with Special Health Care Needs - Entry 2

Priority Need

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

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 IEPs.

3. Youth with and without special health care needs and their families will receive transition-specific, age-appropriate education related to the following aspects of their lives:• Work• Health care• Self-determination and self-management ability (power of attorney/guardianship)• Secondary and post-secondary education

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

5. CMS implements a transition program within the CMS organizational structure that includes specific programmatic outcomes related to quality improvement, measurable performance expectations, maintaining a transition registry, and ensuring provider adequacy.

ESMs

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

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 - 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 with a behavioral health condition who receive treatment consistent with their diagnosis.

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, ASD (Autism Spectrum Disorder) diagnosis and intervention, and others 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 the behavioral health care needs including infant mental health and 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 supports and services to culturally and linguistically diverse individuals that are at risk for or have an ASD.

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	52	53	54	55	56	57

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	45.7 %	3.9 %	343,845	751,777
2007	53.4 %	5.3 %	401,026	751,486

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: National Survey of Children's Health (NSCH) - NONCSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	51.5 %	1.9 %	1,568,017	3,043,085
2007	57.6 %	2.5 %	1,767,248	3,068,966

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

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

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

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	42	44	46	48	50	52

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	37.0 %	3.4 %	89,064	240,468
2005_2006	33.8 %	3.2 %	68,907	203,864

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

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

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

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, as outlined by one of the current models. Medical homeness refers to the degree to which a provider or practice aligns themselves with the medical home principles. CMS has created an internal workgroup that is focusing on the strategies and activities to enhance medical home participation in Florida. This workgroup will expand in 2016 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.

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 SHCN 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. In 2016, CMS will provide educational materials and education opportunities to providers through electronic and in-person communications.

Children's Medical Services 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 ensure that CMS-credentialed primary care providers identify with a level of medical homeness. CMS will provide care coordination support to these providers, and CMS will create an infrastructure to provide leadership in promoting and sustaining medical home for CSHCN. In 2016, CMS will create a Stakeholder Workgroup to seek understanding of the education and training needs of providers in medical home, including assessing barriers in incorporating the PCMH principles into practice. 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 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 engage the Stakeholder Workgroup to identify steps necessary to assist the CMS Plan in matching enrollees with providers based on acuity-scores where applicable.

CMS is preparing to form eight Regional Title V Registered Nursing Consultant positions. The consultants will survey staff and providers (primary and specialty) to identify education and training needs related to medical home and transition; 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 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 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 healthcare 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 will also be updating the anticipatory guidance information available to care coordinators and families. An additional activity that will address this objective will be the development 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 2016, CMS will identify transition navigators. 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.

The CMS Plan is working towards increasing the number of CMS Plan enrollees with a behavioral health condition who receive behavioral health treatment by collaborating with Concordia Behavioral Health to manage benefits to include 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.

In the coming year, an integrated Behavioral Health Task Force will be formed with the purpose and goal to work with CMS to collect data on top diagnosis, 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. CMS has care coordinators to manage the special needs of the CMS enrollee SIPP population. The care coordination performance measure strategies and quality improvement program have been revised to incorporate behavioral health measures.

Children's Medical Services is preparing to form a Behavioral Health Consultant position. The consultant will survey staff and providers (primary and specialty) to identify training needs; create a behavioral health policy for required annual CMS staff training on behavioral health issues and recommend provider training; and 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.

2015 Efforts

Children's Medical Services (CMS) is a specialty plan option through the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance Program. April 2016 enrollment is over 51,000 children. CMS also continues to be a choice through Florida KidCare. April 2016 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). The 2014 and 2015 reports reflect CMS member satisfaction and highlights several measures that the plan performed well on, including customer service and children and adolescents accessing primary care providers. While CMS has always strived to meet and exceed national benchmarks related to customer service and quality health care delivery, the CMS Plan will be completing and implementing a new care coordination curriculum with 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, subsequently impacting the Plan's HEDIS and CAHPS measures.

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 2015, they began working on a training module for educators. All CMS staff complete these modules as part of their orientation training. Additionally, FloridaHATS continued to have oversight and direction of the healthcare 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.

CMS transitioned from 11 Primary Care/ Medical Home programs to two. This has resulted in several CMS area offices aligning care coordinator caseloads based on the child's primary care provider. The provider response has been largely positive, as they are able to establish a working relationship with one care coordinator rather than potentially a dozen or more. This has improved care coordinator/ provider relationships in some areas, improving communications and loop closures, and assists in timely information being shared. The CMS Plan is working with staff and providers to continue improving our information sharing to ultimately impact the health outcomes for the children we serve.

The CMS Plan has a governing body that meets quarterly. The governing body oversees and reviews the Plan's various committees, projects, reports, and policies. In 2015, the CMS Plan established a technical advisory panel. The panel has representatives from various CMS stakeholders and includes internal and external partners. The panel also has a family representative, which ensures that the voices of the children and families we serve are considered during meeting topics.

In 2015, CMS created a medical home workgroup with plans to expand the workgroup to include external stakeholders in 2016. The medical home workgroup will build off of the Children's Health Insurance Reauthorization Program Act grant to continue to identify and evaluate strategies related to medical home implementation and other medical home initiatives.

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 began working with an epidemiologist to analyze the impact of social determinates of health on child deaths. This analysis will inform our prevention strategies for our state and local Child Abuse Death Review committees.

Children's Medical Services has been focusing 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). In Florida, the IDEA Part C program is known as Early Steps. Florida's Early Steps program is administered throughout the state in 15 geographic regions through contracts with

14 organizations. These contractors, referred to as Local Early Steps programs, provide direct early intervention services for eligible infants and toddlers and their families by working with internal and community service providers and other community resources. Early Steps conducted a root cause analysis, identified systemic issues and developed objectives to focus on strategies and activities that will ultimately improve social and emotional development of infants and toddlers served through the Early Steps Program. Phase I activities included: developing policies and procedures that improve the capacity of Early Steps to appropriately identify and support social/emotional development for infants and toddlers; establishing a training and professional development system to support evidence-based practices related to social/emotional development; align state and local initiatives to improve practices of the early intervention workforce to support social/emotional development of children served; ensuring providers have the information on the social/emotional development of a child through screening, evaluation, and assessment to determine supports and interventions needed; developing Individualized Family Support Plans (IFSP) that include functional outcomes that address social/emotional development when identified through screening and assessment and/or as a family priority through screening, evaluation, and assessment; supporting selected demonstration sites in developing and implementing a coaching structure to sustain the Local Early Steps' efforts; ensuring that families have the capacity to access resources to promote the social/emotional development of their children; and conducting a review of program costs, projected revenues and expenditures, and estimated needs to identify resources.

During Phase II, the program focused on professional development to ensure early intervention providers have the support needed to understand and implement evidence-based practices. As a result, early intervention providers and families will be better equipped to develop more effective IFSPs and to address the family's priorities related the social/emotional developmental needs of infants and toddlers.

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).

Cross-Cutting/Life Course

State Action Plan Table

State Action Plan Table - 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. Implementing the Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) program for Healthy Start and other home visiting programs for pregnant women.

2a. Rewrite the Healthy Start Standards and Guidelines to clearly define SCRIPT as the approved, evidence-based intervention for smoking cessation services during pregnancy.

2b. Ensure each Healthy Start 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 healthcare providers who utilize preconception health screening tools and resources to identify smokers.

5. Implement a statewide public awareness campaign on the dangers of secondhand smoke on children and families.

ESMs

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

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

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	6.5	6.4	6.3	6.2	6.1	6.0

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.5 %	0.1 %	14,064	218,111
2013	6.6 %	0.1 %	14,145	214,708
2012	6.7 %	0.1 %	14,129	212,481
2011	6.7 %	0.1 %	14,226	212,674

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

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

Annual Objectives

	2016	2017	2018	2019	2020	2021
Annual Objective	22.5	22.0	21.5	21.0	20.5	20.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	24.6 %	1.5 %	967,635	3,932,309
2007	26.1 %	2.0 %	1,045,136	4,008,805
2003	30.0 %	1.3 %	1,017,719	3,390,890

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

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

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

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

As the performance measure for the Cross-Cutting/Life Course Domain, Florida chose NPM 14: A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes. Smoking during pregnancy increases the risk of miscarriage and certain birth defects such as cleft lip or cleft palate. It can also cause premature birth and low birth weight and is a risk factor for SIDS. Second hand smoke exposure actually doubles an infant's risk of SIDS and increases a child's risk of respiratory infections and common ear infections. Children with asthma who are exposed to second hand smoke are likely to experience more frequent and more severe attacks, which can put their lives in danger.

The Maternal and Child Health Section continues to promote Tobacco Free Florida's 3 Free Ways To Quit – call, click, or come in. The Florida Quitline is available 24 hours a day, seven days a week, offering telephone counseling in English and Spanish, and other languages through a translation service. Pregnant tobacco users who are ready to quit receive expanded services including 10 counseling sessions, and with a medical release 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. In its second year of operation, WebCoach served 18,890 users.

If callers prefer an in-person option, they are referred to one of the Area Health Education Centers (AHEC), which provides free cessation services in a group environment. The Area Health Education Centers (AHEC) saw a record setting 16,978 Floridians through their single and multi-session in person program provided in a group environment. Additionally, AHECs train health care practitioners and students to identify tobacco users and refer them for treatment each time they are seen in a clinical setting.

Florida implemented the nation's first statewide e-referral through the electronic health record to the Florida Quitline through the county health departments. During FY 2014-2015 9,735 people were referred for tobacco cessation services.

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

Local 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.

The MCH staff continue to promote Text4baby on statewide calls with partners that provide MCH services.

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 Maternal, Infant and Early Childhood Home Visiting Program (MIECHV), the Bureau of Tobacco Free Florida, and the MCH Title V program to plan for the statewide implementation of the Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) curriculum. SCRIPT is an evidence-based program shown to be effective in helping thousands of pregnant women quit smoking. It is designed to be a component of a patient education program for prenatal care providers, and is cited by the Agency for Healthcare Research and Quality's Smoking Cessation Clinical Practice Guidelines.

Florida's SCRIPT implementation pilot was funded by the March of Dimes in 2014-2015. This was an implementation/training grant to begin the process of using the SCRIPT curriculum as the official evidence-based smoking cessation curriculum in Florida's Healthy Start program and as a model for interested community partners. The Florida Association of Healthy Start Coalitions was recently awarded a second grant from the March of Dimes 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 matched the grant with Title V funds to ensure the success of this ongoing effort.

The Florida Association of Healthy Start Coalitions has established a stakeholder group to review, and revise the SCRIPT training program, provide consultation to revise the Healthy Start Standards and Guidelines and test the new training package in two pilot communities. Additionally, the stakeholder group will assist in the design of three webinars for current SCRIPT trainers to highlight process and training standardizations and improvements. The webinars will be recorded and archived on a variety of learning management systems for community partners to access. The expectation is that these efforts will support ongoing training and capacity will be strengthened.

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

Healthy Start Coalitions and local health departments will continue to encourage pregnant women and new mothers to sign up for Text4baby. The Department is exploring ways to strengthen Text4baby's presence in Florida and increase the number of enrollees.

Family Planning providers across the state will screen their clients for the extent of tobacco use, and provide information on the Florida's 3 Free Ways To Quit. The Department will continue to encourage all health care providers to counsel women of childbearing age and all pregnant women on the dangers of tobacco use as well as the dangers of secondhand smoke. The Department will also continue to monitor compliance with the Healthy Start Standards and Guidelines for tobacco cessation.

Cross-Cutting/Life Course - Annual Report

The Department participated in the national Infant Mortality CoIIN smoking cessation strategy team. The Florida team engage state and community partners in the national initiative. The Healthy Start Coalition of Miami Dade County conducted a pilot project focused on increasing the number of care coordinators that are comfortable and competent using a carbon monoxide monitor using the SCRIPT intervention. The coalition shared their success on a national level and with partners in the state. The partners were able to take the information back and implement the same type of training in their respective communities.

The Florida Association of Healthy Start Coalitions conducted an evaluation to review the strengths and opportunities for improvement in the way the SCRIPT curriculum was disseminated and implemented. All of the 39 educators originally trained were emailed a link to an online survey and 21 completed the survey. Additionally, key stakeholders involved in the implementation completed a pre-interview form and were then interviewed by telephone. The evaluation has been used to inform the next steps to revise the way care coordinators are trained on SCRIPT.

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. During FY 2014-2015, a total of 76,629 Florida residents received cessation services from Tobacco Free Florida.

In FY 2014/15, a total of 5,969 pregnant women received 11,093 Healthy Start smoking cessation services during the prenatal period. In addition, 2,902 mothers, family members, or caregivers received 6,027 Healthy Start smoking cessation services postpartum.

A new webpage was developed on the Tobacco Free Florida website targeting obstetric provider practitioners with information on smoking cessation reduction strategies for pregnant women.

Text2Quit, a new digital service that texts positive messages to tobacco users before, during, and after they quit is in its second year of operation. WebCoach served 18,890 users. The Florida Quitline served 45,118 people by telephone and 14,533 through the online service.

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 2014-2015, a total of 76,629 Floridians received cessation services from Tobacco Free Florida. The Area Health Education Centers (AHEC) saw a record setting 16,978 Floridians through their single and multi-session in person program provided in a group environment. Additionally, AHECs trained health care practitioners and students to identify tobacco users and refer them for treatment.

Florida implemented the nation's first statewide e-referral through the electronic health record to the Florida Quitline with through the county health departments. During FY 2014-2015, a total of 9,735 people were referred to for tobacco cessation services.

Florida is conducting additional activities to enhance the life course approach across all population groups. The Department applied to a request for applications from the 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 has lead efforts to create an indicator report for all 59 final indicators, where data is available. The resulting document is intended to be a mechanism to further cross-cutting collaboration within and outside the Department. The Florida Life Course Metrics Report will be made available to staff, stakeholders, and the general public. The report will include statistics and figures for the indicators, and comparisons of Florida data to the national average will be included as well as recommendations for Florida. Detailed CDC/CSTE Fellow activities entail: (1) reviewing the current literature on the life course approach to public health, including information on the Life Course Metrics project provided by AMCHP; (2) completing a spreadsheet to identify data sources and availability of required data; (3) obtaining necessary

statistics from various data sources including, but not limited to, vital records, Medicaid claims data, the Pregnancy Risk Assessment Monitoring System, and the National Survey of Children's Health; and (4) comparing Florida data to national rankings on life course indicators. These specific activities are necessary for creating a comprehensive data report and developing recommendations for Florida.

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

Other Programmatic Activities

Title V MCHBG funding is being used to help support the Department in conducting and collecting information for a Women and Infants Survey for Health (WISH). The WISH project is a random population-based surveillance system of maternal behaviors and experiences before, during, and shortly after pregnancy. Data collected includes information on maternal health and behaviors, prenatal and postpartum care, and infant health. The survey is conducted statewide and results are tabulated down to the county level. While greatly assisting the state Title V program in their planning and evaluation of MCH services, WISH will also enable local health departments and Healthy Start Coalitions to use survey findings for planning and evaluating prenatal health programs at the local level. WISH targets women that were not sampled by PRAMS. Unlike PRAMS, WISH questions can be developed and added to address emergent issues in Florida, and WISH focuses on rural areas and small counties. The WISH survey is scheduled to conclude at the end of June 2016 after three years of data collection. At the conclusion, an evaluation and analysis of the data will be performed to determine if the project should be continued.

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

Title V funding was used in SFY 2014-2015 to support the expansion of dental sealant programs in a five county area of high unmet needs due to a lack of dental providers, transportation barriers, and low social economic factors influencing access to care. The School-based Sealant Pilot Project was carried out in five rural counties, providing preventive services to children in second, third, and fifth grades. Final data reveal that 3,197 children were screened, 2,101 children received 6,867 sealants and 3,165 fluoride varnish applications and 2,958 oral health instructions were provided.

There were six new School-Based Sealant Programs (S-BSPs) funded to increase access while reducing barriers to receiving oral healthcare. Funding was disseminated in September 2015 for program initiation during SFY 2015/2016. To date, all programs have pursued 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 are currently providing services. As of May 2016, a total of 864 children have

been served with at least one dental sealant and 2,471 sealants have been placed. To promote these S-BSPs to the children and increase positive consent rates from parents, an oral health workbook was produced and disseminated to each of the new programs, utilizing Title V funding. The workbooks incorporate best practices for implementation of healthy oral health behaviors in second and third grade children, the target population of the S-BSPs. The workbook encourages discussion of improved oral hygiene, specifically the benefits of dental sealants, between teachers, children, and their parents or guardians.

Dental sealants are the most effective way of preventing caries in permanent molars, where more than 80 percent of decay occurs in the permanent teeth of children. 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 that are 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 39,095 children receiving one dental sealant by a county health department during calendar year 2015 is $2,526,660.73.

The Public Health Dental Program (PHDP), in conjunction with the Oral Health Florida Sealant Action Team, promotes the use of a cost efficient dental hygienist workforce model for School-based Sealant Program service delivery. Working with local health department dental programs, FQHCs, and local oral health coalitions across the state, preventive services are provided to children in Title I Schools. Providing services to the children in school settings eliminates many barriers that impact access to dental care. School-based programs are supported by Title V funding and make possible reaching high-risk children in need of dental services and improving dental outcomes for all children in the state.

During SFY 2015-2016, Title V funding was provided to the PHDP to purchase a modified and updated community water fluoridation training curriculum and technical assistance services for health professionals to promote water fluoridation in Florida. The PHDP contracted with an organization 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 water fluoridation. In Florida, the increase in oral health literacy regarding 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.

The PDHP contracted with an organization to train water and health professionals on how and why water fluoridation benefits a community and what action steps are required to initiate fluoridation in a local community. The contractor also works to promote the provision of quality water fluoridation services by nationally recognized water systems in the state. This recognition helps citizens understand they have access to fluoridation and their local utility is providing the service in an appropriate manner. The project continues to grow in the number of individuals and associations/organizations provided the professional training.

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. As a result, programs to teach and provide relevant scientific support for water fluoridation are needed to effectively promote water fluoridation at the community level. In FY 2014-15, 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 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. Funding was again provided in FY 2015-2016 to continue the training and education activities. Funding was also provided to specifically support water operator fluoridation training conducted by the Florida Rural Water Association to help sustain and encourage water fluoridation in smaller systems within the state.

Title V funding is currently being utilized to implement an Early Childhood Caries (ECC)/Women, Infants, and Children (WIC) pilot project in three regions of the state that have the highest ECC rates, as identified by the 2014/2015 Head Start Oral Health Surveillance Project. Three counties were selected where the county health

department dental program utilizes existing portable equipment to provide preventive dental care services for pregnant, postpartum or breastfeeding women and their children less than 5 years of age who are participating in the WIC program and are referred by WIC staff to the ECC/WIC Pilot Project. The intent of the pilot is to increase oral health education and to promote optimal well-being for both mother and child, especially as it relates to improving birth outcomes and preventing early childhood caries. As of April 2016, 628 clients have been served. The pilot project will continue through September 2016.

Title V funding was used to support Florida's Healthy Babies, a collaborative statewide initiative to positively influence social determinants of health and reduce racial disparity in infant mortality. Florida's Healthy Babies is an effort of the Department's Health Equity Program Council. This project engages the department's 67 local county health departments (CHDs) and numerous partners within each county to address disparities with evidence-based interventions. The CHDs will conduct or enhance data analysis on infant mortality, including an environmental scan of existing pertinent programs. The CHDs will also host community meetings to highlight disparities in infant deaths and the role of social determinants of health.

Though Florida has experienced declining morbidity and mortality rates, disparities persist and the Department is committed to achieving health equity and eliminating these differences. The council is comprised of county health officers and leaders in the state health office, and works to assist local efforts, monitor emerging research, and determine how to expand best practices statewide. The council is currently working through a process to possibly introduce a health equity performance expectation for all county health department officers.

During SFY 2015-2016, Title V funding supported the PHDP's FLOSS Database. Florida's Linked Oral Status System will have three modules which will improve communication between the state and local programs, as well as increase data capacity of the PHDP. FLOSS will automate business process regarding CHD Dental Program Inventory (program and site), Monthly Operational Reports (monthly data submitted from each community water system adding fluoride at an optimal level to prevent tooth decay), and Community Water System Inventory (reporting data functions for local and state populations receiving the benefits of water fluoridation). Initial development of FLOSS is scheduled for completion in June 2016.

Title V funding also supported the 2014-2015 Early Head Start/Head Start Oral Health Surveillance Project. During the 2014-2015 school year, the PHDP completed the first statewide oral health surveillance of Florida's preschool aged population enrolled in Early Head Start (EHS) and Head Start (HS) centers. The project was conducted in 48 EHS and HS centers across 29 Florida counties. There were 680 EHS children screened in 22 centers and 1,535 HS children screened in 26 centers to gain a representative sample of Florida's low income early childhood population. Based on those whose parents consented, 58.1 percent of the sampled population were screened. Dental screenings were provided by contracted Florida Dental Hygiene Association Registered Dental Hygienists following the Association of State and Territorial Dental Directors' Basic Screening Survey protocols.

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

The MCH Section is collaborating with REACHUP, Inc., a Federal Healthy Start site and community partner in Tampa, to receive the translation project sub-award for the Every Mother Initiative and implement enhancements to the Preconception Peer Educator (PPE) program at the community level. The PPE Program originated in the Department of Health and Human Services, Office of Minority Health, and works with the college age population, enlisting college students who serve as peer educators on college campuses and in the community. They help disseminate essential preconception health messages that may seem too foreign for a population that may not be

actively seeking to start a family. Because over 50 percent of all pregnancies are unplanned, it is imperative to provide all women, and in particular sexually active women and their partners, with information to make timely, informed decisions about their reproductive futures. PPE training was originally designed to emphasize reduction in infant mortality by education of women and men on the importance of preconception health. REACHUP, Inc. for the EMI included additional training information which highlights the relationship between a woman's health status and health behaviors now and eventual pregnancy/maternal outcome in the future. The project is directed at Historically Black Colleges and Universities (HBCUs) in an effort to promote preconception health to a population impacted by higher rates of infant mortality. The project activities include plans for PPE training at the University of South Florida, Bethune-Cookman University and Florida Agricultural and Mechanical University.

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

II.F.2 MCH Workforce Development and Capacity

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

In 2015, Cassandra Pasley and Kelli Stannard participated in AMCHP's Leadership Institute for State CSHCN Directors and AMCHP's New Director Mentor Program. AMCHP's Leadership Institute is a 16-month program focusing on developing leadership skills at the state and national level. AMCHP's New Director Mentor Program is an 18-month commitment, utilizing learning, mentoring, and peer-to-peer interaction to increase effectiveness and performance of the CSHCN Director. Ms. Stannard attended the *2015 Workforce Academy: Leading in a Transformative Environment to Improve Population Health*, which focused on continuing to transform the efforts of the block grant, with an emphasis on population health and action planning.

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

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

The Department has a partnership with Florida Agricultural and Mechanical University (FAMU) to assist students working towards their Masters of Public Health degree to participate in a summer rotation between their first and second years. Students participate in three 40-hour rotations through different divisions within the agency to see

public health in action. The Division of Community Health Promotion provides mentors for students each summer. The FAMU students are assigned to specific projects within the division based on their skills and areas of interest. This unique program is one strategy in the agency's workforce development plan.

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

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

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

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 Florida Department of Health has recently implemented a Research/Investigations Workgroup at the state office designed 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 in department operations. 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 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

II.F.3. Family Consumer Partnership

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

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

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

Community involvement is an important component to the success of a Healthy Start Coalition. Such involvement requires coalition leadership to be knowledgeable of and understand the communities they serve, as well as, allow for input and engagement of community members and consumers in the work of the coalition to achieve the program's intent and purpose.
Providers of Healthy Start services must provide culturally and linguistically appropriate services (CLAS) to the best of their ability in order to reach the diverse population of Florida. One of the goals contained in the Department's State Health Improvement Plan requires the provision of equal access to culturally and linguistically competent care. The provision of CLAS to Healthy Start participants is to be considered during program planning, recruitment of bilingual staff, and in the availability of diverse educational materials and classes.

Consumers are also valuable contributors in various advisory roles. With the support of the legislature, the Department was authorized in Section 383.141, Florida Statutes, to create an information clearinghouse website to provide information for parents and families on Down syndrome and other prenatally diagnosed developmental disabilities.

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

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

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

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

into Qualtrics survey software. Qualitative analytic methods were used to compile the results.

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

The Department 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.

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

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

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

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.

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.

In 2016, Children's Medical Services established the Medical Home Workgroup and the same family representative

participates.

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

II.F.4. Health Reform

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

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

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

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

For children who are not eligible for Title XIX Medicaid or Title XXI KidCare, the CMS Safety Net Program serves children with chronic and serious special health care needs from birth to 21 years of age who are unable to access specialized services that are medically necessary or essential family support services. Families are required to participate financially in the cost of care based on a sliding fee scale. The Program provides a limited health services package for the enrollee's primary and secondary qualifying conditions, based on the availability of funds.

II.F.5. Emerging Issues

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

Also of critical importance is addressing the wide disparities in health status, with minority populations bearing a disproportionate burden of disease. The Department uses community-focused strategies to provide the tools,

planning support and policy direction communities need in order to address the challenges presented by a broad spectrum of public health issues.

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

Transmission of the Zika virus, and the possible effect on babies born in Florida, is a major concern of the Department of 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. As of June 20, 2016, a total of 199 cases of imported Zika fever have been confirmed in Florida, 39 of them in pregnant women, and numerous travelers from areas now impacted by Zika virus arrive in the state annually. Florida is also known to have known or suspected competent mosquito vectors that may transmit 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 including 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 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, and condoms as well as prevention information, would be distributed to pregnant women in affected areas. In addition, mosquito repellant would be provided to homeless individuals in affected areas.

II.F.6. Public Input

The Department has a policy of seeking ongoing input on priorities and programs from partners and stakeholders. This is accomplished through advisory groups; workgroups; direct meetings with partners; surveying parents, providers and community organizations; program specific websites, social media, working with parent organizations, and our own Online Newsroom.

During the 2015 Needs Assessment process, the MCH Section developed a web-based electronic survey that was sent to 55 MCH stakeholders, professionals, and partners who were then asked to complete the survey and distribute the survey to consumers, other members of the community, and community partners; some of whom posted the survey on Facebook pages. The purpose of the survey was to obtain feedback on which MCH topics should be identified as priorities for the state and thus become the basis for the 2016 MCHBG application. A total of 708 individuals completed the survey during a two-week period in August 2014. This was the highest response rate for any MCH needs assessment survey ever conducted by the Department.

The framework used for the CSHCN Needs Assessment was to first engage families and stakeholders for input to assess needs, then to examine strengths and capacity, and finally selecting priorities and setting performance objectives as outlined in the state action plan. The CSHCN Needs Assessment utilized an Advisory Group to steer the direction of the needs assessment process. This core group provided the CMS Needs Assessment Team with valuable feedback related to the needs assessment activities. Families and stakeholders were also asked to complete surveys and participate in workgroups developing the action plans.

Public input was also gained through the state's 32 Healthy Start Coalition's local needs assessment and service delivery plan development and implementation. Consumer experience surveys and focus groups are heavily relied on for community input. Consumers must serve on the coalition boards and the boards must represent the racial, ethnic, gender composition and socioeconomic diversity of the catchment population. In the course of developing their service delivery plans, coalitions use surveys to gain additional input from both providers and the general community, and share that information with the Department.

The state's 67 local health departments complete a Community Health Assessment and Community Health Improvement Plan (CHIP) using the Mobilizing for Action through Planning and Partnership (MAPP) strategic approach. This process engages lead organizations in the community, local county and municipal governments, and residents to provide input and an understanding of the issues they feel are important, then prioritizes issues related to the community's health and quality of life.

As recipients of Title X funding, local health departments are required to establish an advisory committee of five to nine members who are broadly representative of the community to review and approve all informational and educational materials prior to distribution to ensure the materials are suitable for the population and community for which they are intended. The advisory committees also discuss and advise the local staff on community concerns and needs as they relate to the reproductive age population.

CMS has a long standing relationship with private physicians, the University Health Systems, hospitals, and regional and local programs that support children with special health care needs. CMS has continuous communications with these groups to ensure continued understanding of the needs of children with special health care needs and our partners providing services to this population. Along with the representation of local health departments, Healthy Start Coalitions, health advocacy interest groups, universities, migrant and community health centers, hospitals, local medical societies, and others, this helps to ensure widespread inclusive input.

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

II.F.7. Technical Assistance

A fundamental first step in accessing health care in the United States is having a way to pay for it, either out of

pocket, or through some form of private or public health insurance coverage. Since health care costs are often unpredictable as well as prohibitively expensive, health insurance is vital.

Medicaid eligibility for adults in states not expanding their programs is quite limited: the median income limit for parents in 2014 is just 50 percent of poverty, or an annual income of $9,893 a year for a family of three. In states that do not expand their programs, many adults will fall into a “coverage gap” of having incomes above Medicaid eligibility limits but below the lower limit for Marketplace premium tax credits. The majority of people in the coverage gap are working poor—that is, employed either part-time or full-time but still living below the poverty line. If they remain uninsured, adults in the coverage gap are likely to face barriers to needed health services or, if they do require medical care, potentially serious financial consequences. Many are in fair or poor health or are in the age range when health problems start to arise, but lack of coverage may lead them to postpone needed care due to the cost. While the safety net of clinics and hospitals that has traditionally served the uninsured population will continue to be an important source of care for the remaining uninsured, this system has been stretched in recent years due to increasing demand and limited resources.

Further, the racial and ethnic composition of the population that falls into the coverage gap indicate that decisions not to expand their programs disproportionately affect people of color, particularly blacks. This disproportionate effect occurs because the racial and ethnic composition of states not expanding their programs differs from the ones that are expanding. In Florida, it is estimated that 669,000 fall within the coverage gap, 50 percent are female and 64 percent are in a working family. (Kaiser Family Foundation, Nov. 2014)

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

III. Budget Narrative

	2013		2014	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$18,904,025	$18,904,025	$18,920,363	$18,920,363
Unobligated Balance	$0	$0	$0	$0
State Funds	$169,390,341	$169,390,341	$169,402,594	$169,402,594
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$188,294,366	$188,294,366	$188,322,957	$188,322,957
Other Federal Funds	$362,324,908	$362,324,908	$415,342,314	
Total	$550,619,274	$550,619,274	$603,665,271	$188,322,957

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.

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

	2017	
	Budgeted	Expended
Federal Allocation	$18,984,911	
Unobligated Balance	$0	
State Funds	$155,212,322	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$174,197,233	
Other Federal Funds	$14,466,727	
Total	$188,663,960	

III.A. Expenditures

Expenditure amounts for the FY2015 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 $18,984,911 budgeted as the expected federal allotment for FY2017, a total of $5,881,919 is budgeted for preventive and primary care for children (31 percent) and $8,539,800 for children with special health care needs (45 percent), which meet the 30 percent requirements. In addition, $1,807,880 (9.5 percent) is budgeted towards Title V administrative costs. Total state match for FY2017 is $155,212,322. Budgeted amounts for FY2017 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 - IAA-MOU.pdf

V. Supporting Documents

No Supporting documents were provided by the state.

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Florida

	FY17 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 18,984,911	
A. Preventive and Primary Care for Children	$ 5,881,919	(31%)
B. Children with Special Health Care Needs	$ 8,539,800	(45%)
C. Title V Administrative Costs	$ 1,807,880	(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)	$ 174,197,233	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 14,466,727	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 188,663,960	

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 2,738,485
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 10,125,800
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 1,602,442

	FY15 Application Budgeted		FY15 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	$ 6,064,675	(31.9%)	$ 6,064,675	(31.9%)
B. Children with Special Health Care Needs	$ 8,539,800	(45%)	$ 8,539,800	(45%)
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)	$ 378,242,185		$ 378,242,185	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 566,698,816		$ 566,698,816	

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 45,305
US Department of Agriculture (USDA) > Food and Nutrition Services > Child and Adult Care Food Program (CACFP)	$ 110,223,512
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 2,740,351
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 205,669,553
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 9,298,726
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 2,257,597
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Emergency Medical Services for Children (EMSC)	$ 268,226
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Various	$ 12,844,753
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > School Health	$ 11,625,846
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medipass Waiver	$ 23,268,316

Form Notes for Form 2:

FY14 Other Federal Funds Expended 378,242,185 based on grant earnings for three quarters of the grant period.

Due to a realignment of responsibilities within the Department of Health, many of the other federal funds previously listed on Form 2 are no longer under the control of the person responsible for the administration of the Title V program. Federal funds omitted from this report, such as WIC, CACFP, School Health, SSDI, etc., are still being provided and still serve the MCH population.

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	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 1,882,136	$ 2,574,186
2. Infants < 1 year	$ 873,175	$ 0
3. Children 1-22 years	$ 5,881,919	$ 6,064,675
4. CSHCN	$ 8,539,800	$ 8,539,800
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 17,177,030	$ 17,178,661

IB. Non Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 26,417,098	$ 46,169,268
2. Infants < 1 year	$ 12,224,330	$ 32,410,826
3. Children 1-22 years	$ 82,537,920	$ 76,350,334
4. CSHCN	$ 34,032,974	$ 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	$ 172,389,352	$ 186,638,544

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures for Infants < 1 year and Children 1-22 years were combined in 2015. Infants < 1 year = $478,790 and is included in 1.A.3 Children 1-22.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures for Infants < 1 year and Children 1-22 years were combined in 2015. Infants < 1 year = $478,790 and is included in 1.A.3 Children 1-22.	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Florida

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	$ 3,000,000	$ 1,432,314
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	$ 1,432,314
2. Enabling Services	$ 14,177,031	$ 15,746,347
3. Public Health Services and Systems	$ 1,807,880	$ 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		$ 630,806
Physician/Office Services		$ 799,936
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 600
Dental Care (Does Not Include Orthodontic Services)		$ 202
Durable Medical Equipment and Supplies		$ 738
Laboratory Services		$ 32
Direct Services Line 4 Expended Total		$ 1,432,314
Federal Total	$ 18,984,911	$ 18,996,748

IIB. Non-Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	$ 6,107,347	$ 7,025,695
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	$ 6,107,347	$ 7,025,695
2. Enabling Services	$ 149,104,975	$ 162,434,188
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		$ 7,025,695
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 7,025,695
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: 220,984

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	217,293 (98.3%)	1,328	441	441 (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
Medium-chain acyl-CoA dehydrogenase deficiency	Very long-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	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	211,893 (95.9%)	8,108	264	264 (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 listed under Other Newborn Screening Tests rather than as a Core RUSP Condition due to a difference in the number of newborns screened, related to a difference in the testing methodologies.

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Florida

Reporting Year 2015

		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	144,916	96.1	1.1	2.8	0.0	0.0
2. Infants < 1 Year of Age	83,334	97.7	0.5	1.8	0.0	0.0
3. Children 1 to 22 Years of Age	221,081	97.3	0.7	2.0	0.0	0.0
4. Children with Special Health Care Needs	104,050	73.5	17.1	9.4	0.0	0.0
5. Others	0	0.0	0.0	0.0	0.0	100.0
Total	553,381					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2015**
	Field Note: Florida data on source of coverage does not distinguish between other, none, and unknown. All numbers for columns D, E, and F are included in column D.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2015**
	Field Note: Florida data on source of coverage does not distinguish between other, none, and unknown. All numbers for columns D, E, and F are included in column D.	
3.	**Field Name:**	**Children 1 to 22 Years of Age**
	Fiscal Year:	**2015**
	Field Note: Florida data on source of coverage does not distinguish between other, none, and unknown. All numbers for columns D, E, and F are included in column D.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2015**
	Field Note: Florida data on source of coverage does not distinguish between other, none, and unknown. All numbers for columns D, E, and F are included in column D.	

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

State: Florida

Reporting Year 2015

Types Of Individuals Served	Total Served
1. Pregnant Women	170,675
2. Infants < 1 Year of Age	217,293
3. Children 1 to 22 Years of Age	2,978,025
4. Children with Special Health Care Needs	125,455
5. Others	0
Total	3,491,448

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2015**

Field Note:
Number of pregnant women screened for Healthy Start.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Florida

Reporting Year 2015

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	223,724	160,413	49,018	287	6,366	272	3,527	3,841
Title V Served	144,916	103,907	31,751	186	4,124	176	2,285	2,487
Eligible for Title XIX	139,264	99,854	30,513	179	3,963	169	2,195	2,391
2. Total Infants in State	219,905	156,999	49,059	281	6,307	333	3,298	3,628
Title V Served	81,911	58,480	18,274	105	2,349	124	1,228	1,351
Eligible for Title XIX	80,028	57,135	17,853	102	2,295	121	1,200	1,322

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	159,114	63,929	681	223,724
Title V Served	103,065	41,410	441	144,916
Eligible for Title XIX	99,046	39,795	423	139,264
2. Total Infants in State	157,385	61,784	736	219,905
Title V Served	58,624	23,014	273	81,911
Eligible for Title XIX	57,275	22,484	269	80,028

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	2017 Application Year	2015 Reporting Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 451-2229	(800) 451-2229
2. State MCH Toll-Free "Hotline" Name	Family Health Line	Family Health Line
3. Name of Contact Person for State MCH "Hotline"	Marcia Thomas-Simmons	Marcia Thomas-Simmons
4. Contact Person's Telephone Number	(850) 245-4444 x2957	(850) 245-4444 x2957
5. Number of Calls Received on the State MCH "Hotline"		12,821

B. Other Appropriate Methods	2017 Application Year	2015 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	Interim Chief, Bureau of Family Health Services
Address 1	4052 Bald Cypress Way, Bin A-13
Address 2	
City/State/Zip	Tallahassee / FL / 32399
Telephone	(850) 245-4464
Extension	
Email	Shay.Chapman@flhealth.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Celeste Philip, MD, MPH
Title	State Surgeon General
Address 1	4052 Bald Cypress Way, Bin A-06
Address 2	
City/State/Zip	Tallahassee / FL / 32399
Telephone	(850) 245-4210
Extension	
Email	Celeste.Phillip@flhealth.gov

3. State Family or Youth Leader (Optional)	
Name	Kelly Rogers
Title	Early Steps Program Consultant
Address 1	4052 Bald Cypress Way, Bin A-06
Address 2	
City/State/Zip	Tallahassee / FL / 32399
Telephone	(850) 245-4200
Extension	3091
Email	Kelly.Rogers@flhealth.gov

Form Notes for Form 8:

Shay Chapman is currently the Interim Title V MCH Director.

Form 9
List of MCH Priority Needs

State: Florida

Application Year 2017

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, 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 for adolescents and young adults with special health care needs to all aspects of adult life.
8.	Improve dental care access for children and pregnant women.
9.	Improve access to appropriate mental health services to all children.
10.	Address the social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies.

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

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

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Florida

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

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	170.8	2.9 %	3,506	205,220
2012	166.2	2.9 %	3,384	203,557
2011	164.2	2.9 %	3,352	204,118
2010	158.5	2.8 %	3,265	205,959
2009	150.7	2.7 %	3,183	211,276
2008	140.7	2.5 %	3,121	221,901

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.5 - Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

NOM 10 - Notes:

None

Data Alerts: None

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	10.8	0.2 %	2,211	205,223
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
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
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
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
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
2012	28.4 %	0.1 %	48,745	171,960

Legends:

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

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

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

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

Legends:

Indicator has an unweighted denominator <100 and is not reportable

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

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	68.0	69.0	70.0	71.0	72.0	73.0

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	67.7 %	1.6 %	2,205,303	3,257,052
2013	64.6 %	1.4 %	2,093,161	3,240,620
2012	67.4 %	2.0 %	2,184,556	3,241,114
2011	62.0 %	1.6 %	1,923,190	3,101,087
2010	57.9 %	1.5 %	1,477,625	2,553,334
2009	67.5 %	2.0 %	2,131,020	3,157,714

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	81.3	82.3	83.2	84.0	84.7	85.3

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	81.6 %	3.5 %	162,064	198,524
2011	77.0 %	3.6 %		
2010	72.5 %	3.8 %		
2009	76.5 %	2.8 %		
2008	76.6 %	2.8 %		
2007	74.4 %	2.6 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

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

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	27.7	29.4	31.1	32.8	34.5	36.2

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	22.3 %	3.7 %	42,582	191,068
2011	18.3 %	3.0 %		
2010	15.6 %	3.2 %		
2009	15.9 %	2.2 %		
2008	13.0 %	2.0 %		
2007	10.1 %	1.6 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

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

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	78.3	80.0	81.6	83.1	84.5	85.8

FAD not available for this measure.

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)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	42.7	43.3	43.8	44.3	44.7	45.1

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	40.7 %	2.9 %	521,434	1,282,761
2007	43.3 %	3.8 %	557,105	1,288,248
2003	34.4 %	2.4 %	436,607	1,270,940

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	20.2	19.9	19.6	19.3	19.0	18.7

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	10.1 %	1.9 %	138,029	1,370,209
2007	17.8 %	3.1 %	246,089	1,385,335

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: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	21.1 %	0.6 %	168,274	798,216
2011	20.2 %	0.6 %	158,477	784,047

Legends:

Indicator has an unweighted denominator <100 and is not reportable

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

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	52.0	53.0	54.0	55.0	56.0	57.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	45.7 %	3.9 %	343,845	751,777
2007	53.4 %	5.3 %	401,026	751,486

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: National Survey of Children's Health (NSCH) - NONCSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	51.5 %	1.9 %	1,568,017	3,043,085
2007	57.6 %	2.5 %	1,767,248	3,068,966

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	42.0	44.0	46.0	48.0	50.0	52.0

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	37.0 %	3.4 %	89,064	240,468
2005_2006	33.8 %	3.2 %	68,907	203,864

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	6.5	6.4	6.3	6.2	6.1	6.0

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.5 %	0.1 %	14,064	218,111
2013	6.6 %	0.1 %	14,145	214,708
2012	6.7 %	0.1 %	14,129	212,481
2011	6.7 %	0.1 %	14,226	212,674

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

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	22.5	22.0	21.5	21.0	20.5	20.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	24.6 %	1.5 %	967,635	3,932,309
2007	26.1 %	2.0 %	1,045,136	4,008,805
2003	30.0 %	1.3 %	1,017,719	3,390,890

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: Florida

SPM 1 - The percentage of children with a behavioral health condition who receive treatment consistent with their diagnosis.

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

Field Level Notes for Form 10a SPMs:

None

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	34.4	35.9	37.4	38.9	40.4

Field Level Notes for Form 10a SPMs:

None

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

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

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	69,000.0	70,000.0	71,000.0	72,000.0	73,000.0

Field Level Notes for Form 10a ESMs:

None

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

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

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**

Field Note:
The number may decrease as hospitals reach certification.

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

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	15.0	20.0	25.0	30.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.1 - The number of county School Health Programs who are utilizing the evidence-based program for the reduction of childhood obesity

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	7.0	14.0	21.0	28.0	35.0

Field Level Notes for Form 10a ESMs:

None

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

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

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

Field Note:
The number may stay the same as the program takes 3-5 years to implement.

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

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

Field Level Notes for Form 10a ESMs:

None

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

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

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

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

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: Florida

SPM 1 - The percentage of children with a behavioral health condition who receive treatment consistent with their diagnosis.
Population Domain(s) – Children with Special Health Care Needs

Goal:	Increase the percentage of children with a mental/behavioral condition who receive treatment.
Definition:	**Numerator:** Number of children receiving services. **Denominator:** Number of children eligible for 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:	Children's Medical Services Managed Care Plan Data
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

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

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 Measure (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

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 become Baby Friendly Certified 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

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

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 program 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

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:** 40
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 Green Dot evidence-based violence prevention and intervention strategy
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

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 providers 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

Goal:	Increase access to medical homes and primary care for children with special health care needs.
Definition:	<table><tr><td>**Numerator:**</td><td>Number of CMS credentialed providers who have received information related to PCMH and who have completed a Medical Home Assessment Tool for their practice.</td></tr><tr><td>**Denominator:**</td><td>Number of CMS credentialed providers.</td></tr><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>4,000</td></tr></table>
Data Sources and Data Issues:	Children's Medical Services Data
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 providers who have practices that have a 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

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:	<table><tr><td>**Numerator:**</td><td>Number of CMS-credentialed providers who have practices that have a HCT policy or youth with readiness assessment (with physicals) and plans of care.</td></tr><tr><td>**Denominator:**</td><td>Number of CMS-credentialed providers.</td></tr><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>4,000</td></tr></table>
Data Sources and Data Issues:	Children's Medical Services Managed Care Plan Data
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

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:** 10,000
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 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Florida

Form Notes for Form 10d NPMs and SPMs

None

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

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	1,218	1,175	1,314	1,328	1,259
Denominator	1,218	1,175	1,314	1,328	1,259
Data Source	Florida Newborn Screening Program	Florida Newborn Screening Program	Florida Newborn Screening Program	Florida Newborn Screening Program	Florida Newborn Screening Program
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	55.0	69.0	70.0	71.0	72.0
Annual Indicator	68.2	68.2	68.2	68.2	68.2
Numerator					
Denominator					
Data Source	National Survey of Children with Special Health Ca	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
3.	**Field Name:**	**2013**

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

4. **Field Name:** **2012**

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

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

5. **Field Name:** **2011**

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

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

Data Alerts: None

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

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

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
3.	**Field Name:**	**2013**

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

4. **Field Name:** **2012**

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

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

5. **Field Name:** **2011**

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

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

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	62.0	60.0	67.0	68.0	69.0
Annual Indicator	56.5	64.3	64.3	64.3	64.3
Numerator		435,089	431,822	431,822	431,822
Denominator		676,655	671,574	671,574	671,574
Data Source	Florida State Profile data for CSHCN survey	CSHCN survey and American Community Survey	CSHCN survey and American Community Survey	CSHCN survey and American Community Survey	CSHCN survey and American Community Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

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

2. **Field Name:** **2014**

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

3. **Field Name:** **2013**

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

4.	**Field Name:**	**2012**

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

5.	**Field Name:**	**2011**

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

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

Data Alerts: None

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

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

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
3.	**Field Name:**	**2013**

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

4. **Field Name:** **2012**

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

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

5. **Field Name:** **2011**

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

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

Data Alerts: None

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

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

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

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

2. **Field Name:** **2014**

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

3. **Field Name:** **2013**

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

4. **Field Name:** **2012**

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

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

5. **Field Name:** **2011**

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

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

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	90.0	90.0	90.0	90.0	90.0
Annual Indicator	86.1	83.0	86.7	85.6	85.5
Numerator	190,618	178,050	186,573	188,239	191,234
Denominator	221,391	214,519	215,194	219,905	223,666
Data Source	DOH Survey of Immunization in 2-Year-Old Children	DOH Survey of Immunization in 2-Year-Old Children	DOH Survey of Immunization in 2-Year-Old Children	DOH Survey of Immunization in 2-Year-Old Children	DOH Survey of Immunization in 2-Year-Old Children
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	15.0	13.4	11.9	10.2	10.0
Annual Indicator	13.4	12.0	10.5	9.1	8.7
Numerator	4,723	4,219	3,698	3,206	3,080
Denominator	353,110	352,066	352,403	351,029	352,682
Data Source	Florida DOH CHARTS	Florida DOH CHARTS	Florida CHARTS	Florida CHARTS	Florida CHARTS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	14.0	14.1	14.2	17.9	18.8
Annual Indicator	14.6	15.6	17.6	18.9	23.8
Numerator	13,516	16,531	19,615	23,399	30,252
Denominator	92,889	106,218	111,259	123,673	126,949
Data Source	Agency for Health Care Administration/DOH	Agency for Health Care Administration/DOH	Agency for Health Care Administration/DOH	Agency for Health Care Administration/DOH	Agency for Health Care Administration/DOH
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Counts may duplicated due to possible participation in multiple agencies or providers.	
2.	**Field Name:**	**2011**
	Field Note: 2011 data is an estimate based on 2010 data because data for 2011 is not yet available to the Public Health Dental Program from the Florida Medicaid Program.	

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	1.6	2.0	2.0	1.8	1.7
Annual Indicator	2.1	1.8	2.2	2.4	2.0
Numerator	69	60	75	80	68
Denominator	3,274,059	3,303,959	3,344,701	3,382,656	3,419,005
Data Source	DOH Office of Vital Statistics	DOH Office of Vital Statistics	Florida Charts	Florida Charts	Florida Charts
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	39.5	40.0	46.5	41.0	41.2
Annual Indicator	39.0	46.2	4.4	49.4	49.4
Numerator					
Denominator					
Data Source	CDC National Immunization Survey	CDC National Immunization Survey	CDC National Immunization Survey	CDC National Immunization Survey	CDC National Immunization Survey
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

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

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

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

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

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

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

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

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	99.0	99.0	99.0	99.0	99.0
Annual Indicator	95.8	96.5	96.4	86.4	94.9
Numerator	204,721	205,860	207,821	190,141	212,431
Denominator	213,722	213,403	215,658	220,140	223,791
Data Source	CMS Newborn Screening Database	CMS Newborn Screening Database	CMS Newborn Screening Database	CMS Newborn Screening Database	CMS Newborn Screening Database
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	16.3	14.0	12.5	10.6	10.3
Annual Indicator	14.3	11.8	10.9	11.7	8.3
Numerator	576,000	529,450	488,010	504,907	366,549
Denominator	4,042,000	4,486,862	4,477,159	4,297,777	4,391,135
Data Source	US Census	US Census	US Census	US Census	US Census
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

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

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	28.7	28.5	28.2	27.7	26.0
Annual Indicator	28.8	28.3	27.8	26.3	26.3
Numerator	51,346	49,118	51,146	45,791	46,238
Denominator	178,223	173,603	183,974	174,172	175,820
Data Source	Office of WIC and Nutrition Services	Office of WIC and Nutrition Services	Office of WIC and Nutrition Services	Office of WIC and Nutrition Services	Office of WIC and Nutrition Services
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	8.5	9.2	7.9	7.8	7.7
Annual Indicator	8.1	8.1	6.9	6.9	6.9
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	Florida PRAMS Report 2013	Florida PRAMS Report 2013	Florida PRAMS Report 2013
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Since Florida's birth certificate does not ask about smoking during the third trimester, PRAMS data is used to determine performance on this indicator. Data come from the 2011 PRAMS, the last year available. For the PRAMS data, the numerator and the denominator are weighted to be representative of the state.	
2.	**Field Name:**	**2013**
	Field Note: Since Florida's birth certificate does not ask about smoking during the third trimester, PRAMS data is used to determine performance on this indicator. Data come from the 2011 PRAMS, the last year available. For the PRAMS data, the numerator and the denominator are weighted to be representative of the state.	
3.	**Field Name:**	**2012**
	Field Note: Since Florida's birth certificate does not ask about smoking during the third trimester, PRAMS data is used to determine performance on this indicator. Data come from the 2010 PRAMS, the last year available. For the PRAMS data, the numerator and the denominator are weighted to be representative of the state.	
4.	**Field Name:**	**2011**
	Field Note: Since Florida's birth certificate does not ask about smoking during the third trimester, PRAMS data is used to determine performance on this indicator. Data come from the 2010 PRAMS, the last year available. For the PRAMS data, the numerator and the denominator are weighted to be representative of the state.	

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	5.8	6.0	7.4	6.2	6.0
Annual Indicator	6.9	8.4	6.5	7.1	7.8
Numerator	83	101	78	85	93
Denominator	1,207,467	1,201,681	1,200,272	1,192,611	1,196,478
Data Source	DOH Vital Statistics	DOH Vital Statistics	Florida CHARTS	Florida CHARTS	Florida CHARTS
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	90.0	90.0	91.6	92.4	92.6
Annual Indicator	88.8	92.2	79.9	77.9	77.9
Numerator	3,099	3,133	2,645	2,766	2,766
Denominator	3,488	3,398	3,311	3,550	3,550
Data Source	Florida DOH CHARTS	Florida DOH CHARTS	Florida CHARTS	Florida CHARTS	Florida CHARTS
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Data for 2015 is not yet available. Data for 2014 has been entered here as provisional.	
2.	**Field Name:**	**2013**
	Field Note: Data for 2013 differs substantially from 2012 due to a change in how the data was determined. Data for 2013-2015 comes from Florida CHARTS.	

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	81.0	81.5	82.0	82.5	83.0
Annual Indicator	80.3	80.0	79.9	79.4	79.3
Numerator	154,294	159,307	160,620	160,873	162,346
Denominator	192,194	199,097	200,923	202,715	204,852
Data Source	Florida DOH CHARTS	Florida DOH CHARTS	Florida CHARTS	Florida CHARTS	Florida CHARTS
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

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

State: Florida

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

	2011	2012	2013	2014	2015
Annual Objective	98.0	98.0	98.0	98.0	98.0
Annual Indicator	94.3	97.6	83.2	85.2	100.0
Numerator	35,079	34,637	24,947	14,541	28,798
Denominator	37,189	35,490	29,982	17,071	28,798
Data Source	Early Steps Data System Annual Report.	Early Steps Data System Annual Report	Early Steps Data System Annual Report	Early Steps Data System Annual Report	Early Steps Data System Annual Report
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

   Field Note:
   Data obtained from CMS-KIDS for 2014-15 includes all children with IFSP. Unable to obtain encounter data so numerator and denominator is the same.

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

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

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

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

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	36.6	35.2	34.9	34.0	33.8
Annual Indicator	35.7	35.3	34.3	34.6	34.3
Numerator	41,496	42,911	42,172	43,318	43,427
Denominator	116,089	121,453	123,080	125,267	126,615
Data Source	Florida CHARTS	Florida CHARTS	Florida CHARTS	Florida CHARTS	Florida CHARTS
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	21.0	22.0	23.0	24.0	25.0
Annual Indicator	16.7	16.7	12.7	12.7	12.7
Numerator					
Denominator					
Data Source	PRAMS 2011	PRAMS 2011	Florida PRAMS Report 2013	Florida PRAMS Report 2013	Florida PRAMS Report 2013
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d SPMs:

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

Data Alerts: None

SPM 4 - The percentage of infants not bed sharing.

	2011	2012	2013	2014	2015
Annual Objective	78.0	79.0	80.0	42.0	43.4
Annual Indicator	39.4	39.4	41.8	41.8	41.8
Numerator					
Denominator					
Data Source	PRAMS 2011	PRAMS 2011	Florida PRAMS Report 2013	Florida PRAMS Report 2013	Florida PRAMS Report 2013
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d SPMs:

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

Data Alerts: None

SPM 5 - The percentage of infants back sleeping.

	2011	2012	2013	2014	2015
Annual Objective	65.0	66.0	67.0	68.0	69.0
Annual Indicator	67.2	67.2	65.4	65.4	65.4
Numerator					
Denominator					
Data Source	PRAMS 2011	PRAMS 2011	Florida PRAMS Report 2013	Florida PRAMS Report 2013	Florida PRAMS Report 2013
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d SPMs:

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

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	8.8	8.1	7.3	6.7	6.3
Annual Indicator	8.3	7.4	7.4	7.3	8.0
Numerator	391	314	274	235	245
Denominator	4,723	4,219	3,698	3,210	3,080
Data Source	Florida CHARTS	Florida CHARTS	Florida CHARTS	Florida CHARTS	Florida CHARTS
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	30.3	38.4	38.6	29.6	31.4
Annual Indicator	26.3	27.8	29.0	30.1	33.1
Numerator	594,914	670,173	745,342	793,504	881,839
Denominator	2,261,437	2,414,583	2,567,729	2,640,145	2,662,802
Data Source	Agency for Health Care Administration	Agency for Health Care Administration	Agency for Health Care Administration	Agency for Health Care Administration	Agency for Health Care Administration
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

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

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

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

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

Data Alerts: None

Form 11
Other State Data

State: Florida

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

State Action Plan Table

State: Florida

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

Abbreviated State Action Plan Table

State: Florida

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Improve access to health care for women, specifically women who face significant barriers to better health, to improve preconception 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 for adolescents and young adults with special health care needs to all aspects of adult life.	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	