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## **D. Public Input**

Public input begins with the Healthy Start coalition local needs assessment process and service delivery plan development and implementation. Consumer experience surveys and focus groups are heavily relied on for needs assessment, plan development, and ongoing implementation, and consumers serve on the coalition boards. Coalitions encompass minority participation on the boards, and emphasize minority input in their assessment of local needs. Headquarters MCH staff review and evaluate coalition needs assessments, service delivery plans, and implementation reports and use this information in planning MCH programs.

We will make the application available over the Internet on our department website. Applications from previous years, and the current application when it is final, are at <http://www.doh.state.fl.us/family/mch/docs/grant.html>. You may also find this page by going to the Department of Health webpage at [www.doh.state.fl.us](http://www.doh.state.fl.us). On that page, go to the A-Z list pull down menu and click on maternal and child health. From there, click on the documents link, click on the link for MCH documents, and then click on the link for the MCH Block Grant Application. You can also reach the DOH website by going to [www.myflorida.com](http://www.myflorida.com) and clicking on the "Find an Agency" link, and then clicking on the link for health.

## **II. Needs Assessment**

### **C. Needs Assessment Summary**

The needs assessment process resulted in the identification of the following issues as priority needs for the Florida maternal and child health population, including children with special health care needs:

1. Prevent unintended and unwanted pregnancies.
2. Promote preconception health screening and education.
3. Promote safe and healthy infant sleep behaviors and environments.
4. Prevent teen pregnancy.
5. Improve dental care access, both preventative and treatment, for children.
6. Increase access to medical homes and primary care for all children, including 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. Increase early intervention services for children with special health care needs.

Selection of priority needs for this assessment included the consideration of quantitative and qualitative data. There was substantial input from key stakeholders and providers. A needs assessment advisory group was formed that consisted of key partners in

maternal and child health as well as consumer representation. This advisory group made initial recommendations using a nominal group process. There was consensus among the group especially around the issues pregnancy prevention, preconception health screening and education, and promoting safe infant sleep behaviors. Increasing access to primary care and medical homes for children, particularly children with special health care needs was also identified as a priority need, as well as increased early intervention services and health care transition.

### **III. State Overview**

#### **A. Overview**

Florida is the fourth most populous state in the nation, and the diversity of its population creates unique challenges. The Florida Legislature, Office of Economic and Demographic Research (EDR) estimates there were 18,818,998 residents in Florida in 2009. This represents a 17 percent increase over the 2000 EDR estimate of 16,074,896 residents for 2000.

According to the 2009 EDR estimates, females account for 51 percent of the total population. There are 4,150,372 children under 18, which is 22 percent of the total population. Estimates indicate there are 3,302,610 residents 65 or older, 17.5 percent of the total. Of those, 524,289 or 2.8 percent of the total are 85 or older. Of the total population, 80.7 percent are white, 16.5 percent black, and 2.8 percent are nonwhite other. Florida residents also reflect diverse ethnicities, as evidenced by the 24 percent who are identified as Hispanic. Of all residents over 5 years of age, 23.1 percent speak a language other than English at home.

The diverse population creates unique challenges for the Title V program. The programs within Title V must tailor services to meet the needs of different cultures. We produce pamphlets and other educational materials in English, Spanish, and Haitian Creole. Efforts are made to ensure clinic staff represents the diversity of their local clients. The Title V program and both private and public health faces additional challenges in meeting the needs of tourists, illegal immigrants, and other temporary residents in Florida.

Florida is a temporary home to over 80 million tourists and visitors each year. This constant influx places a significant burden on the health care system. Migrant farm workers and other undocumented aliens are also populations that create significant impact on public health services and resources. According to a report by the Pew Hispanic Center, Florida was home to 1,050,000 illegal immigrants in 2008, following only California and Texas. In 2008, Florida accounted for 9 percent of the total illegal immigrants in the nation.

Historically, many illegal immigrants have come to Florida seeking jobs, particularly in agriculture. Construction jobs and service-related jobs have recently seen tremendous increases in the use of illegal immigrants as a source of cheap labor. Following a trend in the 1990s that saw some advancement in the pay and benefit opportunities for immigrant labor, recent trends indicate pay is decreasing and services are becoming scarcer.

The large illegal immigrant population can have a taxing effect on the social service system, as illegal immigrants and their families need medical care and other services as well. Medicaid costs for just the births for this population are staggering. For example, Medicaid paid approximately \$15.3m for 5,332 deliveries to undocumented aliens in state fiscal year FY98-99. A decade later, that amount increased to over \$85.4m for 18,220 deliveries in FY08-09. This does not include births to illegal immigrants for which the hospital absorbed the cost. Children born here to immigrant families are U.S. citizens. Without the same advantages of others, many of these families face generations of poverty-level existence, creating the possibility of years of public support and costs.

***//2012/ There were 17,695 deliveries to illegal immigrants paid by Medicaid in fiscal year 2010/2011, at a cost of \$86.5 million. //2012//***

The geography of Florida can also create challenges in both the delivery of services and the response to events or disasters. With a total area of 58,560 square miles, Florida ranks 22<sup>nd</sup> among states in total area, though 4,308 square miles are covered by water. Driving from Pensacola in the western panhandle to Key West at the southernmost point is nearly an 800 mile journey. The 1,197 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.

With the threat of tropical depressions and hurricanes looming every summer, the Department of Health has published a Family Preparedness Guide for residents and visitors as a tool that includes items such as: a fill-in family plan for disasters and emergencies, steps for making a disaster supply kit, and facts about natural and man-made threats. The guide is posted on the department's website, and is available in English, Spanish, and Creole. Disaster preparedness was tested in 2004 when Florida was hit with four major hurricanes and a tropical depression within a two-month period.

Florida's shorelines are facing a more prolonged threat this year, the oil spill in the Gulf of Mexico. Oil from this ecological disaster is likely to have an adverse affect on tourism, commercial and recreational fishing, and the many businesses supporting or supported by those industries. Tourism is a \$65 billion a year industry that directly employs over one million people in Florida, and any serious setback in tourism greatly reduces revenue needed to sustain government services and infrastructure.

Unemployment continues to be a concern in Florida. In March 2010, the unemployment rate in Florida was 12.3 percent, the highest rate since 1970 when records began. In April, the rate dropped to 12 percent, which was still considerably higher than the national rate of 9.9 percent. An unemployment rate of 12 percent means that 1.1 million residents of the state are currently unemployed and looking for work. Additional residents who have been unemployed long-term or who have given up on finding work are not included in that total. Many who become unemployed lose health insurance coverage for themselves and their families.

***//2012/ In April 2011, the unemployment rate in Florida fell to 10.8 percent, the lowest level in 19 months. An unemployment rate of 10.8 percent means that 996,000 residents of the state are currently unemployed and looking for work. Florida still has one of the highest unemployment rates in the country and is substantially above the U.S. rate of 9 percent. //2012//***

Like many states, Florida is facing ever-increasing Medicaid costs. For many indigent families and the working-poor, whose jobs offer salaries below the federal poverty level with no medical benefits, Medicaid is the sole source of health care coverage. Yet even those who qualify may have difficulty receiving care, as the number of providers who accept Medicaid does not keep up with service needs. The 2010 Florida Legislature introduced a bill that would have established a Medicaid Managed Care Program, requiring that all Medicaid recipients be assigned to an HMO. The legislation did not pass during the current session, but it did set the stage for possible Medicaid reform next year.

***//2012/ During the 2011 session, the Florida legislature passed a bill establishing the Medicaid program as a statewide, integrated managed care program for all covered services. There is mandatory participation for most populations, with some populations excluded. The bill calls for competitive, negotiated selection of qualified managed care plans that meet strict selection criteria, with a limited number of plans to ensure stability but allow significant patient choice. There are over 2.9 million Medicaid enrollees in Florida, and 1.9 million are currently enrolled in some type of managed care. Estimated Medicaid spending for fiscal year 2011-12 is \$20.3 billion, or about \$7,000 per recipient. Over half the childbirths in Florida are paid for by the Medicaid program, and 27 percent of Florida children are covered by Medicaid.***

***If the legislation is implemented, county health departments that wish to continue serving Medicaid recipients will have to be part of a managed care plan's network as either a HMO or a provider service network. Florida applied for a federal waiver to implement this version of reform. The state recently received a letter from federal CMS indicating CMS had major concerns about a statewide Medicaid managed care system and many issues would have to be addressed before this type of expansion was approved. //2012//***

Addressing racial disparities in health outcomes continues to be an important focus of the Department of Health. In March 2005, the department hosted the 2005 Closing the Gap Summit, where national, state and local leaders, community-based organizations, health care professionals, and residents gathered to address this year's topic, *Working Towards a Common Vision: Reducing Racial and Ethnic Health Disparities*. The summit was held by the DOH Office of Equal Opportunity and Minority Health to address ways to decrease the morbidity and mortality rates in seven targeted diseases: cardiovascular, cancer, diabetes, HIV/AIDS, maternal and infant mortality, adult and child immunizations, and oral health care.

In an effort to address racial disparities in birth outcomes, the 2007 Florida Legislature passed a law creating a black infant health practice initiative. The purpose of the initiative was to review infant mortality in selected counties in order to identify factors in the health and social services systems contributing to higher mortality rates among black infants, and to produce recommendations on how to address the factors identified by the reviews. Broward, Dade, Duval, Gadsden, Hillsborough, Orange, Palm Beach, and Putnam counties were selected for the study. The quantitative analysis involved utilizing the Perinatal Periods of Risk process. This revealed that the highest rate of black fetoinfant deaths occurred in the maternal health/prematurity period, which relates to a woman's health prior to pregnancy. As a result of the initiative, community action teams

were formed in each county. The community action teams continue to address racial disparity issues within their communities. Recommendations from the study include: developing and implementing community education and outreach regarding racial disparity in infant mortality; focusing on strategies related to interconception care and education; focusing on infant safety including sleep position and safe sleep environment; working with providers on cultural sensitivity; reducing barriers to prenatal care; providing educational messages; reducing barriers to Medicaid; and improving father involvement during pregnancy and infancy.

Each year since 2002, the legislature has provided funding for *Racial and Ethnic Disparity: Closing the Gap* projects with a primary focus of addressing racial and ethnic disparity in the seven target areas listed above. Projects receiving funding are selected through a competitive bid process. Currently funded maternal and infant mortality projects focus on issues such as: access to prenatal care, education, advocacy, and public awareness; support and education to pregnant women and parenting women in at-risk black communities; early intervention services for Hispanic and Haitian women of childbearing age; education on effects of infections on preterm labor; identification of conditions associated with poor birth outcomes in black women, and maternal health risk factors with strategies designed to increase physical activity and improve eating habits.

In state fiscal year 2008/2009, six maternal and child health projects were awarded a total of \$831,693 in Reducing Racial and Ethnic Health Disparities, Closing the Gap Act funding. For state fiscal year 2009/2010, six projects were awarded a total of \$683,905. Maternal and infant mortality services promote good health before pregnancy (preconception care). Supports include community outreach and education; individual health risk screens; healthy lifestyle education; and medical referral and follow-up for women at risk for preterm labor and poor birth outcomes. Three projects focus on the health risks of women of African-American descent; two projects focus on both African-American and Hispanic women; and a new project provides "Promotoras" (community leaders as lay health workers) for Hispanic women in five farm worker communities, spanning seven Florida counties.

***//2012/ For state fiscal year 2010/2011, six maternal and child health projects were awarded a total of \$604,933. //2012//***

***//2012/ On April 14, 2011, the Office of Minority Health hosted Minority Health Education Day at the Capitol, to help educate legislators and raise awareness of the specific health needs of minority populations. //2012//***

To help address the needs of American Indians in Florida, the Department of Health formed an American Indian Advisory Council. This advisory group is part of the Minority AIDS Network and is comprised of six American Indian representatives from across the state. The council is lead by an Elder and includes members with HIV/AIDS program experience, general medical experience, counseling in drug and alcohol abuse, and a leader in tribal dance, as we understand dance is an important part of religious and holistic healing ceremonies. This council will serve as part of our massive effort to address HIV/AIDS disparities among all racial/ethnic minorities. They will bring the voices of the Native American community together in an advisory role to discuss and address issues they are facing in providing HIV prevention and care services to their communities.

The council voted to keep their focus on HIV education and cancer prevention at this time. The council is interested in addressing other needs as well, but there are trust and cultural tradition issues that must be addressed first. It is hoped that a Tribal Consultation to be held sometime in the summer of 2010 will allow the department to establish further trust and bonds, and gain a better understanding of the health needs of this vast and divergent population. The 2,000 U.S. Census counted over 117,000 American Indians in Florida, although community leaders feel that estimate is much too low. With more than 581 different tribes, bands, and clans in the state, addressing the various cultural needs can be a challenge, but the effort is an important one, as we work to help improve the lives of a population that is so important to the heritage of our state and nation.

Preventing obesity is another major issue for the department. The Healthy Communities, Healthy People (HCHP) program provides health promotion activities in each of Florida's 67 counties. One of the primary objectives is to increase healthy eating habits and physical activity among people of all ages. They provide technical assistance and support for local Healthy Start initiatives geared toward pregnant women and infants. We are discussing the potential to provide Chronic Disease Self-Management programs to women postnatally, possibly through the Centering Pregnancy format for prenatal care.

The department works closely with the Department of Education to provide technical assistance and resources to schools to support their wellness efforts. We also contract with four school districts to provide district wellness coordinators who establish and support wellness programs for district school employees. This models healthy behavior in the school setting and provides opportunities for increased physical activity and healthy eating to pregnant women within the school system. The HCHP staff in 10 counties also support a Robert Wood Johnson Foundation grant that focuses on childhood obesity prevention as a model project for community mobilization.

The Hispanic Obesity Prevention and Education Program (HOPE) was developed to provide nutrition education and obesity information geared to the Hispanic population, including women of childbearing age. The online portion of the project remains active although the program is no longer funded.

In an effort to address adolescent issues, the department created the Positive Youth Development Program in June 2009. The purpose of the program is to enhance the skills and improve the health status of adolescents and young adults through opportunities and programs developed in collaboration with families, communities, schools and other public and private organizations throughout Florida. The program provides a network of community-based support to help adolescents succeed as they move into adulthood by focusing on the assets of individual youth and their families. In the first year, the program provided eight grants to local county health departments to deliver positive youth development programs and activities in their communities. Positive Youth Development sponsored programs reinforce positive attitudes, healthy behaviors and activities, and reduce risk-taking behaviors, such as sexual activity, substance abuse, suicide and behaviors that increase risk of unintentional injury and chronic disease. Since its inception in 2009, more than 4800 youth and 600 parents have been served through the program.

Priorities identified in the 2010 needs assessment are summarized in Section II C and discussed at length in the 2010 Florida Needs Assessment.

## **B. Agency Capacity**

The State Title V agency's capacity to promote and protect the health of all mothers and children begins with Healthy Start. Healthy Start is the primary delivery system for preventive and primary care services for pregnant women, mothers and infants. Healthy Start helps pregnant women and infants obtain the health care and social support they need to reduce the risks for maternal and infant death and to promote good health and developmental outcomes. These efforts include not only assurance of access to health care, but also identification and intervention for psychosocial risks including incidence of domestic violence, substance abuse, potential child abuse, or neglect.

Healthy Start includes the Healthy Start Prenatal and Infant Coalitions, who have the legislative authority and responsibility to plan and develop improved local MCH service delivery systems. Through an allocation methodology developed at the state level, state and federal funding, including MCH block grant funding, is distributed to local Healthy Start coalitions to support infrastructure building and the provision of services to the MCH population. Healthy Start also includes universal risk screening for all pregnant women and infants, and care coordination services for eligible participants.

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.

Quarterly conference calls with all the funded FIMR projects in Florida address issues and opportunities identified by the local FIMR projects and allow the department to provide information and guidance to the projects. The FIMR project representatives use these calls to share information and best practices with each other. The Division of Family Health Services epidemiologist is also available to assist local FIMR projects on an as needed basis.

Additional capacity is provided through the DOH Bureau of Epidemiology, which includes: periods of risk analysis to look at the proportional contribution of various periods to fetal and infant mortality; environmental epidemiology, addressing factors such as lead poisoning; birth defects surveillance; and the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS is a continuing random survey of mothers of Florida newborns, designed to provide information about risk factors for adverse pregnancy outcomes and ill health in newborns. A cooperative agreement between the Centers for Disease Control (CDC) and the Florida Department of Health to conduct population-based surveillance of selected maternal behaviors that occur during pregnancy and early infancy, PRAMS generates data used for the planning and evaluation of prenatal health programs.

The 67 county health departments across the state provide a variety of direct services to the MCH population; however, more and more county health departments are working with community providers to ensure services are delivered, rather than providing the services themselves. These services vary throughout the state and may include pregnancy testing, HIV pretest and post-test counseling, prenatal care, family planning, immunizations, periodic health history and physical examinations, preconception and interconception education and counseling, laboratory screening tests for health indicators such as lead and anemia, developmental screening, risk assessment, provision of anticipatory guidance, accident prevention, and substance abuse prevention education.

County health departments are responsible for ensuring students have access to quality health services that assess, protect and promote their health and ability to learn. Over 2,000 health staff personnel provide more than 18 million services to approximately 2.6 million K-12 students in 3,300 schools. The basic school health services provided to all public school students are: nursing and nutritional assessments; student health record reviews to ensure physical exam and immunization requirements are complete, and that appropriate services are provided for any chronic or complex health conditions; first aid; medication administration; complex medical procedures; age/grade appropriate screening for vision, hearing, growth and development, and scoliosis; emergency health services for students who are injured or become acutely ill at school; health education classes; parent and staff consultations on student health issues that interfere with school participation; and consultation for placement of students in exception education programs. Comprehensive and Full Service school health programs provide a broad range of health and social services in addition to basic school health services, in schools with high numbers of high-risk and medically-underserved children. Comprehensive school health provides significant emphasis on prevention of high risk behaviors, pregnancy prevention and support services for pregnant and parenting teens.

The Florida Department of Health Children's Medical Services (CMS) program provides children with special health care needs, from birth to age 21, a family-centered, comprehensive, and coordinated statewide managed system of care that links community-based health care with multidisciplinary, regional, and tertiary pediatric care. The CMS system of care includes a network of services that range from prevention and early intervention programs to primary and specialty care programs, including long-term care for medically complex children. CMS enrollees may receive medical and support services through 22 CMS area offices staffed by private physicians, in local private physician offices or other health care organizations, through regional programs, hospitals, referral centers and statewide specialty programs.

The CMSN serves as a managed care choice for Medicaid beneficiaries who must choose a managed care option. Families of Medicaid eligible children who meet the clinical screening criteria may choose CMSN as their provider. Services are reimbursed directly by Medicaid on a fee-for-service basis. The Florida legislature directed CMS to maximize federal Titles XIX and XXI funds for its salaried staff. The CMS Program obtained federal approval to draw down Title XIX funds as a result of administrative claiming. In addition to the two CMSN insurance products (funded by Title XIX and Title XXI, depending on the child's income level), CMSN also provides the original Safety Net services for children with special needs who are not eligible for either of the other funding sources. CMS is also responsible for coordinating policy and procedures across

departments that relate to children and youth for special health care needs and has responsibility for the Part C Program of the Individuals with Disabilities Education Act and a major responsibility for the newborn screening program.

***//2012/ Parents report high levels of provider and program satisfaction. More than 90 percent of parents are satisfied with their CMSN doctors. A total of 82 percent report that written care plans were developed, 77 percent reported the nurse care coordinators coordinated care with doctors and specialists, and 41 percent said the nurse care coordinators coordinated with the children's schools. //2012//***

CMS has adopted the Maternal and Child Health Bureau's National Goals as its six program goals and created performance measures for each:

- Goal #1: All children who are enrolled in CMS Programs and their families will partner in decision-making at all levels and will be satisfied with the services they receive.
- Goal #2: All children who are enrolled in CMS Programs will receive coordinated, ongoing, comprehensive care within a medical home.
- Goal #3: All children enrolled in CMS Programs and their families will have the resources to fund services within the guidelines of the CMS Program.
- Goal #4: All children will be screened early and continuously assessed for emerging or changing special health care needs.
- Goal #5: CMS Offices will identify culturally competent, comprehensive community-based service systems for all children enrolled in CMS Programs and their families.
- Goal #6: Beginning at age 12, all teens and young adults with special health care needs who are enrolled in the CMS Network and their families will receive the services needed to make transitions to all aspects of adult life, including adult health care, work, and independence.

Each CMSN enrollee is eligible to receive care coordination. The care coordinator is a critical link in the development of a medical home for the child and family. Care coordination services to all CMSN enrollees are documented in the CMS Child Assessment and Plan (CAP), a web-based application. CMS area office staff utilizes CAP to record patient assessments, care plans, and notes. The integration of the six national goals into the CMS program goals, performance measures and CAP further enhances the care coordination activities by ensuring the provision of ongoing, coordinated, culturally competent, comprehensive care, within the context of a medical home. A total of 70,000 CMSN children receive care coordination services and are linked to a medical home. Of the 70,000 children, 18,000 receive care coordination and services through the Early Intervention Program.

***//2012/ The CMS Network served 95,668 children in 2009-10 and over 18,000 through the Early Steps Program. //2012//***

***//2012/ A Family Health Consultant (FHC) was hired in 2010 to collaborate and strengthen partnerships at the national, state, and local level. The FHC will ensure a family-centered system of care is provided to CMS enrollees and serve as the point of contact for the family support workers in CMS area offices. //2012//***

***//2012/ All children who are “removed from home and placed in out of home care” become clinically eligible for CMS. This will allow for swift access to care for all dependent children. Children in foster care will be served through CMSN, providing a medical home assuring continual and comprehensive care that is managed and coordinated with the primary health care provider. //2012//***

The CMSN Title V Director is a member of the national medical home advisory council supported by the American Academy of Pediatrics. The state was awarded a five-year CHIPRA demonstration grant and one component is training and evaluation of medical homes for children with special health care needs. This next year will be a planning year for the grant followed by two to three years of implementation and evaluation. Additionally, the AAP will provide training to about 10 pediatric practices in Florida on the use of the medical home toolkit followed by quality improvement activities that will be a collaborative effort between practices and the CMS Program. This training will occur during 2010-11.

***//2012/ CMS Primary Care (PC) programs provide a medical home to CMS enrollees and their siblings offering the full range of PC services as well as providing care coordination activities, parenting, safety and health education to enrolled families. The network continues work to assist and support the 11 CMS PC programs in the development of medical home practices throughout Florida. Several CMS PC Programs have applied for the CHIPRA grants. The CMS PC Program is a collaborative effort between state government, local pediatric physician groups, and community providers. Number of clients served in 2009-10 was 40,532. //2012//***

In 2008, Senate Bill 988 / House Bill 793 called for the creation of a time-limited task force to address the needs of young adults with disabilities moving into adult health care systems in Florida. The main focus of the Health Care Transition Services Task Force for Youth and Young Adults with Disabilities is to “assess the need for health care transition services, develop strategies to ensure successful transition from pediatric to adult health care systems, and identify existing and potential funding sources.” CMS led the establishment of a statewide task force created through a legislative initiative. The task force included members of stakeholders and state agencies in order to assess the need for health care transition services, develop strategies to ensure successful transition from pediatric to adult health care systems, and identify existing and potential funding sources. CMS has established local/regional health care transition coalition pilot sites to support health care transition initiatives on a local level. Activities include working with local health planning councils to develop county-level data reports to provide information about youth and young adults, and secondary data sets for health condition, disability status, SSI enrollment, CMS enrollment, and other pertinent data. The local coalitions will also provide education and training activities for both consumers and providers; and advocate for improved health care financing strategies and policies. The initial meetings for the coalitions were held in January 2010.

***/2012/ CMS contracts with the University of South Florida 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. FloridaHATS has organized a Medical Advisory Committee, comprised of pediatricians, pediatric and adult specialty physicians, a representative from the Florida Pediatric Society and the Florida Medical Association that meets to discuss how to achieve successful health care transition outcomes. Health care transition and insurance information is available at [www.floridahats.org](http://www.floridahats.org). The website includes a directory of adult health care physicians, by city and by county, who provide services to young adults who have grown up with chronic health diagnoses. //2012//***

The CMS Pharmacy Benefits Program (PBM) provides increased pharmacy access for families of CMS enrollees. CMS contracts with MedImpact Healthcare Systems, Inc. to link with national, regional, and locally owned pharmacies throughout Florida to assist with the processing of prescriptions and to decrease waiting time for prescription refills, improve evening and weekend coverage, and provide a toll-free help desk to answer questions.

CMS, in coordination with Medicaid, has established 10 Children's Multidisciplinary Assessment Teams (CMAT) to provide cost containment, quality assurance, and utilization review for medically complex children receiving high cost, long-term medical services. CMAT functions through a multidisciplinary, inter-program, and inter-agency effort. Team members include the family and representatives from the Children's Medical Services and Early Steps Programs of the Department of Health, Child Welfare & Community Based Care of the Department of Children and Families, the Agency for Persons with Disabilities, and the Medicaid Program of the Agency for Health Care Administration, in addition to any other community based agencies that may be able to assist in the care of a child. CMS has lead responsibility to facilitate this collaboration.

***/2012/ There were 1146 CMAT clients served during FY 2009-2010. //2012//***

The Department of Children and Families' Behavioral Health Network works in conjunction with CMS to address the behavioral health needs for children age 5 to 19 who are between 101 percent and 200 percent of the federal poverty level. Diagnoses covered include mood, psychiatric, or anxiety disorders; severe emotional disturbance; and substance dependence. Children who are eligible for Medicaid receive behavioral health services through Medicaid.

The Medical Foster Care (MFC) Program is a coordinated effort between the Florida Medicaid Program within the Agency for Health Care Administration, Children's Medical Services within the Department of Health, and the Child Welfare and Community Based Care (CBC) Program within the Department of Children and Families. To be eligible for the MFC program, children must be under the age of 21, be identified as needing medically necessary services to meet their medical complex condition, be in the custody of the Department of Children and Families, and be medically stable for care in the home setting. The MFC Program establishes and supervises the oversight and training of foster parents to provide MFC services for these children. Medical foster parents are Medicaid providers, child-specifically trained, and are responsible for performing most of the day to day functions necessary for the child's care. This program is a cost-effective

alternative to hospitalization, long-term, in-home, private duty nursing, or skilled nursing facility placement. The program currently serves approximately 742 children per year.

***//2012/ The MFC program served 712 children in 2009-2010. //2012//***

Florida's Early Steps Program offers early intervention services to infants and toddlers from birth to 3 years of age with developmental delays or established medical conditions that place them at risk for developmental delay. Funding for this program is provided through Part C of the Individuals with Disabilities Education Act (IDEA), enhanced by state and local resources. It is suggested that pediatric practices could be better equipped to follow children's development and connect parents with community resources. Within the context of the CMSN medical home approach, Florida's early intervention program will provide for more efficient and comprehensive primary care in partnership with parents. Early intervention services teach and empower parents to advocate and seek the services that their children need. Through 15 contracted local offices across the state, the goal of Early Steps is to increase opportunities for infants and toddlers with disabilities to be integrated into their communities and to learn, play, and interact regularly with children who do not have disabilities.

***//2012/ There were 44,860 enrollees in Early Steps during calendar year 2010. //2012////***

Florida's Newborn Screening Program provides screening for all newborns for certain metabolic, congenital, and hereditary disorders prior to discharge from the birthing facility. Florida screens statewide for 35 disorders. The primary goals of the program are: to ensure all newborns born in Florida are screened and testing is processed within two weeks of birth; to ensure all affected newborns receive appropriate confirmatory testing, counseling, and treatment as soon as possible; and to ensure all affected newborns are placed into a system of care in a timely fashion.

***//2012/ Electronic birth registration and newborn screening information will be linked in 2011 to ensure accurate data and provide an accounting of each baby issued a birth certificate to receive a newborn screening test. In 2011, the Genetics and NBS advisory Council recommended Severe Combined Immunodeficiency (SCID) be added to Florida's panel of newborn screening disorders. Implementation of SCID screening will begin with budget authorization. //2012//***

The CMS Early Hearing Loss Detection and Intervention (EHDI) program promotes universal newborn hearing screening, effective tracking and follow-up as a part of the public health system, appropriate and timely diagnosis of the hearing loss, and prompt enrollment in appropriate Early Intervention services. EHDI links newborns to a medical home and strives to eliminate geographic and financial barriers to service access. A component specific to serving families of children with hearing loss has been established in the Part C Early Steps program with ongoing emphasis on improving the number and quality of early intervention service providers.

The CMS Genetics Program provides genetic evaluation, diagnosis, and counseling for children with or at risk for having a genetic disorder. Services provided include initial and follow-up diagnostic and evaluation; genetic counseling; lab studies required for confirmation of genetic disorders; confirmatory testing for infants with abnormal test

results for PKU and galactosemia; dietary consultation for treatment of PKU or galactosemia; and educational programs for CMS staff. The genetics telemedicine project enables a pediatrician and a University of Florida geneticist to communicate via two-way interactive video technology.

***/2012/ In addition to PKU and galactosemia, the CMS Genetic Program provides confirmatory testing and dietary consultation for infants with abnormal test results for Biotinidase and various metabolic disorders. Services are provided through a network of three Genetic Centers and CMS community based clinics. Centers are located at University of Florida (UF), University of Miami (UM) and the University of South Florida (USF). UM and USF offer genetic consultations via telemedicine with the CMS Network. //2012//***

The Pediatric HIV/AIDS Program provides infants and children with HIV/AIDS access to a continuum of services through a network of seven Pediatric HIV Referral Centers and 10 CMS satellite clinics. Pediatric HIV Program services include evaluation, diagnosis, care coordination, nutrition counseling, permanency planning, assistance with transportation, and other support services. The HIV Program at the University of South Florida conducts monthly pre-clinic chart reviews with CMS staff in Ft. Myers via two-way interactive video technology. This enables the HIV specialist to see more patients during the satellite clinics in Ft. Myers. A similar arrangement occurs between CMS staff in Pensacola and the HIV specialist from the University of Florida prior to monthly satellite clinics. Over 1,350 infants and children enrolled in the CMSN received services at a Pediatric HIV Referral Center or CMS HIV Satellite Clinic.

***/2012/ The Pediatric HIV/AIDS Program provides services through a network of six Pediatric HIV Referral Centers and 10 CMS satellite clinics. Over 1,000 infants and children enrolled in the CMSN received services at a Pediatric HIV Referral Centers or CMS HIV Satellite Clinics in FY 2009-10. //2012//***

CMSN has partnered with the Agency for Health Care Administration (AHCA) and Florida Hospices and Palliative Care to provide pediatric palliative care services to children with life-threatening conditions enrolled in CMSN. As the first publicly-funded palliative care program in the nation, the Partners in Care: Together for Kids (PIC:TFK) program provides palliative care from the time of diagnosis through the course of treatment. Palliative care services include pain and symptom management; patient and family counseling; expressive therapies; and respite, nursing and personal care. Services are provided to eligible CMSN children enrolled in the state's Title XXI program (KidCare), and under the 1915(b) Managed Care Waiver, allowing palliative care services to be extended to children with Medicaid who have life-threatening conditions. PIC;TFK is in the fifth year of implementation and is expected to be statewide by 2011. The Partners in Care: Together for Kids program has served over 1000 children since July 2005 by Title XXI, XIX and Safety Net.

***/2012/ During 2010/11, program sites expanded from seven to 14, providing services to over 1,100 children. It is expected that PIC:TFK will expand to the 11 counties not served by 2012. //2012//***

The Department of Health, Children's Medical Services, Division of Prevention and Intervention, promotes the safety and well being of children in Florida by providing specialized services to children with special health care needs associated with child

abuse and neglect. The division consists of three units: the Child Protection Unit, the Prevention Unit, and the Special Technologies Unit.

The CMS Child Protection Team (CPT) Program is a medically led, multidisciplinary program based on the concept that child abuse and neglect involve complex issues and require the expertise of many professionals to protect children. CPTs supplement the assessment and protective supervision activities of the Department of Children and Families, child protective staff at local sheriff offices, and other community based care providers in reports of child abuse and neglect. There are 25 teams throughout the state to provide specialized assessments and services to child victims, siblings, and their families. Services provided may include: medical diagnosis and evaluation, medical consultation, forensic interviews of suspected child victims, specialized interviews of children and their family members, family psychosocial assessment, nursing assessment, psychological evaluation, multidisciplinary staffing, and expert court testimony. The CPTs handled 28,452 cases involving child victims and their families and provided 39,139 assessments per year.

***//2012/ The CPTs handled 29,453 cases involving child victims and their families and provided 48,979 assessments. //2012//***

The CMS Telehealth Program works with the CPTs to provide medical examinations of alleged child victims who are located in remote areas. CPT Telemedicine capabilities are now available at 17 service sites, which provided assessment for 378 children in 2009.

***//2012/ CPT Telehealth services are available at 16 sites and 439 children were provided medical or other assessments via telemedicine technology. //2012//***

The CMS Sexual Abuse Treatment Program (SATP) promotes the safety and well-being of children in Florida by providing specialized, comprehensive, multidisciplinary assessment and treatment services for children who have experienced sexual abuse, their siblings, and their non-offending caretaker. SATPs work with child protective investigators and CPTs. Community agencies, individuals, and other professionals may also make direct referrals. The SATPs may provide therapeutic services for children (and their non-offending family members) who have been the victim of interfamilial sexual or physical abuse or child on child sexual abuse. The number of SATP providers are 17; with all areas of the state having an area provider. The SATP served 5,716 child victims, their siblings and families in 2007-2008.

***//2012/ The SATP service 9,138 child victims, plus 6,557 of their siblings and parents/caregivers in 2009-10. //2012//***

The CMSN works with the Special Technologies Unit to maintain the CMS contracted program with the University of Florida's (UF) pediatric endocrinology staff that provides telehealth services for CMS enrollees with diabetes and other endocrinology diagnoses served by the Daytona Beach CMS area office. The use of two-way interactive video technology has proven to be an effective way of ensuring the availability of expert medical services to outlying rural areas.

Other CMS telehealth and telemedicine initiatives include: a partnership with the Institute for Child Health Policy at the University of Florida to refer CSHCN who are seen at three

of the state's community health centers to a CMS office for enrollment; nutritional, neurological, and orthopedic consults for CMS enrollees in Ft. Pierce, West Palm Beach, and Ft. Lauderdale; craniofacial team meetings; various educational presentations between CMS area offices; and numerous administrative and consultative meetings with CMS staff. Some CMS offices are beginning to work with the University of Miami to develop teledermatology clinics as well.

***//2012// The University of Florida provide pediatric endocrinology clinics, genetics evaluations, and counseling to CMS enrollees in other locations of the state. The University of Miami provides dermatology, neurology, genetics, and nutritional counseling via telemedicine for CMS enrollees who live in the Ft. Lauderdale, West Palm Beach, and Ft. Pierce area. //2012//***

CMS oversees the statewide Poison Information Center Network. Poison prevention and management information is provided 24 hours a day through a toll-free number. The centers provide access to poison information, triage of the potentially poisoned patient, collection of pertinent data, professional consultation for health care providers, and professional and consumer education. Since FY 2003-04, the Poison Centers received HRSA bioterrorism funds to develop, enhance, and maintain a system for rapid response to bioterrorism threats, natural disasters, and man-made disasters. The system involves real-time data reporting and analysis. During fiscal year 2007-08, the network handled 191,494 calls, provided 6,395 consults, provided education services to 1,766 community programs, 372 professional events, and participated in 824 health fairs or other special events. Over 500,000 pieces of informational materials and 78 media/public relation activities were provided.

***//2012/ There are three nationally certified Poison Information Centers in Florida that are overseen by CMS. During fiscal year 2009-10, the network handled 193,929 calls, provided 7,310 consults. The network provided education services to 1,223 community programs, 157 professional events, and participated in 369 health fairs or other special events. Over 568,000 pieces of informational materials and 111 media public relation activities were provided. //2012//***

CMS has responsibility for the Shaken Baby Syndrome/Abusive Head Trauma (SBS/AHT) information program. In fiscal year 2007-2008, over 350,000 *Coping with Crying* brochures (the SBS brochure) were distributed to all birthing facilities. The brochures and educational information are required to be given to parents of every newborn prior to hospital discharge. This initiative includes conducting training for hospital nurses to provide *Coping with Crying* education and coping strategies to new parents prior to discharge. A total of 43 facilities received the training and over 600 participants statewide viewed the distance-learning satellite broadcast *Coping with Crying-Shaken Baby Syndrome Prevention*.

***//2012/ In state fiscal year 2009-10, over 380,000 copies of the Coping with Crying brochure were distributed. Training was provided to parents of newborns in 23 facilities. //2012//***

The basic statutory authority for MCH is Section 383.011, Florida Statutes, Administration of Maternal and Child Health Programs. The statute authorizes the Department of Health to administer and provide MCH programs, including the WIC program and prenatal care programs. This statute also designates the Department of

Health to be the agency that receives the federal MCH and Preventive Health Services Block Grant funds. Other statutes related to the MCH program:

Section 409.810, F.S., establishes Florida KidCare.

Section 154.01, F.S., authorizes the Department of Health to operate primary care programs through the county health department delivery system, establishing a system of comprehensive integrated care.

Section 91.297, F.S., provides the authority for the Department of Health to implement a comprehensive family planning program.

Section 381.0056, F.S., delineates the joint responsibilities and cooperative efforts the Department of Health and the Department of Education have in implementing the school health services program.

Section 381.0057, F.S., establishes comprehensive school health services to provide health services in the schools, to promote the health of students and to reduce teenage pregnancy.

Section 381.0052 (e), F.S., the Public Health Dental Program Act, makes available dental preventive and educational services to all citizens and treatment services to indigent persons.

Section 383.014, F.S., 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.

Section 383.216, F.S., establishes 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.

The basic statutory authority for CSHCN and their families is Chapter 391, Florida Statutes, known as the Children's Medical Services Act. Related statutes include statutory authority and mandates pertaining to: screening of infants for metabolic and other hereditary and congenital disorders; infant hearing impairment; perinatal and neonatal services; child protection; sexual abuse treatment; developmental evaluation and intervention; hematology; oncology; poison centers; and parent support and training programs. Other statutes related to the Children's Medical Services Program:

Section 383.144, F.S., Infant Hearing Impairment Program.

Section 383.15-.21, F.S., Regional Perinatal Intensive Care Centers Program.

Section 383.215, F.S., Developmental Intervention and Parent Support and Training.

Sections 415.5055, 415.5095, F.S., Child Protection Teams.

Section 402.24 F.S., Recovery of Third Party Payments for Medical Services.

Chapter 385, F.S., Chronic Disease, Hematology/Oncology Care Centers Program.

Section 395.038, F.S., Regional Poison Control Centers.

Chapter 187, F.S., State Comprehensive Plan.

Section 409.905, F.S., Early and Periodic Screening, Diagnosis and Treatment Services.

Chapter 411, F.S., Florida Prevention, Early Assistance and Early Childhood Act.

98.282, Florida Laws, Healthy Start Act.

Section 383.14, F.S., Screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.

Section 383.145, F.S., Newborn and infant hearing screening.

### **C. Organizational Structure**

The Florida Department of Health is directed by the State Surgeon General, who answers directly 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: responsible for Communication and Marketing, and assists with policy direction.

Deputy Secretary: responsible for Administration, Legislative Planning, Medical Quality Assurance, Office of Public Health Research, Women's Health, Correctional Medical Authority, and Health Access and Tobacco.

Deputy Secretary for Health and Director of Minority Health: responsible for Minority Health, Health Statistics and Assessment, Disease Control, Emergency Medical Operations, Environmental Health, and Family Health Services.

Assistant Deputy Secretary for Health: responsible for the County Health Departments.

Deputy Secretary for Children's Medical Services: responsible for Children's Medical Services, Disability Determination, and Information Technology.

The Florida Department of Health is responsible for the administration of programs carried out with allotments under Title V. Many of these programs fall within the auspices of the Division of Family Health Services and the Division of Children's Medical Services. The directors of these two divisions serve as the primary Title V contacts for the state, and play an important role in the Title V direction.

The Division Director of Family Health Services provides leadership, policy, and procedural direction for Family Health Services, which includes the bureaus of Family and Community Health, WIC and Nutrition Services, Public Health Dental, Chronic Disease Prevention and Health Promotion, and the Child Nutrition Program.

The Bureau of Family and Community Health is responsible for many of the Title V activities related to pregnant women, mothers, and infants; and children. The Chief of the Bureau of Family and Community Health directs the offices of Infant, Maternal, and Reproductive Health (IMRH); Child and Adolescent Health; and Adult and Community Health.

Programs within Infant, Maternal, and Reproductive Health include Title V, Family Planning (Title X), Healthy Start, Pregnancy Associated Mortality Review, and Fetal and Infant Mortality Review.

***//2012/ The 2010 Florida Legislature passed a bill requiring the department of Health to conduct a comprehensive evaluation and justification review of its divisions and programs. Among many identified opportunities for improvement, two in particular stood out: the need to establish a clear mission and the need to establish and cultivate a culture of accountability and performance excellence. The evaluation will help the Department of Health identify health priorities and focus efforts and resources on towards those priorities with the highest potential for improving health status. //2012//***

#### **D. Other (MCH) Capacity**

Following is a description of senior level management employees in lead positions.

***/2012/ Governor Rick Scott appointed H. Frank Farmer Jr., MD, PhD, to serve as Florida State Surgeon General. Dr. Farmer began his tenure at the Department of Health on April 4, 2011. His work in the field of medicine includes his role as the Medical Director for Blue Cross/Blue Shield of Florida; private practitioner at East Volusia Internal Medicine Associates; and President of Endeavors Medical Group. Most recently, he was the Medical Director for Covance (Medical Research) in Daytona Beach, Florida. Dr. Farmer has served on the Florida Medical Association (FMA) Board of Governors and Florida Board of Medicine and has also served as FMA President and Chair of the Board of Medicine. //2012//***

Ana M. Viamonte Ros M.D., MPH, serves as the State Surgeon General of the Florida Department of Health. She is the first woman and the first Cuban American to lead the department. She came to DOH from Armor Correctional Health Services, where she worked to organize and monitor the health care delivery services in Florida's correctional institutions, and also oversaw the development of medical discharge programs.

***/2012/ Dr. Viamonte Ros is no longer with the Department of Health. //2012//***

Robert Siedlecki, Jr., was appointed Chief of Staff for the Florida Department of Health in March 2009. He previously served six years in the federal government with two agencies, at the Department of Health and Human Services as Special Assistant to the Assistant Secretary for Children and Families, and the Department of Justice as Senior Legal Counsel to the Task Force for Faith-Based and Community Initiatives.

***/2012/ Mr. Siedlecki is no longer with the Department of Health. The Chief of Staff position has not been filled. //2012//***

Kim Berfield was named the Deputy Secretary for the Florida Department of Health in February 2007. Prior to joining the Department of Health, she served four terms as a representative in the Florida House. She served in numerous positions during those terms, including Chairman of the Insurance Committee and Chairman of the Republican Conference.

***/2012/ Ms. Berfield currently serves as the Deputy Secretary for Policy and Advocacy. //2012//***

Shairi R. Turner, M.D., M.P.H., serves as both the Deputy Secretary for Health and the Director of Minority Health. Prior to joining the Department of Health, she served as the first Chief Medical Director in the Florida Department of Juvenile Justice, where she was responsible for assisting that department with the provision and oversight of quality medical, mental health, substance abuse, and developmental disability services.

***/2012/ Dr. Turner left the department on June 30, 2012. The department is currently recruiting a new Deputy Secretary for Health. //2012//***

***//2012/ Richard Solze was appointed as the Executive Office Director in May 2011. Mr. Solze will coordinate activities between the Surgeon General's office and the Divisions. He will also serve as a liaison with the Attorney General's office regarding the prosecution of practitioners who violate laws and regulations designed to halt prescription drug abuse. //2012***

Michael Sentman, Assistant Deputy Secretary for Health, is responsible for the oversight and direction of the 60 county health department directors and administrators responsible for the 67 county health departments in Florida. He has over 13 years experience at the county health department level, 10 of which was as an Administrative Services Director, and over five years at the department level.

Joseph Chiaro, M.D., was appointed as the Deputy Secretary for Children's Medical Services in January 2005. He has 25 years experience as a CMS physician provider and served eight years as the medical director for the Orlando (Region IV) CMS region. Dr. Chiaro spent 18 years in pediatric critical care medicine at the Arnold Palmer Hospital for Children and Women, and is board certified in Pediatrics and Pediatric Critical Care.

***//2012/ Dr. Chiaro is no longer with the Department of Health. Due to changes in the department's structure, there are no plans to fill or continue this position. //2012//***

The Title V programs are distributed among the Division of Family Health Services and Children's Medical Services Program, which has two divisions. As of May 2010, there are 30 central office staff in the Division of Family Health Services, Bureau of Family and Community Health, who perform duties for Title V funded programs. There are approximately 2,000 county health department staff who create the local infrastructure for Title V funded programs. The senior level management employees include: Annette Phelps, A.R.N.P., M.S.N., Division Director for Family Health Services, State Title V Director and Terrye Bradley, M.S.W., Bureau Chief, Family and Community Health. Capacity is also provided through the 30 Healthy Start coalitions covering 65 of the 67 counties in Florida. Department of Health county health departments serve as the Healthy Start coalition in the other two counties. Additional capacity is provided through partnerships with the private sector, the public sector, state government, local governments, community alliances, and maternal and child health care providers, and through linkages with state and national work groups and associations that provide capacity building by enhancing current competencies for staff and technical assistance.

Annette Phelps, A.R.N.P., M.S.N., has served as the Division Director for Family Health Services since 2002. Prior to that, Ms. Phelps served as the Bureau Chief for Family and Community Health, and was the Executive Community Health Nursing Director in the Office of Maternal and Child Health (now known as Infant, Maternal and Reproductive Health). Before joining the Central Office staff in 1989, Ms. Phelps worked for a number of years in county health departments.

Katherine Kamiya, M.Ed., serves as the Assistant Division Director for Family Health Services. She joined the division in 2007, bringing over 25 years of experience in direct services, administration, and executive leadership with addressing the needs of at-risk children and families. In this role, Ms. Kamiya also coordinates orientation, training and

professional development activities, as well as legislative bill tracking for the Division of Family Health Services.

Terrye Bradley, M.S.W., joined the Department of Health in 2002 to become the Bureau Chief of the Bureau of Family and Community Health. Ms. Bradley's prior experience includes serving as the Chief of Volunteer Services in the Department of Juvenile Justice, and as the Chief Operating Officer for an eight-site Community Health Center. She also worked several years as an administrator within a community-based hospice program.

William M. Sappenfield, M.D., M.P.H., joined the Division of Family Health Services in 2005. Dr. Sappenfield serves as the director of the MCH Practice and Analysis Unit. The main role of the unit is to enhance and support policy and program decision-making through surveillance, health monitoring, epidemiology investigations, evaluation, training, and capacity building.

Kris-Tena Albers, A.R.N.P., C.N.M., M.N., joined the Division of Family Health Services in 2008 as the Executive Community Health Nursing Director in the Infant, Maternal, and Reproductive Health Unit, which includes programs related to maternal and infant health and the Family Planning Program. Ms. Albers experience includes work within the department in the Office of Public Health Preparedness and in Public Health Nursing. She has also worked as a certified nurse midwife, an adjunct instructor for nursing students, and in nursing positions focusing on women's health.

Additional capacity within the Infant, Maternal and Reproductive Health Unit includes the following personnel:

Margaret Rankin, R.N. B.S.N., serves as the leader of the Family Planning Program, and has worked in Family Health Services since 1998.

Carol Scoggins, M.S., joined Infant, Maternal, and Reproductive Health in October 2009, serves as the leader of the Quality Improvement Team, and has worked in Family Health Services since 2004.

Nicole Hill joined Infant, Maternal, and Reproductive Health in November 2009, and serves as the Project Administrator.

Karen Coon, A.R.N.P., M.S.N., joined Infant, Maternal, and Reproductive Health in July 2010, and serves as the leader of the Healthy Start contracts team, and has previous experience working in the bureau of Family and Community Health as well as CMS.

As of May 2010, there were approximately 79 central office staff members in the Children's Medical Services Program. The CMS Network Division performs the duties for the Title V children with special health care needs component. There were approximately 673 out-stationed staff members in the 22 CMS area offices located throughout the state. The senior level management employees include: Joseph Chiaro, M.D. Deputy, Secretary for CMS; Phyllis Sloyer, R.N., Ph.D., Division Director for CMS Network and Related Programs; Michael Haney, Ph.D., Division Director for CMS Prevention and Early Interventions Programs, Marybeth Vickers, R.N., MSN., Chief for CMS Network Operations Bureau, and Peggy Scheuermann, M.Ed., Deputy Division Director for CMS Prevention and Early Interventions Programs.

Joseph Chiaro, M.D., was appointed as the Deputy Secretary for Children's Medical Services in January 2005. He has 30 years experience as a CMS physician provider and served eight years as the medical director for the Orlando (Region IV) CMS region. Dr. Chiaro spent 18 years in pediatric critical care medicine at the Arnold Palmer Hospital for Children and Women, and is board certified in Pediatrics and Pediatric Critical Care.

***/2012/ Dr. Chiaro is no longer with the Department of Health. //2012//***

Phyllis Sloyer, R.N., Ph.D., has served as the Division Director for Children's Medical Services since 1996 and is the Title V CSHCN Director. Prior to that Dr. Sloyer has served in several managerial positions in Children's Medical Services since 1979. She also served as Associate Director of the National Center for Policy Coordination at the Institute for Child Health Policy from 1990 to 1993 and has extensive experience in developing systems of care for CSHCN. She has also been recognized as Florida's Public Health Woman of the Year, has served as treasurer of AMCHP, and is the Past-President of AMCHP. She serves on the Florida Developmental Disabilities Council.

Mary Beth Vickers, R.N., M.S.N. joined CMSN as Chief for CMS Network Operations Bureau in June 2010. Previously, Ms. Vickers served a variety of CMSN programs in the nursing consultant role, as well as the Director of the Quality & Practice Management Unit. During her tenure with the Department of Health she has worked as a Nursing Consultant with the Florida Board of Nursing, and as the Executive Director of a Home Health Agency. Ms. Vickers is an adjunct instructor in nursing at Florida State University and Tallahassee Community College.

Peggy Scheuermann, M.Ed., C.P.M., has served as the Deputy Division Director for the Children's Medical Services Division of Prevention and Intervention, and has been with the division since 1998. Prior to working for the Department of Health, Ms. Scheuermann worked for a variety of social services agencies in the areas of criminal justice, domestic violence and child welfare. She currently serves on several statewide advisory councils on substance abuse prevention and child welfare.

Charlotte Curtis, R.N., B.S.N., C.P.M., has served as the Executive Community Health Nursing Director with the CMS Network since 2006, currently serving as the Director of Program Planning and Development. Prior to joining CMS in January 2006, for the Partners in Care: Together for Kids Program/CHIPACC, she served as a Nursing Consultant for the Maternal and Child Health Unit and Executive Community Health Nursing Director for the Child and Adolescent Health Unit. She has been the Department of Health since 1998. Ms. Curtis has been instrumental in the development, implementation and expansion of the first publicly funded palliative care program in the nation, and provides technical assistance to other states who would like to replicate Florida's palliative care model.

Susan Redmon, R.N., M.P.H., C.C.M., joined CMSN in 1997. She currently serves as the Program Director for the CMS Partners In Care Together For Kids palliative care program, the statewide healthcare transition liaison, and the programmatic telemedicine liaison. She serves on the Board of Directors of the Florida Alliance for Assistive Services and Technology, the Florida Developmental Disabilities Council, and is the Chair of the Health Care Task Force, Florida Developmental Disabilities Council.

## **E. State Agency Coordination**

The Department of Health collaborated with the University of Florida, the Florida Chapter of the March of Dimes, and the Agency for Health Care Administration as sponsors of a summit meeting for providers, health care plans, families, and other interested parties held June 10, 2010. The theme of the summit was *Developing Florida's Perinatal Quality Collaborative*. The purpose of the collaborative is to improve the understanding of possible root causes of adverse birth and infant outcomes for Florida residents. Once established, the group will measure infant and birth outcomes and the effect of generated perinatal interventions to address those outcomes, monitor and share key perinatal care indicators, identify and address statewide priority quality improvement issues, and provide quality improvement components for health providers and health plans at a state and provider level. Findings will be reported to state and local leaders, the public, health providers, health plans, and other agencies and organizations, in order to strengthen initiatives and minimize duplication.

The Department of Health provides or coordinates public health services through headquarters programs, county health departments, CMS area offices, primary care associations, and tertiary care facilities. Services are often provided in collaboration with other state agencies, including: education; juvenile justice; corrections; social services; child welfare; Medicaid and SCHIP; social security; emergency medical services; and alcohol, drug abuse, and mental health. This effort focuses on health and preventive care services, the promotion of optimal health outcomes, and the monitoring of the health status of the population.

In order to present an integrated, seamless service delivery system to families of vulnerable children, the Division of Family Health Services works in close collaboration with Children's Medical Services to ensure communities have procedures for coordinating services to those eligible for both Healthy Start and the CMS Early Steps Program.

School health services are provided under the direction of the Department of Health and in cooperation with the Florida Department of Education. Comprehensive school health service projects provide health care services in schools with high incidences of underserved high-risk children, teenage pregnancy, and poor birth outcomes.

Under Title XXI and Medicaid, the MCH role in the State Children's Health Insurance Program is to ensure access to care through outreach and the eligibility application process, provide interagency coordination, and staff the KidCare Coordinating Council. CSHCN are served through the CMS Network. The Florida KidCare plan provides services to children under 200 percent of the federal poverty level from birth to age 19 through either a Medicaid managed care plan, MediPass, or through the Title XXI programs, MediKids and Florida Healthy Kids. MediKids is for children age 1 to 5.

The Department of Health works in partnership with the Department of Children and Families (DCF) and the Ounce of Prevention Fund of Florida on implementation of the Healthy Families Florida initiative. Healthy Families Florida provides a community-based approach that uses intensive home visiting and coordination with other support services to build an integrated, coordinated, and comprehensive system of support for the

prevention of child abuse and neglect. The agencies work together to avoid duplication of services and to facilitate services needed by families served in either program.

***//2012/ The Department of Health partnered with the Department of Children and Families to establish the Maternal, Infant and Early Childhood Home Visiting Program. A federal grant by the Health and Human Services will provide \$31.5 million over a five-year period to implement the program. The objective to provide services to families at high risk of experiencing domestic violence, unemployment, substance abuse, poor birth outcomes, and low educational achievement. At this time, the department does not have budget authority to continue the grant program. //2012//***

In addition, the Department of Health has a letter of agreement with the Department of Children and Families that details collaboration between the two agencies to facilitate services for clients of both agencies. The letter of agreement includes interagency collaboration relating to facilitating the following health care services to DCF clients and its contracted service providers: HIV counseling, testing, and AIDS clinic services; family planning; Healthy Start; Early Intervention Program (Infants and Toddlers) services; prenatal care; immunizations; primary care/EPSTD; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); dental care; multiple handicap assistance teams; medical foster care; and other services as appropriate.

Coordination with WIC includes collaboration regarding breastfeeding initiatives, early entry into prenatal care, coordination with Healthy Start, addressing nutrition issues such as folic acid to prevent neural tube defects, and the development of general nutrition guidelines for inclusion in the Healthy Start standards. Coordination with other grant programs administered outside of the Department of Health includes working with Florida's Federal Healthy Start projects in selected counties, and other MCH-funded projects, including the Pediatric Pulmonary Project at the University of Florida, the MCH program of the College of Public Health at the University of South Florida, the Lawton and Rhea Chiles Center for Healthy Mothers and Babies, the Florida State University Center for Prevention and Early Intervention, and Community Integrated Services Systems (CISS) grants related to reproductive health and child abuse and neglect prevention.

Coordination with the Family Planning Program, which includes work on reducing teen pregnancy, reducing subsequent births to teens, preconception and interconception education and counseling, and abstinence education, has long been an integral part of our MCH efforts. This relationship was further enhanced in 2003 when the Family Planning Program (formerly housed within Women's Health) merged with the Maternal and Child Health Unit, to form the Infant, Maternal, and Reproductive Health Unit. This reorganization reflects a desire to fully integrate women's health care through the preconception, prenatal, and interconception periods, in order to promote optimal health prior to and between pregnancies, to help ensure positive birth outcomes.

The Department of Health and the Department of Children and Families continue coordinated efforts to prevent substance abuse during pregnancy and to reduce the impact of children affected. An IMRH staff person serves on the Florida Substance Abuse Prevention Advisory Council, and the IMRH unit has had the lead on the Florida Fetal Alcohol Spectrum Disorders Interagency Workgroup. The Department of Health also is a co-sponsor of the annual statewide Substance Abuse Prevention Conference.

In 2004, the Substance Abuse Program Office of DCF co-sponsored the IMRH unit's *Partners Sharing Solutions Conference*. The Department of Health works to increase the proficiency of health care providers in recognizing and getting needed treatment for women who abuse drugs during pregnancy and for substance-exposed infants, and in identifying and working toward resolution on issues impacting continuous and comprehensive prenatal and infant care for this high-risk population. One concrete example of these collaborations is *Fetal Alcohol Spectrum Disorders – Florida Resource Guide*, which has been included on CSAP's FASD Center for Excellence website as a recommended resource. The guide may be seen at <http://www.doh.state.fl.us/family/socialwork/pdf/fasd.pdf>. The interagency accomplishments of the FASD Workgroup earned the group a Davis Productivity Award in 2004.

In an effort to ensure that we continue to employ best practices to help reduce infant mortality, the Department of Health and the Florida Association of Healthy Start Coalitions have assembled a statewide Research to Practice Workgroup. The purpose of the workgroup is to review existing and ongoing research to ensure the continued effectiveness of the Healthy Start model. The workgroup will employ evidence-based practices to evaluate the Healthy Start program at the state and local levels, providing program improvements through the identification, implementation, and evaluation of best practices across the state.

The department works collaboratively with Florida universities to implement maternal and child health initiatives. These collaborations enable the state to access resources unique to the university setting. The Perinatal Data/Research Center, located at the University of Florida, provides a warehouse for maternal and child health data. The center stores and validates data, links related data files, publishes and analyzes data, and studies the impact of program interventions on health status outcomes. The department also serves as a site for public health, nursing, and social work interns from Florida A&M University and Florida State University.

Community health centers play an important role in Florida's health care delivery system. There are 41 community health centers in Florida and 283 clinic locations, though not every clinic provides a full-range of services. Centers are located in 54 of the 67 counties in Florida. Funded in part by the U.S. Public Health Service, they provide care in federally designated medically underserved areas. The centers offer primary health care, preventive health services, emergency medical services, transportation services, preventive dental care, and pharmaceutical services. Their patients include high-risk clients such as migrant farm workers, low birth weight infants, the elderly, homeless people, and HIV patients. A number of Healthy Start coalitions contract with the centers for prenatal care and infant services, based on need and available resources. In some areas, the centers play an active role as members of the local Healthy Start coalition, which might include activities such as service delivery planning.

The Bureau of Chronic Disease Prevention and Health Promotion was established in 1998 to improve individual and community health by preventing and reducing the impact of chronic diseases and disabling conditions. The bureau administers the following programs: Heart Disease and Stroke Prevention; Healthy Communities, Healthy People; Breast and Cervical Cancer Early Detection; Comprehensive Cancer Control; Colorectal Cancer Screening; Diabetes Prevention and Control; Arthritis Prevention and Education; Epilepsy Services and Education; and Communities Putting Prevention to Work. The

bureau programs develop, implement, and manage health promotion activities, primary and secondary prevention services, and community-based health interventions. The bureau manages the federal Preventive Health and Health Services Block Grant, the Florida Preventive Health Advisory Committee, and the Diabetes Advisory Council for the Florida Department of Health. The bureau strives to be a leader in developing an integrated and unified, statewide system to promote healthy lifestyles and detect, prevent, and reduce complications of chronic diseases. Toward that end, the bureau collaborates with federal, state, public, private, and voluntary organizations; obtains funding for planning, developing, and implementing evidence-based programs and interventions; and establishes and participates in councils and partnerships. The bureau supports community and state-level partnerships. These partnerships ensure coordination and collaboration among and between different stakeholders and providers and promote efficient and effective health resources. Some of these partnerships include the Florida Cardiovascular Health Council, the Florida Interagency Food and Nutrition Committee, the Diabetes Advisory Council, the Florida Alliance for Diabetes Prevention and Care, the Comprehensive Cancer Research Advisory Board (CCRAB), and the Florida Cancer Plan Council. The bureau receives funding from a variety of federal and state sources, including the Preventive Health and Health Services Block Grant, grants from the Centers for Disease Control and Prevention (CDC), state trust funds, and general revenue.

Projects that specifically relate to maternal and child health include:

The Healthy Communities, Healthy People (HCHP) Program provides funding, training and guidance to all 67 county health departments to develop, implement, and support environmental and policy strategies to promote healthy life choices and reduce death and disability from chronic disease. Prevention efforts focusing on healthy eating and active living are accomplished through collaboration with local partners and coalitions for community-wide impact. Local focus areas include worksites, schools, health care settings, and organizations, including faith-based organizations.

Sun Protection in Florida (SPF) Project: Annually the HCHP Program coordinators have been collaborating with the Comprehensive Cancer Control Program to implement the SPF project, which educates elementary school-aged children on sun safe behaviors based on the Environmental Protection Agency's SunWise curriculum. This project includes provision of a shade shelter for the playground of the schools that are implementing the program.

Community Gardens: Each Spring the Comprehensive Cancer Control Program implements the "Grow Healthy" Garden project, which has been providing an increasing number of school garden kits and materials to the Department of Education for their program of "Gardening for Grades" as part of the Florida Next Generation Sunshine State Standards (<http://www.fldoe.org/bii/cshp/schoolgar.asp>). Additionally the program provides over 50 community garden kits statewide through a simple application process.

Road to Health Curriculum: *The Road to Health Toolkit* (RTH) provides community health workers with interactive tools that can be used to counsel and motivate those at high risk for type 2 diabetes. These tools will help reduce their risk for type 2 diabetes by encouraging healthy eating, increased physical activity, and moderate weight loss for those who are overweight. Women who have gestational diabetes (GDM) have a 20-50 percent chance of developing diabetes within 5-10 years postpartum. The Diabetes

Prevention and Control Program has partnered with Florida's Healthy Start Coalitions to identify and educate women at risk for type 2 diabetes due to previous or current history of GDM.

The Communities Putting Prevention to Work Program (CPPW) consists of two components. Component I focuses on obesity prevention and tobacco cessation/prevention through local policy and environmental change promoted by 13 regional coordinators located throughout the state. These activities include increasing physical activity for elementary aged children through participation in the Safe Routes to School – Walking School Bus Program, increasing support for lactating employees of state agencies and school districts, and increasing the number of tobacco-free parks and recreational facilities. Component II of CPPW provides resources to implement an evidence-based, comprehensive physical activity program in all 590+ Florida middle schools. Training will be delivered to designated teachers and Train the Trainer training will be conducted in the summer of year two to certify future trainers in an effort to assure sustainability of this program.

The programs mentioned above demonstrate the bureau's belief in promoting health across the lifespan. The decline in the amount of physical activity that children engage in begins in middle school; however, students who are physically active in middle school have a greater likelihood of becoming physically active adults. Adults who are physically active significantly reduce their risk of heart disease, stroke, and other chronic diseases such as diabetes. It is expected that this future generation of healthier adults will result in reduced future healthcare costs. The bureau will continue to collaborate with the Infant, Maternal, and Reproductive Health Unit sharing data, initiatives, and interventions that affect all residents in Florida.

Florida utilizes funding from HRSA through the State Systems Development Initiative Grant Program (SSDI) to enhance and improve statewide data capacity. Efforts have included: establishing and improving linkages between existing data files; developing and expanding local level data access and capacity; expanding the agency's data capacity for national reporting; and increasing the evaluation and analytic activities for MCH issues. Immediate goals include: improve access to linked and unlinked files for the department, for state partners and for Florida communities while protecting confidentiality and program integrity; improve accuracy, efficiency and sustainability of current file linkage activities; and improve use of linked and unlinked files for policy and program purposes. The ultimate goal of the SSDI grant is to have information needed to improve the health of women, children and families in a useable format that is readily available to people who can make decisions at individual, family, neighborhood, community, or state levels.

In the fall of 2008, the Infant, Maternal, and Reproductive Health Unit successfully applied for the HRSA First Time Motherhood/New Parents Initiative. Grant funding in the amount of \$223,362 enabled us to partner with the Healthy Start Coalition of Pinellas, Inc. on a project entitled Florida Right from the Start. The project will create a statewide social marketing campaign to promote positive birth outcomes by increasing awareness of preconception and interconception care, prenatal care, and parenting among first time parents. An evaluation team will gauge the effectiveness of the social marketing campaign based on increased awareness as measured by pre-intervention and post-intervention surveys. They will administer Web-based surveys to a convenience sample of first-time mothers and parents. They will also conduct Web-

based post-implementation key informant surveys, and compile utilization statistics from the website and hotline to evaluate actual use. Funding for the second year is \$230,064.

***//2012/ The Florida Right from the Start project resulted in culturally-appropriate messages accepted by both consumers and providers. The project promoted improved health care provider involvement. It also identified the limited usefulness of written Creole materials and highlighted the need for additional evaluation involving partner input and post-program debriefing of lessons-learned. //2012//***

## **F. Health Systems Capacity Indicators**

Following is a discussion of each individual Health System Capacity Indicator.

HEALTH SYSTEMS CAPACITY INDICATOR #01: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 – 493.9) per 10,000 children less than five years of age.

The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 – 493.9) per 10,000 children less than 5 years of age is calculated with inpatient hospital discharge data from the Florida Agency for Health Care Administration (AHCA) and population data for children 0 – 5 from Florida Community Health Assessment Resource Tool Set (CHARTS) - <http://www.floridacharts.com/charts/PopQuery.aspx>.

There were a number of efforts in FY 2010 to reduce early childhood asthma. The Healthy Start program assesses pregnant and parenting mothers for issues related to household indoor air quality, such as use of tobacco products, appropriate removal of dust and animal dander, and other allergens. Additionally, the Infant, Maternal, and Reproductive Health Unit works to reduce the prenatal smoking rate that includes education to pregnant mothers on the relationship between secondhand smoke sudden infant death syndrome, lung problems, ear infections, and more severe asthma. Mothers or their infants and children are referred for medical specialty care if asthma is suspected.

The Department of Health, Division of Environmental Health inspects daycare and pre-kindergarten facilities. The state asthma data workgroup tracks the relationships between environmental asthma triggers and rates of asthma hospitalization and student asthma. Hospital discharges for asthma among 0 – 14 year-olds increased slightly from 1.9 per 1,000 in FY2009 to 2.0 per 1,000 in FY2010.

HEALTH SYSTEMS CAPACITY INDICATOR #02: The percent of Medicaid enrollees whose age is less than one year who received at least one initial or periodic screen.

Local organizations and communities initiate outreach activities to increase awareness of the availability of Medicaid coverage for eligible children, and the Florida KidCare partners ensure the public understands families may apply for and have their eligible children enrolled in Medicaid at any time. In addition, the Covering Kids Coalition is working to ensure that eligible low-income children apply for Medicaid coverage through Florida KidCare through collaboration with community, regional, and state organizations and Florida KidCare community coalitions.

HEALTH SYSTEMS CAPACITY INDICATOR #03: The percent of SCHIP enrollees whose age is less than one year who received at least one initial or periodic screen.

In Florida, infants whose family income is <200 percent of poverty are eligible for Medicaid. A small number of families choose not to apply for Medicaid, instead opting for SCHIP coverage. The Agency for Health Care Administration collects data on the number of SCHIP enrollees who receive at least one initial or periodic screen and shares that with the Department of Health.

HEALTH SYSTEMS CAPACITY INDICATOR #04: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

The department works in collaboration with Healthy Start coalitions statewide to ensure an adequate infrastructure is in place for the provision of first trimester prenatal care and continuous care for all pregnant women. The MomCare program, implemented statewide during FY2002, facilitates Medicaid coverage for prenatal care under the Sixth Omnibus Budget Reconciliation Act (SOBRA). MomCare provides prenatal care choice counseling outreach, helps women access health care services, assists in follow-up of missed prenatal care appointments, and promotes coordination between prenatal care providers and supportive health related enabling services. MomCare sends a seven-month packet to all clients that includes information on the Family Planning Waiver. MomCare provides follow-up services as needed to recipients as well as a mandatory post-enrollment follow-up service to all recipients between the sixth and ninth month of facilitating access to family planning services, health care coverage for the infant and help choosing a pediatrician for the infant. Follow-up can be by telephone or by mail. We continued to ensure the statewide process of presumptive and Simplified Medicaid eligibility for pregnant women. Additionally, we work through the Healthy Start coalitions to implement strategies to remove barriers and improve access to care as well as develop solutions for increasing the first trimester entry rate.

HEALTH SYSTEMS CAPACITY INDICATOR #05A, B, C, and D (Medicaid and Non-Medicaid Comparison).

As expected, for all indicators on this form, the non-Medicaid population has considerably better outcome indicators than the Medicaid population. Please see form 18 for data.

HEALTH SYSTEMS CAPACITY INDICATOR #06 (Medicaid and CHIP eligibility levels):

Infants 0-1 whose family income is 185 percent or below of the Federal Poverty level and below are covered by Medicaid. Infants 0-1 whose family income is between 185 percent and 200 percent of the Federal Poverty level are covered by SCHIP. Children 1 to 6 whose family income is 133 percent of the Federal Poverty level or below are covered by Medicaid. Children 1 to 6 whose family income is between 134 percent and 200 percent of the federal poverty level are eligible for KidCare. Children 6 to 18 whose family income is 100 percent of the Federal Poverty level or below are covered by Medicaid. Children 6 to 18 whose family income is between 101 percent and 200 percent of the federal poverty level are eligible for KidCare. Pregnant women whose family income is 185 percent of the Federal Poverty level and below are covered by Medicaid.

HEALTH SYSTEMS CAPACITY INDICATOR #07A: The percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

The Florida KidCare partners continue to work with community-based organizations, health care providers, and others to ensure people understand the Medicaid program availability. The Covering Kids and Families project at the University of South Florida implemented special initiatives to work with hard-to-serve populations and leaders in minority communities to ensure that they promote the Florida KidCare message to eligible children year-round. These services are targeted towards providing easy-to-understand, accurate information about children's health insurance and preventing loss of coverage among eligible children in the state.

HEALTH SYSTEMS CAPACITY INDICATOR #07B: The percent of EPSDT eligible children aged 6 through 9 years who have received any Medicaid dental services during the year

Improving access to dental care for low-income persons below 200 percent of the federal poverty level is a priority of the department. Over the last several years, the department has funded initiatives to expand the infrastructure of county health department safety net dental programs. During 2010, two additional counties began to provide dental services, increasing the total number of Florida counties with dental programs to 50. A large majority of clients served through county programs are Medicaid-enrolled children, and during 2010 the number of Medicaid children receiving dental care grew from 103,227 to 113,145, a 9.6 percent increase. A state oral health improvement plan for disadvantaged persons utilizes ongoing broad-based stakeholder input to facilitate the continued development of an integrated, coordinated oral health system between the public and private sectors. The state oral health coalition, Oral Health Florida, and numerous local coalitions work collaboratively to implement diverse strategies around prevention, education, and treatment.

The Oral Healthcare Workforce Ad Hoc Advisory Committee was convened in 2008 to evaluate and strategically address the complex range of oral health workforce concerns. These include issues surrounding public policy, professional practice, supply and demand of services, current and projected education and training, and regulatory questions. The committee's final recommendations were published in a report in February 2009.

The Florida Oral Health Workforce Workgroup supported by a Health Resource Services Administration (HRSA) Grant built upon the recommendations of the State Oral Health Improvement Plan (SOHIP) and the Surgeon General's Ad Hoc Oral Healthcare Workforce Committee Report. Drawing upon the Department of Health's and SOHIP's existing partnerships, collaborations, and experiences, a statewide oral health workforce workgroup was convened in the fall of 2008. The workgroup was charged with initiating a statewide oral health needs assessment and developing a realistic strategic plan that will act as a blueprint to improve the State's oral health workforce and service delivery infrastructure. Their report was made available in January of 2010.

HEALTH SYSTEMS CAPACITY INDICATOR #08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs (CSHCN) Program.

When a family, who meets the financial eligibility criteria for SSI, applies for benefits, the application is sent to the Office of Disability Determination Services for a medical eligibility decision. After a medical decision is made, the information about the child, whether eligible or not eligible for SSI benefits, is sent to the CMS Program Office. The CMS SSA/SSI Liaison reviews the information about the child. The information about the child is sent to the CMS office in the area where the child resides. An individual in the local CMS office contacts the child's family to find out if the child has a health care provider. If not, the family is invited to apply for services of CMS. When a child with mental illness applies for SSI benefits, the CMS SSA/SSI liaison sends the information about that child to the Children's Mental Health Program in the Department of Children and Families for follow-up.

HEALTH SYSTEMS CAPACITY INDICATOR #09A: The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data.

Infant Death Certificates: This linkage has been accomplished and extended during the project period to include birth records linked to the following:

- Fetal and infant death records
- Healthy Start prenatal risk screening data
- Healthy Start infant risk screening data
- Healthy Start prenatal services
- Medicaid participation
- WIC participation
- Census Tract Information

The data has been made available to county health departments and Healthy Start coalitions for analysis of outcomes in their area.

Medicaid Eligibility or Paid Claims Files: The project that links maternal Medicaid eligibility files to birth certificates is an ongoing collaboration of the Florida Agency for Health Care Administration; the Office of Planning, Evaluation, and Data Analysis; the University of South Florida Lawton and Rhea Chiles Center for Healthy Mothers and Healthy Babies; and the University of Florida's Maternal Child Health and Education Research and Data Center (MCHERDC). The actual linkage is completed by the MCHERDC and provides the information on Medicaid participation identified above. The project produces annually a Medicaid MCH Indicator Report. The University of Florida is also using this and other data to evaluate Florida's 1915(B) Healthy Start Medicaid Waiver.

WIC Eligibility Files: The maternal WIC eligibility files are linked to birth certificates as part of the Medicaid collaboration. This linkage provides the data listed under infant death certificates and is included in the annual Medicaid MCH Indicator report. The Department of Health is currently planning to evaluation the WIC linkage quality.

Newborn Screening Files: Newborn Screening data has been linked once to live birth certificates in 2004. This linkage identified that only a small percentage of live births are not receiving newborn screening. However, screening of every newborn is important. Plans are under development to integrate the data entry for live birth certificates and

newborn screening at the delivery hospital to establish an ongoing process for identifying newborns who are not screened.

Hospital Discharge Survey Data: Ability to access to this data has been consistently available in recent years, but access can change over time. Once established for a user, is consistent. Direct access is limited to de-identified data without a special data sharing agreement. Other parts of the Department do have access to identified discharge data.

Birth Defects Registry: SSDI staff continues to work closely with Birth Defects Registry staff to develop further data linking and utilization strategies. Increased awareness of Birth Defects Registry availability and access was achieved through convening a meeting of local and regional public health leaders, lead by SSDI staff. Plans are underway to develop a birth defects research data file that will allow this data to be more readily analyzed by internal and external partners including SSDI staff. Current plans exist to link this research data file to CDC's assisted reproductive technology clinic records, and other files already linked to birth certificates.

HEALTH SYSTEMS CAPACITY INDICATOR #09B: The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

There are two surveys in Florida that can be utilized to determine the percent of adolescents who smoke, the Youth Risk Behavior Survey (YRBS) and the Florida Youth Tobacco Survey. We can access the results of the surveys, but the MCH program does not have direct access to the survey databases for analysis.

#### **IV. PRIORITIES, PERFORMANCE, AND PROGRAM ACTIVITIES ANNUAL REPORT/ANNUAL PLAN**

##### **A. Background and Overview**

The Government Performance and Results Act (GPRA - Public Law 103-62) requires that each Federal agency establish performance measures that can be reported as part of the budgetary process that links funding decisions with performance and related outcome measures to see if there were improved outcomes for target populations. Priorities and state performance measures have been established based on needs assessment activities.

##### **B. State Priorities**

State priorities were determined through the five-year needs assessment. That process indicated a need to focus on reducing risk factors that adversely affect outcomes for the maternal and child health population. The priorities also reflect an increased focus on reducing racial disparities. Priorities were determined using both quantitative and qualitative data, as well as the recommendations of our needs assessment advisory committee. Following is a list of the eight state priorities for Florida, and the performance measures they relate to.

1. Prevent unintended and unwanted pregnancies.

SPM#2 (new) The percentage of births with inter pregnancy interval less than 18 months.

2. Promote preconception health screening and education.

SPM#3 (new) 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.

3. Promote safe and healthy infant sleep behaviors and environments.

SPM# 4 (new) The percentage of infants not bed sharing.

SPM# 5 (new) The percentage of infants back sleeping.

4. Prevent teen pregnancy.

NPM#8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

5. Improve dental care access, both preventative and treatment, for children.

NPM#9 Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

SPM#7 (new) The percentage of low-income children under age 21 who access dental care.

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

NPM#3 The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.

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

NPM#6 The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life.

8. Increase early intervention services for children with special health care needs.

SPM#1 The percentage of Part C eligible children receiving service.

### **C. National Performance Measures**

**NPM#1: 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.**

#### **A. Last Year's Accomplishments**

Florida statutes require that every newborn born in the state must be screened before one week of age. Although parents have the option of refusing the test, almost all babies are tested. It is estimated that less than 1 percent of parents refuse to have their newborns participate in the statewide screening program. This is a population-based service. All of the MCH population groups are served by this measure. Follow-up activities include contracts with genetic specialty centers for referral of patients with abnormal test results, and contracts with cystic fibrosis, endocrine and hematology/oncology specialty centers. Specialty referral centers arrange for confirmatory testing and treatment for patients identified through the Florida Newborn Screening Program. Genetic counseling, follow-up, and nutritional counseling activities

related to treatment and dietary management are included. Educational materials are distributed to all birthing facilities regarding the 34 disorders that are tested in the newborn metabolic screening.

In 2009, testing identified 1,275 babies with presumptive positive screening results. After confirmatory testing, 379 were found to have one of the 34 disorders. Of the 379 confirmed cases, all of them received timely follow-up and treatment. Final data for 2010 are not yet available.

Direct Health Care Service activities provided by the department include referral of patients with presumptive positive test results to genetic specialty centers, endocrine specialty centers, and hematology/oncology specialty centers. Specialty referral centers provide confirmatory testing and treatment to patients identified through the Florida Newborn Screening Program. Genetic counseling, follow-up, and nutritional counseling activities, related to treatment and dietary management are included. Educational materials are distributed to all birthing facilities regarding the five disorders that are tested in the newborn metabolic screening. The previous two activities are population-based services.

### **B. Current Activities**

The Florida Newborn Screening Program expanded the number of disorders screened to 35 including hearing. Beginning on September 17, 2007, all babies born in Florida were screened for 29 disorders recommended by the American College of Medical Genetics plus five more recommended by the 2002 Florida Infant Screening Task Force. Entities that submit specimens for testing are responsible for forwarding the lab results to the newborn's primary care physician to ensure that the medical home is informed of the results. Beginning December 2005, hearing screening results were included on the lab report. All newborns identified through the Newborn Screening Program are medically eligible for the Children's Medical Services Network Program. The Florida Newborn Screening Results (FNSR.Net) web-based program was developed for physicians and hospitals to access for newborn screening results. In 2010, there were 1,829 registered users who accessed the site 61,543 times. This statewide outreach program is a population-based service.

### **C. Plan for the Coming Year**

There are plans to link the electronic birth registration information with newborn screening in summer 2011. This will allow the vital statistics information to be uploaded nightly to auto-populate the newborn screening demographic fields. This will ensure accurate data and also provide an accounting of each baby issued a birth certificate to also receive a newborn screening test. The Florida Newborn Screening Program is also currently implementing another web-based program for hospitals and providers to access and enter hearing screen results. These results will upload into the Newborn Screening data system nightly; this will ensure accurate reporting and timely follow-up. The Florida Newborn Screening Follow-Up Program will continue to contract with specialty centers for appropriate referrals; provide genetic counseling, follow-up, and nutritional counseling activities; and continue distributing educational materials to all birthing facilities. In January 2011, the Genetics and Newborn Screening Advisory Council recommended that Severe Combined Immunodeficiency (SCID) be added to Florida's panel of newborn screening disorders. Implementation will begin after final approval for budget authorization.

**NPM#2: The percent of children with special health care needs age 0-18 whose families partner in decision-making at all levels and are satisfied with the services they receive.**

**A. Last Year's Accomplishments**

The six CMS goals incorporate the key systems outcomes of the Maternal and Child Health Bureau. The first CMS goal states: "Children who are enrolled in CMS Programs and their families will be partners with CMS in decision-making at all levels and will be satisfied with the services they receive." Data collection for this infrastructure building service consists of:

Measure 1: Children and their families will have a positive perception of care.

- A. Percent of families reporting satisfaction with the quality of primary care, obtaining referrals, needed services, and coordination among providers.
- B. Percent of Title XXI families reporting satisfaction with the quality of primary care, obtaining referrals, needed services, and coordination among providers.
- C. Percent of complaints and grievances (# complaints/#eligible clients within the quarter).
- D. Percent of families reporting satisfaction with CMS Area Office operations and staff (# positive response surveys/# surveys completed within the quarter).

Measure 2: Children and their families are partners with CMS in decision-making.

- A. Percent of parents who report satisfaction with their level of involvement in setting concerns/priorities about their child's care.

Satisfaction surveys for parents of children enrolled in CMS Programs were conducted through a CMS contract with the Institute for Child Health Policy (IHP), University of Florida. In state fiscal year 2009-2010, 640 families completed the CMSN satisfaction survey. On average, 73 percent of parents statewide rated the quality of care in the CMS Network program as excellent or very good. Statewide, parents gave family centered care-shared decision making a score of 89 percent.

The surveys showed that 90 percent of parents who responded were satisfied with CMSN benefits. A total of 79 percent of parents indicated their nurse care coordinator is knowledgeable and helpful.

In October 2010, the CMSN Central Office hired a family member part-time to serve as a Family Health Partner Consultant. Her role is to provide parent/family input in CMS policies and procedures. Each of the CMS regional offices employ one or more Family Support Workers to provide family input, assist the families of CMS enrollees to navigate the health and social services systems in their communities, and provide families with resources and information. The Family Support Workers work closely with CMS nurses and social workers in their region.

**B. Current Activities**

The Institute for Child Health Policy continues to conduct satisfaction surveys, under contract, for the CMSN. Populations within CMS are identified for surveys to support internal and other performance improvement measures. Surveys are aimed at describing and quantifying satisfaction and health-related quality of life for children enrolled in the CMSN.

In addition, CMS continues to collect data from each of the 22 area offices for this and the other five national performance measures. The data is collected via the electronic records that are created and maintained for each CMS enrollee.

The CMS Family Health Partner Consultant is assisting with a review of information for families that the Florida Department of Juvenile Justice is up-dating to ensure it is family-friendly. She is consulted by programmatic and contract CMS staff in Central Office to obtain input for family-centered and family-friendly language and works closely with medical home issues.

### **C. Plan for the Coming Year**

The CMS Network will continue to collect data on performance measures from each of the 22 area offices and track performance.

CMS will continue to contract with the ICHP to conduct the CMS Satisfaction Surveys of the families of CMS Network enrollees to evaluate issues including access to health care and satisfaction with services. This activity allows CMS to collect data from families to ensure a high level of satisfaction from all of its customers.

The CMS Family Health Partner will continue to contribute ideas and identify resources to guarantee that family participation is understood and promoted within CMS.

**NPM#3: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.**

### **A. Last Year's Accomplishments**

#### **1. Medical Home Education and Training-Population-Based Services-CSHCN:**

CMS continued to participate in multiple national medical home learning collaboratives and continued to strive for excellence in its Medical Home Spread with continued education and oversight of current medical homes through a variety of strategies in Florida's communities. CMS collaborated with many community-based programs to provide a multi-level strategy for implementing the Medical Home concept. CMS developed outreach programs to recruit primary care physicians and specialists in the communities surrounding the CMS offices and to educate physicians about the benefits of participating in a medical home. CMS Primary Care Programs have initiated home visits for medical home clients, expansion of research into private practices, and have placed CMS care coordinators in federally qualified health centers.

In 2009, in collaboration with the American Academy of Pediatrics (AAP) and the Center for Medical Home Improvement (CMHI), CMS finalized a proposal to seek interest in medical home demonstrations projects using practice improvement techniques and quality improvement with a care coordination focus. Through conference calls and meetings, the timeline and medical home implementation project were developed. Recruitment and training of physician practices was initiated to participate in a Building Your Medical Home Toolkit web-based four part training series.

#### **2. Medical Home Outreach-Population Based Services-CSHCN**

CMS began development of an accountable and comprehensive administrative claiming process and a comprehensive system of payment accuracy review for the CMS regions. CMS began assessing the care coordination system as part of the administrative claiming process.

### 3. Medical Home Community Supports-Infrastructure Building Services-CSHCN

CMS participated in an interagency agreement signed by the DOH, Agency for Health Care Administration, Persons with Disabilities, and Juvenile Justice to participate in moving the service delivery system towards medical homes for Medicaid beneficiaries based on the NCQA's published set of standards for a patient centered medical home. This group was convened in 2009 with the purpose of addressing health care planning. AHCA obtained a sizable demonstration grant proposal to the federal CMS that includes focusing on CMS medical home pilots for Medicaid beneficiaries.

## **B. Current Activities**

### 1. Medical Home Education and Training-Population-Based Services-CSHCN

CMS, the American Academy of Pediatrics (AAP), and the Center for Medical Home Improvement hosted the Medical Home Implementation Project. The first phase, the CMS Medical Home Demonstration Project to implement the AAP Building Your Medical Home Toolkit statewide was attended by CMS physicians, lead staff; CMS care coordinators, and parent partners who have CHSCN. Training includes practice improvement techniques, ongoing quality improvement initiative (working toward NCQA Medical Home Recognition), medical home care coordination, and ongoing program evaluation.

### 2. Medical Home Outreach-Population Based Services-CSHCN

CMS continued the development of an accountable, comprehensive administrative claiming process and a comprehensive system of payment accuracy review.

### 3. Medical Home Community Supports-Infrastructure Building Services-CSHCN

CMS worked toward the implementation of a joint effort between Children's Medical Services (CMS), Department of Children and Families (DCF), Persons with Disabilities, and Juvenile Justice and their contract entities for comprehensive health care that is managed and coordinated by a medical home provider for children in out-of-home care (foster care, relative placement, non-relative placement). CMS and DCF hosted a workgroup on the needs of children in out-of-home care and development of a strategic plan for meeting the needs of this population.

## **C. Plan for the Coming Year**

### 1. Medical Home Education and Training-Population-Based Services-CSHCN

In an effort to unify and standardize the term medical home and what it means to CMS and CMS families, the following activities are planned for the next year. In 2011, CMS will collaborate with the AAP and CMHI to provide medical home training opportunities to the participants in the Medical Home Implementation Project (MHIP). A training focused on Meaningful Use of Electronic Medical Records is scheduled. A training opportunity for the participating CMS pediatricians will provide Education in Quality Improvement for

Pediatric Practice (EQIPP) training. Participants in MHIP will continue to receive training and technical assistance in developing a team approach to quality improvement in their medical home projects. CMS will continue to provide technical assistance to prepare the MHIP participants to prepare for the National Committee for Quality Assurance Certification.

CMS will develop a strategic plan to oversee implementing the medical home implementation project statewide. CMS will continue to recruit CMS pediatricians to participate in the statewide implementation plan.

CMS medical home projects will continue to collaborate and develop partnerships with community resources and agencies. CMS will continue to move care coordinators into pediatrician practices and federally qualified health centers.

## 2. Medical Home Outreach-Population Based Services-CSHCN

CMS will continue to develop an accountable and comprehensive administrative claiming process and a comprehensive system of payment accuracy review for the CMS regions. Decision Support and Information Technology: develop a comprehensive information system and determine the critical decision support functions and reports. Medical Services: improve our clinical services through the development of clinic standards, the development of medical homes throughout the state, newborn screening expansion, and enhancement of the Early Steps Program.

## 3. Medical Home Community Supports-Infrastructure Building Services-CSHCN

CMS will continue to work toward the implementation of the joint effort between Children's Medical Services (CMS), the Department of Children and Families (DCF), Persons with Disabilities, and Juvenile Justice and their contract entities to ensure comprehensive health care that is managed and coordinated by a medical home provider for children in out-of-home care (foster care, relative placement, non-relative placement). CMS is developing an implementation plan for children in out-of-home care.

**NPM#4 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).**

### **A. Last Year's Accomplishments**

The U.S. Department of Health and Human Services Health Resources and Services Administration estimates that 13.4 percent of Florida children have a special health care need (National Survey of Children with Special Health Care Needs Chartbook, 2005-06).

In state fiscal year 2009-10 (July 1, 2009- June 30, 2010), the CMS Network for children with special health care needs provided coverage to 60,344 Title XIX-funded and 36,348 Title XXI-funded unduplicated children. In addition, 10,382 unduplicated children received "Safety Net" services, state-funded services designed to provide limited wraparound services to children ineligible for Title XIX or Title XXI coverage, or whose private health insurance coverage is insufficient to meet the child's needs.

The statutorily created Florida KidCare Coordinating Council, section 409.818(2)(b), Florida Statutes, includes a diverse membership that makes recommendations to

improve the implementation and operation of the Florida KidCare program. Some of the council recommendations from the January 2011 report address fully funding the Florida KidCare program, including annualization needs, projected growth, outreach and increased medical and dental costs; implementing a medical income disregard for children with catastrophic illness who would otherwise qualify for Title XXI subsidies; implementing the state option Family Opportunity Act, and taking advantage of federal funding to cover otherwise eligible legal immigrant children, pregnant women and public employees' children.

### **B. Current Activities**

The Florida Healthy Kids Corporation continues support for community outreach campaigns targeting organizations whose memberships and clientele focus on families potentially eligible for Florida KidCare. Currently, 34 organizations are partnering with Florida KidCare.

As part of the federal CHIP reauthorization law, the U.S. Department of Health and Human Services awarded almost \$1 million to the University of South Florida Covering Kids and Families (CKF) Project to help find and enroll eligible children in Florida KidCare, and to promote retention, with special emphasis on racial and ethnic minority groups whose children are more likely to be uninsured. The Florida Department of Health (DOH) works closely with CKF to support these critical efforts.

DOH maintains the Florida KidCare website. Staff provides Florida KidCare information to families through Children's Medical Services, county public health departments, school health, and Healthy Start programs.

The Agency for Health Care Administration (AHCA) works with the CKF project to build partnerships and create community-based coalitions to promote and sustain Florida KidCare. AHCA also includes promotional materials in its presentations.

The Department of Children and Families provides materials and information to their community partners and uses direct mail techniques to contact families who do not qualify for Medicaid to encourage them to apply for Florida KidCare for their children.

### **C. Plan for the Coming Year**

In collaboration with other Florida KidCare partners, the Department of Health will continue to reach out to families with potentially eligible children and encourage them to apply for coverage. The department will also continue efforts at the state and local level to help eligible children retain their health care coverage.

**NPM#5 The percent of children with special health care needs age 0 to 18 whose families report the community-based service system are organized so they can use them easily.**

### **A. Last Year's Accomplishments**

CMS Central Office hired a parent of a CMS enrollee in October 2010 to serve as a CMS Family Health Partner Consultant and provide input on CMS policies and procedures. The Family Health Partner Consultant works with the CMS Central Office staff and the regional Family Support Workers to ensure a family-centered and family-friendly focus.

CMS area offices in various areas continued to provide specialty services through telemedicine. The clinics included neurology, nutrition, and dermatology in the southeast Florida area. The University of Florida continues to provide endocrinology and genetics consults and follow-up with other areas of the state through telemedicine. Discussions continued to increase telemedicine clinics in areas where access to specialty care is hampered by distance required for travel or the wait time it takes to schedule an appointment and be seen by the physician.

CMS also used their video conferencing equipment statewide for regional meetings and educational presentations. This saved travel time and costs for CMS staff and medical directors.

The CMS on-line, web-based provider application process continued to decrease the time required for enrolling new providers. The on-line application process started during the summer of 2008 and has continued to be refined. Feedback from providers was very positive.

### **B. Current Activities**

The CMS activities support: caregivers and partners; children, teens, and young adults, family leadership programs; family organizations and initiatives, and to promote the use of telemedicine. These activities provide direct health care, enabling, population-based, and infrastructure building services.

The CMS Family Health Partner Consultant works with CMS programmatic and contract managers to ensure a family-friendly and family-centered approach. She provides input for CMS policies and procedures.

The CMSN provides telemedicine services to ensure access to specialty services in underserved areas of the state. Telemedicine specialty care services include endocrinology/diabetes care, genetics, nutritional counseling, neurology, and dermatology. Many parents report telehealth services allow for better access to services, decrease cost and time for travel, and decrease wait times to see a specialist. CMS continues to use the video conferencing equipment for CMS meetings and educational presentations to minimize travel time and costs whenever possible.

The Institute for Child Health Policy (IHP), University of Florida, continues to conduct annual satisfaction surveys from randomly selected parents of CMS enrollees. Results indicated that 89 percent of the respondents had one person they thought of as their child's personal doctor or nurse.

### **C. Plan for the Coming Year**

CMS will continue gathering quarterly data reports from CMS area offices to measure and analyze success with its six goals on a community, regional, and statewide basis as well as in comparison with national data. IHP will continue to conduct telephonic satisfaction surveys for CMS.

CMS will continue to rely on the Family Health Partner Consultant and the Family Support Workers to provide guidance for a family-centered and family-friendly focus.

CMS will continue to provide telemedicine specialty clinics through two-way interactive video teleconferencing. The telehealth program benefits CMS children and families by

reducing travel time, costs, and inconvenience. Access to specialty care is improved by reducing wait times. CMS will continue to evaluate ways in which to expand telemedicine services.

CMS will continue to use the web-based provider application process to increase CMS Network provider participation.

**NPM#6 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. (CSHCN Survey)**

**A. Last Year's Accomplishments**

The sixth CMS Goal states that "Beginning at age 12, all teens and young adults with special health care needs who are enrolled in the CMS Network and their families will receive the services needed to make transitions to all aspects of adult life, including adult health care, work, and independence." Measures and indicators for this goal are:

Measure 1: Teens and young adults will participate in the development and periodic review of their care coordination and transition plans.

Measure 2: Teens and young adults will receive transition services that are age appropriate.

The CMS Transition Liaison at Central Office worked with the nurses and social workers in the CMS offices around the state that are identified as Transition Liaisons for their office to assist them identify information and resources about health care transition.

CMS Network Care Coordinators facilitated transition activities with CMS enrollees and their families. CMS tracked the successful completion of transition activities for each enrollee through the electronic Child Assessment Plan (CAP) with quarterly data. In fiscal year 2009-2010, the statewide average for the CMS Performance Measure 1 was 74 percent and the statewide average for CMS Performance Measure 2 was 51 percent.

Planning for the eventual transition of all teens and young adults with special health care needs to adult services, and coordinating and facilitating transition activities with each teen, were examples of providing services to increase the percentage of teens ready to transition to adulthood. CMS provided educational transition material to teens and their families. Materials and resources were made available in English and Spanish, and on the CMS website. In many regions of Florida a CMS Network representative attended meetings of local and state workgroups, consisting of young adults, state agency professionals (including Exceptional Student Education and Vocational Rehabilitation), and other stakeholders to discuss youth transition issues and challenges.

CMS contracted with John Reiss, Ph.D., of the University of Florida, Institute for Child Health Policy (IHP) for the development of transition training and materials for CMS Network enrollees and their families, CMS care coordinators, and CMS providers. IHP also continued to maintain the web-based transition curriculum for professional development (<http://transition.mchtraining.net/>). The website provided information and best practices to CMS staff for implementing health care transition.

The Jacksonville Health and Transition Services (JaxHATS) program continued to provide health and related transition services in a five county area in northeast Florida to youth and young adults age 16 to 26 with special health care needs and disabilities. In state fiscal year 2009-10, the program assisted over 80 adolescents and young adults with health care transition referrals to adult physicians, both primary care and specialists, and worked with other agencies, organizations, and post-secondary schools for successful youth transition to adult life.

CMS contracted with the University of South Florida for a statewide health care transition program, the Florida Health and Transition Services (FloridaHATS) program. This program developed as a result of a 2008 Florida Legislature bill and became a statewide resource for health care transition. The FloridaHATS website ([www.floridahats.org](http://www.floridahats.org)) included health care transition education and related resources for young adults, their families, and their providers as well as a physician resource guide to locate doctors in Florida who treat young adults with chronic health conditions.

In collaboration with CMS, the FloridaHATS program identified three implementation sites and developed regional coalitions that will result in health care transition clinics for adolescents and young adults. The sites chosen were Panama City/Panhandle area, Jacksonville/Duval County, and Tampa/Hillsborough County. Community partners and stakeholders were identified and meetings have taken place to complete a MAPP (Mobilizing for Action through Planning and Partnerships) strategic planning process to improve community health.

The CMS Division Director serves as an Advisory member of the National Health Care Transition Center (Got Transition?) and the CMS Statewide Transition Liaison participates in their webinars and related activities.

## **B. Current Activities**

Contracts for transition related activities with the Institute for Child Health Policy, JaxHATS, and FloridaHATS remain in place as CMS continues to work toward more transition options for adolescents and young adults with special health care needs and their families, as well as to keep information and resources up-dated and available.

CMS continues to work with regional transition coalitions in the three pilot sites. Activities include working with local health planning councils to develop county-level data reports to provide information about youth and young adults, and secondary data sets for health condition, disability status, SSI enrollment, CMS enrollment, and other data. The local coalitions will provide education and training activities for both consumers and providers; and advocate for improved health care financing strategies and policies. The FloridaHATS website provides up-dated information about the progress of each site; information, activities, and program updates are available at: <http://www.floridahats.org>.

CMS staff continues to participate in collaborative partnerships with statewide, regional and community organizations and state agencies to promote successful health care transition. Collaborative partners include the Department of Education, the Division of Vocational Rehabilitation, the Agency for Persons with Disabilities, the Department of Children and Families, the Department of Juvenile Justice, and the Agency for Health Care Administration.

## **C. Plan for the Coming Year**

CMS will continue to work with the Institute for Child Health Policy, the JaxHATS program, and FloridaHATS program. The local CMS offices will participate in the development and evaluation of the regional health care transition coalitions in the identified pilot sites. Further coalitions may be developed as resources allow.

CMS will continue to collaborate with other Florida agencies, including: the Department of Education, the Division of Vocational Rehabilitation; the Florida Developmental Disabilities Council, the Agency for Persons with Disabilities; the Department of Children and Families, Mental Health; the Department of Juvenile Justice; and other Florida stakeholders such as the University of Florida, and the University of South Florida to ensure health is included in all youth transition projects.

Additionally, in collaboration with ICHP, CMS will help to evaluate web-based interactive tools to help children and young adults learn how to perform specific tasks related to taking responsibility for their own health care needs.

**NPM#7: 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, Hepatitis B.**

**A. Last Year's Accomplishments**

The following initiatives were designed to improve immunization coverage levels in 2-year-old children: the department's missed immunization opportunities policy; outreach clinics; linkages with WIC and CMS; community partnerships and immunization coalitions; coordination with Healthy Start and managed care organizations; promotion of the Standards for Pediatric Immunization Practices in the private sector; measurement of immunization coverage levels in public and private site reviews; outreach and increased enrollment in Medicaid and SCHIP; and continued implementation of the Vaccines for Children Program. Activities performed that impact this measure generally fall within the category of population-based services, offering disease prevention interventions to the entire population. Changes in immunization rates of 2-year-old children can be attributed to the following: immunization registry not fully implemented with all private health care providers and the partnership with WIC not fully implemented for 2009/10 in all county health departments.

During CY 2009, 81.9 percent of 2-year-olds received four diphtheria, tetanus, pertussis; three polio; and one measles, mumps, rubella, three Haemophilus Influenza B, three hepatitis B and one varicella immunizations (4-3-1-3-3-1 series). The Bureau of Immunization shipped 4.7 million doses of vaccine to over 2,000 public and private healthcare providers. Florida SHOTS (statewide immunization registry) is functional in all 67 county health departments, for over 6,000 healthcare providers and includes over 416 data upload partners that uploaded 27.7 million records in 2010. Florida SHOTS is available for enrollment to private healthcare providers, schools, and licensed childcare centers. The registry includes approximately 10.8 million patient records. The majority of school districts in Florida have schools that participate in the program.

**B. Current Activities**

In CY 2011, we continue activities to meet the state and national goal of 90 percent of all 2-year-old children who are appropriately immunized with the complete 4-3-1-3-3-1 series statewide though selected counties have historically met and surpassed the goal. Specific activities include parent education; involvement of Healthy Start, immunization

coalitions, and community partnerships; linkage with WIC, CMS and managed care organizations; identification of pockets of need for under-immunization; tracking immunizations in the health department; implementation of recall systems; public and private provider site reviews to assess coverage levels and promote the Standards of Pediatric Immunization Practices; increased enrollment of the registry in the private sector; continued implementation of the Vaccines for Children Program; and a statewide initiative to improve collaboration with stakeholders/partners to increase coverage levels in the target population. We are increasing the emphasis on immunizations with all stakeholders with an ultimate goal of surpassing 90 percent immunization coverage by 2012. County health departments have developed immunization plans to raise immunization rates in their area. They work with WIC, local medical societies, CMS, and others to develop then implement their plans.

### **C. Plan for the Coming Year**

Our objective for CY 2012 is that 90 percent of 2-year-olds receive age-appropriate immunizations. Outreach, promotion, and surveillance of rates will be utilized to support efforts in the private sector. The department will continue to coordinate with Healthy Start coalitions to increase parent education about the importance of childhood immunizations and encourage local community partnerships. We will continue to recommend that all health care providers implement the Standards for Pediatric Immunization Practices, and continue expansion of the registry (Florida Shots) in the private sector (infrastructure-building activities). The department will continue an active partnership with coalitions and service agencies. We will continue to implement the missed opportunities policy for public and private health care providers (population-based) and continue the WIC and CMS/Immunization linkage (enabling). We will continue to implement the statewide initiative to improve collaboration with stakeholders/partners in order to increase coverage levels in this target population.

### **NPM#8: The birth rate (per 1,000) for teenagers aged 15 through 17 years.**

#### **A. Last Year's Accomplishments**

Final data for 2009 indicate a birth rate of 17.8 per 1,000 for teens 15 to 17, which is below the annual performance objective of 20 per 1,000. Family planning, positive youth development education and comprehensive school health service projects share the responsibility of providing reproductive health care services to teens throughout the state. Family planning provided an array of services to teenagers beginning with preconception risk assessment, counseling, dispensing contraceptive methods when requested, screening for sexually transmitted disease, and pregnancy testing.

Florida statute authorizes the Department of Health to make comprehensive medical knowledge, assistance, and services relating to the planning of families and maternal health care available to citizens of childbearing age. The overall program goal is to improve the health of women and children by reducing unplanned pregnancies and promoting positive pregnancy outcomes. The program works to improve maternal and infant health; lower the incidence of unintended pregnancy, including teen pregnancy; reduce the incidence of abortion; and lower rates of sexually transmitted diseases, including HIV.

The Positive Youth Development Program is designed to enhance skills and improve the health status of adolescents and young adults through opportunities and programs developed in collaboration with families, communities, schools and other public and

private organizations. The program provides a network of community-based support to help adolescents succeed as they move into adulthood by focusing on the assets of individual youth and their families. Sponsored programs will reinforce positive attitudes, healthy behaviors and activities, and reduce risk-taking behaviors, such as sexual activity, substance abuse, suicide and behaviors that increase risk of unintentional injury and chronic disease.

Along with services, the Abstinence Education Program, as part of the *It's Great to Wait* campaign, sponsored a number of community outreach activities designed to increase public awareness about abstinence as the only 100 percent effective way to avoid teen pregnancy and sexually transmitted diseases. The media campaign consisted of enhancement of the interactive, hyper-media website at [www.greattowait.com](http://www.greattowait.com), and educator training classes held in major cities across the state, as well as radio, television and print advertisement.

During the FY 2010 school year, 46 of the 67 county health departments provided Comprehensive School Health Services Programs in 388 schools, serving 275,864 students in high-risk communities with high teen birth rates. Comprehensive school health programs are designed to provide services that improve student health, reduce high-risk behaviors, and reduce teen pregnancy. The birth rate for comprehensive school health 6<sup>th</sup> – 12<sup>th</sup> grade females (11 to 18) was 8.5 per 1,000. This is accomplished through maintenance of high levels of school nursing services, including nursing assessments, referral and case management; and health education classes and prevention interventions. These projects provided 2,552 pregnancy prevention interventions to 4,703 participants and 2,609 pregnancy prevention classes to 52,363 participants. Comprehensive school health programs also provided an additional 6,805 prevention interventions in general health and high-risk behaviors correlated with teen pregnancy to 12,296 participants, and 50,123 health education classes to 901,493 participants. Aftercare and support services coordinated with Healthy Start and school district Teenage Parent Programs, enabled 85.9 percent of parenting teens to return to school after giving birth.

## **B. Current Activities**

The Teenage Pregnancy Prevention Tier 1 Grant is a five-year grant with \$3,565,351 awarded per year. The program will be working with the University of South Florida, College of Public Health to implement the Teen Outreach Program (TOP) in 26 non-metropolitan counties within the public high schools in Florida. The University of South Florida will conduct a rigorous, experimentally designed evaluation over the five-year period of this grant. TOP is an evidenced-based program shown to reduce birth rates, school suspensions, and school drop-out rates amongst participants.

The Adolescent Health Program also received a Title V Abstinence Education Grant in the amount of \$2,601,681 per year for five years. The grant will fund community-based organizations, faith-based organizations, and county health departments to conduct abstinence education activities in their communities. We will require successful applicants to use evidence-based models, and they will be evaluated to ensure funds are spent correctly.

## **C. Plan for the Coming Year**

Family planning, positive youth development education, and school health programs are critical components of the department's plan to reduce the birth rate for teens 15 to 17. County health departments, local contract providers, Healthy Start programs, Healthy Families Florida programs, and other agencies that provide maternal and infant care services will inform postpartum women about extended family planning services. These providers will have access to applications and information brochures to increase awareness and use of family planning services under the special Medicaid program. We anticipate a reduction in the number of subsequent births to teens who access and utilize family planning services.

The Positive Youth Development Program will continue to manage grants for locally funded projects that deliver positive youth development education. In the coming year, the marketing and media campaign will continue to focus on the marketing of the WAHI, [www.teentruth.org](http://www.teentruth.org), and target the main population centers in Florida. The WAHI technology produces web dialogues in which different segments are addressed in one medium and both message delivery and data collection happen to form a true two-way conversation with individual audience members. The goal of this project is to host an interactive conversation with youth, parents, and community leaders to increase healthy decision making and decrease high-risk behaviors.

The Comprehensive School Health Services Projects will continue to provide pregnancy prevention classes, case management, and aftercare services that enable parenting students to return to school and graduate. These projects will continue to coordinate activities with local county health department abstinence programs, school district educators, county health department Healthy Start programs, Healthy Families Florida home visitors, school district teen parent programs, and case managers from the Department of Children and Family Services. Local county health departments will continue to facilitate access to services for youth, and continue to collaborate with other community agencies on teen pregnancy prevention in their communities. Programs within the department that serve youth will continue to develop strategies to reduce the rate of births to teens.

**NPM#9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.**

**A. Last Year's Accomplishments**

The Department of Health does not have data on the number of third grade children in Florida who receive sealants on permanent molars. In the absence of data, a proxy measure is provided for 2009 and after. For the numerator, it uses the total number of third graders (8-year-olds) who receive a sealant from a county health department plus the number of 8-year-olds who receive a sealant from a dentist in private practice paid by Medicaid. The denominator is the number of Medicaid-enrolled 8-year-olds during the year. Based on the reporting lag of Medicaid claims, data for 2010 are preliminary.

Until survey capabilities are developed, data better suited to this measure will not be available. The proxy data used here are incomplete for private providers in Medicaid managed care arrangements, and no sealant data were available from the community health centers. Thus, the 13.9 percent indicator in 2009 reflects further deficiencies.

**B. Current Activities**

The Public Health Dental Program continues to promote the development of school-based sealant programs and the early placement of sealants on permanent first and second molars in county health department programs. Links to sites to order sealant promotional material are available on the program's Internet site. A strategy contained in the state oral health improvement plan relates to increasing the number of children receiving sealants. A HRSA Grant to States to Support Oral Health Workforce Activities was awarded in 2009 through which an education and prevention specialist position was established. One of the initiatives being researched by this specialist is the development of school-based sealant programs, through the county health departments; five counties were funded this fiscal year. The department's HRSA *Oral Health Workforce funding* also supported county health department infrastructure expansion and contractual service, allowing for increased capacity for dental sealants to low-income and minority populations. Additionally, the state Oral Health Education and Prevention Specialist holds monthly calls dedicated to sealant topics and program sharing.

### **C. Plan for the Coming Year**

The program will continue to promote and financially support the development and expansion of school-based sealant programs through federal and state funding, the departmental quality improvement process, and coordination with school systems. HRSA grant funding will be used to continue the process of implementing the State Oral Health Improvement Plan and its recommendations and objectives. HRSA grant funding initiatives continue to augment the infrastructure of the Public Health Dental Program by the maintenance of an education and prevention specialist, a recruitment and retention coordinator, and a community water fluoridation specialist. Through the department's reducing oral health disparities initiative to support county health department infrastructure expansion, incremental progress will continue to expand access to low-income and minority populations. The Florida Department of Health Public Health Dental Program has completed production of a web automated interactive educational program, which is available at [www.mouthwiseflorida.com](http://www.mouthwiseflorida.com). This site allows the viewer to receive information about oral health for all stages of life: youth, teens, parents (caretakers) and dental professionals. The program is in English and Spanish. Resource links are included for further information. This messaging includes promotion of dental sealants.

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

#### **A. Last Year's Accomplishments**

Activities to reduce child deaths in motor vehicle crashes include evaluation of children with special health care needs to determine the appropriate child safety seat or restraint and provision of loaner special needs seats or restraints when necessary. The Department of Health (DOH), Office of Injury Prevention, received a Florida Department of Transportation grant that funded the Florida Special Needs Occupant Protection Program. Eight program sites are located in children's hospitals in Orlando, Tampa, Miami, St. Petersburg, Gainesville, Ft. Myers, Hollywood, and Pensacola. The Pensacola site was added in 2010.

The DOH Office of Injury Prevention is the lead agency for SAFE KIDS Florida, part of the SAFE KIDS Worldwide Campaign, a global effort to prevent injuries to children 14 and under. Over 85 percent of children 14 and younger in Florida live in a county where Safe Kids 10 local coalitions and seven state chapters are operating. Florida's Safe Kids chapters and coalitions were active in child passenger safety by distributing child safety

seats and launching public awareness campaigns. In 2009, the childhood unintentional injury fatality rate in Safe Kids counties was 30 percent lower than the rate in non-Safe Kids counties, which corresponds to 116 fewer deaths than expected had the fatality rates been the same.

The motor vehicle crash data includes crashes that occur between automobiles and bicycles. The Office of Injury Prevention continued the Florida Bicycle Helmet Promotion Program through a Florida Department of Transportation grant. This program is designed to increase helmet usage among children in low income households, rural counties, and in counties that experience a high incidence of bicycle-related injuries and death. This program provided over 21,000 bicycle helmets to approximately 100 community partners who fit and distributed the helmets within their community. The single most effective safety device available to reduce head injury and death from bicycle crashes is a helmet. Apart from the automobile, bicycles are tied to more childhood injuries than any other consumer product. Helmet use can reduce the risk of head injury by 85 percent and severe brain injury by 88 percent. If 85 percent of all child cyclists wore helmets every time they rode bikes for one year, the lifetime medical cost savings could total between \$134 million and \$174 million. (*Source – SAFE KIDS Worldwide 2007 Fact Sheet*). From 2003-2009, the hospitalization rate for non-fatal traumatic brain injuries sustained in bicycle crashes among residents ages 5-14 decreased 32 percent.

## **B. Current Activities**

The Special Needs Program (SNP) expanded by one new program site in Tallahassee. This is the first non-children's Hospital in the SNP. The SNP trainers are working on completing the new training curriculum. Through the 10 local SAFE KIDS coalitions and seven state chapters, numerous car seat check-up events are conducted on an ongoing basis and during National Child Passenger Safety Week, National SAFE KIDS Week, and Buckle Up America Week.

Staff identified approximately 100 community partners for the Florida Bicycle Helmet Promotion Program, with a goal of at least one in each of the 67 counties in Florida. Over 21,000 bicycle helmets were purchased and distributed to the community partners, who will fit and distribute the helmets within their community.

The 2009-2013 Florida Injury Prevention Strategic Plan encourages evidence-based interventions to address motor vehicle injuries, a leading cause of death and injury among children in Florida. The Florida Injury Prevention Advisory Council, Strategic Plan Goal Team Leaders and Teams are an important part of Florida's plan implementation success.

## **C. Plan for the Coming Year**

- The Office of Injury Prevention submitted a concept paper to the Florida Department of Transportation to continue the Florida Special Needs Occupant Protection Program for the 2011-2012 Grant Year.
- The Office of Injury Prevention staff will continue to seek subject matter experts to review the new Special Needs Training curriculum.
- The Office of Injury Prevention intends to continue to function as the lead agency for SAFE KIDS Florida and to continue our work in the area of child passenger safety.
- Work will continue implementing the 2009-2013 Florida Injury Prevention Strategic Plan.

- A concept paper was submitted to the Florida Department of Transportation to continue the Florida Bicycle Helmet Promotion Program for the 2011-2012 Grant Year.
- The Office of Injury Prevention will continue activities listed above regarding evaluation of needs, provision of child safety seats or restraints, training, and public awareness activities.

#### **NPM#11: Percentage of mothers who breastfeed their infants at six months of age.**

##### **A. Last Year's Accomplishments**

The Department of Health provides breastfeeding promotion and support activities through a number of different programs including WIC and Healthy Start. Activities target both the population at large as well as specific subsets of the population, such as WIC or Healthy Start clients.

The Department of Health does not track breastfeeding data in the non-WIC population. Provisional data from CDC's National Immunization Survey, which tracks data by birth year, indicates that 38 percent of all infants in Florida were being breastfed at six months of age in 2007. Our WIC program tracks breastfeeding rates monthly and this data helps us assess our progress in improving breastfeeding rates during the year.

The WIC program coordinated activities with Healthy Start program staff to ensure Healthy Start care coordinators offered breastfeeding information, education, and support to pregnant women in-need. One of the Department of Health's state office buildings continues to provide a "mothers' place" room for breastfeeding staff to use for pumping or nursing.

WIC continues to participate in the USDA's breastfeeding peer counselor program. The Florida WIC Program is in its sixth year of receiving a United States Department of Agriculture grant for a Breastfeeding Peer Counseling Program. Funding from the USDA was significantly increased for this program in the spring of 2010. Services have been established or expanded to all 43 local agencies to provide breastfeeding promotion and support above and beyond what the regular WIC grant could accomplish. From October 2009 to December 2010, the program provided 77,768 contacts through personal interactions and 8,246 group classes with 34,685 attendees.

Florida WIC participated in a national two-day breastfeeding training opportunity and filming in April 2009 at WFSU. The DVDs of this training and training materials were distributed to all local WIC agencies and will be required training for all WIC staff who provide direct client services by July 2011.

The Florida WIC program was instrumental in helping to establish a statewide, broad-based breastfeeding coalition and sponsors the monthly conference calls. Two new educational breastfeeding booklets were posted to the intranet in this time frame for local WIC agencies to use with clients. The state WIC program purchased and distributed World Breastfeeding Week kits to the local WIC agencies for use in promoting World Breastfeeding Week 2010.

The Department of Health requires that each county health department establish and adopt a written policy that protects, promotes, and supports breastfeeding as the preferred, normal method of infant feeding. This policy encourages each county health

department to have a comprehensive plan for breastfeeding promotion, protection, and support that includes a positive, breastfeeding-friendly clinic environment. The county health department should ensure that maternal and child health providers with whom it contracts include breastfeeding education and support services.

Breastfeeding education and support is one of the services offered through the Healthy Start program. Breastfeeding education and support includes at least one face-to-face contact, an assessment of current infant feeding status, counseling consistent with breastfeeding plan of care, and referrals to local breastfeeding support groups or other support sources. Services provide anticipatory guidance and support to encourage pregnant women to initiate breastfeeding, prevent problems and address barriers, increase the duration and exclusivity of breastfeeding, and enable postpartum women to overcome any perceived or actual breastfeeding problems.

The WIC program implemented the new national food packages and policies in support of exclusive breastfeeding.

The Florida Department of Health received funding from the American Recovery and Reinvestment Act for the Communities Putting Prevention to Work (CPPW) Program. The CPPW program includes an initiative to work with school districts and state agencies to develop lactation support policies for their employees. The CPPW program staff assists administrators with readiness assessment, policy development, and implementation. As of June 2011, 25 percent of school districts have adopted breastfeeding support policies, and more policies are pending.

## **B. Current Activities**

The WIC program will continue to provide breast pumps and breast pump kits, so more women have the equipment they need to breastfeed successfully.

WIC will continue to monitor breastfeeding rates and the percentage of women in the WIC program who breastfeed. Efforts to improve data collection and evaluation are ongoing, with the addition of an epidemiologist. A survey will assess the Loving Support Peer Counseling Program. There are new reports to assist in monitoring breastfeeding rates.

WIC holds monthly conference calls with breastfeeding coordinators and peer counseling program administrators to share successful promotion and support activities. WIC provides breastfeeding updates on the calls attended by county health department clinical staff, Healthy Start service providers and coalition staff, and MomCare advisors. Breastfeeding is one of the topics included in the maternal and child health training provided by the IMRH unit. Representatives from DOH and the WIC Program have been appointed to the Florida Breastfeeding Coalition. The WIC breastfeeding coordinator participates in the Florida Network for Breastfeeding Support in the development of work site breastfeeding support activities. WIC continues to participate in the U.S. Breastfeeding Committee calls and its affiliate Southeast Region calls. The WIC coordinator has provided technical assistance to the CPPW program for policy development and training workshops with human resources administrators.

## **C. Plan for the Coming Year**

For FY 2011, WIC will focus on emphasizing strategies and activities that help WIC mothers to continue breastfeeding, a population with traditionally lower breastfeeding rates.

WIC will distribute breastfeeding equipment and information, as funding is available. WIC will continue the monthly conference calls with breastfeeding staff in the coming year, as well as our efforts to collect, link, and validate breastfeeding data and statistics, monitor breastfeeding rates, and evaluate breastfeeding outcomes.

The expansion and enhancement of breastfeeding peer counselor programs with funding from the USDA Loving Support grant will continue as long as funding is continued.

The WIC program will continue to monitor the new national food packages and policies in support of exclusive breastfeeding.

The Loving Support: "Grow and Glow" training will be completed by all WIC staff who provide direct services to clients.

WIC and Healthy Start will continue to coordinate their efforts so that more women and families receive the education and support they need. The Department of Health will continue to promote and support breastfeeding through both county health department policies and guidelines and through the WIC and Healthy Start programs. WIC will continue working with the Florida Breastfeeding Coalition on statewide breastfeeding activities. In addition, the WIC breastfeeding representative will continue assisting the Department of Health in developing worksite breastfeeding support policies in conjunction with the new national Administration of the Nursing Mother Provision of the Federal Patient Protection and Affordable Care Act of 2010. The CPPW program will continue to provide leadership to local and state administrators on policy development and implementation on the federal law.

## **NPM#12: Percentage of newborns who have been screened for hearing before hospital discharge.**

### **A. Last Year's Accomplishments:**

Section 383.145, Florida Statutes, mandates that all babies born in Florida have their hearing screened prior to hospital discharge or within the first 30 days of life. The program collects hearing results on all babies born in Florida through the metabolic specimen card and paper forms submitted to the State Laboratory and the Newborn Screening Program. Letters are sent to babies' physicians and the families whose babies refer on the hearing screen stressing the importance of the follow-up testing. Phone calls are made to families, physicians, and audiologists to facilitate the completion of hearing testing. By screening infants for a hearing loss within the first 30 days of life, intervention services can be implemented quickly which helps minimize speech and language delays.

Accomplishments from last year include:

1. Guidelines for hearing screenings and evaluations have been revised for clarity and disseminated among hospitals and audiologists.

2. Hearing screening equipment was purchased for each of the local Children's Medical Services (CMS) offices. Training has been accomplished for nine of these.
3. Four statewide conference calls have been held on the various topics related to newborn hearing screening. There was an average of 50 participants for each call and positive feedback has been received on all of them.
4. The top three birthing facilities have received rewards for excellent performance each month since November 2010. This process has created new attention to data and reporting and some facilities with a history of poor performance are now the best performing.
5. The hearing section of the Newborn Screening Program's website has been updated with current and new information for providers and families.
6. The number of audiologists skilled in providing pediatric services to infants has increased from 48 to 66 since June 2010.
7. Hearing follow-up staff have gained access to two different systems (Medicaid and immunization records databases) to obtain updated address and phone numbers of parents whose babies did not pass their newborn hearing screening.
8. Newborn screening specimen collection cards were revised to improve clarity of choices for hearing screening data.
9. Letters sent to parents were translated into Spanish and Creole and are now routinely sent on the back side of the English letters.
10. Packets were created for parents of young children diagnosed with a hearing loss and one is now sent to each newly diagnosed child.

### **B. Current Activities**

Data system enhancements are underway that will improve reporting capabilities. Hearing screening equipment is being distributed and training is being planned for the remaining local CMS offices. Future statewide conference calls on the various topics related to newborn hearing screening are being planned. Videos and brochures continue to be provided to parents, hospitals, and physicians regarding the importance of universal newborn hearing screening. Technical assistance and training at hospitals and audiology clinics regarding newborn hearing screening continues. Collaborative efforts with ECHO Initiative are in process to assist Early Head Start programs with standardizing hearing screenings.

### **C. Plan for the Coming Year**

Data system enhancements will be implemented and tested. Hospital staff across the state will receive face-to-face training on how to use the new web-based system. Screening equipment and training will be provided to the remaining local CMS offices. CMS will link the EHDI data system with the birth defects registry database. Arrangements will be made with Early Steps to obtain needed early intervention data for reporting and planning purposes. Publications such as brochures and videos will be revised, reprinted, and distributed.

### **NPM#13: Percent of children without health insurance.**

#### **A. Last Year's Accomplishments**

The Department of Health continued to work throughout the year with the University of South Florida's Covering Kids and Families (CKF) Project, the Agency for Health Care Administration, Department of Children and Families, Florida Healthy Kids Corporation, and a variety of public and private organizations to promote enrollment and retention in the Florida KidCare children's health insurance program.

The Florida KidCare partner agencies continued special outreach efforts targeted to newly uninsured children whose families lost private coverage due to job loss.

Administrative program enhancements to improve retention were a major focus in 2010. The Florida KidCare partner agencies worked to identify activities that could be accomplished without legislative action. For example, a cash payment option was implemented in 2010 for families as another method to make their monthly premium payments.

### **B. Current Activities**

The Department of Health, Agency for Health Care Administration, Department of Children and Families, and the Florida Healthy Kids Corporation collaborate with the University of South Florida's Covering Kids and Families project and other entities to reach out to families whose children could qualify for Florida KidCare.

The federal CHIPRA reauthorization bill contains new options to encourage administrative simplification, enrollment growth and retention. In Florida, SB 918, enacted in 2009, streamline prior administrative requirements. Some provisions include:

- Using electronic income verification before paper documents
- Reducing the nonpayment cancellation penalty from 60 to 30 days
- Providing good cause reasons for voluntary cancellation of private coverage

Simplified transitions from Medicaid to another Florida KidCare component helps eligible children retain coverage more easily. Outreach efforts were also funded through a federal grant awarded to the CKF project and two other Florida organizations totaling almost \$2 million to promote Florida KidCare enrollment and retention statewide.

The Florida Healthy Kids Corporation revised its website to make it easier for families to check their Florida KidCare account status. This information helps families ensure required information and premium payments are made on time. The corporation also is investigating potential ways to use technology for notifications and updates, as well as payroll deduction on a statewide basis.

### **C. Plan for the Coming Year**

The 2011 Florida legislative session ends in early May 2011. Several bills related to the Florida KidCare program have been filed this session to address program simplification, coordination with school lunch programs, and increased retention. At the time of this writing, however, it is unclear whether any of the bills will be enacted. The Florida KidCare program partners continue to work on ways to improve administrative simplification that do not require legislative action. The Florida Healthy Kids Corporation also plans to apply for a Round Two CHIPRA outreach grant from the federal government.

**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.**

### **A. Last Year's Accomplishments**

Data for FY2010 indicate 28.9 percent of children ages 2-5 who received WIC services had a BMI at or above the 85<sup>th</sup> percentile. This exceeded our goal of 29.4 percent. The FFY 2009 percentage was 29.6 percent.

The Florida Department of Health Bureau of WIC Program Services conducted a number of activities during FY2010 to continue to help reduce the number of children deemed overweight based on body mass index.

The major work effort was the implementation of the new WIC food package. The WIC foods had not changed significantly in over 30 years. Based on recommendations by the Institute of Medicine, the WIC food package underwent significant changes to align with the Dietary Guidelines for Americans, the Healthy People 2010 goals and objectives, and the recommendations by the American Academy of Pediatrics. Much time and effort went into training for clients, vendors, and staff to introduce them to the new, healthier foods. We feel that one major reason for the improvement in BMI levels for children 2-5 in WIC was the healthier food choices. The new WIC food package for children 2 years and older eliminates whole and reduced fat milk, adds whole wheat bread, brown rice, or corn tortillas, and offers fruits and vegetables. It also reduces the monthly amount of juice and eggs.

Nutrition “kits” were also developed to promote the new food items and healthy nutrition with these messages: eat more fruits and vegetables; lower saturated fat; increase whole grains and fiber; drink less sweetened beverages and juice; and babies are meant to breastfeed. Included as part of these kits were lesson plans, English, Spanish, and Haitian/Creole flyers and training flipcharts, coloring sheets for children, and posters.

A nutrition education kit on physical activity, *WIC Families: Be Active Each Day*, was also developed this year. The kit included the distribution of an original music CD produced by the Department of Health, called *Give Me 5 A Day!*, which encourages children and parents to dance along with the songs. The CD was mass-produced and provided to each WIC family. Other materials include a lesson plan, a teaching flipchart and client materials in English, Spanish, and Haitian/Creole.

*Eat Fish, Choose Wisely* was the last kit developed during this fiscal year. It included the promotion of healthy fish (as a low fat alternative to higher fat protein foods) while avoiding fish high in mercury. Materials developed for this kit included a children’s book called *Fish! Fish! Fish!: GO Fish, SOME Fish, NO Fish*; a wallet card in English, Spanish and Haitian/Creole; a lesson plan and a teaching flipcharts in the three languages. A staff training PowerPoint was also developed to teach staff about mercury in fish.

Based on new recommendations by the American Academy of Pediatrics on limiting juice consumption for infants and children, our pamphlets *Feeding Your Infant*, *Feeding Your Toddler*, *Feeding Your Child*, and *Keeping A Healthy Balance in Children* were modified to reflect the new recommendation.

The Florida WIC Program is in its sixth year of receiving a United States Department of Agriculture grant for a Breastfeeding Peer Counseling Program. This special grant allowed expanded breastfeeding promotion and support in all counties above and beyond what could be accomplished with the regular WIC grant. From October 2009 to September 2010, 77,768 personal interactions and 8,248 group classes were provided.

## **B. Current Activities**

Training staff, vendors, and clients on the revised WIC food package continues at both the state and local levels.

Four nutrition education kits have been or are being developed for this federal fiscal year. *Rise and Shine It's Breakfast Time*, *A Healthy Smile for You and Your Family*, *Where's the Sodium*, and *Healthy & Homemade* are the themes.

Nutrition training modules for the staff who provide nutrition services are currently being updated. The modules include information on obesity prevention and healthy nutrition through the lifecycle.

We plan to review the new federal option of allowing children to be certified for WIC for a period of one year (compared with the current requirement of every 6 months). It is anticipated that if this new regulation is adopted in Florida, there will be more time for staff to provide nutrition education and breastfeeding support.

We continue to encourage local WIC agencies to select a nutrition education objective when preparing their nutrition education program plan for federal fiscal years 2010 and 2011 that relates to overweight and obesity prevention. Most local agencies continue to choose obesity-related objectives, and all of the agencies have a breastfeeding promotion and support initiative.

## **C. Plan for the Coming Year**

The Bureau of WIC Program Services will continue to develop and distribute more nutrition education kits for the next year. Those kits proposed for FFY 2012 include the topics: heart healthy eating, limit consumption of soda, portion control and choosing lowfat milk.

Staff will also be involved in the development of the new WIC data system, working to improve efficiencies in the program and reduce duplication and paperwork thus enabling staff to provide more time for nutrition education and breastfeeding promotion.

### **NPM#15: Percentage of women who smoke in the last three months of pregnancy.**

#### **A. Last Year's Accomplishments:**

Florida's 2009 PRAMS data is not yet available, so we cannot determine our progress on this goal since the last report. Behavioral Risk Factor Surveillance System data reveals that in 2007, 53.6 percent of women smokers tried to quit smoking.

The department contracted with its partners, the Area Health Education Centers (AHEC), to deliver in-person tobacco cessation counseling to Floridians and training for health care professionals and students based on the *Clinical Practice Guidelines for Treating Tobacco Use and Dependence*. The AHECs also trained on other skills for health care practitioners to successfully assess, evaluate, and treat tobacco use.

The department met quarterly with the Tobacco Education and Use Prevention Advisory Council to discuss program activities and receive advice on the overall operation of the program. Council members represent Florida's recognized experts in tobacco control

and the department is grateful for the passionate commitment to the effort. The Bureau of Tobacco Prevention Program continued to work to protect people from the health hazards of using tobacco; to discourage use of tobacco, particularly among youth by reducing the prevalence of tobacco use among youth, adults and pregnant women; reducing per capita tobacco consumption; and reducing exposure to environmental tobacco smoke.

The Tobacco Free Florida campaign continued its efforts to educate Floridians on the negative health effects of tobacco through many creative venues, including securing high-profile collegiate and professional sports endorsements. This year the campaign incorporated the new “Be Free” campaign message. The campaign doubled its media budget buy negotiating over \$19 million in added value media.

The Florida Quitline answers calls 24 hours a day, 365 days a year, and counseling appointments are available seven days a week. Telephone counseling is available in English and Spanish. Pregnant tobacco users who are ready to quit can receive eight counseling sessions. Self-help materials are also provided by mail. If callers prefer face-to-face counseling, they are referred to the Area Health Education Centers that provide smoking cessation services. In fiscal year 2008-2009, the Quitline served over 22,000 callers. This year the bureau’s cessation services expanded to include offering free NRT through the 67 Florida county health departments and through Florida Area Health Education Centers. Through their extensive network of centers allied with the state’s colleges of medicine, AHEC delivered face-to-face counseling services and trained the current and future health care workforce. During fiscal year 2008-2009, AHEC provided more than 7,000 Floridians with cessation counseling.

County health departments, Healthy Start coalitions and Department of Health staff monitored prenatal smoking indicators and compliance with guidelines on counseling all pregnant women and women of childbearing age on the dangers of tobacco use and second-hand smoke. In FY 2009/2010, 13,511 pregnant women and 5,416 infants received smoking cessation services through Healthy Start.

## **B. Current Activities:**

Healthy Start coalitions and county health departments continue to encourage pregnant women and new mothers to sign up for Text4Baby. Text4baby provides pregnant women and new moms with information to help them care for their health and give their babies the best possible start in life. These messages focus on various topics including smoking cessation and second hand smoke, and also connect women to additional resources.

County health departments, Healthy Start coalitions and Department of Health staff monitor prenatal smoking indicators and guidelines on counseling all pregnant women and women of childbearing age on the dangers of tobacco use and second-hand smoke. Current research is shared during statewide conference calls.

The Every Woman Florida Initiative is aimed at raising awareness about the importance and benefits of being healthy prior to pregnancy and focuses on promoting change at the individual, provider and system level. It includes a social marketing awareness campaign, the development of a website and addressing preconception health issues within a March of Dimes statewide, multidisciplinary workgroup. The website serves as

an information portal for health tips, assessment tools and printable education handouts on preconception health. A fact sheet on smoking can be obtained from the website which provides information on the risks of smoking while pregnant, the risks of second hand smoke, and where to get help to quit smoking.

### **C. Plan for the Coming Year**

During FY2012, we will continue to provide technical assistance and training on effective interventions for those who smoke. We will support training opportunities on *Make Yours a Fresh Start Family*, ACOG's *Smoking Cessation*, and *A Clinician's Guide to Helping Pregnant Women Quit Smoking*, and promote other vehicles found to be effective. We will continue to monitor smoking cessation activities statewide, evaluate data showing the success of these activities and data on smoking rates in general, and provide technical assistance as indicated.

Family Planning providers across the state screen their clients for the extent of tobacco use, and provide information on the Quitline, one-on-one counseling on smoking cessation, and referral for smoking cessation classes as resources allow or as indicated.

We 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 second-hand smoke. We will also continue to monitor compliance with the Healthy Start Standards and Guidelines for tobacco cessation.

### **NPM#16: The rate (per 100,000) of suicide deaths among youths 15-19.**

#### **A. Last Year's Accomplishments:**

Final data for 2009 indicated a significant increase in the teen suicide rate from the previous year, going from 5.8 per 100,000 in 2008 to 6.8 per 100,000 in 2009. There were 82 teen suicides age 15 to 19, compared to 71 the previous year. Provisional data for 2010 is not sufficiently complete to determine if this is a trend or just a spike in numbers.

During FY 2010, school nurses and social workers from the comprehensive school health services project schools continued to refer students for community-based mental health services. School health nurses and social workers also provided prevention interventions and classes in mental health, suicide prevention, violence prevention, conflict resolution, alcohol prevention, and drug prevention.

Florida has taken significant steps toward preventing suicide. The Statewide Office of Suicide Prevention and the Suicide Prevention Coordinating Council established a centralized structure necessary for integrating and coordinating the statewide effort, providing unified direction, and formulating strategies that can be implemented at both the state and local levels. In addition, the Office and Council have forged strong alliances with national suicide prevention organizations.

Success in suicide prevention depends heavily on empowerment at the local level. An infrastructure built on cooperation among federal, state, and community levels is essential for comprehensively combating this problem. Expansion of community efforts interconnected by a network of shared information, mutual support, and reinforcing activities serve as a first line of defense against suicide. Through these partnerships,

Florida will be able to augment existing suicide prevention capabilities and promote collaborative action.

### **B. Current Year Activities**

During FY 2011, school nurses and social workers at comprehensive school health services project schools will continue to refer students for community-based mental health services. Staff will provide prevention interventions and classes in mental health, suicide prevention, violence prevention, conflict resolution, alcohol prevention, and drug prevention.

The Department of Health internal suicide prevention workgroup met quarterly and coordinates the department's contribution to the FSPCC.

### **C. Plan for the Coming Year**

During FY 2012, school nurses and social workers from the comprehensive school health services project schools will continue to refer students for community-based mental health services. Staff will also provide prevention interventions and classes in mental health, suicide prevention, violence prevention, conflict resolution, alcohol prevention, and drug prevention.

The Florida Suicide Prevention Coordinating Council will continue to meet four times per year while planning and designing strategies to implement the Florida Suicide Prevention Strategy. Other initiatives planned are the eighth annual Suicide Prevention Day at the capitol and a statewide Suicide Prevention Symposium, depending on budget and travel constraints.

The Department of Health's internal suicide prevention workgroup will meet quarterly and coordinates the department's contribution to the FSPCC.

It is expected that during FY2012, health, mental health, education, and law enforcement professionals will work together on strategies to identify youth at risk for suicide so they can receive appropriate prevention and intervention services.

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

### **A. Last Year's Accomplishments**

Infrastructure-activities during the past year to increase the percentage of very low birth weight infants being born at a high-risk facility included: three of the Regional Perinatal Intensive Care Centers (RPICC) providing nine high-risk obstetrical satellite clinics and opening an additional high risk obstetrical satellite clinic in the underserved panhandle region of Florida. RPICC staff at the 11 designated facilities provides a comprehensive high-risk obstetrical outpatient clinic; and RPICCs are monitored annually by physicians and Children's Medical Services Central Office consultants to ensure the quality of care for the high-risk obstetrical patients and appropriate placement for neonates in the Level III NICU. Enabling activities included the provision of yearly educational programs to the community health providers by RPICC staff. Enabling activities also include voluntary RPICC center participation in the newly organized Florida Perinatal Quality Collaborative, whose first initiative is to promote no elective deliveries before 39 weeks. The populations served are high-risk pregnant women and low birth weight/sick infants.

During 2010, 91.45 percent of very low birth weight infants were delivered at high-risk facilities. The goal of 90 percent was exceeded. There was an increase compared to the 87.8 percent rate reported for 2009.

### **B. Current Activities**

The CMS goal is to ensure that high-risk obstetrical patients and very low birth weight newborns are delivered and receive care at appropriate level hospitals. The following types of public health services continue to be provided through the RPICCs and by RPICC staff. Direct health care services are provided at the RPICCs (inpatient and outpatient) and through the nine high-risk obstetrical clinics located at varying distances from the RPICCs. Enabling services include educational programs offered by the RPICC staff to the community health providers. To ensure standards of care are being met, we perform annual quality assurance monitoring of the RPCCS either onsite or by desk review.

### **C. Plan for the Coming Year**

The goal for FY2011 is to ensure 90 percent of very low birth weight infants are delivered at appropriate hospitals with NICU services. Plans include maintaining the number of RPICC high-risk obstetrical satellite clinics. RPICC staff will continue to provide services at satellite clinics to decrease the number of low birth weight infants by providing easier access to high-risk obstetrical maternal care and education. CMS will continue to provide educational programs to community health providers. CMS will continue to monitor RPICCs to ensure appropriate placement of neonates in the Level III NICUs. The CMS RPICC consultants will identify delivering facilities that inappropriately deliver very low birth weight neonates, and encourage the establishment of linkages necessary to transfer high-risk obstetrical women to appropriate delivering facilities.

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

#### **A. Last Year's Accomplishments**

Provisional data for 2010 indicate 79.4 percent of pregnant women received prenatal care in the first trimester. This rate was higher than the 78.3 percent reported in 2009, but still lower than the 2010 performance objective of 80.5 percent. We continue to experience an increase in the number of uninsured pregnant women and a decrease in providers of prenatal care across the state.

We have encouraged county health departments (CHDs) to offer Presumptive Eligibility for Pregnant Women (PEPW) or Simplified Eligibility for Pregnant Women to assist women with early entry. Until a final determination is made, PEPW allows women to be temporarily eligible for prenatal care coverage by showing only proof of pregnancy and completing a limited application. One issue we are seeing around the state is that our private providers are reluctant to accept the PEPW client until final Medicaid approval, thus delaying entry into care.

We worked with Healthy Start coalitions statewide to ensure an adequate infrastructure for the provision of first trimester prenatal care and continuous care for all pregnant women. We continue to work with the coalitions to promote awareness among providers that Medicaid pays additional reimbursement to providers who screen clients for Healthy

Start in the first trimester. We developed policies that promoted wellness among women of childbearing age and helped educate women on the importance of first trimester entry.

Performance Improvement visits to the CHDs helped staff identify barriers to first trimester prenatal care, and allowed our staff to provide focused technical assistance and training to counties with first trimester entry levels below the state average. Healthy Start coalitions provided or facilitated a variety of enabling services, depending on local needs and resources, such as translation services, outreach, health education, family support, case management, and coordination with WIC and Medicaid. All of these services help women access early prenatal care. In some communities there are few resources or options for prenatal care, especially for women who are uninsured and do not qualify for Medicaid. In these communities, the coalitions may provide financial support for the provision of direct health care services (prenatal care), as this is the only way these services are available to some of the women at highest risk.

The MomCare program, implemented statewide in FY2002, facilitates Medicaid coverage for prenatal care. MomCare provides prenatal care choice counseling, helps women access health care services, assists in follow-up of missed prenatal care appointments, and promotes coordination between prenatal care providers and supportive services. MomCare sends a packet to all clients that includes information on the Family Planning Waiver. We continued to ensure the statewide process of presumptive and simplified Medicaid eligibility for pregnant women.

## **B. Current Activities**

We continue to work closely with the Healthy Start coalitions and the Department of Children and Families in addressing issues for women accessing Medicaid coverage for pregnancy, or accessing provider services once Medicaid has been approved.

We have implemented preconception health guidelines for the county health department clinics, Healthy Start programs, and with our family planning clinical staff. We continue to collaborate with the March of Dimes to promote preconception health and encourage women to access early prenatal care through the Every Woman Florida Initiative. With funding from the March of Dimes, the department implemented Every Woman Florida, a statewide preconception health campaign to promote the importance of being healthy prior to pregnancy as well as raise awareness on the importance of early access to care. A preconception health website was developed to supply resources and information for health professionals and the community to promote healthy behaviors and foster access to care.

The department undertook a special analysis in 2009 to explore the availability of prenatal care within the county health department system and to identify areas of obstetrical provider shortage. Currently, 21 out of the 67 county health departments in the state do not offer prenatal services. Some Florida counties have no obstetrical providers or hospitals that offer delivery services.

## **C. Plan for the Coming Year**

The Department of Health will continue to work with the Department of Children and Families and the ACCESS community network on a campaign to educate providers who assist women in the Medicaid application process. Through MomCare, we continue to help pregnant women in obtaining prenatal appointments and following up on their medical care. We continue to encourage CHDs to provide presumptive eligibility for

pregnant women, allowing immediate access to Medicaid services. We will continue to encourage providers outside of the CHD to use the Simplified Eligibility Medicaid application. This streamlined process requires no face-to-face contact, reducing some of the stigma barriers in accessing Medicaid insurance.

We will continue to work through Healthy Start coalitions to encourage providers to see patients during the first trimester of their pregnancies, and we will continue to partner with the Healthy Start coalitions to implement strategies to remove barriers and improve access to care as well as develop solutions for increasing the first trimester entry rate. We will also continue focusing efforts toward counties with first trimester entry levels below the state average for special technical assistance, and develop and implement strategies to improve access to early prenatal care. We will accomplish this through continued quality improvement visits to counties, as well as through working in collaboration with Healthy Start coalitions statewide.

The focus will be on areas that have access to care barriers and low continuation of prenatal care. Through the Every Woman Florida initiative the department will continue to encourage women to be healthy and prepared for pregnancy, and identify activities that will decrease unplanned or mistimed pregnancies. The aim is to increase community awareness of the importance of prenatal care as well as assist women in developing a support network within their community.

NATIONAL PERFORMANCE MEASURES	Pyramid Level of Service			
	DS	ES	PBS	IB
1) 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.				
1. Florida contracts with three genetic specialty centers for referral of patients with abnormal PKU, Galactosemia, Biotinidase and other metabolic disorder test results.	X			
2. Florida contracts with three endocrine specialty centers for referral of patients with abnormal congenital hypothyroidism and congenital adrenal hyperplasia test results.	X			
3. Florida contracts with 10 hematology/oncology specialty centers for referral of patients with abnormal hemoglobinopathy test results.	X			
4. Florida contracts with 11 Cystic Fibrosis Centers for referral of patients with abnormal cystic fibrosis test results.	X			
5. Specialty referral centers arrange confirmatory testing and treatment for patients identified through the screening program. Genetic counseling, follow-up and nutritional counseling activities (treatment and dietary management) are included.	X			
6. Educational materials are distributed to all birthing facilities regarding the 34 disorders that are tested in the newborn metabolic screening.			X	

<p>2) The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive. (CSHCN Survey) Ongoing major activities.</p> <ol style="list-style-type: none"> <li>1. Family-to-family support and contact will be facilitated throughout CMS.</li> <li>2. CMS staff will produce and market materials that explain the CMS Mission, Vision, Goals and Services via their website, printed materials, and other forms of media and advertising.</li> <li>3. Include CMS families in developing policy, training, and in-service education.</li> <li>4. A statistically significant number of Satisfaction Surveys will be obtained from children, teens, and young adults enrolled in CMS Programs or their families regarding the services received through CMS or a CMS contracted provider.</li> <li>5. Data collection and analyses from each CMS area office for CMS Goals/Performance Measures on family partnering and satisfaction with services.</li> </ol>	X	X	X	X  X
<p>3) 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) Ongoing major activities.</p> <ol style="list-style-type: none"> <li>1. Demonstrate the importance of a medical home to the health and well being of children with special health care needs through data collection, satisfaction surveys, and performance measures.</li> <li>2. Medical home interagency leadership and collaboration through Task Forces and Workgroups.</li> <li>3. Health care transition services task force and formation of transition coalition.</li> <li>4. Support initiatives in tele-health, and other innovative delivery systems, that are built on the CMS medical home.</li> <li>5. Assist families to understand the uses of tele-health.</li> <li>6. Identify and recruit potential or approved providers to serve CMS children with special health care needs and their families with a focus on recruiting specialists and dental providers.</li> <li>7. Care coordination and disease management web-based training.</li> <li>8. Collaborate with other state agencies and community partners to provide services to children with special healthcare needs, foster children, and Medicaid beneficiaries in a medical home.</li> <li>9. Data collection and analyses from each CMS area office for CMS Goals/Performance Measures on family partnering and satisfaction with services.</li> </ol>	X	X	X	X  X  X  X  X
<p>4.) 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) Ongoing major activities.</p> <ol style="list-style-type: none"> <li>1. Collaborate and coordinate with Medicaid and KidCare offices to strengthen outreach and enrollment strategies.</li> <li>2. Identify children at risk for and with special health care needs.</li> <li>3. Utilize quality of care measures for children enrolled in CMS Programs.</li> <li>4. Track health expenditures and costs of services.</li> </ol>	X  X	X	X	X X

<p>5) The percent of children with special health care needs age 0 to 18 whose families report the community-based service system are organized so they can use them easily. (CSHCN Survey) Ongoing major activities.</p> <ol style="list-style-type: none"> <li>1. Establish and maintain CMS Programs that support all caregivers and partners.</li> <li>2. Support children, teens, and young adults, and family leadership programs that identify families as leaders and potential leaders.</li> <li>3. Promote use of telemedicine.</li> <li>4 Support family organizations/initiatives as they engage families of children at risk for and with special health care needs in effective partnerships.</li> <li>5. Evaluate the potential benefit of telehealth and telemedicine services for CMS enrollees and their families.</li> <li>6. Data collection and analyses from each CMS area office for CMS Goals/Performance Measures on community-based service systems.</li> <li>7. Provision of a Pharmacy Benefits Program to CMS enrollees.</li> </ol>	<p>X</p> <p>X</p>	<p>X</p> <p>X</p>	<p>X</p> <p>X</p>
<p>6) 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. (CSHCN Survey) Ongoing major activities.</p> <ol style="list-style-type: none"> <li>1 Plan for the eventual transition of all teens and young adults with special health care needs to adult services.</li> <li>2. CMS Network Care Coordinators will coordinate and facilitate transition activities with each teen beginning at age 12, to meet their needs.</li> <li>3. Create and maintain a Transition Guide on the CMS Internet.</li> <li>4. Participate in a collaborative partnership with community organizations and state agencies to support the New Freedom Initiative and the Healthy and Ready to Work Transition services and systems.</li> <li>5. Create and maintain a CMS Youth Advisory Board staffed by CMS enrollees who are between 12 to 21 years of age.</li> <li>6. Data collection and analyses from each CMS area office for CMS Goals/Performance Measures on youth transition.</li> </ol>	<p>X</p> <p>X</p>	<p>X</p>	<p>X</p> <p>X</p> <p>X</p>
<p>7) 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, Hepatitis B. Ongoing major activities.</p> <ol style="list-style-type: none"> <li>1. Recommend all health care providers implement the Standards for Pediatric Immunization Practices.</li> <li>2. Continue implementation of the registry (Florida Shots) in the private sector.</li> <li>3. Implement/Continue missed opportunities policy for public and private health care providers.</li> <li>4. Continue WIC/Immunization linkage.</li> <li>5. Statewide initiative to improve collaboration with public and private stakeholders/partners in order to increase immunization coverage levels in this target population.</li> </ol>	<p>X</p>	<p>X</p>	<p>X</p> <p>X</p> <p>X</p>
<p>8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years. Ongoing major activities.</p> <ol style="list-style-type: none"> <li>1. Teen pregnancy prevention classes, and case management and aftercare for students in Comprehensive School Health Services Projects who give birth.</li> <li>2. Conducting abstinence-only education classes.</li> <li>3. Conducting statewide abstinence media campaign.</li> <li>4. Developing community and Department of Health program collaboration.</li> <li>5. Promoting consumer involvement.</li> <li>6. Provision of confidential family planning counseling and education.</li> <li>7. Provision of confidential family planning comprehensive contraceptive services.</li> </ol>	<p>X</p> <p>X</p>	<p>X</p>	<p>X</p>

<p>9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth. Ongoing major activities.</p> <ol style="list-style-type: none"> <li>1. Promote the development of school-based sealant programs.</li> <li>2. Promote increased sealant utilization in county health department safety net programs.</li> <li>3. Develop and maintain sealant promotional material on Internet site.</li> <li>4. Promote the development of a surveillance system to capture sealant utilization data on permanent molars of third and ninth graders.</li> </ol>	X		X	X X
<p>10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. Ongoing major activities:</p> <ol style="list-style-type: none"> <li>1. The Florida Special Needs Occupant Protection Program operated in seven children's hospitals in Florida.</li> <li>2. Evaluation of children with special health care needs to determine the appropriate child safety seat or restraint.</li> <li>3. Provided loaner special needs seats or restraints when necessary.</li> <li>4. Purchased 416 special needs child safety seats/restraints and 1106 replacement parts to be used at the eight children's hospitals. (DOT GY 09-10).</li> <li>5. Through the local SAFE KIDS coalitions and state chapters, conducted numerous car seat check-up events on an ongoing basis and during National Child Passenger Safety Week, National SAFE KIDS Week, and Buckle Up America Week.</li> <li>6. Purchased over 17,000 bicycle helmets that were provided to community partners who fit and distributed the helmets within their community (DOT GY09-10).</li> </ol>	X X X	X  X	X	
<p>11) Percentage of mothers who breast feed their infants at six months of age. Ongoing major activities.</p> <ol style="list-style-type: none"> <li>1. Tracked "Infants Ever Breastfed" rates and "Infants Currently Breastfed" rates and the "Percentage of WIC Breastfeeding Women/Total Infants for WIC."</li> <li>2. Sponsored monthly telephone conference calls for statewide Florida Breastfeeding Coalition group to support coalition activities.</li> <li>3. Sponsored monthly telephone conference calls for statewide WIC breastfeeding coordinators to share breastfeeding promotion and support activities and ideas.</li> <li>4. Breastfeeding education and support offered through Healthy Start.</li> <li>5. Breastfeeding peer counselor programs now active in 41 WIC local agencies.</li> <li>6. Sponsored monthly telephone conference calls for peer counseling program administrators to share information and support.</li> <li>7. Posted all new breastfeeding education materials on the web for other Florida residents to use as well as other state agencies to adopt and use. The web site is <a href="http://www.FloridaWIC.org/">www.FloridaWIC.org/</a></li> <li>8. Purchased and distributed World Breastfeeding Kits to local WIC agencies to assist in celebrating WBW in August 2010.</li> </ol>	X	X X X X	X  X	X
<p>12) Percentage of newborns who have been screened for hearing before hospital discharge. Ongoing major activities.</p> <ol style="list-style-type: none"> <li>1. Distribution of educational materials to obstetricians, pediatricians, family practitioners, midwives, parents, hospitals and early intervention providers regarding universal newborn hearing.</li> <li>2. Providing technical assistance to all Florida birth facilities hearing screening personnel regarding newborn hearing screening.</li> <li>3. Reporting of hearing screen results on metabolic specimen cards submitted to the state laboratory.</li> <li>4. Running data system reports to provide statistical information regarding births and the number of babies that refer on the hearing screen.</li> </ol>		X	X	X X

<p>13) Percent of children without health insurance. Ongoing major activities.</p> <ol style="list-style-type: none"> <li>1. Ensure families are informed that they can apply for Medicaid using the KidCare application year-round.</li> <li>2. Policy development and evaluation of effects of Florida KidCare program changes on Florida KidCare enrollment and child uninsurance.</li> <li>3. Provide care coordination and other services to uninsured and underinsured families of children with special health care needs.</li> <li>4. Statewide notification of KidCare open enrollment.</li> </ol>	X	X	X	X
<p>14). Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile. Ongoing major activities:</p> <ol style="list-style-type: none"> <li>1. Continue to encourage local WIC agencies to use prevention of overweight as a major nutrition education focus in their nutrition education and breastfeeding promotion efforts.</li> <li>2. Continue to provide tools on healthy eating and physical activity for WIC families such as nutrition education materials, and nutrition education kits focusing on healthy nutrition.</li> <li>3. Continue to translate all campaign materials and nutrition education materials into Spanish, since the Hispanic population has the highest percentage of overweight children on WIC and Haitian/Creole.</li> <li>4. Provide data to local WIC agencies each quarter which tracks the percentage of 2-5 year old WIC children who are <math>\geq 85^{\text{th}}</math> percentile in each county.</li> <li>5. Post all nutrition education kit on the Intranet for other DOH staff in the state to use.</li> <li>6. Post nutrition campaign materials and nutrition education materials on the Internet for Floridians to use as well as other state agencies to adopt and use – <a href="http://www.FloridaWIC.org">www.FloridaWIC.org</a></li> </ol>	X X	X	X X	X
<p>15) The percentage of women who smoke in the last three months of pregnancy. Ongoing major activities.</p> <ol style="list-style-type: none"> <li>1. Provision of guidelines directing health care providers to counsel women of childbearing age and all pregnant women on the dangers of tobacco use.</li> <li>2. Monitoring of prenatal smoking indicators by county health department and state health office staff.</li> <li>3. Training and technical assistance on the Make Yours a Fresh Start Family program and ACOG's Smoking Cessation During Pregnancy: A Clinician's Guide to helping Pregnant Women Quit Smoking.</li> <li>4. Forwarding information on tobacco cessation and secondhand smoke through conference calls, site visits, meetings, and email communications.</li> <li>5. Monitoring of compliance with Healthy Start Standards and Guidelines standards for tobacco cessation.</li> <li>6. Promoting partnerships with public and private sector prenatal care providers to increase access to smoking cessation services and implement programs and policies supportive of prenatal smoking cessation and reduction of second hand smoke.</li> <li>7. Educating the public about dangers of smoking during pregnancy and about the QuitLine using mass media.</li> <li>8. Enhancing preconception identification of smokers and enhanced interventions.</li> </ol>		X	X X X X X	X X X X X
<p>16) The rate (per 100,000) of suicide deaths among youths 15-19. Ongoing major activities.</p> <ol style="list-style-type: none"> <li>1. Suicide prevention small group prevention-interventions and health education classes in Comprehensive School Health Services Projects.</li> <li>2. Youth suicide prevention train-the-trainer workshops for gatekeepers.</li> <li>3. Coalition building by the Florida Suicide Prevention Taskforce.</li> <li>4. Utilization of proven mental health/screening programs.</li> <li>5. Implementation research-based suicide prevention pilot projects.</li> </ol>		X	X X	X X

<p>17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. Ongoing major activities.</p> <ol style="list-style-type: none"> <li>1. Regional Perinatal Intensive Care Centers (RPICC) staff from three of the RPICCs provides 9 high-risk obstetrical satellite clinics.</li> <li>2. RPICC staff at the 11 designated facilities provides a comprehensive high-risk obstetrical outpatient clinic.</li> <li>3. RPICC staff provides yearly educational programs to the community health providers.</li> <li>4. RPICCs are monitored annually by physicians and Children’s Medical Services Central Office consultants to ensure the quality of care for high risk obstetrical patients and appropriate placement of neonates in the Level III NICU.</li> <li>5. Identify hospitals that are inappropriately delivering low birth weight infants, to provide education and linkage to an appropriate facility for high risk mothers and infants.</li> </ol>	<p>X X</p>	<p>X</p>	<p>X</p>	<p>X</p>
<p>18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. Ongoing major activities.</p> <ol style="list-style-type: none"> <li>1. Continue work through Healthy Start coalitions to encourage providers to see patients during the first trimester of their pregnancies.</li> <li>2. Continue focusing special technical assistance for counties with first trimester entry levels below the state average, and develop and implement strategies to improve access to early prenatal care.</li> <li>3. Continue to promote the use of preconception health guidelines in the county health departments.</li> <li>4. Continue the MomCare program.</li> <li>5. Continue Presumptive Eligibility and Simplified Eligibility Medicaid application processes to expedite entry into prenatal care.</li> <li>6. Continue working through the Healthy Start coalitions to implement strategies to remove barriers and improve access to care as well as develop solutions for increasing the first trimester entry rate.</li> </ol>	<p>X X</p>	<p>X</p>	<p>X X</p>	<p>X</p>

**D. State Performance Measures**

**SPM#1 The percentage of Part C eligible children receiving service.**

**A. Last Year’s Accomplishments**

Direct health care activities related to this measure include identifying, evaluating, and providing services to eligible infants and toddlers through contracts with 15 local Early Steps. Early Steps also provided enabling activities such as maintaining reduced caseload sizes; providing technical assistance and training to early intervention staff and providers; providing advocacy, training and support services for families; and coordinating with Medicaid and other agencies to access funding and support for the service delivery system. Population based services included providing ongoing outreach, public awareness, and education. Examples of infrastructure building activities included revision of Early Steps policies and guidance documents to ensure consistency with new requirements of the Individuals with Disabilities Education Act (IDEA) and state requirements, maintaining a centralized system for provider enrollment; collaborating with established systems for personnel development, especially with university Infant Toddler Developmental Specialist (ITDS) programs; maintaining the Early Steps Data System, and implementing quality assurance monitoring to assess performance and ensure compliance with federal regulations and state policy.

Preventing the incidence of disabilities for infants and children is a state priority. It addresses the continuing need to provide adequate screening, assessment, and

services to ensure infants and children receive the services they need to help them lead more healthy lives.

In accordance with the 2004 reauthorization of the IDEA, Early Steps publicly reported on statewide and local Early Steps performance. A determination of each local Early Steps was made in accordance with the provisions of IDEA and to identify local Early Steps that meet requirements and those in need of some level of assistance or intervention to meet the requirements of IDEA.

Technical assistance from national and regional technical assistance sources was utilized to improve the state's performance on State Performance Plan (SPP) Indicator 1 (timely service delivery) and SPP Indicator 9 (timely identification and correction of noncompliance).

### **B. Current Activities**

Monitoring and technical assistance is provided to local Early Steps (ES) to promote performance and to ensure services are provided in accordance with federal regulations and state policy. Local ES with identified noncompliance are required to develop a Continuous Improvement Plan to ensure compliance within one year. A system of child outcome measurement has been implemented to provide information on the extent to which enrollees demonstrate improved outcomes as a result of early intervention services.

In accordance with federal requirements, an annual performance report was submitted on February 1, 2011, which includes actual target data for July 1, 2009 through June 30, 2010.

The Florida Developmental Disabilities Council commissioned and financed an intricate study of the Early Steps system to identify opportunities to promote the sustainability of the service system in light of the current economic climate and elimination of ARRA funding after the current year. A total of 40 recommendations were developed at the conclusion of the study.

### **C. Plan for the Coming Year**

Early Steps will continue to implement the infrastructure and improvement activities described in the Florida Part C State Performance Plan. Recruitment and retention of a highly qualified work force to meet the service needs of eligible children will be a focus, with special emphasis on the Team-Based Primary Service Provider model of intervention and evidence-based intervention for Early Steps children and their families. A Strategic Plan Implementation Committee has been formed to prioritize and assign action steps to stakeholders in the Early Steps system to implement recommendations from the sustainability study.

## **SPM#2 The percentage of births with interpregnancy interval less than 18 months.**

### **A. Last Year's Accomplishments**

Florida's CHARTS data for 2009 indicates 38.2 percent of all births had an interpregnancy interval less than 18 months, with a provisional rate of 36.8 percent for 2010. The Family Planning Program, Healthy Start, MomCare, and community agencies

provided an array of services to ensure new mothers have a method of contraception selected prior to the birth of the baby.

Florida statute authorizes the Department of Health to make comprehensive medical knowledge, assistance, and services relating to the planning of families and maternal health care available to citizens of childbearing age. One goal is to improve the health of women and children by reducing unplanned pregnancies.

We worked with Healthy Start coalitions statewide to ensure an adequate infrastructure for the provision of first trimester prenatal care and continuous care for all pregnant women. We developed policies that promoted wellness among women of childbearing age and helped educate women on the importance of spacing pregnancies to have an interval between pregnancies of 18 months or longer.

The MomCare program, implemented statewide in FY2002, facilitates Medicaid coverage for prenatal care. MomCare provides prenatal care choice counseling, helps women access health care services, assists in follow-up of missed prenatal care appointments, and promotes coordination between prenatal care providers and supportive services. MomCare sends a information packet to all clients. The packet includes information on the Medicaid Family Planning Waiver.

### **B. Current Activities**

We have implemented preconception health guidelines for the county health department clinics, Healthy Start coalitions, and with our family planning clinical staff.

A total of six preconception health grand rounds were provided statewide in 2010-2011. The number of participants who attended the grand rounds included 250 health care providers and health educators. In addition, preconception health tool kits were provided to 797 health care providers and educators.

The Healthy Start population of pregnant women and mothers of infants up to age 3 are counseled about the availability of family planning services to provide clients with the knowledge of where to obtain family planning services in order to ensure birth intervals are 18 months or longer (Healthy Start Standards and Guidelines, Chapter 5). Interconception counseling is provided as part of Healthy Start services.

### **C. Plan for the Coming Year**

We will continue focusing efforts toward counties with a percentage of births with interpregnancy intervals less than 18 months that is higher than the overall state percentage. The counties will be provided technical assistance to develop and implement strategies in reducing the percentage of births with interpregnancy intervals less than 18 months. We will accomplish this through continued performance improvement visits to counties, as well as through working in collaboration with Healthy Start coalitions, MomCare, and community agencies working with mothers and babies.

**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.**

### **A. Last Year's Accomplishments:**

Staff within the Infant, Maternal, and Reproductive Health Unit monitored the provision of preconception health education and counseling services to all family planning clients during statewide performance improvement visits. We also provided Family Planning Waiver eligibility staff with training on preconception health issues.

We collaborated with the March of Dimes Florida Chapter to establish the Every Woman Florida Preconception Health Initiative, which was a statewide campaign to raise awareness and increase knowledge of risk factors that could lead to adverse birth outcomes. This initiative was responsible for garnishing support from healthcare providers and promoting the integration of preconception education into their professional practices.

Through a statewide collaboration with public and private sector leaders in the maternal and child health community, we formed the Every Woman Florida Preconception Health Council. These advisory council members consisted of health insurance representatives, hospital providers, members of the Florida Obstetric and Gynecologic Society, academic institutions, public health agencies, and other community organizations. To prevent workload duplication, the Every Woman Florida Preconception Health Council was consolidated and merged into the March of Dimes Prematurity Workgroup.

We developed a social marketing campaign including the establishment and launching of the Every Woman Florida website. The webpage serves as an information portal to address the knowledge, attitudes and behaviors of providers and consumers. We developed and distributed over 500 Every Woman Florida preconception health education and outreach toolkits statewide.

Staff collaborated on the development of *Preconception Health: An Issue for Every Woman of Childbearing Age in Florida*. This preconception health indicator report provides a comprehensive look at the status of preconception health among women of childbearing age. The report covers 10 different health areas or domains such as health care, chronic diseases, infections, and mental health. The report is intended to both educate health care providers and the public and to serve as a resource in planning strategies and activities to improve preconception health in Florida.

Additional activities included the Every Woman Florida Preconception Health presentation and distribution of toolkits to over 150 students at the Preconception Peer Educators Regional Training, on July 20-21, 2010, at Florida A&M University in Tallahassee. We also completed four of six grand rounds type presentations to health care providers at hospitals throughout the state, providing preconception education and outreach to over 250 providers and consumers. We provided a Every Woman Florida Preconception Health presentation at the Annual Community Baby Shower and distributed toolkits to over 75 participants

## **B. Current Activities:**

Staff completed the remaining two grand rounds presentations to health care providers, providing preconception education and material to over 125 providers and consumers. We continue to incorporate and monitor the provision of preconception health education and counseling services to family planning clients during CHD clinic visits. We also

provided Family Planning Waiver eligibility staff with training on preconception health issues.

We printed and distributed Florida's first preconception health indicator report and modules, *Preconception Health: An Issue for Every Woman of Childbearing Age in Florida*, to be distributed statewide and at the National Preconception Health Conference in June 2011.

The department purchased multivitamins with folic acid to distribute to female clients of child-bearing age accessing services in CHD clinics. We distributed Positive Youth Development outreach materials to raise awareness about the importance of being healthy and preventing STDs before conceiving.

We continue to collaborate on the March of Dimes Preconception/Prematurity Workgroup regarding preconception health issues, and continue to promote Every Woman Florida Preconception Health Awareness Campaign and maintain and update the Every Woman Florida Website.

We continue to monitor the provision of preconception health education and counseling services during CHD clinic visits. We also provided Family Planning Waiver eligibility staff with training on preconception health issues.

### **C. Plan for the Coming Year:**

Staff will continue to collaborate on the March of Dimes Preconception Health/Prematurity Workgroup regarding preconception health issues. We will continue to promote Every Woman Florida Preconception Health Awareness Campaign, maintain and update the Every Woman Florida Website. We will also continue to incorporate and monitor the provision of preconception health education and counseling services during county health department family planning clinic visits. Additionally, we will continue to work with the CHD medical directors to provide continuing medical education opportunities during monthly conference calls to increase preconception health awareness and promotion efforts.

### **SPM#4 The percentage of infants not bed sharing.**

#### **A. Last Year's Accomplishments**

In 2009, bed sharing and unsafe sleep environments were the leading cause of death in children under one year of age and the second leading cause of all verified child abuse and neglect deaths. The State Child Abuse Death Review Committee observed a striking lack of uniformity among Florida's medical examiners in how infant deaths are investigated and in the terminology used in certifying the cause and manner of death in cases of sudden unexpected infant deaths. This made it very difficult to identify the causes of infant mortality and the risk factors that could aid in preventing future deaths.

Since 1990, the prevalence of SIDS deaths in Florida has declined 65 percent. However, the prevalence of SUIDs, which includes deaths from SIDS, accidental suffocation, other accidental suffocation or strangulation, child maltreatment, and neglect, has increased 205 percent. A study conducted by the Florida Department of Health determined that a change in medical examiner coding preferences accounted for the decrease in SIDS deaths and increase in SUID cases (Watson, 2007). Many deaths

previously classified as SIDS are now classified as accidental suffocation or cause unknown, so SUID and SIDS are still key types of infant mortality. PRAMS data for the period 2003-2005 showed the SUID rate among black infants (19 per 10,000 live births) was more than twice the SUID rate for white infants (8.4 per 10,000 live births) (Broussard, 2009). A 2009 study by the Department of Health found that some of this disparity is due to differences in unsafe infant sleep practices between races. Among black women in Florida, 67 percent reported frequent bed sharing compared to 38 percent of white women (Broussard, 2009). Bed sharing was more likely to occur among black women who had late or no prenatal care, breastfed for less than four weeks, and who experienced depression during or after pregnancy (Broussard). Black mothers who experienced depression were 7.5 times more likely to bed share than black mothers who were not depressed (Broussard). These findings were shared with health care providers and Healthy Start staff via teleconference. The presentation is currently available for viewing on the DOH training website.

Quality assurance activities included a discussion of how Healthy Start and county health departments were providing information to parents on safe sleep recommendations.

### **B. Current Activities**

In order to give communities more accurate information on SUIDs, the Department of Health is collaborating with Florida medical examiners in a SUID investigation. The investigation objectives are to: estimate the SUID rate; estimate the proportion of SUID deaths by underlying cause of death reported on the death certificate; describe the changes in reporting that may take place from the medical examiner report, to the death certificate, to the final underlying classification of SUID; identify the types and intensity of SUID investigation completed; determine the factors that impact accurate reporting of SUID causes; and estimate the prevalence of known SUID risk factors. The study will also be analyzing data regarding pacifier use. The findings of the investigation will help communities understand the SUID problem and develop SUID prevention messages and strategies, including safe sleep messages and strategies, to help prevent future SUID cases.

The Department of Health continues to provide training to Healthy Start staff and health care providers on the risks associated with bed sharing. The IMRH unit is collaborating with the WIC program to assure a consistent message is being given regarding breastfeeding and room sharing vs. bed sharing. Training is also provided on maternal depression and its link to bed sharing.

### **C. Plan for the Coming Year**

The data from the SUID investigation will be analyzed and the results shared with communities. The study will provide more accurate information on the number of sudden unexpected infant deaths occurring in Florida; how many of the deaths received complete investigations include autopsies, doll re-enactments, and death scene investigations; the prevalence of risk factors among the deaths; and which programs had touched the families of the infants who died. By identifying which agencies had the most contact with families, specific interventions for those agencies can be developed. The study will also be providing information on the extent of pacifier use.

We plan to work more closely with our FIMR projects to learn which community action steps seem to be the most effective at reducing sleep-related infant deaths and share those best practices during site visits and statewide conference calls.

The Department of Health will continue to provide training on risk reduction strategies based on the latest research finding. Healthy Start staff will also receive training on strategies to change behavior. Because some parents are resistant to following safe sleep recommendations, training will include Motivational Interviewing techniques to assist staff with identifying stages of readiness for change and appropriate intervention.

## **SPM#5 The percentage of infants back sleeping.**

### **A. Last Year's Accomplishments**

For the period 2003-2005, the Sudden Unexpected Infant Death (SUID) rate among black infants (19 per 10,000 live births) was more than twice the SUID rate for white infants (8.4 per 10,000 live births (Broussard, 2009). A 2009 study by the Department of Health utilizing PRAMS data from 2004-2005 found that some of this disparity is due to differences in unsafe infant sleep practices between races. In Florida for that period, 61 percent of black women reported infrequent back sleeping compared to 35 percent of white women. Study results found that infrequent back sleeping was more likely among women with a mistimed or unwanted pregnancy or who experienced traumatic stress, but among black women, infrequent back sleeping was also more likely among those who did not acknowledge the infant's father on the birth certificate (Broussard). These findings were shared with health care providers and Healthy Start staff through a teleconference. The presentation is currently available for viewing on the DOH training website.

Quality assurance activities included a discussion of how Healthy Start and county health departments were providing information to parents on safe sleep recommendations.

### **B. Current Activities**

Communities may not be aware that infants are dying from preventable causes because the deaths are not investigated thoroughly. Without complete information, medical examiners cannot accurately classify the cause and manner of death and communities will not receive the information needed to put appropriate prevention services in place to reduce infant deaths. The CDC developed a standard investigation reporting form and a training curriculum to improve the accuracy of SUID classification but the form is not widely used across Florida. The State Child Abuse Death Review team has been providing training to law enforcement agencies and medical examiners around the state on death scene investigation. During 2010, a total of 33 training presentations on death scene investigations were provided.

To ensure physicians are aware of the safe sleep recommendations and the importance of discussing them with their patients, a distance learning satellite training for pediatricians and family practice physicians was provided in April 2010. DVDs of this training were sent out to health care providers and Healthy Start coalitions. The training can also be viewed on-line.

Training on SUID risk reduction for Healthy Start and county health department staff is in the process of being updated and will be available for on-line access. Information on the latest research findings is shared throughout the year via statewide conference calls.

### **C. Plan for the Coming Year**

The Department of Health will work with the Healthy Start coalitions to develop strategies for engaging hospitals in the development of policies that ensure infants are placed on their backs to sleep before discharge from the hospital and parents are educated about the importance of back sleeping prior to discharge. We will be consulting with Tomorrow's Child/Michigan SIDS to implement a quality improvement project similar to their four-year demonstration project to change attitudes and practices among urban hospital nurses. Information about their initiative will be shared with the FIMR projects and the Association of Healthy Start Coalitions as a possible strategy to reduce sleep-related infant deaths.

We plan to work more closely with our FIMR projects to learn which community action steps seem to be the most effective at reducing sleep-related infant deaths and share those best practices during site visits and statewide conference calls.

The Department of Health will continue to provide training on risk reduction strategies based on the latest research findings. Healthy Start staff will also receive training on strategies to change behavior. Because some parents are resistant to following safe sleep recommendations, training will include Motivational Interviewing techniques to assist staff with identifying stages of readiness for change and appropriate interventions.

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

#### **A. Last Year's Accomplishments**

The family planning program provided services to 21,299 teen users ages 15-17 during 2010, with a total of 39,860 visits and 102,608 services for this age group. A total of 90,956 visits were provided for 48,024 teens ages 13-19 in 2010.

A sexually transmitted infection (STI) family planning grant stressing preconception health, gonorrhea and Chlamydia testing for women age 14 to 25 was implemented in the county health departments (CHDs) beginning in January 2011.

Teen pregnancy prevention informational materials were ordered and distributed to CHD staff. Brochures with teen pregnancy prevention messages, and booklets entitled *Faith Matters* and *Faith, Love and Hope* were printed in English and Spanish and provided to each CHD family planning clinical site.

Two trainings entitled *Caring for Adolescent Clients* were provided in two counties, and a training entitled *Preventing Sexual Coercion Among Adolescents* was provided in another county. All three trainings were provided through the Title X Regional Training Center, Cicatelli Associates, Inc.

Hernando and Martin Counties were awarded teen pregnancy prevention grants in 2009 as Title X Special Initiatives. These projects were in the second year of a three-year

funding cycle. A total of five Male Projects provided family planning services and reproductive health education and outreach to teens and adult males. The counties that were awarded a Male Project in 2009 were: Baker, Bay, Collier, Duval, and Orange. These projects were in the second year of a three-year funding cycle.

Billboard, poster, and bus shelter placement with the message "When you're a teenager, life is full of positives....Don't let a pregnancy test be one of them" surrounding a picture of a positive pregnancy test, continued through the end of December 2010. A total of 16 vinyl billboards and 29 poster billboards remained in place in 17 cities on December 20, 2010. In addition, 201 posters with the same message were in place in 20 cities.

A total of six preconception health grand rounds were provided statewide in 2010-2011. The number of participants that attended the grand rounds included 250 health care providers and health educators. In addition, preconception health tool kits were provided to 797 health care providers and educators.

The Healthy Start population of pregnant women and mothers of infants up to age 3 were counseled about the availability of family planning services to provide clients with the knowledge of where to obtain family planning services in order to deter repeat births to teens. In addition, interconception counseling was provided as part of the HS services to encourage women to allow 18 months between delivery of a baby and the next attempt for conception. Healthy Start care coordinators provided interconception education to 32,848 prenatal women and economic self sufficiency services were provided to 574 women. Case management was provided to 336 women and 574 women were referred for family planning services. Interconception education was provided to 23,285 mothers of Healthy Start infants and to 1,132 Healthy Start interconception women. Referrals to family planning for mothers of Healthy Start infants numbered 477 plus nine interconception women.

## **B. Current Activities**

Reproductive health education, method counseling and family planning services are provided to all teens requesting family planning services.

A three hour Preconception Care training was held in Hillsborough County during March 2011.

The teen pregnancy prevention billboard campaign for teen pregnancy prevention continued for 18 months longer than expected through the use of public service advertising space not purchased for commercial advertising.

The Teenage Pregnancy Prevention Replication Project was awarded to School Health and provided to 26 participating counties. A Request for Applications was released in March 2011 for funding of 13 abstinence grants at \$150,000 per year. Training was provided in March 2011 for all participating CHD staff of the Project, and the CHDs will pilot the program in their communities in the summer of 2011. Implementation is scheduled to begin in August 2011 in 9<sup>th</sup> grade classes of the public schools.

The Adolescent Health Program applied for funds to provide for grants in the CHDs to deliver Personal Responsibility Education Program (PREP) activities in the local communities. The purpose of PREP is to educate youth on abstinence, contraception,

and six other adult preparation topics. Approval of the program is expected in April 2011 and services are expected to begin in 2011.

County health department staff is encouraged to provide activities for teen pregnancy prevention during May, Teen Pregnancy Prevention month.

### **C. Plans for the Coming Year**

The plan to reduce subsequent births to teens age 15 to 17 includes the provision of family planning services in all 67 county health departments, including pregnancy prevention counseling and contraceptive services, comprehensive reproductive health education, Healthy Start services, abstinence education, and school health services.

Educational brochures attractive to teens will be provided to all 67 county health departments for the staff to distribute to the local teen populations.

County health departments, Healthy Start Coalitions, and agencies and programs involved in welfare reform will continue to educate and collaborate with other community agencies in reducing subsequent teen births.

County health departments, local contract providers, Healthy Start programs, Healthy Families Florida programs, and other agencies that provide maternal and infant care services will inform postpartum teens about extended family planning services available through the Medicaid Waiver. Youth not eligible to participate in the Medicaid Family Planning Waiver will be provided services utilizing the department's Title X family planning program.

Implementation is scheduled to begin in August 2011 for the Teenage Pregnancy Prevention Replication Project in 9<sup>th</sup> grade classes of the public schools.

The evidenced-based Abstinence Education grant programs will be notified of awards in May 2011 and contracts will begin August 1, 2011.

### **SPM#7: The percentage of low-income children under age 21 who access dental care.**

#### **A. Last Year's Accomplishments**

Overall, the percentage of low-income children under 21 who access dental care has remained virtually constant since 2006. Apparent small annual increases may reflect measurement error rather than actual change. However, certain facets of oral health care have clearly improved. The number of children treated by county health department dental programs grew by nearly 19 percent over the previous year, reaching over 150,000 children. This increase resulted from growth in the number of county dental programs and in the productivity of county health department dentists.

Recommendations of the state oral health improvement plan for disadvantaged persons, facilitated by a HRSA Targeted Oral Health Services System grant, are ongoing. This broad-based initiative has the potential to increase awareness of oral health issues, collaboration, and partnerships, and to facilitate the continued development of an integrated, coordinated oral health system between the public and private sectors.

Currently, more than 75 percent of Florida's population obtains water from community systems that provide the benefits of fluoridation. Long-term benefits will reduce treatment needs and improve access to existing providers.

County health department program guidelines provide for continuing quality improvement activities, an orientation and guidance resource for newly hired dental directors, and a foundation for technical assistance inquiries.

The Public Health Dental Program hired a quality improvement coordinator to spearhead quality assessment and improvement efforts in the county health department dental programs.

### **B. Current Activities**

We will continue activities outlined in the state oral health improvement plan. State forums to develop specific objectives and to increase awareness of the needs of specific population groups are currently underway. Through a HRSA Grant to States to Support Oral Health Workforce Activities, a pool of funds has been created to help county health departments establish or expand dental facilities and services, to implement or expand school-based sealant initiatives. Other initiatives include contracting with Special Olympics to train dental providers in working with special needs populations and screening athletes; working with the Florida Dental Association to utilize oral health educational materials in practice FCAT testing among third graders; and a contract with the University of Florida, College of Dentistry for a training program for dental providers in the care of very young children, to train medical providers to provide oral health prevention, referral, and education, and to conduct oral health surveillance.

We developed an interactive social media website with targeted oral health messaging in English and Spanish for children, teens, parents and providers. We continue to emphasize the integration of oral health into all appropriate DOH programs through the development of protocols and implementation activities at the county level. Grants to communities for the purchase of water fluoridation equipment and supplies doubled this state fiscal year.

### **C. Plan for the Coming Year**

Ongoing FY 2011 activities include promotional activities to increase fluoridation. Under direction of the quality improvement coordinator, the promotion of increased capacity through county health department programs and increased quality improvement activities will continue. Statewide assessments of county health department guidelines and records will continue, and a schedule will be promulgated for onsite QI visits, conference calls, and technical assistance. Plans include the development of policy and technical assistance guidance on the use of fluoride varnish in dental and medical settings.

Additionally, we will develop a database of providers for special needs populations. Through the department's *Reducing Oral Health Disparities* initiative and the workforce grants to support county health department infrastructure expansion, incremental progress will continue to expand access to low-income and minority populations. The program will continue to advocate for an outcome-based surveillance system that is vitally needed to increase public awareness and to monitor the impact of activities on the improvement in oral health status.

STATE PERFORMANCE MEASURES	Pyramid Level of Service			
	DHC	ES	PBS	IB
<p>1) The percentage of Part C eligible children receiving service. Ongoing major activities.</p> <ol style="list-style-type: none"> <li>Evaluate current service delivery system to improve services for infants and toddlers with disabilities and their families.</li> <li>Provide ongoing outreach, public awareness and education.</li> <li>Identify, evaluate and provide services to eligible infants and toddlers through contracts with 15 regional programs.</li> <li>Maintain reduced service coordination caseload size at 1/65.</li> <li>Develop and implement state policy and standards for providing services in natural environments, and implement a centralized system for provider enrollment.</li> <li>A Continuous Improvement system that includes Quality Assurance monitoring, identification of noncompliance, technical assistance to help local programs achieve and maintain compliance, and implementation of sanctions for systemic noncompliance.</li> <li>Provide for an Early Steps Data System to maintain an electronic record of all children served and services provided.</li> <li>Provide advocacy, training and support services for families.</li> <li>Coordinate with Medicaid, Insurance, Department of Education and other agencies to access funding and support for service delivery system.</li> <li>Implement a child and family outcomes measurement system to determine the extent to which child and family outcomes are positively impacted by receipt of services through Early Steps.</li> </ol>	X	X  X  X		X  X  X  X  X
<p>2) The percentage of births with interpregnancy interval less than 18 months.</p> <ol style="list-style-type: none"> <li>Provide preconception and interconception care education and counseling to all clients seen in the family planning clinics.</li> <li>Encourage county health departments to utilize the limited examination guidelines to initiate a contraceptive method without having to wait for a physical examination appointment.</li> <li>Provide emergency contraception at the county health departments.</li> <li>Encourage prenatal providers to discuss the contraceptive method that will be used following delivery by the eighth month of pregnancy.</li> <li>Ensure CHD clients (females and males) have access to and are informed about sterilization services.</li> <li>Market the availability of family planning services in isolated communities.</li> </ol>	X  X	X  X	X	X
<p>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.</p> <ol style="list-style-type: none"> <li>Promote and encourage the integration of comprehensive preconception health services for women into all health care settings.</li> <li>Encourage health care providers and staff to integrate preconception education into their professional practices.</li> <li>Promote the use of preconception health guidelines in the county health departments statewide.</li> <li>Work with Healthy Start Coalitions on the provision of preconception and interconception education and counseling services throughout the state.</li> <li>Provide preconception education and counseling as a component of any nursing assessments and counseling service provided.</li> <li>Provide ongoing preconception health outreach and education occurs through the local Healthy Start coalitions.</li> <li>Inform colleges and universities of Federal Office of Minority Health Peer to Peer PCH Training for college and university students.</li> <li>Monitor the provision of preconception health education and counseling services during clinic visits to all family planning clients.</li> <li>Distribute the Preconception Health Indicator Reports, report modules, and Every Woman Florida Preconception Health toolkits statewide.</li> </ol>		X  X  X	X  X	X  X  X
<p>4) The percentage of infants not bed sharing. On-going major activities:</p> <ol style="list-style-type: none"> <li>Provide training on safe sleep recommendations and reasons why parents</li> </ol>				X

<p>may not be following them.</p> <p>2. Technical assistance and training on how to talk with parents and caregivers about safe sleep issues.</p> <p>3. Provide information on safe sleep through conference calls, site visits, and meetings.</p> <p>4. Provide information about available written materials and DVDs on safe sleep.</p> <p>5. Provide training on screening and treatment for depression since depressed women are more likely to bed share.</p> <p>6. Provide training to law enforcement on death scene investigation.</p>			X	X
<p>5) The percentage of infants back sleeping.</p> <p>1. Provide training on safe sleep recommendations and the reasons why parents choose not to follow them.</p> <p>2. Technical assistance and training on how to talk with parents and caregivers about safe sleep issues</p> <p>3. Provide information on safe sleep through conference calls, site visits, and meetings</p> <p>4. Provide information about available written materials and DVDs for parents and caregivers on safe sleep.</p> <p>5. Monitor compliance with guidelines for prenatal education regarding risk reduction for sudden unexpected infant death.</p> <p>6. Share best practices.</p> <p>7. Train law enforcement on death scene investigation.</p>	X		X	
<p>6) The percentage of teen births, ages 15-17, that are subsequent (repeat) births.</p> <p>1. Provide confidential family planning counseling, education and comprehensive contraceptive services.</p> <p>2. Increase access to contraceptive services for teen mothers ages 15-17.</p> <p>3. Increase the number of sexually active teens who receive reproductive health services at family planning clinics.</p> <p>4. Reduce the proportion of pregnancies that were conceived within 18 months of a previous birth by providing preconception health counseling.</p> <p>5. Provide individual and small group pregnancy prevention interventions with Adolescent Health Services, Teen Pregnancy Prevention Grants and Healthy Start Programs.</p> <p>6. Provide School Health case management and care coordination in Comprehensive School Health Projects to enable parenting students to remain in school and graduate.</p> <p>7. Collaboration of Department of Health programs striving to reduce subsequent teen pregnancy.</p>	X		X	X
<p>7) The percentage of low-income children under age 21 who access dental care.</p> <p>Ongoing major activities.</p> <p>1. Facilitate the continued development of an integrated, coordinated oral health system between the public and private sectors.</p> <p>2. Conduct community-based dental projects.</p> <p>3. Promote increased access through county health department safety net programs.</p> <p>4. Promote the integration of oral health education in WIC, Child Nutrition and other county health department programs, as appropriate.</p> <p>5. Promote the start of oral health practices in infancy and appropriate use of fluoride products throughout early childhood in conjunction with the CDC's, <i>Brush Up on Healthy Teeth</i> campaign.</p> <p>6. Promote the development of community and school-based preventive and educational programs.</p> <p>7. Update Internet site to facilitate information exchange.</p>	X		X	X

**E. Health Status Indicators**

**Introduction:**

Tracking of the health status indicators includes gathering and evaluating data on low birth weigh, very low birth weight, unintentional injuries, and chlamydia. The surveillance and monitoring of these indicators on an annual basis provides insight into the progress made as we address these particular health issues. Careful evaluation helps direct us in our strategic planning efforts, and helps ensure we direct time and resources towards areas of need where we can have a positive impact on Florida citizens.

**HSI #01A. *The percent of live births weighing less than 2,500 grams***

Factors that may contribute to the risk of low birth weight and very low birth weight include mother's race, age, multiple birth, education, socioeconomic status, and substance use during pregnancy. Black infants are twice as likely as white infants to be born at a low birth weight, and black mothers accounted for 21.8 percent of resident live births in Florida in 2009. In 2009, 18.7 percent of all mothers had less than a high school education. A total of 15,177 mothers (6.9 percent) reported they smoked during pregnancy. Of all babies born that year, 7,181 were multiple births.

The Department of Health and its partners are engaging in a number of strategies to address both low and very low birth weight. We continue to promote prenatal smoking cessation through public awareness and the provision of classes, counseling and cessation methods as resources are available. We have expanded the WIC prenatal caseload, and increased the percentage of pregnant women whose delivery is paid for by Medicaid. We started new preconception health initiatives, and looked at more effective ways of providing prenatal care. We also strengthened our family planning efforts including our Medicaid family planning waiver.

In 2009, babies weighing less than 2,500 grams accounted for 8.7 percent of all live births, with a provisional rate of 8.7 for 2010. Low birth weight deliveries raise the risk of infant mortality, morbidity and developmental disability, and also cause greater health care costs. The percentage of twins and multigestation pregnancies is no longer increasing in Florida and does not contribute to these recent trends. We have recently studied the increase in preterm and late preterm births, a major determinant of low birth weight. The following do not explain the increase in preterm delivery in Florida: multiple gestations, maternal age, maternal race, maternal ethnicity, parity, maternal education, or marital status. Approximately one-third of the increase in preterm births is related to Cesarean delivery.

**HSI #01B. *The percent of live singleton births weighing less than 2,500 grams***

Same as HIS #01A above, except for the following data interpretation.

In Florida, singleton birth babies weighing less than 2,500 grams accounted 7 percent of all live singleton births, with a provisional rate of 7.0 in 2010. The difference between all births with low birth weight (8.7 percent) and singleton births with low birth weight (7.0 percent) in 2009 is attributable to multiple births. Studies have shown that more than half of twins and other multiples are born low birth weight. Previous increases in multiple births have been associated with older age at childbearing and an increase in fertility therapies.

**HSI #02A. *The percent of live births weighing less than 1,500 grams***

Same as HIS #01A above, except for the following data interpretation.

In Florida the percentage of infants born very low birth weight in Florida has remained consistently at or near 1.6 percent since 2006. The risk of early death for infants born with very low birth weight is more than 100 times that of infants born at more than 2,500 grams.

**HSI #02B. *The percent of live singleton births weighing less than 1,500 grams.***

Same as HIS #01A above, except for the following data interpretation.

In Florida the percentage of singleton infants born very low birth weight in Florida has remained at 1.3 percent from 2003 to 2009, and the provisional rate for 2010 is also 1.3 percent. The difference between all births with very low birth weight (1.6 percent) in 2009 and singleton births with very low birth weight (1.3 percent) in 2009 is attributable to multiple births.

**HSI #03A. *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.***

The death rates from unintentional injuries and motor vehicle crashes among children ages 14 years and younger are influenced by Florida's ability to maintain a strong Safe Kids Coalition and Chapter network. The Office of Injury Prevention is the lead agency for Safe Kids Florida, the statewide organization. Florida has a Safe Kids presence in 34 of the 67 counties and covers 85 percent of the children ages 14 and under. Safe Kids conducts community activities that provide education on prevention of children's unintentional injuries. Child passenger safety education and child safety seat check ups events are a regular Safe Kids activity. In 2009, the childhood unintentional injury fatality rate in Safe Kids counties was 30 percent lower than the rate in non-Safe Kids counties which corresponds to 116 fewer deaths than expected had the fatality rates been the same.

Safe Kids Florida, Office of Injury Prevention staff, is working to establish additional Safe Kids Chapters in areas without a Safe Kids presence.

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger remained relatively stable year to year from 2005 to 2007. In 2008, the death rate decreased 20 percent from the previous year, but increased slightly in 2009. Overall, the death rate decreased 16 percent from 2005 to 2009. This decrease is due in part to a decrease in motor vehicle deaths.

**HSI #03B. *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger.***

The rates of all non-fatal injuries and motor vehicle crashes among children ages 14 years and younger are influenced by Florida's ability to maintain a strong Safe Kids Coalition and Chapter network. The Office of Injury Prevention is the lead agency for Safe Kids Florida, the statewide organization. Florida has a Safe Kids presence in 34 of the 67 counties and covers 85 percent of the children ages 14 and under. Safe Kids conducts community activities that provide education on prevention of children's

unintentional injuries. Child passenger safety education and child safety seat check ups events are a regular Safe Kids' activity. In 2009, the childhood unintentional injury fatality rate in Safe Kids counties was 30 percent lower than the rate in non-Safe Kids counties which corresponds to 116 fewer deaths than expected had the fatality rates been the same.

The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes decreased almost every year between 2005 and 2009. Overall, the death rate decreased 50 percent from 2005 to 2009.

**HSI #03C. *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.***

The 2005-2009 Florida data reflects a national trend in a decreasing death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years. Several factors to consider are increased awareness of traffic safety issues, Click-it or Ticket campaign, decreased exposure due to decreased miles driven, higher cost of gasoline and the weakening economy. With Florida recently passing the Primary Seat Belt law, effective June 30, 2009, we anticipate increased seat belt usage, which should further reduce motor vehicle crash injuries and deaths.

The death rate per 100,000 for unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years decreased every year from 2005 to 2009. Overall, the death rate decreased 39 percent from 2005 to 2009.

**HSI #04A. *The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger.***

The rates of all non-fatal injuries and non-fatal injuries from motor vehicle crashes among children ages 14 years and younger are influenced by Florida's ability to maintain a strong Safe Kids Coalition and Chapter network. The Office of Injury Prevention is the lead agency for Safe Kids Florida, the statewide organization. Florida has a Safe Kids presence in 34 of the 67 counties and covers 85 percent of the children ages 14 and under. In 2008, the childhood unintentional injury fatality rate in Safe Kids counties was 31 percent lower than the rate in non-Safe Kids counties which corresponds to 106 fewer deaths than expected had the fatality rate been the same as non-Safe Kids counties. Safe Kids conducts community activities that provide education on prevention of children's unintentional injuries. Child passenger safety education and child safety seat check ups events are a regular Safe Kids' activity.

Safe Kids Florida, Office of Injury Prevention staff, is working to establish additional Safe Kids Chapters in areas without a Safe Kids presence. Florida is working to provide additional resources to Safe Kids Chapters and Coalitions.

The hospitalization rate per 100,000 of all non-fatal injuries among children aged 14 years and younger decreased each year from 2005 to 2007. However, the hospitalization rate increased 3 percent in 2008 and 2.7 percent in 2009. The increase from 2007 to 2009 was almost 5 percent.

**HSI #04B. *The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.***

The rates of all non-fatal injuries and non-fatal injuries from motor vehicle crashes among children ages 14 years and younger are influenced by Florida's ability to maintain a strong Safe Kids Coalition and Chapter network. The Office of Injury Prevention is the lead agency for Safe Kids Florida, the statewide organization. In 2008, the childhood unintentional injury fatality rate in Safe Kids counties was 31 percent lower than the rate in non-Safe Kids counties which corresponds to 106 fewer deaths than expected had the fatality rate been the same as non-Safe Kids counties. Safe Kids conducts community activities that provide education on prevention of children's unintentional injuries. Child passenger safety education and child safety seat check ups events are a regular Safe Kids' activity.

Safe Kids Florida, Office of Injury Prevention staff, is working to establish additional Safe Kids Chapters in areas without a Safe Kids presence. Two chapters were recently established, one in Bay and one in Lake county. Safe Kids Florida is working to provide additional resources to Safe Kids Chapters and Coalitions.

The hospitalization rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger decreased every year from 2005 to 2009. Overall, the hospitalization rate decreased 33 percent from 2005 to 2009.

***HSI #04C. The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.***

The 2003-2007 Florida data reflects a national trend in a decreasing death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years. Several factors to consider are increased awareness of traffic safety issues, Click-it or Ticket campaign, etc., decreased exposure due to decreased miles driven, higher cost of gasoline and the weakening economy. With Florida recently passing a primary seat belt law, effective June 30, 2009, we anticipate increased belt usage, which should have a corresponding reduction in motor vehicle crash injuries and deaths.

The hospitalization rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years increased from 2005 to 2006. However, the hospitalization rate decreased each year from 2006 to 2009 for a 24 percent decrease overall.

***HSI #05A. The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.***

Close examination of the disease distribution reveals that 80 percent of all reported cases of chlamydia are reported in populations 26 and under. Chlamydia trachomatis is the most prevalent sexually transmitted bacterial infection reported among persons age 15 to 24. The highest rate among females was in the 20 to 24 age group (34.3 per 1,000); the rate for females in the 15 to 19 age group was slightly lower at 33.3 per 1,000 population. The high rates of chlamydia seen in females may be due to existing policy which places stronger emphasis on screening and treatment of chlamydia in women than in men.

Chlamydia trends and rates continue to rise in persons age 15 to 19 in the state. Some of this rise may be explained by the increase in testing, improved access to care afforded to clients in clinics and county health departments, increase in electronic lab reporting, and shifting of testing technology to an more sensitive and specific test in the past two years. Additionally, increased disease awareness, HEDIS performance measures, and Healthy People 2020 benchmarks have prompted communities to increase screening in a population of sexually active females that has been previously underserved as well as uninsured.

Adolescent women may have a physiologically increased susceptibility to chlamydia trachomatis infection. The higher prevalence of STDs among adolescents reflects multiple barriers to quality STD prevention services, including lack of insurance or other ability to pay, lack of transportation, discomfort with facilities and services designed for adults, and concerns about confidentiality. Early chlamydia detection and prevalence monitoring remains a priority nationwide. The American Congress of Obstetricians and Gynecologists (ACOG) and Centers for Disease Control and Prevention (CDC) recommends annual chlamydia screening for all sexually active women under age 26, as well as older women with risk factors such as new or multiple sex partners. Infertility Prevention Project (IPP), Healthy People 2020 and the National Committee for Quality Assurance HEDIS (Healthcare Effectiveness Data and Information Set) indicators monitor progress towards these goals and ultimately aim to reduce disparities. These strategies along with improved access to effective STD prevention and treatment services in local communities are imperative to the reduction of chlamydia transmission within Florida's population.

**HSI #05B. *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.***

Chlamydial infections are widespread and continue to increase each year. In Florida, chlamydia accounts for 75 percent of all reportable STDs. The most prominent risk factor for chlamydial infection is age. Persons between the ages of 15-24 represent only 13 percent of Florida's population in 2010, yet account for 71 percent (53,012) of all reported chlamydia cases in Florida. In 2010, females disproportionately accounted for more than 70 percent of reported chlamydia cases. National trends indicate chlamydia infections are most prevalent in women under the age of 25. In 2010 and previous years, the highest number of cases in females were reported in those between the ages of 15 to 24. Historically, chlamydia morbidity is low in females over the age of 30. Rates of infection in females under 30 were more than five times the rates of older women. The high rates of chlamydia seen in females may be due to existing policy, which places stronger emphasis on screening and treatment of chlamydia in women than in men. The vast differences in the distribution of chlamydia infections by age are caused by higher biological susceptibility to STD infections, risky sexual behaviors, and a combination of other factors that leave adolescents and young adults disproportionately affected with chlamydia compared to older populations.

The Bureau of STD supports the national screening criteria recommended by the Centers for Disease Control and Prevention. The bureau also aligns with revised Healthy People 2020 STD Objectives for chlamydia screening. Any client who enters a STD clinic is offered a chlamydia and gonorrhea test. Family planning partners are encouraged to screen those under 26 at annual family planning visits. We continue to collaborate with Florida private labs for electronic reporting of morbidity and provide

adequate verification of treatment and/or intervention to private clients. The bureau maintains its relationships with managed care organizations, and incorporates health promotion activities into the populations most affected. In hopes of decreasing the prevalence and incidence of chlamydia, and their associated complications when left untreated, the Bureau of STD continues to implement these and other strategies as needed.

**HSI #06A - Demographics (Total Population) Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race.**

Population estimates for 2010 show there were 5,805,327 children younger than 24. Of that number, 4,304,674 (74.2 percent) are white and 1,277,454 (22 percent) are black. Florida only gathers race data categorized as race white, black, or other. Estimates for other racial groups are based on proportion of 2009 deliveries in that racial group. Of all children up through age 24, we estimate there were 6,314 American Indians or Native Alaskans (0.11 percent), 54,596 Asians (0.94 percent), and 1,627 Native Hawaiians or other Pacific Islanders (0.03 percent). A total of 68,987 (1.58 percent) reported more than one race. There were no significant changes in the percentages for each race when broken down by the specific age groups listed on Form 21.

**HSI #06B - Demographics (Total Population) Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity.**

Florida does not gather data on the number of Hispanics. In order to complete HSI #06B the Florida Department of Health, Office of Planning, Evaluation, and Data Analysis provided projections for the 2010 population of 0-24 year olds by race-ethnicity. According to those projections, of the 5,805,327 children 24 or younger, 1,524,450 (26.3 percent) are identified as Hispanic or Latino.

**HSI #07A - Demographics (Total live births) Live births to women (of all ages) enumerated by maternal age and race.**

Provisional data for 2010 indicate there were 213,425 total live births in Florida during 2008. This represents a decrease from the previous year as 220,206 total births were reported in 2009. Of the 2010 provisional total, 152,672 were white (71.5 percent), 49,027 were black (23 percent), 285 were American Indian or Native Alaskan (0.13 percent), 6,097 were American Indian or Native Alaskan (2.9 percent), and 178 were Native Hawaiian or Other Pacific Islander (0.08 percent). More than one race was reported for 2,679 births (1.3 percent) and 2,488 births were other or unknown (1.2 percent).

Of the total births, women younger than 15 had 246 babies (0.12 percent of the total), women 15 through 17 had 5,359 babies (2.5 percent), women 18 through 19 had 13,650 babies (6.4 percent), women 20 through 34 had 162,222 babies (76 percent), and women 35 or older had 31,948 babies (15 percent).

When compared to whites, black women account for a disproportionate number of births at younger ages. While 71.5 percent of the total births were white and 23 percent were black, births to women less than 15 were 52.85 percent white and 44.7 percent black. Births to women 15 through 17 were 59 percent white and 37.7 percent white. Births to

women 18 through 19 were 63.6 percent white and 33.1 percent black. White and black women 20 through 34 were broken down by race at percentages similar to the total births, with white women accounting for 72 percent of the births and black women 22.6 percent of the births in that age category. White women account for a disproportionate number of births to women 35 or older, where 75 percent of the births were white and 17.7 percent were black.

**HSI #07B - Demographics (Total live births) Live births to women (of all ages) enumerated by maternal age and ethnicity. (Demographics)**

Of the 213,425 births in 2010 (provisional), 152,962 (71.7 percent) were not Hispanic or Latino, 59,510 (27.9 percent) were Hispanic or Latino, and 953 (0.4 percent) were ethnicity not reported.

**HSI #08A - Demographics (Total deaths) Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and race.**

Of the 3,637 total deaths to children 24 and younger, 2,289 (70 percent) were white, 1,207 (33.2 percent) were black, 11 were American Indian or Native Alaskan, 25 were Asian, 72 were more than one race reported, and 33 were other or unknown. There were 1,355 deaths from birth to age 1, white infants accounted for 728 deaths (53.7 percent) and black infants accounted for 558 deaths (41.2 percent) in that age category, yet black infants account for just 23 percent of infants 0-1. Black children account for about 22 percent of the population in all other ages groups on this form, yet they account for 36.2 percent of the deaths in children 1 through 4, 28.8 percent of the deaths in children 5 through 9, 35.95 percent of the deaths in children 10 through 14, 26 percent of the deaths in children 15 through 19, and 26.8 percent of the deaths in children 20 through 24. Overall, in children from birth through 24, black children account for 22 percent of the population, and 33.2 percent of the deaths. In contrast, white children account for 74.2 percent of the population from birth through 24, but only 63 percent of the deaths.

**HSI #08B - Demographics (Total deaths) Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and ethnicity. (Demographics)**

Of the 3,637 total deaths to children 24 and younger, 2,877 (79 percent) were not Hispanic or Latino. Of the total deaths, 754 (20.8 percent) were Hispanic or Latino, even though children of those ethnicities account for 26.3 percent of the children 0 through 24. Hispanic or Latino infants account for 28.9 percent of infants from birth to 1, yet only 22.9 percent of the infant deaths. For children 1 through 4, Hispanic or Latino children account for 28.8 percent of the population and 23 percent of the deaths. For children 5 through 9, Hispanic or Latino children account for 27.5 percent of the population and 17.8 percent of the deaths. For children 10 through 14, Hispanic or Latino children account for 25.8 percent of the population and 22.9 percent of the deaths. For children 15 through 19, Hispanic or Latino children account for 24.9 percent of the population and 18.9 percent of the deaths. For children 20 through 24, Hispanic or Latino children account for 24.5 percent of the population and 17.7 percent of the deaths.

**HSI #09A - Demographics (Miscellaneous Data) Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race.**

Of children 19 and younger in Florida, 16.5 percent live in a household headed by a single parent, 13.4 percent of white children and 23.5 percent of black children. About 1.2 percent of all children live in families that receive Temporary Assistance for Needy Families (TANF) grants, 0.8 percent of white children and 2.7 percent of black children. There are 2,084,582 children 19 and younger on Medicaid, 1,195,114 white children and 637,163 black children. A total of 355,370 children are enrolled in SCHIP, 98,472 white children and 37,236 black children. Of the 7,252 children 19 and younger in foster care, 4,162 are white and 2,635 are black. A total of 1,571,351 children are enrolled in the food stamp program, 737,454 white children and 521,989 black children. There are 410,936 children enrolled in WIC, 266,586 are white and 125,437 are black. The rate for juvenile crime arrest in Florida is 2,648 per 100,000, with a rate of 1,898 per 100,000 for whites and 5,561 per 100,000 for blacks. In Florida, 2 percent of children are high school dropouts, 1.4 percent of white children and 2.9 percent of black children. Numbers or estimates for other races can be found in Form 21, #09A.

**HSI #09B - Demographics (Miscellaneous Data) Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by ethnicity.(Demographics)**

Of children 19 and younger identified as Hispanic or Latino, 14.5 percent live in a household headed by a single parent, compared to 17.2 percent who are not Hispanic or Latino. About 0.8 percent of Hispanic or Latino children live in TANF families, compared to 1.4 percent of children who are not Hispanic or Latino. Of the 2,084,582 children 19 and younger on Medicaid, 616,480 are Hispanic or Latino. Of the 355,370 children enrolled in SCHIP, 88,027 are identified as Hispanic or Latino. Of the 7,252 children 19 and younger in foster care, 1,061 are Hispanic or Latino. Hispanic or Latino children account for 523,567 of the 1,571,351 children in the food stamp program. Of the 410,936 children in WIC, Hispanic or Latino children account for 166,827 of the total. The rate for juvenile crime arrest for Hispanic or Latino children is 1,480 per 100,000, compared to 3,073 per 100,000 for children who are not Hispanic or Latino. About 2.5 percent of Hispanic or Latino children are high school dropouts, compared to 1.5 percent of those who are not Hispanic or Latino.

**HSI #10 - Demographics (Geographic Living Area) Geographic living area for all resident children aged 0 through 19 years old.**

In Florida, 4,324,937 children 19 and younger live in urban areas, and 300,665 live in rural areas.

**HSI #11 - Demographics (Poverty Levels) *Percent of the State population at various levels of the federal poverty level.***

Of the 18,819,000 people living in Florida, we estimate that 5.7 percent live below 50 percent of the federal poverty level. Approximately 15.6 percent live below 100 percent of the federal poverty level, and 35.3 percent live below 200 percent of the federal poverty level.

**HSI #12 - Demographics (Poverty Levels) *Percent of the State population aged 0 through 19 at various levels of the federal poverty level.***

Of the 4,625,602 children 19 and younger living in Florida, we estimate that 7.9 percent live below 50 percent of the federal poverty level. Approximately 19.6 percent live below 100 percent of the federal poverty level and 43.1 percent live below 200 percent of the federal poverty level.

## **F. Other Program Activities**

**Childhood Lead Poisoning Prevention Initiative:** A Department of Health program through which the environmental health program works with county health departments to enhance their data collection and case management capabilities for following and treating children with elevated blood lead levels.

**Comprehensive Child Health Services:** Child health services are provided to children age birth to 21 in most of the 67 county health departments in Florida. Counties may also contract services to private providers or other agencies. Comprehensive child health services are designed to integrate preventive health services and health promotion while minimizing cultural, geographic and financial barriers to care.

**Every Woman Florida:** A preconception health initiative that increases awareness on the importance of good preconception health. One of the goals of this initiative is to improve the integration of preconception health within all clinical settings. Another goal is to ensure the health of women of childbearing age. The Every Woman Florida website serves as a portal for preconception information for both providers and patients. The Every Women Florida Preconception Health Council is responsible for guiding the integration of preconception care in clinical and public health practice throughout Florida.

**Family Health Line:** A toll-free hotline that promotes the importance of early and continuous prenatal and infant care. The hotline provides basic information on pregnancy and how to access prenatal care, infant care, family planning, WIC, drug abuse treatment, and other pregnancy-related services. The hotline also arranges referrals to private, public, and volunteer health promotion groups. During 2010, there were 12,194 incoming calls to the Family Health Line.

**Fetal and Infant Mortality Review:** An information-gathering process designed to identify deficiencies in the maternal and infant health care system. Through individual case review, local FIMR projects attempt to identify factors that may contribute to fetal and infant death.

**Florida Folic Acid Coalition:** The Florida Folic Acid Coalition (FFAC) was created in 1999 to ensure that women in Florida and their health care providers are aware of the benefits of folic acid in decreasing the risk of birth defects of the brain and spine usually referred to as neural tube defects. Comprised of public and private partners throughout the state, the group supports a wide range of educational activities that have contributed to documented increases in what health care providers and women of childbearing age know about folic acid. The coalition seeks to establish folic acid education as a routine and standard part of the delivery of preventive health care services, as well as increase awareness and education of the nutritional and health benefits of folic acid across the lifespan.

**Pregnancy Associated Mortality Review:** A population-based surveillance and selective case review process aimed at reducing maternal mortality in Florida. The PAMR project

monitors trends in pregnancy-associated deaths, and identifies gaps in care, service delivery problems, and areas in which communities can facilitate improvements in the service delivery system for women.

**Pregnancy Risk Assessment Monitoring System:** The PRAMS project conducts population-based surveillance of selected maternal behaviors that occur during pregnancy and early infancy, in 35 states and the District of Columbia.

**Reach Out and Read:** An early literacy program that involves pediatricians and nurses supporting children's language and literacy development through various interventions.

**Responsible Fatherhood Project:** This project encourages fathers of children (age birth to 5) to become better fathers by making available resources, support, information and education. The project also seeks to increase awareness in the local community of the importance of fathers being actively involved with the care of their children.

**Sexual Violence Prevention Program:** The primary goals of the Sexual Violence Prevention Program (SVPP) are to provide statewide, integrated, primary rape prevention education; services to rape victims; county health department screening and assistance for domestic violence victims; and information on human trafficking. Additionally, the SVPP develops program and policy guidelines, responds to legislative issues, and manages a public awareness campaign called "Rape. Talk About It. Prevent It" comprised of radio and television public service announcements, and print media aimed to educate 10-24 year-olds about rape prevention.

**Staff Development, Education and Training:** MCH staff develops training materials targeted towards MCH providers. They provide ongoing training and technical assistance to increase skills needed to screen, assess, identify needs, coordinate and provide services.

**State Early Childhood Comprehensive Systems (SECCS) Project:** The purpose of the SECCS Project is to support state maternal and child health agencies and their partner organizations in collaborative efforts to strengthen the early childhood system of services for young children and their families. There are five focus areas of the project: access to medical homes, social-emotional development and mental health, parent education, early care and education services, and family support services.

**Statewide Birth Defects Surveillance System:** A system designed to reduce the impact of birth defects, investigate possible causative agents, disseminate information, and plan and evaluate the effects of interventions. Of added importance, the file linkage efforts used to develop the birth defects surveillance system also links other datasets to vital records that are used for other maternal and child health purposes. These linked file efforts are of importance because they address identified block grant priorities and are therefore supported by MCH Block Grant funding.

**Sudden Infant Death Syndrome:** The Department of Health oversees the professional support activities offered to people affected by SIDS. Activities focus on increasing the awareness of SIDS and providing the latest prevention information to health providers and trainers of secondary caregivers, such as childcare providers.

Voluntary Pre-Kindergarten: A program designed to prepare 4-year-olds for kindergarten and build the foundation for their educational success. The program allows a parent to enroll his or her eligible child (four years old by September 1 and residing in Florida) in a free VPK program.

**G. Technical Assistance Needs**

State performance measure 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. Request evaluation of the effectiveness our current counseling and education, and consultation on how preconception efforts might be strengthened and improved.

**V. BUDGET NARRATIVE**

**A. Expenditures**

There were no significant variations in expenditures in forms 3, 4, and 5 from previous years. Expenditure data for Florida is included on forms 3, 4, and 5.

**B. Budget**

Federal funding through the Title V MCH Block Grant provides needed support to our statewide efforts. Of the \$18,672,124 budgeted as the expected federal allotment for FY2011, \$6,704,513 is budgeted for preventive and primary care for children (35.91 percent), \$6,383,712 for children with special health care needs (34.19 percent) which meets the 30 percent requirements. In addition, \$1,503,350 (8.05 percent) is budgeted towards Title V administrative costs. Total state match for FY 2011 is \$169,216,415, which exceeds the state's FY 1989 maintenance of effort amount of \$155,212,322. Sources of other federal funds include the SSDI grant, WIC, the USDA CACFP grant, the Preventive Health Services Block Grant, Florida's Medipass Waiver, and CDC grant awards. A complete list of other federal funds with funding amounts is included on Form 2 and the notes for Form 2. Budget numbers for Florida are included on forms 2, 3, 4, and 5.