Maternal and Child Health Services Title V Block Grant

Florida

FY 2021 Application/ FY 2019 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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

Florida HEALTH

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

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

September 11, 2020

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

Dear Sir or Madam:

Enclosed is Florida's Maternal and Child Health Services Title V Block Grant for FY2021. Authority has been delegated by the Governor to the Department of Health State Surgeon General to submit this grant application.

Having given the required assurances and certifications, we request your approval of the Maternal and Child Health Block Grant Application for FY2021.

If you have any questions, please contact Anna Simmons (850) 558-9682.

Sincerely,

Shamarial Roberson, DrPH, MPH
Deputy Secretary for Health

Veronica Bishop
Budget and Revenue Management Chief
Office of Budget and Revenue Management

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

I.B. Face Sheet

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

I.C. Assurances and Certifications

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

I.D. Table of Contents

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

II. Logic Model

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

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The Florida Department of Health (Department) is responsible for administering the Title V Maternal and Child Health Block (MCHB) Grant, encompassing the MCH and Children and Youth with Special Health Care Needs (CYSHCN) programs. These programs fall under the Division of Community Health Promotion (CHP) and the Office of Children's Medical Services (CMS) Managed Care Plan and Specialty Programs. Title V leaders in CHP and CMS meet monthly to coordinate efforts across all programs.

Title V programs serve a large, diverse population. Florida is the third most populous state in the nation, with an estimated population of 21 million citizens, of which 77.3 percent are white; 16.9 percent are black; and 5.8 percent are other races, mixed race, or unknown. Of the total population by ethnicity, 25.6 percent are Hispanic. The racial, ethnic, and cultural diversity of Florida's population creates unique challenges as well as opportunities.

Priorities to meet the needs of the Title V population include the promotion of safe sleep behaviors, breastfeeding, and smoking cessation to reduce poor birth outcomes; encouraging children to be physically active; improving access to care for women; and dental care access for children and women. Priorities for CYSHCN include access to medical homes/primary care and improving access to mental health services for all children. Corresponding strategies and activities are intentionally inclusive in the areas of health equity, family partnership, transition, life course, workforce and essential public health services.

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

Strategies identified to address priority needs and selected performance measures are implemented through a variety of mechanisms, including statewide projects administered through the state health office, Schedule C funding through a statement of work with county health departments (CHDs), contracts with academic and university partners, Florida's Perinatal Quality Collaborative, Healthy Start Coalitions, and other partners and stakeholders.

The state Title V program plays an important role in supporting and ensuring comprehensive, coordinated, and family-centered services. These efforts begin with reviewing epidemiologic research and reports, and collecting and studying data to ensure our efforts and decision making are data driven and factually relevant. The Title V program collaborates with other programs within the Department to ensure comprehensive, coordinated services are available to the people of Florida, particularly women, pregnant women, infants, and children (including CYSHCN). The Bureau of Family Health Services' MCH Section and the Office of CMS Managed Care Plan and Specialty Programs have primary responsibility for the Title V application and oversight of Title V activities. Other coordinating programs include, but are not limited to: The Bureau of Chronic Disease Prevention; School Health Services Program; Adolescent Health; Family Planning; Public Health Dental; Violence and Injury Prevention; Tobacco Free Florida, Early Steps, Newborn Screening, and Communicable Diseases.

Efforts to improve health have traditionally looked to the health care system as the key driver of health and health outcomes. However, the Department recognizes that improving health and achieving health equity also requires broader approaches that address social, economic, and environmental factors that influence health as well. Under the leadership of the State Surgeon General, the Title V program works with a diverse group of public and private partners across the state who make up Florida's public health system, including a range of stakeholders such as state and local government agencies, health care providers, employers, community groups, universities and schools, nonprofit organizations, and advocacy groups. State examples include CHDs, the Florida Perinatal Quality Collaborative, the Agency for Health Care Administration (AHCA), the Department of Children

and Families (DCF), the March of Dimes, and Healthy Start Coalitions. Partners on the national level include, the Association of Maternal & Child Health Programs, National Maternal Child Health Workforce Development Center, Centers for Disease Control and Prevention (CDC), and the Association of State and Territorial Health Officers. CMS partnerships include the MCHB funded training programs at the University of Florida's Pediatric Pulmonary Center, the University of South Florida's Department of Pediatrics Adolescent Medicine and College of Behavioral & Community Sciences, the University of Miami's Mailman Center for Child Development, the Family Café, and the Family Network on Disabilities of Florida.

CMS continues to address the needs of CYSHCN and their families through population health strategies that strengthen the system of care, especially for children with medical complexities. As foundational elements, the *Standards for Systems of Care for Children and Youth with Special Health Care Needs, Version 2* and tasks that address identified CYSHCN priorities have been woven into the majority of the Department's CYSHCN contracts. This includes the implementation of quality of life measurement tools and how programs plan to use the resulting information for quality improvement activities. A framework of change management, adaptive leadership, and a learning action network for quality improvement projects has helped to align many of the state's regional condition specific programs into a statewide network focused on quality and access. To engage multiple sectors and community partners to generate collective impact and improve social determinants of health, CMS' regional approaches include public health detailing, annual community assessments, and the formation of regional networks for access and quality.

Specific to its role as a health plan option for CYSHCN enrolled in Title XIX or Title XXI health insurance, CMS partnered with WellCare of Florida in February 2019. Approximately 75,000 CYSHCN have enrolled in this health plan built on the *Standards for Systems of Care for CYSHCN.* Children and families receive specialized care coordination services, as well as expanded benefits to address family needs and social determinants of health such as caregiver behavioral health services, non-medical transportation, over-the-counter stipends, swimming lessons, and home and grocery allowances.

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

The Department's ongoing efforts to address avoidable inequities, historical and contemporary injustices, and to eliminate health disparities, would not be possible without the leadership of our county health officers and the cooperation of our valuable partners at the federal, state, local, tribal, and territorial levels.

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

Domain: Women/Maternal Health

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

ESM 1.1: The number of interconception services provided to Florida's Healthy Start Program clients.

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

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

babies.

NPM 14.1: Percent of women who smoke during pregnancy.

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

State Priority: Promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children Smoking during pregnancy increases the risk of miscarriage, certain birth defects, premature birth, and low birth weight. Smoking is also a risk factor for sudden infant death syndrome (SIDS), as secondhand smoke doubles an infant's risk of SIDS.

Domain: Perinatal/Infant Health

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

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

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

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

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

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

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

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

Domain: Child Health

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

ESM 8.1: The number of school districts that apply for the evidence-based Florida Healthy School District recognition State Priority: Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment.

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

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

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

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

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

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

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

Domain: Adolescent Health

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

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

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

Bullying is a serious detriment to a child's health, sense of well-being, safety, education, and emotional development; and greatly increases the risk of self-injury and suicide.

Domain: Children and Youth with Special Health Care Needs

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

ESM 11.1: Number of DOH team members, providers (pediatric, family practice, and adult), families, family partners, and other partners serving CYSHCN in Florida receiving education or technical assistance about the patient-centered medical home model and related topics that impact the health and wellness of CYSHCN.

ESM 11.2: Number of caregivers of CYSHCN in Florida who perceive themselves as a partner in their child's care.

ESM 11.3: Percentage of underserved geographic areas that have at least one pediatric practice that is designated as a patient-centered medical home.

ESM 11.4: Number of Adult Care Providers/Practices that accept CYSHCN transitioning to adult care.

State Priority: Increase access to medical homes and primary care for CYSHCN.

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

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

ESM 1.1: Number of DOH team members, providers, (pediatric, family practice, and adult), families, family partners, and community service providers receiving education or technical assistance about accessing or providing access to behavioral health services.

ESM 1.2: Number of providers that have initiated integrating behavioral health services.

ESM 1.3: Number of activities identified that support families in enhancing mental health protective factors and build resilience.

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

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

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

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

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

The Department continues to successfully implement system changes through its partnership with the Florida Perinatal Quality Collaborative (FPQC) and extended relationships with other partners such as the Florida Hospital Association to roll out the Maternal Opioid Recovery Effort (MORE) initiative. Another example is the funding of the Florida Pregnancy-Associated Mortality Review team and the Urgent Maternal Mortality Messages disseminated to prompt systems changes within hospital settings. Both examples are discussed more thoroughly in this application.

III.A.3. MCH Success Story

Florida was selected for a site placement of a Maternal & Neonatal Opioid Prevention Coordinator to support the Opioid, Maternal Health, and Neonatal Abstinence Syndrome (NAS) Initiative. The goal of the project was to support existing efforts in the state pull together stakeholders in communities with high rates of NAS to connect resources, identify system barriers, and share insights, gaps, and lessons learned.

In the beginning, the coordinator conducted meetings with 18 counties to meet local leaders and hear their biggest challenges in addressing opioid use disorder among pregnant women. Most counties have hospitals in the MORE initiative. Meetings utilized a framework to identify current needs, system barriers, relationship strengths, and areas that communities self-identified as needing to improve.

Issues arose: challenges with implementing Screening Brief Intervention and Referral to Treatment, identifying sufficient medication assisted therapy providers, getting women to accept treatment, and not knowing where to refer patients.

We partnered with the Florida Hospital Association, FPQC, and AHCA to launch a webinar series addressing Narcan, Stigma, Plans of Safe Care, SBIRT, and Communication & Referral that averaged 100 participants per session, with most hospitals participating in multiple sessions. A video series that includes four brief videos addressing the same topics, including one that is designed to encourage women to enter treatment was developed.

III.B. Overview of the State

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

According to statewide population estimates conducted by the Florida Legislature, Office of Economic and Demographic Research, Florida has a total population of 21.5 million citizens in 2020, following only California and Texas as the third most populous state. Between 2010 and 2020, Florida's population increased by 14.4 percent. The most recent demographic data for April 1, 2020, shows 78.2 percent of Florida's population is white,18.0 percent black, and 3.8 percent other races, mixed race, or unknown. Of the total population by ethnicity, 26.8 percent are Hispanic and 73.2 percent non-Hispanic. More than half of the state's population (50.7 percent) is between the ages of 25-64 and 28.8 percent are between the ages of 0-24. Individuals 65 and older comprise 20.4 percent of the state's population compared to just 15.2 percent in this age group nationally in July 1, 2016. A greater percentage of health care resources are expended on the elderly population in Florida compared to other states.

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

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

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

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

To maintain momentum and keep projects on track, SHIP objectives have Priority Area Workgroups that meet quarterly. These workgroups are comprised of partners around the state who share updates on their projects that are impacting the SHIP goals. This time is also used to identify any barriers individuals may be experiencing and problem solving to overcome these barriers.

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

the state.

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

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

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

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

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

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

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

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

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

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

6. Inhaled Nicotine – Decrease inhaled nicotine use to provide a longer and healthier life. Cigarette smoking is the leading cause of preventable death in the U.S. and remains a major cause of cancer deaths. Florida has led the nation with innovative strategies to teach young people about the dangers of smoking and give current smokers the resources and support they need to quit.

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

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

The PACE EH initiative is also supported through the Department's Florida Healthy Babies program. Florida Healthy Babies started as an effort of the Department's Health Equity Program Council, but is now housed in the MCH Section. Florida Healthy Babies focuses on helping all Floridians achieve health equity, or the highest level of health. Though Florida has experienced declining morbidity and mortality rates, disparities persist and the Department is committed to achieving health equity and eliminating these differences.

Children and youth with special health care needs is the primary focus of the Office of Children's Medical Services Managed Care Plan and Specialty Programs (CMS). Florida has 4.3 million children, of whom approximately 860,000 are CYSHCN. Children with medical complexity, a subset of CYSHCN, number approximately 86,000 children in Florida; despite their small numbers, they account for a third of health care spending, 40 percent of deaths, and 25 percent of hospital days. Florida has 18 pediatric children's hospitals statewide to serve the acute, chronic, and complex needs of children. Despite this large number of hospitals, there is remarkable geographic variation in access to specialty care.

To ensure that all CYSHCN receive the health care services they require, CMS engages in a wide variety of activities in three main categories: (1) statewide infrastructure support to pediatric medical specialists and primary care clinicians, especially regarding behavior health; (2) regional Title V public health teams to address geographic variation in our state; and (3) a managed health care plan specifically designed for CYSHCN.

1. CMS contracts with over 63 vendors statewide to ensure that CYSHCN have access to high-quality health care, a subset of this includes seven specific conditions (Behavioral Health, Chronic Kidney, Craniofacial, Endocrine, Hematology-Oncology, HIV/AIDS and Pulmonary). Over the last several years, CMS has worked with 24 tertiary care/university teams across the state to form statewide networks that focus on quality improvement and increased access to care through a collaborative learning approach. The focus has shifted away from direct care services and to building an integrated system

of care. Fewer than half of Florida's 400,000 children with behavioral health conditions receive treatment, so CMS has implemented contracts with five university system partners across the state to integrate behavioral health services in primary care practices. These regional partners, along with additional system stakeholders, form a statewide network focused on building capacity of primary care clinicians to address common behavioral conditions and by collecting common data, each region participates in a statewide approach to quality improvement.

2. CMS's infrastructure is built on six regional programs that provide public health detailing on identified CYSHCN and other public health priorities to providers and community partners. These regional Title V CYSHCN teams complete annual community assessments to ensure that state Title V CYSHCN action plans are informed by regional variation. The regional teams also ensure that local health planning includes CYSHCN. Community system approaches that maximize outcomes for CYSHCN include the integration of multisector service systems that work together on addressing social determinants of health and emerging community needs assessments. To accomplish this goal CMS has also partnered with a community system to pilot its regional network for access and quality model. Results from that will inform future community infrastructure building for CYSHCN.

3. Given the importance of health care services to CYSHCN, CMS administers a Medicaid Managed Care plan and CHIP option for clinically eligible CYSHCN, known as the Children's Medical Services Health Plan operated by WellCare (CMS Health Plan). Effective February 1, 2019 CMS implemented its new health care delivery system model which was conceived with comprehensive stakeholder input at the family, provider, and community levels; as well as state and national experts. Over 75,000 of Florida's CYSHCN are currently enrolled in the CMS Health Plan, receiving direct care services for their medical, behavioral, and developmental needs. The CMS Health Plan provides increased payments to high-performing providers and enhanced care coordination services to families. To address social determinates of health, the CMS Health Plan offers families "in lieu of" services and enhanced benefits, such as over-the-counter stipends, home and grocery allowances, non-medical transportation and caregiver behavioral health services. The CMS Health Plan is a valuable partner for the Title V CYSHCN program, and bi-directional communication help inform each other of needs, trends and leverage opportunities to improve the service delivery system for CYSHCN in Florida. For example, a Title V initiative to review quality measures led to the inclusion of quality of life measures in the CMS Health Plan; this innovative approach promises to help ensure that health care services are aimed at addressing critical child and family needs.

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

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

The first project of the Health Equity Program Council was Florida's Healthy Babies Initiative, the Department's direct response to focus on the black-white infant mortality gap. During phase one of the initiative, the Department invested $1.5 million in Title V funding. Funding was provided to the county health departments to conduct an enhanced data analysis on infant mortality, including an environmental scan of existing pertinent programs, and to host a community action-planning meeting to examine disparities in infant deaths, the role of social determinants of health, and to propose local action. Phase IV began in July 2018 with the selection of six evidenced-based projects for county health departments to select one or more from. The workplan templates are attached as Supporting Document 2. Phase V of this initiative was a continuation of existing efforts. Future phases will be adjusted to align with the results of the 2020 Title V Needs Assessment and Agency

Strategic Plan.

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

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

Following the Centers for Disease Control and Prevention (CDC) declaration of a national opioid epidemic, Florida's Governor signed Executive Order 17-146 on May 3, 2017 directing the Surgeon General to declare a statewide public health emergency. Signing the emergency order allowed the state to immediately draw down more than $27 million in federal grant funding from the United States Department of Health and Human Services (HHS) Opioid State Targeted Response Grant, which was awarded to Florida in April 2017 to provide prevention, treatment, and recovery support services to address this epidemic. The State Surgeon General issued a standing order for Naloxone, an emergency treatment for opioid overdose, ensuring first responders have immediate access to this lifesaving drug to respond to opioid overdoses.
The rate of pregnant women diagnosed with opioid use disorder (OUD) during labor and delivery in the U.S. more than quadrupled from 1999 to 2014, according to a 2018 analysis by the Centers for Disease Control and Prevention (CDC). In Florida, the rate increased from 0.5 per 1,000 delivery hospitalizations in 1999 to 6.6 in 2014.

To identify Neonatal Abstinence Syndrome (NAS) cases, the Department currently uses a passive case ascertainment methodology that relies on linked administrative datasets and diagnostic codes indicative of NAS. First, birth certificate records from the Bureau of Vital Statistics are linked to the infant's birth hospitalization record, which is provided as part of quarterly submission of inpatient hospital discharge data by hospitals to the Agency for Health Care Administration (AHCA). Each discharge record includes International Classification of Diseases, Clinical Modification (ICD) diagnosis codes documented during the hospital encounter. NAS has decreased from 66.4 occurrences out of 10,000 live births in 2014, to 62.1 occurrences out of 10,000 live births in 2018 births (most recent data available).

Florida shares borders with the reservations of two tribal governments, the Seminole Tribe and the Miccosukee Tribe. These governments have their own public safety and emergency services for reservation residents, but a substantial portion of their tribal citizens live outside the reservation boundaries. The Department established the American Indian Health Advisory Committee to provide guidance on issues impacting American Indian populations in Florida. The committee consists of representatives from tribes and stakeholders serving American Indian communities and staff from the Office of Minority Health and Health Equity. Florida is also home to many non-governmental tribal communities, whose members may be spread out geographically but who gather frequently to maintain their community's identity, culture, language, traditional knowledge, and traditional ways. These groups do not have government status either as a preference, or because their structure is not suited to political governance, or because they cannot provide documentation that they maintained a tribal government during the years that it was illegal to do so. A subset of this category would be American Indian Christian Churches, which bring members and descendants of various American Indian nations together around a shared faith practice that incorporates inter-tribal practices in their worship. Another subset of this category would be American Indian associations that organize cultural gatherings that are open to visitors. Yet another subset are American Indian associations concerned with activism in favor of American Indian causes.

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

Florida is a temporary home to well over 100 million tourists and visitors each year, which presents challenges to the state's public health system. In the first six months of 2019, Florida welcomed nearly 69 million tourists the highest number ever for

any six-month period. This is a 5.6 percent increase over the same period in 2018. It includes 61.2 million domestic visitors, 5.2 million overseas visitors and 2.4 million Canadian visitors. Migrant farm workers and unauthorized immigrants also have a significant impact on the state's public health services and resources. According to the most recent data, Florida was home to 775,000 unauthorized immigrants in 2016. California and Texas are the only states with greater numbers of unauthorized immigrants.

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

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

The health of the economy plays a major role in the health status of the state's MCH population. The economy in Florida has been recovering since the economic downturn suffered during the most recent nationwide recession. The average annual wage in Florida currently stands at 89.3 percent of the national average in May 2019. Florida's economy is heavily reliant upon the service-related industry, where minimum wage jobs with little or no benefits are more the norm than the exception. A lack of well-paying jobs makes it difficult for many individuals and families to meet their basic needs. Those households most disproportionately affected are female-headed households, blacks, Hispanics, people living with a disability, and unskilled recent immigrants. According to the latest final numbers from the U.S. Bureau of Labor Statistics, Florida's unemployment rate was 11.3 percent in July 2020, this is higher than the national employment rate of 10.2 percent. However, prior to the COVID-19 pandemic, Florida had historically low unemployment rates Florida had a four-year adjusted cohort graduation rate for public high schools of 86.1 percent in 2017-18. In comparison, the corresponding national rate was 88.8 percent during the 2017-18 school year. Florida's standard diploma is a rigorous credential for which standards and testing requirements have periodically increased. As states have different criteria for awarding a standard diploma, comparing rates among states is problematic.

Florida's total area is 58,560 square miles. Driving from Pensacola in the western panhandle of Florida to Key West at the southernmost point is nearly an 800-mile journey. The 1,200 miles of coastline become a target during hurricane season, and 2,276 miles of tidal shoreline are subject to concerns regarding water quality and fish and wildlife habitat degradation. With the threat of tropical depressions and hurricanes looming every summer, the Department takes emergency preparedness seriously for all sorts of possible threats or disasters. Most recently this includes preparation and response as a result of the COVID-19 pandemic. Florida's Public Health Preparedness effort is an excellent model of public-private cooperation. Funding made available post-9/11 facilitated conversations beyond just emergencies that enhanced the integration of services and systems among state, federal, local, and private entities. Well organized public-private partnerships benefit from the strengths and competencies of both systems.

When hurricanes approach, the Department operates and staffs Special Needs Shelters (SpNS) to allow people with special or complicated medical needs, their family members, and aides to safely shelter from the storms, with nurses on hand to assist with their needs.

At-risk or vulnerable populations include those groups whose needs may not be fully integrated into planning for disaster response. These populations include persons with physical, cognitive, or developmental disabilities. Included in this group are persons with limited English proficiency, the geographically or culturally isolated, medically or chemically dependent, homeless, frail elderly, children, and pregnant women. Meeting the needs of vulnerable populations during or following a disaster is a key component of public health and medical preparedness planning. Department staff collaborate with the county health departments in planning for disasters, staffing the SpNS around the state, and assisting in recovery efforts.

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

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

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

The basic statutory authority for CYSHCN and their families is Chapter 391, F.S., known as the Children's Medical Services Act. Section 391.016, F.S., establishes the Children’s Medical Services Program, and defines two primary functions: provide to children and youth with special health care needs a family-centered, comprehensive, and coordinated statewide managed system of care that links community-based health care with multidisciplinary, regional, and tertiary pediatric specialty care; and provide essential preventive, evaluative, and early intervention services for children at-risk for or having special health care needs, to prevent or reduce long-term disabilities. Section 391.026(13), F.S., is specific to the administration of the CYSHCN program in accordance with the Title V of the Social Security Act.

III.C. Five-Year Needs Assessment Summary (as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

Since 2010, the Department has completed a more data-driven Title V Needs Assessment (NA). Our stakeholder and capacity surveys were quantitative tools used to help identify performance measures and develop five-year work plans. A major emphasis was placed on coordinating the selected priorities with the Department's State Health Improvement Plan (SHIP), Agency Strategic Plan, the Collaborative Improvement and Innovation Network (CoIIN) priorities, and the partners engaged in the activities addressing the priorities. The intent was to focus efforts across the Department and state for collective impact. A comprehensive explanation of the Maternal and Child Health (MCH) Section's NA can be found as an attachment, with a brief overview below.

As the MCH Section began the 2020 Five-Year NA process, an internal advisory workgroup and a statewide advisory workgroup were established. The internal workgroup included staff from sections and divisions across the Department. The statewide advisory workgroup consisted of Department staff and various partners throughout the state, including local health departments, Healthy Start Coalitions, local advocacy organizations, and university partners.

A public input survey was disseminated to obtain feedback from stakeholders and the public on how to prioritize MCH and Children and Youth with Special Health Care Needs (CYSHCN) matters in Florida. A total of 404 responses were received. A second survey was sent to assess Florida's capacity to carry out the 10 essential services of maternal and child health. This survey was distributed to 43 MCH partner organizations in Florida, of which 24 responded.

Finally, a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis was conducted of priority topics using the Capacity Assessment for State Title V tool. The statewide advisory workgroup recommended that Florida should keep the priority areas and corresponding national and state performance measures from the previous five-year NA. The advisory group also recommended the state give serious consideration to the following three performance measures: (1) risk appropriate perinatal care, (2) adequate insurance, and (3) adolescent physical activity.

Recognizing there is still work to do on many of the priorities identified from the 2015 NA the Florida Department of Health decided to (1) continue working on the National Performance Measures (NPMs) and State Performance Measures (SPMs) selected in 2015 and (2) add risk appropriate perinatal care and adolescent physical activity to our final list of 2020 MCH priorities given the results from the general input survey and CAST-V process as well as recommendations from the Title V state advisory workgroup.

The Office of Children's Medical Services Managed Care Plan and Specialty Programs (CMS) underwent a multi-phase NA process, specific to the CYSHCN Domain. Keeping in line with the overarching goal of improving the system of care that serves CYSHCN, guiding principles from the *National Standards for Systems of Care for CYSHCN, the Title V Maternal & Child Health (MCH) Pyramid of Health Services, and the Public Health Pyramid of Prevention* served as the underpinnings of this process. While the NA phases themselves, aligned with the *State MCH Block Grant Needs Assessment, Planning, Implementation, and Monitoring Process* Framework, coined by the Federal MCH Bureau. These phases included: (1) assessing needs; (2) examining strengths and capacity; (3) priority selection; and (4) setting performance objectives and development of a five-year action plan to achieve these aims. To ensure goals were achieved and tasks were tracked and fulfilled, a Gantt chart was constructed and sustained throughout the process.

To foster objective and inclusive progression, stakeholder engagement (including families, field experts, and Department leadership/staff) and mixed data collection practices were critical components of the NA process. In addition to analyzing secondary data sources like the *National Survey of Children's Health* and *Florida Charts*, surveys and focus groups were quantitative and qualitative methodologies utilized to comprehensively inform the process.

To adequately assess needs, strengths, and be intentional about stakeholder voice, caregivers of CYSHCN and young adults that identified as having special needs were asked to participate in primary data collection processes. A total of 247 parent/caregiver and 65 young adult questionnaires were administered. Additionally, over 75 participants, inclusive of caregivers, providers, and champions, participated in nine focus groups and key informant interviews-conducted virtually and face-to-face across the State of Florida.

Also, a CYSHCN NA statewide workgroup was formed and met monthly to provide their knowledge base and advisement throughout the NA process. Representation for this group was extensive and included leadership from CMS, Florida Health and Transition Services, Florida Family Leaders Network, University of South Florida College of Public Health, Family Network on Disabilities, Leadership Development in Neurodevelopmental Disabilities (LEND) training program, Broward Health Specialty Program, National Alliance on Mental Illness, Department of Children and Families, Agency for Health Care Administration, Florida Healthy Kids, Florida Chapter of American Academy Pediatrics, Florida Association of Children's Hospitals, Florida Military Family Special Needs Network, and other key players. Eleven potential priority areas (mental health, family partnership, medical home, early screening, adequate insurance, access to care, adult transition, obesity, suicide, health promotion, and workforce development) were determined with the assistance of the aforementioned stakeholders and procedures.

To evaluate strengths and capacity, workgroups, comprised of internal CMS staff and family support specialists, were assembled to undertake the CAST-V Process. These groups added their area of expertise, reviewed issue briefs (outlined the issue, trend data, national/state goals, current initiatives, evidence-based practices and capacity), conducted SWOT analyses, which were converted into an appreciative inquiry approach using strengths, opportunities, aspirations and results (SOAR), and completed capacity worksheets (have or need certain structural resources, data/information systems, organization relationships, and competencies) for each of the 11 potential priority areas.

During the priority selection phase, a NA Scoring Team, including lived family experience, was provided the CAST-5 materials and a scoring tool, for ranking the 11 potential priorities. Medical home and mental/behavioral health were identified as the priority areas for the CYSHCN domain. The above-mentioned approaches resulted in two action planning workgroups launching with the role of thinking collaboratively, to develop priority specific performance objectives, strategies, and activities. Participants were CMS staff and external partners like volunteers from the statewide workgroup, physicians, and CYSHCN experts, including family leaders. Many of those emergent themes from the focus groups were included in the action plans. Action plans also integrated the following priority-inclusion areas: Transition, Family partnership, Health Equity, Workforce Development, Life Course/Cross-Cutting and leveraging core Public Health functions, these inclusion areas were embedded within various activities of the plans.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

Women/Maternal Health

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

Racial disparity is evident in pregnancy related mortality ratio (PRMR). From 2008-2018, the Florida Pregnancy Associated Mortality Review (PAMR) classified 408 cases as pregnancy-related deaths (PRDs). During this period, the pregnancy related mortality ratios for non-Hispanic black women were significantly higher compared with non-Hispanic white and Hispanic women. For example, in 2018 the PRMR per 1,000 live births was 32.0 for non-Hispanic black women, 12.9 for non-Hispanic white women, and 10.6 for Hispanic women.

Three goals of the Department are: reduce the rate of maternal deaths per 100,000 live births from 16.3 to 16.0; increase from 17 percent to 21 percent women having a live birth who received preconception counseling about healthy lifestyle behaviors and prevention strategies from a health care practitioner prior to pregnancy; and increase from 76 percent to 84.5 percent of pregnant women receiving prenatal care during the first trimester.

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

Perinatal/Infant Health

In Florida, infant mortality rates (IMR) have declined slightly from 6.2 infant deaths per 1,000 live births in 2015 to 6.0 infant deaths per 1,000 live births in 2019. Non-Hispanic white infant mortality has remained relatively flat with an IMR of 4.9 infant deaths per 1,000 live births in 2009 and 5.0 infant deaths per 1,000 live births in 2013. Between 2015 and 2019, non- Hispanic black IMR declined significantly from 11.0 to a low of 10.4 infant deaths per 1,000 live births. With Florida's recent declines in non-Hispanic black infant mortality, the infant mortality disparity between non-Hispanic black and non-Hispanic white infants have decreased from a ratio of 2.6:1 in 2015 to 2.4:1 in 2019. It is important to note that despite this decline in the magnitude of disparity, non-Hispanic black IMR has consistently remained more than two times higher than non-Hispanic white and Hispanic IMR.

During the same period, the neonatal mortality rate declined from 4.4 per 1,000 live births to 4.2 per 1,000 live births. The post-neonatal mortality rate declined from 1.9 per 1,000 live births to 1.8 per 1,000 live births.

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

Florida Healthy Start Coalitions conduct planning and service delivery approaches that incorporate Florida communities as partners and participants in disparity elimination. To help reduce infant mortality, Florida has established safe infant sleep as a priority in the State Health Improvement Plan with the following objectives related to infant sleep position and bed-sharing: (1) By December 31, 2021, reduce percent of black mothers in Florida whose infant sleeps in bed with a parent or anyone else from 26.4% (2014) to 24.8%. (2) By December 31, 2021, increase percent of black mothers in Florida who placed their infant on their back to sleep from 56.4% (2014) to 58.4%.

According to the 2015 Florida PRAMS data, 73.3 percent of infants were placed to sleep on their backs and 77.8 percent never bed-shared. For non-Hispanic black infants, 2015 percentages were worse for both back-sleeping (57.8 percent) and never bed-sharing (68.5 percent) compared to state and national data, overall and specific to the non-Hispanic black infant population. These, Florida safe sleep statistics are comparable with overall national data.

In 2019, 78.9 percent (2,737 out of 3,469) of Very Low Birth Weight (VLBW) infants in Florida were delivered at facilities for high-risk deliveries and neonates, an increase from 75.8 percent (2,652 out of 3,497) in 2015. No clear or consistent racial/ethnic disparities were observed.

The Department provides statewide access to high-risk perinatal care through 11 designated Regional Perinatal Intensive Care Centers (RPICCs) and two obstetrical satellite clinics. RPICCs provide perinatal intensive care services that contribute to the well-being and development of a healthy society. This regionalized network of hospitals also includes obstetrical care for high-risk pregnant women at obstetrical satellite clinics in rural areas.

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

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

Child Health and Adolescent Health

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

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

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

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

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

According to the Behavioral Risk Factor Surveillance System (BRFSS), 65.9 percent of Florida residents age 18 and older were overweight or obese in 2018. This percentage ranked Florida 23rd in the nation. The Department has many initiatives and programs in place to increase physical activity among children and adolescents. Ongoing projects include working with early childhood education centers and schools to develop and implement policies relating to physical activity of the children and adolescents while they are in the centers/schools. Programs such as the Alliance for a Healthier Generation's Healthy Schools Program and the Healthier United States Schools Challenge emphasize the importance of incorporating physical activity into the school day and teaching children and their parents about the importance of physical activity.

Children with Special Health Care Needs

The literature tells us that a patient centered medical home (PCMH) is of importance to children with special health care needs. Data from the 2009-2010 National Survey of Children with Special Health Care Needs (CSHCN) shows that 36.2 percent of children in Florida have a PCMH, compared to 43 percent nationally. The survey data also shows that 37 percent of Florida's CSHCN are receiving appropriate transition services, compared to 40 percent nationally. Transition services are vital to children and youth with special health care needs as it improves lifelong functioning and well-being. In addition to medical home and transition being top priorities for Florida, mental health was also identified through the needs assessment to be of extreme importance. The CDC estimates that one in five children under age 18 has a diagnosable mental health disorder and one in 10 youths have a serious mental health problem that is severe enough to impair their function; yet four out of five children who need mental health services do not receive them.

Other Findings/Strengths/Needs

Maternal deaths are increasing in Florida. From 2001–2003 there were 63 maternal deaths (ratio: 10.1 per 100,000 live births). From 2016–2018 there were 100 maternal deaths (ratio: 14.9 per 100,000 live births). In 2017, Florida PAMR began the transition to implementing the new Maternal Mortality Review Information Application (MMRIA). MMRIA is an electronic data system designed to support standardized data collection and help Maternal Mortality Review committees organize available data and begin the critical steps necessary to comprehensively identify, access, and abstract cases.

During state FY 2013-2014, the Public Health Dental Program implemented a statewide oral health surveillance system to collect data on specific oral health indicators to provide information about unmet dental needs, workforce deficiencies, access to care barriers, and populations at risk for poor oral health outcomes. Specific goals of the surveillance system include: monitor the status of high risk populations; identify unmet dental needs and barriers to care for disparate populations; assess workforce shortages and the distribution of Medicaid providers; and develop policies and programs to address barriers to care and service limitation. In 2016-2017 school year, the second Florida Third Grade Oral Health Surveillance Survey was conducted. The surveillance survey was conducted in a representative sample of schools screening over 1,200 third-grade students for evidence of caries experience, untreated decay, and presence of dental sealants. This data indicated that 25.1 percent had untreated caries, 45.5 percent had the presence of either untreated or treated (restored or filled) tooth decay, 40.5 percent had sealants present, three percent needed urgent care, and 20.6 percent needed early dental care. The Program completed its second Head Start Surveillance Project during the 2017-2018 school year. Preliminary data indicates 24 percent of Head Start children had untreated decay and 34.3 percent had caries experience.

Through the issue briefs and SWOT analyses, current efforts for the CSHCN population were examined for each priority need. Through the Children's Health Insurance Reauthorization Program Act (CHIPRA) grant project, Florida identified medical home strategies that worked well in several Florida locations. Florida's CHIPRA report will be utilized to determine what strategies should be encouraged as well as utilizing other recognized tool kits. CMS has implemented care coordination guidelines and performance standards that outline transition education standards for CMS care coordinators to follow. Further education and training across professions needs to occur to raise awareness about the importance of transition activities.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

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

Chief of Staff: oversees the offices of Communications and Legislative Planning

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

Deputy Secretary for County Health Systems: provides oversight and direction to the state's 67 local health department directors/administrators.

Deputy Secretary for Health: provides oversight to the divisions of Public Health Statistics and Performance Management; Emergency Preparedness and Community Support, Community Health Promotion, Disease Control and Health Protection, the Office of Minority Health and Health Equity and the Office of Medical Marijuana use.

Deputy State Health Officer for Children's Medical Services: oversees the division of Children's Medical Services and 22 CMS Regional/Area Offices.

The Department is responsible for the administration of programs carried out with allotments under Title V, as authorized under Section 383.011(1)(f), Florida Statutes. Many of these programs fall within the auspices of the Division of Community Health Promotion and the Division of Children's Medical Services. The Title V Maternal and Child Health and Children with Special Health Care Needs programs are located within these divisions. Shay Chapman, BSN, MBA, Chief of the Bureau of Family Health Services, serves as the Title V MCH Director. Robert Karch, M.D. was named as Deputy Secretary for Children's Medical Services in March 2020. Jeffrey P. Brosco, MD, PhD, in a physician consultant role with the Department, continues as the Title V CYSHCN Director.

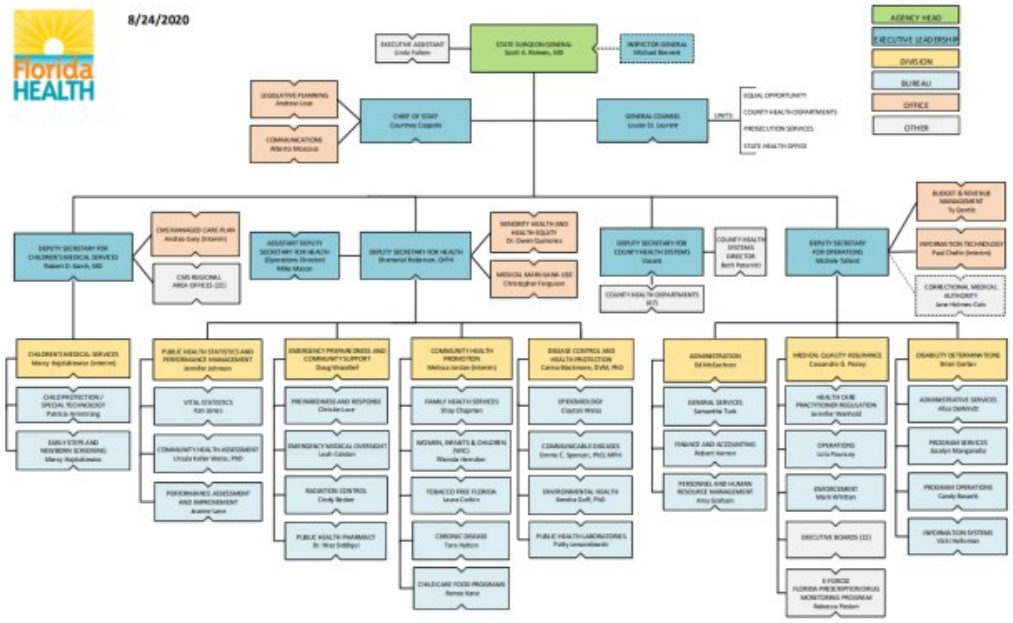
The Division Director of Community Health Promotion provides leadership, policy, and procedural direction for the Division, which includes the Bureaus of Child Care Food Programs, Chronic Disease Prevention, Family Health Services, Tobacco Free Florida, and WIC Program Services.

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

The MCH Section includes the Healthy Start Program; the MCH Program which has, among other responsibilities, Pregnancy Associated Mortality Review and Fetal and Infant Mortality Review; and the Grants/Data/Budget/Procurement

unit, which has primary responsibility for coordinating and collating information for the Title V MCH Block Grant application.

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



III.C.2.b.ii.b. Agency Capacity

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

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

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

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

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

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

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

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

The PHDP also participates in dental health initiatives planned by the Oral Health Florida, Inc. coalition. This organization is comprised of a wide group of individuals and agencies that work in partnership to address their mission to promote and advocate for optimal oral health and well-being of all persons in Florida. The PHDP works with the coalition on several initiatives to increase oral health services for children and families in Florida.

Through the support of funding from the MCHBG and in collaboration and partnership with the Florida Dental Hygienists' Association, the Association of State and Territorial Dental Directors, various primary schools and Head Start Centers throughout the state, the PHDP conducted Third Grade and Head Start Oral Health Surveillance Projects. These projects are important for identifying the unmet dental needs of children and for assisting high risk families with establishing a dental home and identifying local resources for continuing dental care. The Third Grade Oral Health Surveillance Project was completed in 2017 and the results were posted in 2018. The Head Start Surveillance Project was completed in 2018 and results will be posted in the Fall of 2020.

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

During the state fiscal year (SFY) 2018-2019, school-based sealant programs provided services across 48 counties in Florida.

Dental sealant programs served over 1,250 schools, Early Head Start Centers, Head Start Centers, Early Learning Centers and WIC sites resulting in 146,535 children served. This resulted in the following services provided: 240,747 sealants, 35,320 cleanings and 136,983 fluoride varnish applications. In the first year of this initiative (SFY 2014-2015) three local health department programs developed and implemented a school-based sealant program with the support of MCHBG. Since 2014-2015, 37 local health department programs have received funding to initiate or expand school-based sealant programs. Currently, in SFY 2020-2021 eight school-based sealant programs received funding. At the time of this application, 50 out of the 67 Florida counties operate a school-based sealant program, many in part, due to MCHBG funding support for the start-up and expansion costs of programs.

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

III.C.2.b.ii.c. MCH Workforce Capacity

At the Florida Department of Health Central Office, there are 20 full-time staff within the Maternal and Child Health Section. Title V provides funding for 17 of those positions. Within the Adolescent, and Reproductive Health Section, there are 13 positions, one is funded by Title V. There are 11 positions within the Public Health Dental Program, one of which is funded by Title V. Statewide, there are approximately 2,900 Department staff working in positions directly related to Title V.

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

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

Scott Rivkees, MD, was appointed by Governor DeSantis as Florida State Surgeon General and Secretary of Health in April 2019. Before his tenure as Florida's Surgeon General, Dr. Rivkees served as chair of the department of pediatrics at the University of Florida College of Medicine and physician-in-chief of UF Health Shands Children's Hospital, part of UF Health Shands Hospital and the University of Florida's Academic Health Center. He also served as academic chair of pediatrics at Orlando Health and the University of Florida College of Medicine pediatric chair at Studer Family Children's Hospital at Sacred Heart in Pensacola.

Shamarial Roberson, DrPH, MPH, was appointed as the Deputy Secretary for Health in Fall 2019. Dr. Roberson most recently served as the Department's Director for the Division of Community Health Promotion.

Robert D. Karch, MD was appointed as the Deputy Secretary for Children's Medical Services in Fall 2019. Dr. Karch joined The Nemours Foundation in 2011. He served as the President of the Medical Staff at Nemours Children's Hospital and as the Chairman of the Medical Executive Committee. Dr. Karch is board certified by the American Board of Pediatrics and the American Board of Physician Nutrition Specialists and is a fellow of the American Academy of Pediatrics.

Melissa Jordan, MS, MPH, is the Director of the Division of Community Health Promotion, which includes the Bureaus of

Child Care Food Programs, Chronic Disease Prevention, Tobacco Free Florida, Family Health Services, and WIC Program Services. Ms. Jordan also serves as the Director of the Office of Public Health Research.

Shay Chapman, BSN, MBA, serves as the Chief for the Bureau of Family Health Services, under which the Title V programs are located, and is the Title V MCH Director in Florida.

Anna Simmons, MSW, joined the MCH Section in 2013 and was promoted to her current position as Section Administrator in December of 2019. Ms. Simmons has spent her time at the Department in the Maternal and Child Health section.

Andrea Gary currently serves as the Interim Director for the Office of Children's Medical Services Managed Care Plan and Specialty Programs, previously having served as the Bureau Chief for Administration under the Office. Ms. Gary joined the department in 2015, her expertise includes 14 years in state government with a background in business and communications.

Jeffery Brosco, MD PhD, previous Deputy Secretary for CMS, continues to serve in a contracted position as the Title V CYSHCN Director. Dr. Brosco completed his MD and a PhD at the University of Pennsylvania, he is board-certified in Pediatrics and in Developmental-Behavioral Pediatrics. He continues to teach and practice medicine at the University of Miami; his research focuses on ethics and health policy. Dr. Brosco is active in state and national health policy groups, including the National Workgroup on Standards for Systems of Care for Children and Youth with Special Health Care Needs (Association of Maternal and Child Health Programs/National Academy for State Health Policy).

Joni Hollis, RN, MSN, CNL, CCM has been with CMS since 2002 and is the Bureau Chief, Director of Clinical Operations, for the Office of Children's Medical Services Managed Care Plan and Specialty Programs. She supports Dr. Brosco in his role as the Title V Children with Special Health Care Needs Director.

Robert W. Brooks, PhD, has been an epidemiologist within the Division of Children's Medical Services since 2017. He serves as the Project Director of the State Systems Development Initiative (SSDI) grant, which funds supplemental data support to Florida's Title V CYSHCN program.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

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

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

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

The Department receives funding each year from the Administration for Children and Families to administer the Title V State Sexual Risk Avoidance Education Program. The goal of the program is to reduce the incidence of teen births and sexually transmitted infections through education on building healthy relationships and avoiding risky behaviors.

The Department receives funding each year from the federal Office of Population Affairs for the Title X Family Planning Grant. The Department's Family Planning Program provides services using minimum guidelines for routine contraceptive management. Services include: education and counseling; history and physical assessment; provision of contraceptives; and treatment of related problems such as anemia and sexually transmitted infections. Florida has a robust statewide

program with 67 local health departments and 143 clinic sites throughout the state. All women and men of childbearing age can receive services. Priority is given to teens and women ages 20-44 that are at or below 150 percent of the federal poverty level.

There are two federally recognized tribes in Florida - the Miccosukee Tribe of Indians of Florida and the Seminole Tribe of Florida. While these are the two main tribes whose governmental headquarters are in Florida, there are people of American Indian descent from more than 150 different tribes, each with their own distinct set of cultural beliefs. In total, the federally-recognized tribes comprise less than an estimated 5 percent of the American Indian population in the state.

The Office of Minority Health and Health Equity supports and provides resources to a volunteer committee called the American Indian Health Advisory Council (AIHAC). The AIHAC was formed initially in the HIV/AIDS Program Prevention Section. Since its inception, the AIHAC has grown to serve as a resource for agencies and officials such as the Florida Department of Health and its various programs, Florida American Indian governments, American Indian non-governmental organizations, and other organizations that serve American Indian persons, households and/or descendants in Florida. The AIHAC serves by providing a forum for discussion of the health, health care needs, and concerns of American Indian persons.

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

The Department participates in and contracts with the Florida Perinatal Quality Collaborative (FPQC), which is located at the University of South Florida, Lawton and Rhea Chiles Center for Healthy Mothers and Babies. The FPQC seeks to create an all-inclusive culture of cooperation and transparency across the specialties of obstetrics, neonatology, pediatrics and all fields engaged in maternal and infant health care by bringing together the specific expertise of physicians, nurses, nurse-midwives and all specialists involved with perinatal-related health care. Over recent years, the Department has partnered with the FPQC on the following initiatives, Access LARC, Mother’s Own Milk, Obstetric Hemorrhage, and Hypertension in Pregnancy.

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

CMS area offices may choose to employ a Family Support Worker who has personal experience raising a child with special needs. Additionally, each Early Steps program has a Family Resource Specialist.

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

The Department's Public Health Dental Program, in partnership with the Florida Dental Hygiene Association and Head Start, conducted the two Head Start Oral Health Surveillance Projects in 2014-2015 and 2017-2018 to provide oral health screenings in more than 47 Head Start centers across 29 counties for each project. Screening teams consisting of a dental hygienist and a recorder reached over 2,000 Head Start children during both projects and provided screenings, oral health education and referrals for follow-up care through providers in local health departments, Federally Qualified Health Centers, and private dentists registered as Medicaid providers.

The PHDP promotes prevention and emphasizes the importance of public health measures such as dental sealants and community water fluoridation through collaborative activities implemented by dental partner organizations.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 1 - Percent of women, ages 18 through 44, with a past year preventive medical visit.
- NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU).
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months.
- NPM 5 - Percent of infants placed to sleep on their backs.
- NPM 8 - A) Percent of children ages 6 through 11 and B) adolescents 12 through 17 who are physically active at least 60 minutes per day.
- NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others.
- NPM 11 - Percent of children with and without special health care needs having a medical home.
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes.

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

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

This measure was chosen because of the link to the state's priority to improve access to health care for women, to improve preconception health. The Title V program focuses on both preconception and interconception health, fully recognizing the importance of improving the health of all reproductive age women to ensure better birth outcomes and healthier babies. Women's health at all ages of the lifespan is important and contributes to the well-being of Florida families as too often women are the primary caregiver for families.

NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

This measure was chosen because of the link to the state's priority to promote the health and well-being of pregnant women and the most fragile newborns to reduce maternal and fetal/infant mortality as well as reduce the risk of developmental disabilities in infants. CMS contracts with 11 Regional Perinatal Intensive Care Centers (RPICCs) and two obstetrical satellite clinics across the state to deliver optimal medical care to high-risk pregnant women and sick or low birth weight infants. With Title V funding support from the Department, participation of RPICCs in the Florida Perinatal Quality Collaborative (FPQC) has grown.

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

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

protect, promote, and support breastfeeding as the preferred, normal method of infant feeding. The Florida SSDI project has published and presented data on the benefits of breastfeeding practices.

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

This measure was chosen because of the link to the state's priority to promote safe and healthy infant sleep behaviors and environments, including improving support systems and the daily living conditions that make safe sleep practices challenging. The Department formed a Statewide SUID Workgroup that provides input on the state work plan to reduce sleep-related infant deaths, and created a logic model for conducting training efforts on safe sleep practices for health care providers, the Florida Hospital Association and other birthing centers, parents, caretakers, and the public. These activities, along with data showing that safe sleep initiatives have a significant impact on reducing infant mortality, made the selection of this measure a valid choice for the Title V program.

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

This measure was chosen because of the link to the state's priority to promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment. Studies have shown that for many children, a decline in physical activity begins in middle school, and those children who continue to be physically active through middle school and high school have a much better chance of being physically active adults. Focusing on children and adolescents to increase physical activity can have a tremendous impact on improving health throughout the life span, by reducing obesity and the risk of many chronic diseases.

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

Bullying is a priority for the Title V program. This focus can have an impact on improving health throughout the life span, by looking at adverse childhood experiences and the long-term impact and risk factors associated with many chronic diseases. Bullying is defined as: attack or intimidation with the intention to cause fear, distress, or harm that is either physical (hitting, punching), verbal (name calling, teasing), or psychological/relational (rumors, social exclusion); a real or perceived imbalance of power between the bully and the victim; and repeated attacks or intimidation between the same children over time. Bullying is a serious detriment to a child's health, sense of wellbeing, safety, education, and emotional development, and greatly increases the risk of self-injury and suicide.

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

This measure was chosen because of the link to the state's priority to increase access to medical homes and primary care for children with special health care needs. A patient-centered medical home (PCMH) provides accessible, continuous, comprehensive, family-centered, coordinated, compassionate, culturally effective medical care. All children should have a PCMH, but the PCMH is especially advantageous for children with special health care needs as they typically require coordination of care between primary care providers and specialists.

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

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

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

someone smokes

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

Linkage of State Selected Priorities with State Performance and Outcome Measures

Based on the findings from assessing the needs and examining strengths/capacity phases, a scoring tool worksheet was developed. The tool entailed scores for issue brief packets (completed topic briefs, SOARs, capacity needs scoring sheets), and a section for public health impact based on the recommendation of an advisory workgroup member. To remain objective, a three-member Needs Assessment Scoring Team (CMS staff, including one with lived-experience as a CYSHCN caregiver) were asked to review the materials and use the tool to submit anonymous and individual scores, to rank the eleven priorities. To ensure inter-rater reliability, project managers of the needs assessment process individually computed the averages from the scorers. After, a one-page ranking document, containing the average scores for each scoring tool section and total score for all potential priority areas, was created and presented to leadership. After a debriefing, leadership selected Patient Centered Medical Home (PCMH) and Mental/Behavioral Health (MH) as the 2020 Title V Needs Assessment priorities.

Adequate insurance, transition, access to care, and workforce development were the additional top-scoring priorities. Adequate insurance was not selected as a final priority for CYSHCN because Medicaid and KidCare have specific roles in insurance coverage for the State of Florida. Likewise, there is also the Florida Covering Kids & Families at the University of South Florida's Chiles Center that focuses on insurance coverage; CMS does participate on their hard-to-reach subcommittee and will continue to partner and collaborate with statewide stakeholders pertaining to adequate insurance for children and youth with special health care needs. Although not identified as final priorities, transition, early screening, family partnership, access to care, and workforce development, are enveloped as tenets under the umbrella of the PCMH concept, along with family partnership, and early screening.

Sustainment of MH and PCMH as state priorities from the previous five-year reporting cycle is backed by a review of literature, findings from stakeholder input, ongoing regional needs assessment efforts, and the successful initiation and planning of interventions that will be evaluated for effectiveness.

Over the past several years, CMS has transitioned towards making a greater impact on population health by focusing efforts on the infrastructure-building level of the MCH Health Services Pyramid. Hence the focus on National Outcome Measure 17.2 Systems of Care as the foundation for this most recent needs assessment process; PCMH is associated with NOM 17.2, linked to NOM 19 (health status) and NOM 25 (able to obtain care) a component of the National Standards for Systems of Care, and overtly derives from national performance measure (NPM) 11, with the aim of increasing access to medical homes and primary care. PCMH will drive improvement by: 1) Providing Education and/or technical assistance; 2) Increase the number of caregivers that feel like partners in their child's care; 3) Increase number of designated PCMHs in underserved areas; and 4) Increase the number of adult care providers that will accept CYSHCN.

Mental/Behavioral Health is a state performance measure (SPM) that is directly derived from NOM 18, concerned with increasing access to behavioral health services. The focus of this priority will be education and/or technical assistance, behavioral health integration, and prevention of these conditions. The needs assessment findings coupled with prior investments and fruitful collaborative efforts, upholds continuing Patient-Centered Medical Home and Mental/Behavioral Health as priority needs for Children and Youth with Special Health Care Needs.

- SPM 1 - The percentage of children with a behavioral health condition who receive treatment consistent with their diagnosis.
- SPM 2 - The percentage of low-income children under age 21 who access dental care.
- SPM 3 - The percentage of parents who read to their young child age 0-5 years

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

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

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

This measure was chosen because of the link to the state's priority to improve dental care access for children and pregnant women. Oral health is vitally important to overall health and well-being. Research has shown a link to diabetes, heart and lung disease, stroke, respiratory illnesses, and other conditions for pregnant women, including the delivery of preterm and low birth weight infants.

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

This measure was chosen because of the link to the state's priority to address social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies. Encouraging parents to read to their children has a positive impact, including improvement in the parent-child bond, improved language development in children, and increased positive parenting.

III.D. Financial Narrative

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$18,984,911	$18,984,911	$19,243,069	$19,478,535
State Funds	$155,212,322	$155,212,322	$155,212,322	$155,212,322
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$174,197,233	$174,197,233	$174,455,391	$174,690,857
Other Federal Funds	$14,466,727	$15,247,136	$28,194,845	$27,465,676
Total	$188,663,960	$189,444,369	$202,650,236	$202,156,533

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$20,922,688	$19,444,613	$20,940,088	
State Funds	$155,212,322	$155,212,322	$155,212,322	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$176,135,010	$174,656,935	$176,152,410	
Other Federal Funds	$16,568,999	$16,085,512	$29,375,939	
Total	$192,704,009	$190,742,447	$205,528,349	

	2021	
	Budgeted	Expended
Federal Allocation	$20,703,392	
State Funds	$15,527,544	
Local Funds	$0	
Other Funds	$0	
Program Funds	$139,684,778	
SubTotal	$175,915,714	
Other Federal Funds	$29,183,143	
Total	$205,098,857	

III.D.1. Expenditures

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

The expenditures for FY 2019 are presented in Forms 2, 3a, and 3b of the Title V Block Grant application. The Department received $19,444,613 in Title V funds in FY 2019 (October 1, 2019 - September 30, 2020), and plans to expend the full amount by the end of the grant period (September 30, 2020). As in prior years, the Department will meet the Title V requirement as specified in Section 501(a)(1)(D): a 30/30/10 split, as shown on Form 2.

While CMS previously reported in its FY2019 application to be budgeted for $8,585,354, alignment of funding categories for the MCH Healthy Babies program resulted in a reduction for a revised and actual expenditure budget of $7,464,576 for CYSCHN from the MCH Block Grant. For FY2019 Florida had two significant public health emergencies with CMS contributing $2,005,209 of funding to support the states enabling and public health services and system's needs specific to Hepatitis A and COVID-19. This contributed to CMS FY2019 total expenditures of $9,182,539 (a 9.3% variance from previously reported budget) with $7,677,330 going to CYSHCN and $1,505,209 going to All others. The TVIS system would not allow for an expended entry that exceeds the original reported budget, therefore, CMS is reporting current year expenditures of $7,464,576 with $5,959,367 (36%) going to CHSCN and $1,505,209 going to All others category for support of Florida's Public Health emergencies that may not have been specific to CYSHCN.

Children's Medical Services (CMS) has various other federal funding sources. CMS receives $1,450,737,203 for Title XIX, $184,389,550 for XXI CHIP funding which supports the operations of the CMS Health Plan and the services provided to its 78,499 members. For Medicaid and the Children's Health Insurance Program (CHIP) related activities, CMS draws down the allowable federal match.

CMS expended $8,916,008 in non-federal general revenue for additional programs and activities separate from the CMS Plan and Title V federal funding.

For CYSHCN that are uninsured or underinsured the department expended $423,873 of nonfederal funding that is used to provide direct specialty health care services, as part of the Department's Safety Net program. While statutorily CMS Title V funds are expected to be used as part of this program, its allocation is used for operational systems support of the Safety Net program. In addition, approximately $55,000 was spent on direct services for Fetal Alcohol Spectrum evaluation and services, that were otherwise not covered by third party payors.

CMS's general revenue dollars are also used to provide support for the systems of care that serve CYSCHN through various legislative supported member projects and specialty contracts. This state-federal partnership helps ensure a cadre of condition specific specialists across the state to help support access and quality to services for CYSHCN.

Historically many of these specialty contracts focused on condition specific direct care, clinic based services. Transformation efforts have included aligning programs with the National Standards for Systems of Care for Children and Youth with Special Health Care Needs, Florida's Title V CYSHCN priorities, and quality improvement initiatives. The next iteration of this change management process will focus on providing further technical assistance to better align budget narratives and expenditures to better capture their public health services and systems (PHSS) efforts versus the historical enabling service documentation of expenditures captured in this year's review. The significance of this evolution may not be fully realized in the reported expenditures vs upcoming budget, due to the decrease of funding between the years.

Title V funding is also used, in part, to help support various condition specific specialty contracts, including: Craniofacial and Cleft Lip/Palate Centers, Hematology/Oncology Programs, HIV Programs, Endocrine, Pulmonary and Children's Comprehensive Kidney Failure Centers. This funding year also included on emphasis on quality improvement initiatives

through a learning action network, in partnership with NICHQ. The secondary gain of framework of peer to peer learning, is the formation of a statewide network of existing partners, with the goal of expansion of new ones to better support access for CYSHCN throughout the state.

In working to address the priority need for access to PCMH, CMS increased its Title V funding for practice transformation technical assistance through the University of Central Florida (USF) HealthARCH program. CMS works closely with the Florida Health and Transition Services (FloridaHATS) Program at the University of South Florida for transition related activities. CMS provides funding to FloridaHATS for website hosting; transition consultation; resource identification; and education for youth, families, and providers. In addition, Title V funding is used to support the JaxHATs program, a clinic based youth transition program.

In support of its' SPM on increasing access for children's mental/behavioral health treatment CMS used its Title V funding to expanding its Behavioral Integration pilot work from two to five regional behavioral health (academic) partnerships. This model includes provision of telepsychiatry, provider skill building training and family resource identification and linkage through care coordination services. Title V funding was provided to further support the State's current pediatric psychiatry hotline, which includes the addition of care coordination services to build capacity with this valuable resource for primary care providers. Title V also provided Public Health Services and Systems support to the state's existing Behavioral Health Network program.

CMS expanded its community health connectors pilot during this reporting year. State general revenue dollars were used as match to support regional teams responsible for community outreach and education on priority needs for CYSHCN as well as providing linkages to available resources. Title V funding was then used to support paid family leader positions, workforce development, program planning, quality assurance and other public health services and system's needs.

Electronic documentation and robust data reporting are essential elements for health care transformation. The migration of the CMSHealth plan to a contracted vendor, created the infrastructure need for an in-house custom build application to monitor and track programs under CMS's Title V CYSHCN purview. This included referrals and ongoing management for clinical eligibility, safety net, children's multidisciplinary assessment team and the medical foster care program.

Title V funds were also used to support significant change management needs, including program planning, quality assurance and evaluation for specialty programs that serve CYSHCN. Title V funds were also used as to meet with family and youth at statewide conferences and in the community as part of its needs assessment process. CMS continues to provide support to the Florida Family Leader Network; a second annual summit was held September 2019.

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

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

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

Title V funds were expended to enhance the MCH system of care and ensure more infants have the best possible start in life.

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

In partnership with the Florida Perinatal Quality Collaborative housed at the University of South Florida, the Maternal Opioid Recovery Effort (MORE) was initiated. This project's purpose is to work with providers, hospitals and other stakeholders to improve identification, clinical care and coordinated treatment/support to pregnant women with opioid use disorder and their infants. The project focuses on OUD screening, prevention, treatment and comprehensive discharge planning.

As a component of Florida's Healthy Babies Initiative, the Department allocated $1,200,000 in Title V funding divided among all 67 county health departments to implement evidence-based community projects aimed at addressing social determinants of health and lowering disparities in infant mortality.

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

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

- Promote school-based sealant programs to children and increase positive consent rates from parents by producing and disseminating a postcard that explains dental sealants and their effectiveness in preventing tooth decay.
- Support the Florida Breastfeeding Coalition to enhance current efforts and expand capacity for projects related to breastfeeding promotion.
- Promote awareness of the Adolescent Health program housed at DOH.
- Promote awareness of suicide prevention.

III.D.2. Budget

Florida's FY 2021 MCH program budget totals $20,703,392. This is $236,696 less than the FY 2020 amount. This decrease is a result of the appropriation for the Bright Expectations public awareness campaign being eliminated this year. States must match every four dollars of federal Title V money they receive by at least three dollars of state and/or local money. The required state general fund match for Florida for FY2020 is $15,527,544. This match is met with the general revenue appropriation that the department receives for Healthy Start.

Florida's Title V program complies with allocating and spending at least 30 percent of the federal allotment for preventive and primary services for children and at least 30 percent for services for children with special health care needs. A total of $6,230,706 is budgeted toward preventive and primary services for children, which is 30 percent of the FY2021 estimated allotment. A total of $4,033,357 is budgeted for Pregnant Women and all others which is 24 percent of the total block grant funds. A total of $8,991,764 is budgeted towards children with special health care needs. Due to our projected FY 19 over-expenditures, we will have approximately $7,273,801 remaining for the upcoming budget year. This may mean realignment of our proposed timeline for the additional strategies and activities as part of our action plan for the upcoming block grant cycle.

For FY 2021, the estimated administrative cost is $1,415,638 or 6.84 percent of the federal allotment, which is below the 10 percent threshold for administrative spending. The budgeted administrative costs in this application represent the grant funds used to administer the Title V program for MCH and include, but are not limited to, contract management, budgeting, policy development, personnel, and clerical support for these functions. State general funds for FY 2021 are anticipated to be $155,212,322. Florida will continue to provide the maintenance of effort amount of $155,212,322 as required.

For FY 2021, the Department has budgeted a total of $29,183,143 in other federal funds under the control of the Title V MCH Director. This includes $3,834,831 for the Sexual Risk Avoidance Education Grant, $1,872,466 for the Rape Prevention and Education Program, $11,200,000 for Title X Family Planning, $650,000 for the Perinatal Mental Health Grant and $11,625,846 or School Health.

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

The Department will continue to use Title V funding for four regional part-time nurse abstractors, an epidemiology staff for data analysis, and additional staff as needed to support the statewide, voluntary Pregnancy Associated Mortality Review (PAMR) team.

For the coming year, plans to expend funds similarly to the outlined financial narrative. In working to address the priority need for access to PCMH, CMS will increase its Title V funding for practice transformation technical assistance through the UCF program. CMS plans on working with UCF to implementing a population health approach with the creation of a learning action network to increase the reach and capacity of this valuable service to pediatric and family providers across the state with a focus on underserved areas.
Investing over $1,500,000 of Title V funding CMS will continue is partnership with at least five public state university academic centers to start Florida's Regional Pediatric Behavioral Health Hubs (BHH). Building on existing resources and partnership in the community, the goals is for the BHH's to come together with other stakeholders to form a statewide network focused on access and quality for integrated behavioral health services. An external evaluation of data and outcomes collected by the BHH's will be done by a University partnership. This evaluation will help determine if projected

outcomes are being achieved and help with quality assurance while also measuring collaboration and network analysis. As the effects of COVID on the emotional and behavioral needs of children continue to be manifested, additional strategies and resource allocation will be prioritized.

CMS will use Title V funds to expand its current condition specific specialists network with the intentional engagement of new partnerships to strengthen access and quality throughout the state for CYSHCN. CMS will use its continued partnership with NICHQ, and build on its quality improvement learning collaborative framework with a second co-hort as part of these efforts. Specific to its current specialty contracts, CMS will provide focused technical assistance for FY 2021 specific to budget narratives to better align population health strategies with fiscal reporting.

CMS continues to provide support to the University of Florida's Pediatric Pulmonary Center for more capacity-building opportunities for family leaders in MCH careers. A third annual summit will be held September 2020 with quarterly learning opportunities for family leaders.

As the value and demonstrated outcomes from CMS's community connections model continues to be realized, Title V funding will be used to support community outreach and collaboration, leveraging available opportunities, as well as communication needs including health promotion campaigns to address the needs of CYSHCN in Florida's diverse region.

For its non-federal general revenue allocation for its Safety Net program, serving under or uninsured CYSHCN and subsequent direct services reporting for this category, CMS is budgeting $410,000 for FFY 20. Additional non-federal general revenue that supports the system of care for CYSHCN with its specialty contracts and legislative member projects includes $8,947,581.

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

- The Department will continue to use Title V funding to provide interconception care (ICC), which is not reimbursable by Medicaid, through the Healthy Start program.

- Contracts with 11 Fetal Infant Mortality Review (FIMR) projects through the Healthy Start program to provide for the implementation of FIMR services to address the behavioral, environmental, and structural processes that may impact fetal and infant deaths, to learn more about why infants die, and to propose recommendations for change.

- Contract with the FPQC to engage perinatal stakeholders to improve maternal and infant health outcomes through design, implementation, and evaluation of processes, and to enhance quality improvement efforts.

- Contract with the Ounce of Prevention Fund of Florida to identify, fund, and evaluate innovative prevention programs for at-risk children and families using general revenue funding. One specific project under this contract is to provide culturally linguistic and age appropriate books to Reach Out and Read sites throughout Florida to support one of the MCH priorities and performance measures. Additionally, funds support public education on critical prevention issues facing Florida's at-risk children and families.

- Provide support to the Florida Breastfeeding Coalition to enhance current efforts and expand capacity for projects related to breastfeeding promotion and provide technical assistance.

- Continuing to establish new school-based sealant programs in Florida.

- Continue Title V funding for county health departments to create a reading rich environment in waiting room areas equipped with children's reading tables, chairs, bookshelves, and children's books. Funds may also be used to

establish a Reach Out and Read (ROR) program

- Title V funding will be available to county health departments to establish a Best Babies Zone (BBZ) Initiative. BBZ is a place-based, multi-site, multi-sector approach to reducing disparities in infant mortality and birth outcomes by mobilizing community residents and organizational partners to address the social and economic determinants of health.

- Title V funding will be available to county health departments to establish a Fresh Access Bucks (FAB) Initiative. Fresh Access Bucks encourages healthy behaviors by making fresh, local produce more affordable and accessible to SNAP recipients while supporting Florida farmers and enhancing local economies. FAB increases the purchasing power of SNAP participants by providing a one-to-one match for Florida grown fruits and vegetables. A SNAP cardholder who spends $10 of their benefits receives an additional $10 to purchase more fresh, local produce. The goals of FAB are to increase access to and affordability of fruits and vegetables in underserved communities and increase awareness of the importance of eating fresh fruits and vegetables. This program strategically targets farmer's markets in and around food deserts, low-income communities, and along transportation routes.

- Title V funding will be available to county health departments to implement the Protocol for Assessing Community Excellence in Environmental Health (PACE EH) in high-need communities, to assess neighborhood and community identified social determinants of health needs and provide action plans to address the top issues as defined by the communities.

- Title V funding will be available to county health departments to facilitate partnerships with local birthing hospitals to obtain Cribs for Kids Safe Sleep Hospital Certification.

III.E. Five-Year State Action Plan

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

State: Florida

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

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

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

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

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

CMS is at a new juncture as a Title V program. CMS is focused on infrastructure rebuilding as it transforms its health care delivery systems for CYSHCN, ensuring access to quality primary care and specialty health services. CMS is strengthening its public health services and systems for all CYSHCN with the creation of Regional and State Networks for Access and Quality. Utilizing the life course perspective as a framework and building off the *Standards for Systems of Care for Children and Youth with Special Health Care Needs 2.0*, CMS completed a re-assessment of community needs in 2018 using the Mobilizing for Action through Planning and Partnerships (MAPP) process, and driven by family voice. The needs assessment framework included Forces of Change: National Standards for System of Care, Statewide Systems of Care Assessment Tool; and for one community, the GOT Transition Assessment. Needs assessment results have been used to create a scope of work to drive action planning at the community level with an emphasis on whole-community systems approaches with the prioritization given to the linkage or integration of multisector services systems to maximize protective factors and minimize risks for CYSHCN.

HRSA awarded funds to the Department for its project, *The Development of a Sustainable Screening and Treatment Model to Improve Maternal Mental Health Outcomes in Florida*, which will increase the capacity of health care providers to deliver evidence-based screening, treatment, and referral for perinatal mental health services in three targeted regions. To increase routine screening and referral by prenatal care providers, the project team will develop and implement a perinatal screening and treatment model to directly train health care providers in prenatal health care practices and birthing hospitals. The

project team will also train community mental health providers in evidence-based management of perinatal mental health disorders and provide access to a professional perinatal psychiatrist consultation to increase the use of evidence-based therapeutic interventions for perinatal depression. To increase access to services, the project team will expand mental health and substance abuse referral networks through provider outreach, develop community resource guides, and expand the Moving Beyond Depression and Mothers & Babies programs in statewide home visiting programs. Title V funding will be used to hire a psychiatrist to be available for inquiries related to care for pregnant women with perinatal depression.

As access to mental health services continues to be an ongoing challenge and emerging issue, CMS is focusing its role as convener, collaborator and partner with academic and community partnerships across the state in formalizing a regional and statewide network. These academic hubs have historically served geographic referral patterns. Specific to mental health, partnering with the universities and the division heads for their Child and Adolescent Psychiatry programs, CMS will help to build on existing community and state resources as well as plan for bridging unmet needs with training, the use of evidence-based behavioral health integration models, and use of tele-psychiatry consultation to help address access and quality. The partnerships will extend into the communities with representation from Florida's DCF-Substance and Abuse Mental Health (DCF-SAMH) their regional managing entities and child welfare organizations, local pediatricians, school system, family and youth organizations, juvenile justice, community mental health partners, etc. At the state level, partnerships include the Florida Chapters of the American Academy of Pediatrics, the American Academy of Child and Adolescents Psychiatrists, Florida Chapter of the National Alliance on Mental Illness, Insurance Payors, and AHCA. Evidence-based evaluation will include the Wilder Collaboration index which will help measure the forming partnerships over time.

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

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

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

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

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

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

The Department's Public Health Research Section offers the Research Excellence Initiative, a year-long educational program that provides structured education and mentoring to Department professionals interested in conducting research, epidemiology, and program evaluation. The program was developed to promote high quality, innovative research and develop experienced researchers who can promote excellence by serving as role models and mentors, foster collaborations, and promote research on Department priorities.
CMS staff participated in the National MCH Workforce Development center in 2017 and again in back to back 2018 cohorts focused on various Title V initiatives as well as their strategic skills institute. The information and tools learned as part of this experience have been shared and utilized on other initiatives statewide with staff at all levels.

CMS is transitioning a portion of their direct care service workforce (nurses, social workers and family leaders) under the CMS Health Plan to population health services. To be purposeful and intentional in strategic planning, implementation, and evaluation, a new state performance measure specific to Workforce Development was developed.

Job descriptions, qualifying questions, and interview questions were developed in partnership with the National MCH Workforce Development Center. Once the workforce was identified, a statewide face-to-face training was held. Topics focused on change management, adaptive leadership, appreciate inquiry, leadership strengths, implementation science and persuasive communication skills. Activities were recorded and will be used for future onboarding of new program staff.

CMS is enhancing workforce training and growth to staff statewide by sponsoring evidence-based training that focuses on core competencies and industry standards for public health workers. The training ensures staff, who are experts in their specific disciplines, have the proper education, skills, and experience needed to deliver appropriate services in the achievement of desirable outcomes for population health.

CMS established a Motivational Interviewing Learning Collaborative with a sampling of staff from around the state, to explore the use of this evidence-based practice and its potential fit in working with families of CYSHCN. As CMS moves away from direct care services and focuses more on population health, Motivational Interviewing for providers will be explored as part of community outreach, engagement, and education.

CMS furthered collaboration with the UF's Pediatric Pulmonary Center and their family leader to provide statewide training to support and increase the skills of family leaders across organizations. A statewide summit was held in 2018 which included 82 participants, of which 43 were family leaders from various organizations across Florida. Outcomes included evolution of Florida's Family Leadership Network who, through guided facilitation, identified 10 specific areas of interest to further work on during the upcoming year. Workgroups, including an advisory group, were formed and meet quarterly to discuss progress, needs, and an evaluation. A 2019 summit will focus on Family Leaders strengths.

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

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

Family engagement and voice is an essential element for CYSHCN. There are six paid family leader positions dedicated to Title V activities. This includes a statewide position that works with CMS on strategic program planning and implementation, quality improvement, advisory committees, etc. Five regional family leaders also provided community health connections representing the family voice to community providers.

CMS values its partnership with the Family Network on Disabilities (FND), which includes Florida's family to family health information center. FND is instrumental in helping CMS gather youth and family feedback including dissemination of satisfaction survey's through social-media platforms. CMS was a sponsor for the 2019 annual Family Café, an event that connects throughs of individuals with disabilities and their family members for three days of information, training and networking. Because of this networking, CMS engaged its newest family partnership with the Florida Military Family Special Needs Network. CMS was also a sponsor for the 2019 annual Florida Youth Council.

Florida continues to collaborate with the University of Florida's Pediatric Primary Care Center, our MCHB partner, for training activities that serve to strengthen and advance CYSHCN family leaders across all organizations. This includes an annual professional development summit and quarterly educational activities specific for family leaders, their champions and emerging public health professionals. This partnership has evolved into the Florida Family Leader Network (FFLN) which now includes 189 members (117 Family/Youth Leaders; 52 Champions and 20 Emerging Professionals), which has doubled in its numbers from the previous year. 2019's annual summit included skill building topics such as strengths based leadership, collaborative engagement to resolve conflict and social media tools. A third summit is planned for September 2020. Future plans include a more formal partnership in this work with our state's other MCHB partners, to ensure an ongoing collaborative and sustainable framework.

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

The Florida State Systems Development Initiative (SSDI) program, which resides in the Division of Children's Medical Services (CMS), submitted a successful, non-competitive application for the 2017-2022 project period. Title V Block Grant resources allocated for Florida's SSDI program have been instrumental in the ongoing effort to track and expand electronic access to key Maternal and Child Health (MCH) indicators. These efforts are accentuated by supplemental activities focused on data initiatives that serve Children and Youth with Special Healthcare Needs (CYSHCN), abused and neglected children, and strengthening Title V programs that serve these populations.

FLHealthCHARTS, a community health assessment resource toolset, continues to act as the principal stage in which national and state performance measures are updated and displayed in real-time. In addition to the required indicators, the SSDI team generates supplemental variables which include new profiles and keyword searches designed to capture data relevant to Title V performance measures. These efforts have provided new MCH categories within FLHealthCHARTS that encompass data points related to newborn screenings, Child Abuse/Neglect and CYSHCN. The funding received through the SSDI grant represented the primary funding source necessary to program the information into the public forum. The dynamic capacity of FLHealthCHARTS has been driving innovative data-infrastructure changes to SSDI information dissemination protocols.

These innovations can be observed in the implementation of Business Intelligence (BI) software and is revolutionizing how data is collected, analyzed, visualized and applied to support data-driven decision making throughout CMS programs. Utilizing dynamic mapping technologies to expand Title V initiatives has been vital in sharing complex information in a visual realm, establishing an engaging atmosphere for stakeholder meetings. These initiatives extend beyond the federal and state levels, providing dynamic data support to local stakeholders where access to such data can provide the necessary resources to drive significant changes in Florida's MCH populations.

Linkages between data sources remain a key objective, particularly within Title V programs that serve the same or similar populations. Presently, the SSDI team has begun merging databases within CMS to track vulnerable populations of children through each stage of development, beginning with newborn screening and culminating in the Early Steps and Child Protection Team programs. Collaborative efforts to expand these initiatives beyond the Florida Department of Health are currently being executed with the Departments of Education and Office of Early Learning. These linkages are providing invaluable insight into the efficiency and reliability of programs that serve MCH populations and will be a fundamental resource regarding future data-driven decisions required for timely collection and reporting of MCH-related materials.

Research to evaluate emerging issues that impact MCH populations served by Title V programs is ongoing. These include utilizing state-level population data (ex: Behavioral Risk Factor Surveillance System, Child Abuse Death Review, National Survey of Children's Health, vital statistics, etc.), workgroups and other supplemental enterprises to advance Title V program evaluation. These initiatives also improve interagency and intra-agency communication that has translated into improved data systems while simultaneously decreasing duplication of efforts. To note, SSDI staff have assisted with several data-driven initiatives designed to improve the health and well-being of Florida's MCH population:

- In 2019, SSDI staff provided data support to an imperative project initiated by the state Child Abuse Death Review (CADR) team. The Child Abuse Death Review Committee along with Florida's vital statistics and the National Center for Disease Control have consistently identified sleep-related death to be the number one cause of preventable child death in Florida. Analyzing data between 2016-2018, demonstrated that 10 Florida judicial circuits had sleep-related death incidence rates higher than the state average. This analysis proved instrumental in guiding the data-driven implementation of Sleep Baby Safely program, a campaign aimed at reducing incidents of sleep-related child death in Florida's communities through educating new parents on safe sleep practices. Title V grant funding made available by the Office of Children's Medical Services Managed Care Plan and Specialty Programs, allowed the Child Abuse Death Review Unit to provide the selected local CADR Committees with items imprinted with safe sleep messaging to create Welcome-Baby bags for each new parent for 10-12 months. Child Abuse Death Review

Committee members are partnering with local birthing hospitals, neo-natal hospital staff, pediatrician offices, first responders, and others in the community who have contact with parents of newborns. The campaign utilizes a universal safe sleep message and provides valuable items to help strengthen the new parent's engagement in ensuring that their baby sleeps safely "every night and every nap." The campaign has seen promising results in counties where previously implemented and the initiative has sparked optimism that Florida can strategically reduce sleep-related deaths.

- SSDI staff are currently assisting Florida's Title V CYSHCN program on several data initiatives that would satisfy strategic efforts put forth in Florida's CYSHCN Action Plan. These initiatives focus on the utilization of dynamic mapping to provide clear visual representations of region-specific patient-centered medical home (PCMH) provider characteristics. These data can include locations (zip code level), number of PCMH providers per region, practice type, services provided and accreditation status. While providing direct benefit to the state through the creation of dynamic dashboards which include maps, our teams expect these data sources to expand our initiative capacity. For example, overlaying PCMH provider maps with census information, including but not limited to, demographics, socioeconomic status and access to care through transportation availability. We strongly believe these initiatives will be imperative to providing the highest level of accessible care to Florida's MCH population.

- Division of CMS strategic planning: SSDI staff are involved in the oversight of performance management and administrative functions which include coordinating quarterly/annual reporting and Division Performance Management Council meetings. This encompasses Early Steps, Newborn Screening/Hearing and Child Protection programs. The SSDI team also support efforts to develop additional performance measures to inform the decision-making of CMS management. BI software will provide visual analytics of key program measures on a continual basis, accommodating everchanging data needs and provide transparency in reporting of CMS program progress.

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

Forty-seven percent of Florida's children are enrolled in Medicaid with almost all receiving services through a managed care delivery system. Children's Medical Services and the Agency for Health Care Administration (AHCA) work closely to ensure CYSHCN are provided quality health care and related services through a cohesive system of care. Children are identified during the Title XIX and Title XXI eligibility and enrollment process as being potentially clinically eligible for the CMS Plan. Upon referral, CMS conducts clinical eligibility determinations and files are sent electronically daily back to the referring entity.

CMS works with Florida Medicaid, Florida KidCare, and community partners to identify children that are uninsured and underinsured. When a child is identified, CMS works to enroll them in the CMS Safety Net Program, which will pay for certain direct specialty care services depending on the child's needs. Additionally, CMS is part of the Hard-to-Reach Subcommittee of the Covering Florida Consortium, an initiative of Florida Covering Kids and Families (FL-CKF).

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

Beginning in February 2019, CMS partnered with WellCare to operate the CMS Health Plan. Through this new model, the CMS Plan works with providers on value-based care and other innovative and effective payment models. The foundational principles of the CMS Health Plan were based on the *Standards for Systems of Care for Children with Special Health Care Needs 2.0* and design elements reflect feedback from families and the community. The CMS Health Plan continues to keep care coordination as a cornerstone of the program. Every child is assigned to a care coordinator and interaction frequencies are based on a tiered system. The CMS Health Plan offers expanded benefits, and special programs, all designed to support the child and family. Beginning in 2019, dental services for CMS Plan Medicaid enrollees are covered under a separate Medicaid dental plan. Performance measures for the CMS Plan are enhanced to include specific child measures, including linkages to PCMHs and transitioning to adult health systems, and quality of life measures utilizing the SF-10 and SF-12.

Through a joint agreement between the Department and AHCA, CMS operates the Children's Multidisciplinary Assessment Teams (CMAT) in Florida, as well as the Medical Foster Care (MFC) Program. For children and youth referred to MFC or skilled nursing facility services, CMATs provide a thorough multidisciplinary (nursing and social work) assessment. Team members include the child's parent/guardian, the CMAT Team, a representative from AHCA or the Medicaid Managed Assistance Health Care Plan, a representative from the Agency for Persons with Disabilities, and if under the age of three, a representative from Early Steps. Other relevant stakeholders are also invited to attend and may include MFC staff and child welfare representatives. Through a consensus building process, the level of care is determined, which drives the reimbursement rate for MFC Parent Providers and skilled nursing facilities. The CMAT process also provides a comprehensive review and clinical education of child's care needs to the members of the child's team.

Florida's MFC Program is a partnership between the Department and AHCA, in addition to the DCF. CMS trains MFC parents who are then credentialed with the various Medicaid Managed Care Plans to provide MFC parent provider services for the MFC program. CMS provides child specific trainings, ongoing nursing and social work oversight, and technical assistance to MFC parent providers. CMS collaborates with various stakeholders as part of the MFC program including, but not limited to, biological pre-adoptive parents, the Medicaid Managed Care Plan, the child welfare agency (licensing, child protection investigators, case managers, guardian ad-litems, providers, specialists, among others).

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

The Partners in Care: Together for Kids Program is Florida's Program for All-Inclusive Care for Children. This program is administered by CMS and AHCA and serves children enrolled in the CMS Plan with life threatening and life limiting illnesses. Partners in Care: Together for Kids Program Providers are hospices who deliver pain and symptom management services, including nursing and social services supports, activity therapies, and respite care.

The Behavioral Health Network (BNet) was created pursuant to Florida Statute 409.8135 requiring the Department to contract with the DCF to provide behavioral health services to Title XXI eligible CYSHCN. This is to ensure a high level of integration of physical and behavioral health services and to meet the more intensive treatment needs of enrollees with the most serious emotional disturbances or substance use disorders. BNet is a statewide network of behavioral health service providers who serve non-Medicaid eligible children ages 5 to 19 years with mental health or substance use disorders who are determined eligible for Title XXI benefits, also known as Florida's KidCare program. BNet treats the entire spectrum of behavioral health disorders and provides both children and their parents with intense behavioral health planning and treatment services for the duration of the child's enrollment. BNet Service Providers address the family's needs through in-home and outpatient individual and family counseling; targeted case management; psychiatry services and pharmaceuticals for the child's behavioral health or substance use condition; and advocacy and wrap-around services to meet each child's social, educational, nutritional, and physical activity needs. To increase referrals and enrollments to the BNET program, CMS is collaborating with the CMS Health Plan and DCF for quality improvement needs including increasing outreach and awareness, for access and enrollment in this valuable program.
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III.E.2.c State Action Plan Narrative by Domain

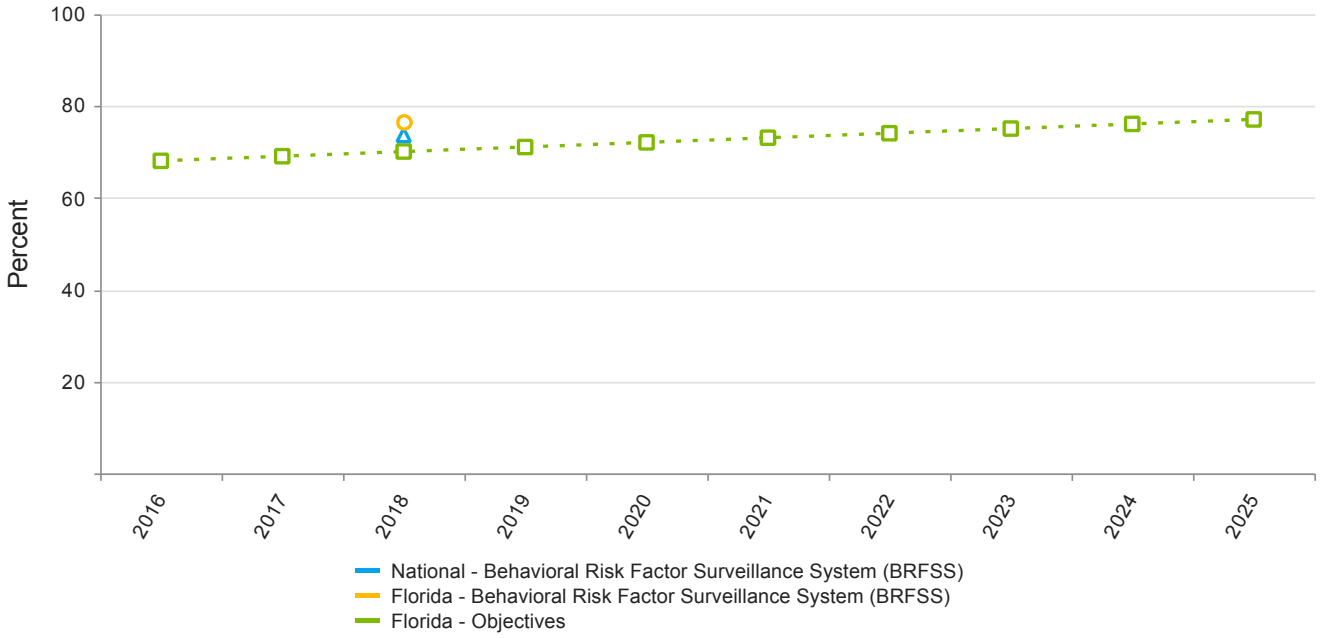
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2017	70.5	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2014_2018	16.7	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2018	8.7 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2018	10.3 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2018	27.5 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	6.5	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	6.1	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	4.1	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	2.0	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	211.5	NPM 1 NPM 14.1
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	101.5	NPM 14.1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS	Data Not Available or Not Reportable	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2017	7.2	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	90.8 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	16.7	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS	Data Not Available or Not Reportable	NPM 1

National Performance Measures

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



Federally Available Data				
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	68	69	70	71
Annual Indicator	68.8	69.6	69.0	76.4
Numerator	2,287,771	2,337,875	2,350,898	2,630,508
Denominator	3,324,933	3,359,251	3,405,087	3,443,178
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	72.0	73.0	74.0	75.0	76.0	77.0

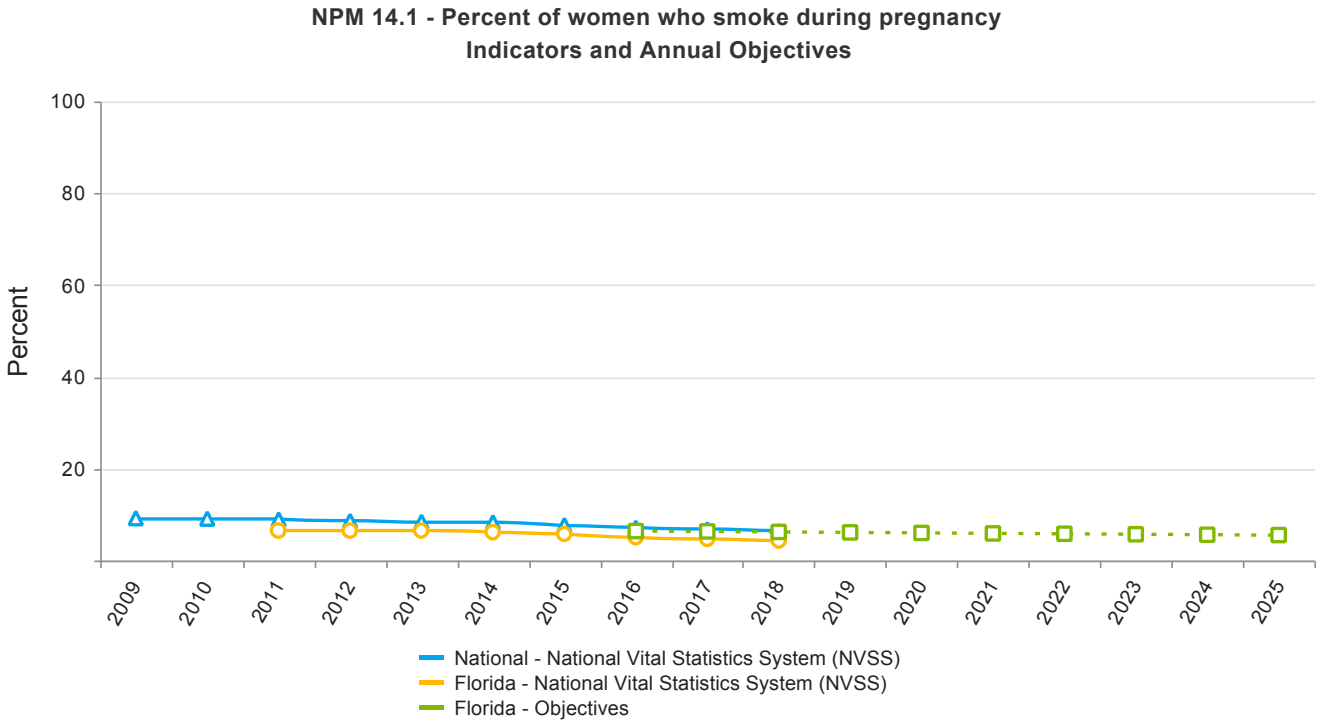
Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		27,000	44,000	44,500
Annual Indicator	25,558	43,507	26,508	54,553
Numerator				
Denominator				
Data Source	Well Family System	Well Family System	Well Family System	Well Family System
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	45,000.0	45,500.0	46,000.0	46,500.0	47,000.0	47,500.0



Federally Available Data				
Data Source: National Vital Statistics System (NVSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	6.5	6.4	6.3	6.2
Annual Indicator	5.8	5.1	4.8	4.5
Numerator	12,970	11,454	10,639	9,836
Denominator	223,231	224,109	221,925	220,538
Data Source	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	6.1	6.0	5.9	5.8	5.7	5.6

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			7,000
Annual Indicator			9,736
Numerator			
Denominator			
Data Source			Well Family System
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	7,250.0	7,500.0	7,750.0	8,000.0	8,250.0	9,800.0

State Action Plan Table

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

Priority Need

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

NPM

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

Objectives

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

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

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

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

5. By Dec. 31, 2021, reduce the rate of late-stage (advanced stage) female breast cancer from 41.3 per 100,000 (2012) to 40.2 per 100,000.

6. By Dec. 31, 2021, reduce invasive cervical cancer from 8.4 per 100,000 (2012) to 8.0 per 100,000.

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

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

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

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

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Priority Need

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

NPM

NPM 14.1 - Percent of women who smoke during pregnancy

Objectives

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

2. By December 31, 2021, decrease the percentage of women who smoked cigarettes in the three months prior to becoming pregnant from 19.1 percent in 2014 (2014 PRAMS Report) to 16.6 percent.

Strategies

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

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

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

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

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

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

In 2018, a total of 23.6 percent of women age 18-44 in Florida did not have a routine checkup (BRFSS). In 2018, a total of 30.9 percent of non-Hispanic white women, 16.4 percent of non-Hispanic black women, and 20.1 percent of Hispanic women did not have a routine checkup in the last year (BRFSS).

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

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

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

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

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

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

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

As women move from childhood into early adulthood, too many women of childbearing age already suffer from chronic conditions or use substances that can adversely affect pregnancy outcomes, leading to miscarriage, infant death, birth defects, or other complications for mothers and infants. According to the 2015 Pregnancy Risk Assessment Monitoring System (PRAMS), among women age 14148 who recently gave birth in Florida, approximately nine percent had asthma, five percent had hypertension, two percent had diabetes, seven percent had depression, 47 percent were overweight or obese, six percent were underweight, and 10 percent smoked before becoming pregnant.

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

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

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

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

Services include:

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

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

The Department uses Title V funding to provide interconception care (ICC), which is not reimbursable by Medicaid, through the Healthy Start program. The ICC services are provided to all women who participate in the program.

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

Since the Department incorporated a Coordinated Intake and Referral (CI&R) system, known as CONNECT, in 2018, ongoing technical assistance meetings have occurred to improve the process. CI&R occurs as part of the Healthy Start

Program and all of Florida's Prenatal Risk Screens and Infant Risk Screens are sent to CONNECT. The Department engages in a continuous quality improvement cycle with stakeholders examine what is going well and what needs improvement.

The Department provided many services to women at local health departments located in each of Florida's 67 counties. Services for women include: family/reproductive health planning; STD and HIV/AIDS screening, prevention, treatment, and control; breast and cervical cancer early detection; immunizations; prenatal care (in 17 counties); health assessments; community education; and other activities.

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

Building on the Duval County pilot project, the Department contracted with the Florida Perinatal Quality Collaborative (FPQC) at the University of South Florida, to implement a LARC quality improvement initiative. The purpose of the initiative was to work collaboratively with maternal health care providers and hospitals to develop and implement policies to improve the use of LARC methods immediately after delivery, to reduce the number of unintended and closely spaced pregnancies. Highly-effective contraception, such as LARCs, can help reduce maternal and infant mortality.

The initiative launched in the fall of 2017, with 10 Florida hospitals and obstetrical and gynecology residency clinics and two hospitals in North Carolina. The LARC Initiative had two phases, the pre-implementation phase and the implementation phase. The pre-implementation phase focused on creating and modifying hospital systems to enable acquisition and reimbursement for immediate postpartum LARC placement. The implementation phase focused on the delivery of the immediate postpartum LARC. The FPQC hosted workshops which offered continuing education units, featured a review of the need for immediate postpartum LARCs, clinical recommendations, a review of the Access LARC toolkit, presentations from participating hospitals on the successes and challenges of the initiative, a review of patient education and counseling materials, and intrauterine device (IUD) insertion training for providers.

By February 2019, 83 percent of participating hospitals added LARC devices to their hospital formularies. The initiative ended in March 2019, with a total of 221 IUDs and 361 implants placed by participating hospitals. FPQC continued to work with hospitals and AHCA after the end of the initiative to resolve any billing and reimbursement issues. FPQC also collaborated with ACOG's PCAI to discuss ongoing support for project expansion and sustainability after the LARC initiative ended.

The Department's MCH Section contracts with the Florida Pregnancy Care Network to implement the Department's Florida Pregnancy Support Services Program. The program is a network of nonprofit pregnancy support centers that provide support and assistance to women, men, and their families faced with difficult pregnancy decisions. Services include free pregnancy tests, peer counseling, and referrals; and most of the centers offer classes on pregnancy, childbirth, parenting, and personal finance management. Funding is provided through the General Appropriations Act through proviso language for Crisis Pregnancy Centers. Over the years, wellness services have been added to the list of services provided to include, but not limited to, smoking cessation counseling, sexually transmitted disease testing, blood pressure screenings, diabetes screenings and pap smears.

This program receives a total of $4,000,000 annually. The Department's MCH Section promotes the availability of the services to the Florida Association of Healthy Start Coalitions and to the county health departments as a referral source. For state fiscal year 2019, the FPSSP served 41,732 women providing 134,886 services.

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

A recurring recommendation from the PAMR team is to stress the importance of a woman receiving education on preconception health and the need to have a medical home to manage chronic disease processes including maintaining optimal weight. An increasing number of maternal deaths are due to substance use disorder and mental health conditions. Florida's PAMR data also notes that non-Hispanic black women are significantly more likely to die from pregnancy complications compared to non-Hispanic white and Hispanic women. Between 2008 and 2018, the pregnancy-related mortality ratio for non-Hispanic black women was significantly higher than for non-Hispanic white and Hispanic women. However, the gap between non-Hispanic black and non-Hispanic white has decreased from 8.7 in 2008 to 2.5 in 2018. In response to issues determined by PAMR, the MCH Section collaborated with the Bureau of Chronic Disease prevention to analyze severe maternal morbidity data that will enable the Department to identify strategies to enhance preventative services for women of reproductive age.

A PAMR Action Subcommittee was formed to develop Urgent Maternal Mortality Messages, guided by the professional recommendations of the PAMR Committee which support initiatives related to preventing maternal deaths in Florida. These messages for providers contain information on risk assessment, counseling, and treatment from preconception through the postpartum and interconception period. Distribution of the messages is accomplished through Florida professional organizations such as ACOG, District XII; American College of Nurse Midwives; FPQC; and others. The messages distributed to providers are on the topics of hemorrhage-placental disorders, peripartum cardiomyopathy, maternal early warning systems and opioid use during pregnancy.

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

- *Collaboration Between Maternal and Child Health and Chronic Disease Epidemiologists to Identify Strategies to Reduce Hypertension-Related Severe Maternal Morbidity. Public Health Research, Practice, and Policy. Volume 16 E162, December 2019.*
- *Florida's Pregnancy-Associated Mortality Review 2018 update*
- *Urgent Maternal Mortality Message (Maternal Early Warning System)*
- *Urgent Maternal Mortality Message (Peripartum Cardiomyopathy)*
- *Urgent Maternal Mortality Message (Placental Disorders-Hemorrhage)*

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

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

Ensure any pregnant woman in a substance use disorder (SUD) program during their pregnancy will be care coordinated in a system of care by a maternal-child home visiting program and by DCF Child Welfare, and will enter the hospital with an initial plan of safe care. These actions will be coordinated with the hospital and Medicaid Managed Care plans as appropriate.

- Ensure any mother in SUD treatment with an infant (under the age of 1) has a plan of safe care and is working the plan including referrals to early intervention.

- Ensure women who give birth to infants who are identified as substance affected, have entry to behavioral health treatment and services and are coordinated with a maternal-child home visiting program, Medicaid Managed Care plans and/or Child Welfare as appropriate.

- Ensure treatment components of the plan of safe care for women entering behavioral health treatment after giving birth to a substance affected infant are implemented and coordinated with a maternal-child home visiting program, Medicaid Managed Care plans and/or Child Welfare as appropriate.

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

Deaths related to substance use accounted for 29.1 percent of all pregnancy-associated deaths in 2018 in Florida, a decrease from 36.0 percent in 2017. Although substance overdose deaths are not typically categorized as pregnancy-related, the PAMR team deemed it necessary to start reviewing and analyzing some of the cases where the death occurs during pregnancy and involves substance abuse. Reviewing these cases allows the PAMR case review team to make recommendations, such as the need for community services and treatment facilities for pregnant women with substance use or abuse problems. A PAMR subcommittee was formed to discuss the relation between substance abuse and mental health, as well as the need to include a mental health discipline on the PAMR case review team.

Florida's Department of Health, AHCA, and the Department of Children and Families joined the Opioid use disorder, Maternal outcomes, Neonatal abstinence syndrome Initiative (OMNI) Learning Community to learn how other states are engaged in a variety of policies and strategies aimed at addressing opioid use disorder. This learning collaborative is being facilitated by the Association of State and Territorial Health Officers (ASTHO).

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

- Contracts with 11 Fetal Infant Mortality Review (FIMR) projects through Healthy Start Coalitions to provide for the implementation of FIMR services to address the behavioral, environmental, and structural processes that may impact fetal and infant deaths, to learn more about why infants die and to propose recommendations for change. These contracts are funded with Title V.

- Contract with the Family Health Line to provide counseling, information, and referrals related to women, pregnant women, and child health issues for all callers in Florida through a toll-free hotline. Services will be consistent with the individual needs of each caller. This contract is funded through Title V.

- Contract with the Ounce of Prevention Fund of Florida to identify, fund, and evaluate innovative prevention programs for at-risk children and families and to raise awareness of maternal and child health initiatives such as Text4baby, safe sleep, and Reach Out and Read campaigns throughout the state, with a focus on television and radio advertisements. This contract was funded through general revenue.

- Contract with the Florida Pregnancy Care Network to establish, implement, and monitor a comprehensive system of care through subcontracts that provide pregnancy support services that solely promote and encourage childbirth to women who suspect or are experiencing unplanned pregnancies. Services will include employability skill training to clients through the *Win at Work* program, a program that addresses work equity. This contract was funded through general revenue.

- Contract with the FPQC to engage perinatal stakeholders to improve maternal and infant health outcomes through design, implementation, and evaluation of processes, and to enhance quality improvement efforts. This contract was funded through Title V.

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

In Florida, 11.9 percent of women reported smoking in 2018 (BRFSS). Smoking during pregnancy increases the risk of miscarriage and certain birth defects such as cleft lip or cleft palate. It can also cause premature birth and low birth weight and is a risk factor for SIDS. Secondhand smoke exposure doubles an infant's risk of SIDS and increases a child's risk of respiratory infections and common ear infections. Children with asthma who are exposed to secondhand smoke are likely to experience more frequent and more severe attacks, which can put their lives in danger.

The MCH Section continues to collaborate with the Bureau of Tobacco Free Florida (BTFF) on the promotion of program services to reduce tobacco use. To advertise the website, the BTFF Media Agency Team uses a mix of digital advertising platforms and social media in addition to traditional broadcast advertising. These digital advertising platforms in 2019 included Google Search Ads, YouTube, Facebook, Twitter, and more, with a spend of $1,194,000. The BTFF Media Agency Team also operated social media communities on Facebook, Instagram, and Twitter. Ads and social media posts in 2019 included videos, images, and messages describing the dangers of smoking and encouraging users to quit.

On Facebook, the BTFF had 119 posts resulting in 404,807 organic impressions and 4,284 engaged users. On Instagram, the BTFF had 51 posts resulting in 19,085 impressions and 326 engagements. There were 657 tweets on Twitter resulting in 722,172 impressions and 9,490 engagements. More than four in five adult smokers in Florida recalled seeing one or more campaign advertisements in 2019. Awareness levels for the campaign exceed the guidelines for exposure for effective media campaigns. The specific advertisements originally created for CDC's *Tips From Former Smokers* campaign and aired in Florida as part of the *Tobacco Free Florida* campaign were most widely recognized among Florida smokers.

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

Women/Maternal Health - Application Year

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

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

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

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

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

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

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

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

The Department will continue to use Title V funding to provide interconception care (ICC) through Florida's Healthy Start Program. In addition, to reach women before their first pregnancy, the Department's MCH Section will be partnering with the Adolescent and Reproductive Health Section to work on a statewide project promoting preconception health targeting the adolescent population.

Title V funding will continue to be provided through Schedule C and a Statement of Work to all 67 county health departments to provide well-woman preventative health visits; prenatal care; education for chronic disease management and prevention

for pregnant women; preconception health counseling; reproductive health services; dental care services for pregnant women and children with an emphasis on children up to age six; and activities that promote access to care, health literacy, community engagement and/or establishment of policies that positively influence social and economic conditions to address the social determinants of health.

The Department will use Title V funding to focus on human trafficking. Populations who are the most vulnerable for becoming victims of human trafficking also have risk factors that increase their chance of a poor pregnancy outcome such as having experienced childhood abuse or neglect, being of a racial and ethnic minority, having a low income, having a history of substance abuse, etc. The Department will be working with LiveStories to create a web based visual communication tool that will present a story of human trafficking and provide current county level data.

The CDC Vital Statistics Online Data Portal (2018) suggests that Florida has the 11th highest stillbirth rate in the country. In 2019, the stillbirth rate in Florida was 6.8 per 1,000 deliveries (FLCHARTS). Women who are black experience stillbirth at twice the rate of the general pregnant population. The Department is planning to use Title V funding to continue implementation of the Count the Kicks campaign. Count the Kicks is a stillbirth prevention campaign that teaches moms to count their babies' movements daily during their third trimester of pregnancy and to call their obstetric provider if they notice a change in what is normal for their baby.

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

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

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

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

MCH Section staff will continue to serve on the core team for the Policy Academy on Pregnant Women with Opioid Use Disorders In-Depth Technical Assistance Project with the National Center for Substance Abuse and Child Welfare. Florida's

Department of Children and Families (DCF) serves as the lead agency as they are the recipient of the SAMHSA grant.

The Department's MCH Section will continue to work with the FPQC on the Neonatal Abstinence Syndrome (NAS) Quality Improvement Initiative. The goal is to develop a standard of care for treating infants born with NAS.

The Department will continue their efforts related to the perinatal mental health grant from HRSA, *The Development of a Sustainable Screening and Treatment Model to Improve Maternal Mental Health Outcomes in Florida*. The purpose of the project is to develop a sustainable screening and treatment model to improve maternal mental outcomes in Florida. Over the five-year grant period the team members will work to achieve the following overarching goals:

- Build capacity in Florida to fully and competently deliver all aspects of screening, referral, engagement, and mental health consultation trainings to all major obstetrics practices and birth hospitals in the targeted region.
- Build and implement a screening and treatment model for maternal mental health in all major prenatal health care practices in the targeted region.
- Develop and implement training program for obstetrics providers on tool use, follow up, and the Massachusetts Child Psychiatry Access Program (MCPAP) model; develop and refine the psychiatric consultation model.
- Initiate and maintain provider participation and engagement in the program.
- Expand mental health and substance abuse referral networks in the regions.
- Increase statewide maternal mental health resources and capacity.
- Increase access to screening, referral, and treatment for women in rural and non-rural areas through telehealth resources.
- Train community mental health providers in evidence-based psychotherapy and management of perinatal mental health disorders.
- Develop and implement a State Data Dashboard System.

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

The Tobacco Free Florida program has spent more than 10 years bringing awareness to the dangers of tobacco, while also providing free resources that have helped tens of thousands of Floridians to quit. The program has made remarkable progress in helping reduce tobacco use across the state. However, when it comes to tobacco use and exposure to secondhand smoke, there are still many geographic and demographic inequalities across our state. Over 2.4 million adults in Florida, 14.5 percent of the adult population, still smoked cigarettes during 2018.

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

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

It is not a coincidence that these disparities in tobacco use exist. The tobacco industry has a long history of heavily

marketing its products to vulnerable populations. There is a higher density of tobacco retailers in communities with higher percentages of blacks, Hispanics, people living below the poverty line, or women older than 25 without a high school diploma.

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

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

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

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

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

As a new component of Florida's Healthy Babies Initiative, the MCH Section will continue to collaborate with the Bureau of Tobacco Free Florida to expand existing tobacco cessation activities and ensure these efforts will continue. The Bureau of Tobacco Free Florida is providing additional funding to county health departments that may be used for staffing, education materials, and training that support cessation objectives.

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

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

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

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

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

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

Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	6.5	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	6.1	NPM 3 NPM 4 NPM 5
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	4.1	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	2.0	NPM 4 NPM 5
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	211.5	NPM 3
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	101.5	NPM 4 NPM 5

National Performance Measures

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
Indicators and Annual Objectives

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2019
Annual Objective	
Annual Indicator	78.9
Numerator	2,737
Denominator	3,469
Data Source	Florida CHARTS
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	79.4	80.0	80.5	81.0	81.6

Evidence-Based or –Informed Strategy Measures

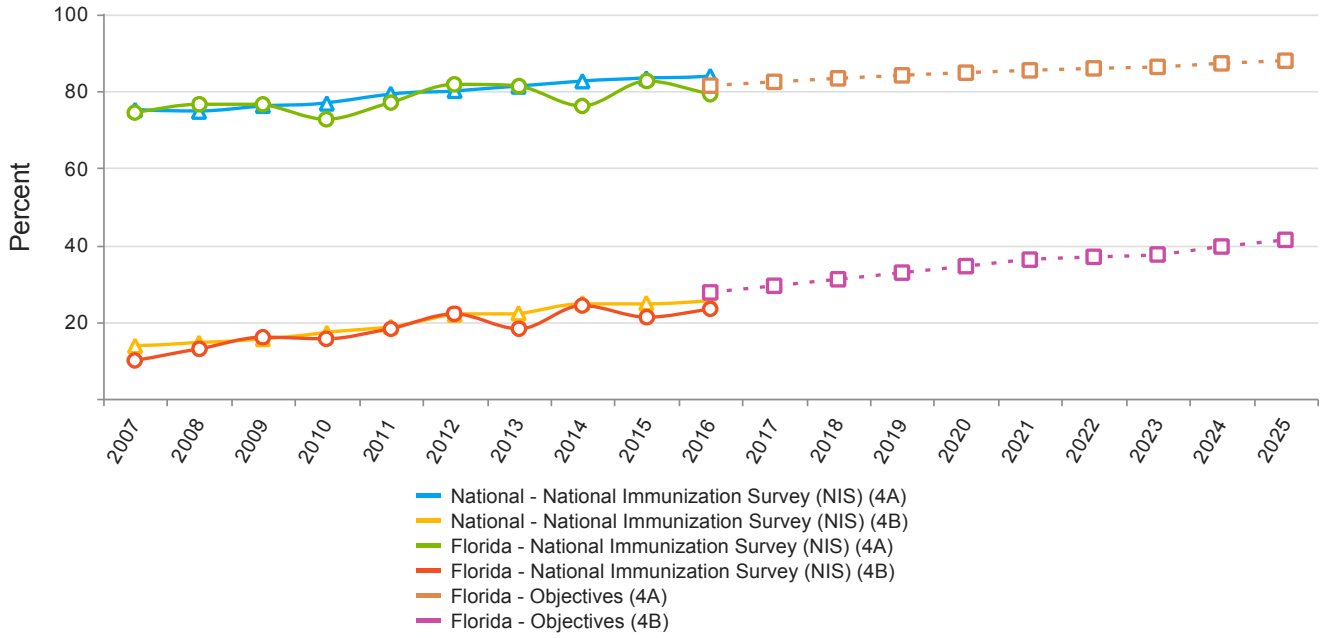
ESM 3.1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	78.9
Numerator	2,737
Denominator	3,469
Data Source	Florida CHARTS
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	79.4	80.0	80.5	81.0	81.6

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



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	81.3	82.3	83.2	84
Annual Indicator	81.1	76.1	82.6	79.2
Numerator	171,099	155,283	190,605	168,560
Denominator	210,888	203,992	230,680	212,751
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	84.7	85.3	85.8	86.2	87.1	87.8

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

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	27.7	29.4	31.1	32.8
Annual Indicator	18.4	24.3	21.3	23.4
Numerator	37,940	49,156	47,798	48,426
Denominator	206,047	201,974	224,023	206,578
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	34.5	36.2	36.9	37.5	39.6	41.3

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			19
Annual Indicator			26
Numerator			
Denominator			
Data Source			Baby-Friendly USA
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	20.0	21.0	22.0	23.0	24.0	30.0

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

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data				
	2016	2017	2018	2019
Annual Objective	78.3	73.3	74.5	75.4
Annual Indicator	69.5	74	74	74
Numerator				
Denominator				
Data Source	FL PRAMS Data	FL PRAMS Data	FL PRAMS	FL PRAMS
Data Source Year	2014	2015	2015	2015
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	76.3	77.1	77.9	78.9	79.8	80.9

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data			
	2017	2018	2019
Annual Objective			82
Annual Indicator	78	78	78
Numerator			
Denominator			
Data Source	FL PRAMS Data	FL PRAMS Data	FL PRAMS
Data Source Year	2015	2015	2015
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	83.0	84.0	85.0	86.0	87.0	88.0

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data			
	2017	2018	2019
Annual Objective			62
Annual Indicator	60	60	60
Numerator			
Denominator			
Data Source	FL PRAMS Data	FL PRAMS	FL PRAMS
Data Source Year	2015	2015	2015
Provisional or Final ?	Provisional	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	63.0	64.0	65.0	66.0	67.0	68.0

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - The number of birthing hospitals that are Safe Sleep Certified

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			17
Annual Indicator			10
Numerator			
Denominator			
Data Source			Cribs for Kids
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	19.0	21.0	23.0	25.0	27.0	28.0

State Action Plan Table

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

Priority Need

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

NPM

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

Objectives

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

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

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

Strategies

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

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

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

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

4. Support the FPQC in future breastfeeding initiatives.

ESMs	Status
ESM 4.1 - The number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation.	Active

NOMs

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

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

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

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

Priority Need

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

NPM

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Objectives

To increase the number of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU).

Strategies

Contract with the Florida Perinatal Quality Collaborative (FPQC) to implement the self-designated and verified maternal and newborn hospital level of care project.

Contract with the FPQC for the monitoring maternal health care quality project.

Promote the current regional perinatal intensive care centers program.

Implement the My Birth Matters Campaign to help educate pregnant women and birthing people of all backgrounds about a woman's birthing options.

Participate in the Agency for Healthcare Administration's Birth outcomes workgroup.

Continue quarterly pregnancy associated mortality review committee meetings to review maternal mortality and morbidity and make recommendations for system change.

ESMs	Status
ESM 3.1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	Active

NOMs

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

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

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

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

State Action Plan Table (Florida) - Perinatal/Infant Health - Entry 3

Priority Need

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

NPM

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

Objectives

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

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

Strategies

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

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

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

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

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

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

ESMs	Status
ESM 5.1 - The number of birthing hospitals that are Safe Sleep Certified	Active

NOMs

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

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

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

Safe infant sleep and breastfeeding are significant protective factors against infant mortality. From 2010-2019, breastfeeding initiation, for all races, increased from 80.1 percent to 86 percent. During this period, the gap between the breastfeeding percentages for non-Hispanic black and white infants decreased. However, the breastfeeding initiation percentages for non-Hispanic black infants are still the lowest of the racial/ethnic groups examined. In 2019 the percentage was 76.3 percent for non-Hispanic black, 86.4 percent for non-Hispanic white, and 90.3 percent for Hispanic infants. According to the CDC as of August 2020, the 2017 percentage of exclusive breastfeeding at three months in Florida (41.1 percent) is lower than in the nation (46.9 percent).

In Florida, sudden and unexpected infant death (SUID) consistently ranks in the top four leading causes of post-neonatal infant death. In 2019, the rate was approximately one SUID per 1,000 live births in Florida for all racial and ethnic groups. However, non-Hispanic black infants experience rates that are consistently two times higher than the rates among other ethnic groups. From 2017-2019, most of SUID-related cases were due to unintentional injuries from suffocation or strangulation in bed (n=247 cases), with highest rates among non-Hispanic black infants.

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

Florida's WIC Program provides peer counseling and breastfeeding support to women who qualify for WIC. The Department plans to explore alternative breastfeeding support options for women who need breastfeeding support and do not qualify for WIC.

Florida began the development of the Florida Safe Sleep Hospital Certification Project, a partnership with county health departments to recruit birthing hospitals to complete the requirements needed to achieve Safe Sleep Certification from the Cribs for Kids Organization. Six county health departments are assisting participating hospitals to train hospital staff who may not always provide current information or model correct safe sleep practices to their patients. Hospitals are also working on developing a Safe Sleep policy, submitting an annual report on educational activities and staff compliance, and assessing whether proposed activities address disparities.

To help reduce SUID-related deaths, the American Academy of Pediatrics (AAP) most recently published updated safe sleep recommendations in 2016 promoting supine positioning, room-sharing, no bed sharing, and breastfeeding among others. Health care providers and community partners, such as Healthy Start staff, are positioned to educate infant caregivers on these recommendations during direct interactions. Little is known about whether health care providers and community partners in Florida are following the updated 2016 AAP recommendations and if their practices differ. The Department designed the Florida Health Professionals Survey to assess safe sleep educational practices of health professionals to share with key partner organizations. We received 260 completed surveys. We found that, overall, health professionals discussed AAP recommendations with their patients/clients; however, consistency can be improved. Practice differences between health care providers and community partners were few.

The Department is participating in the National Institute for Children's Health Quality's (NICHQ) five-year project, "National Action Partnership to Promote Safe Sleep Improvement and Innovation Network (NAPPSS-INN): Making Safe Infant Sleep and Breastfeeding a National Norm." In our role, we analyzed data to identify birthing hospitals that could have the greatest impact on improving breastfeeding and safe sleep behaviors and invited them to participate. After interested hospitals

completed competitive applications, one birthing hospital participated in the first phase of the project and another hospital in the second phase. We also built Florida's Community of Practice roster of leaders from public and private sectors in the state. The group included members from the Executive Office of the Governor, March of Dimes, the Florida Perinatal Quality Collaborative, the Florida SIDS Alliance, and the American College of Obstetrics & Gynecology. Under our leadership, we completed an asset map and SMART objectives for the group to follow in their respective work.

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

Multiple safe sleep programs in Florida communities provided safe sleep information, cribs, and infant onesies with safe sleep messages this past year. Healthy Start Coalitions in partnership with Cribs for Kids provided portable cribs with a standardized education component focusing on the risks associated with unsafe sleep practices and a safe sleep environment checklist was completed with each crib recipient.

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

The Department contracted with the FPQC to develop and implement a breastfeeding project, Mother's Own Milk (MOM), in Florida's NICUs. The project is a hospital-based quality improvement initiative designed to promote best practices related to providing breast milk, especially to Florida's most vulnerable very low birthweight (VLBW) infants. The initial phase of the MOM initiative was completed in June 2018 and a sustainability phase started in July 2018 and ended in June 2019.

A total of 25 Florida hospital NICUs participated in the initial MOM project. With support from the Department and Title V funding, FPQC assisted hospitals that participated in the MOM Initiative to implement the following key practice interventions:

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

FPQC monitored the following outcome measures from hospitals that participated in the MOM Initiative:

- Intent to provide mother's own milk.

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

The final MOM data report showed that 100 percent of mothers of VLBW infants expressed the intent to provide their own breastmilk and 93 percent of those mothers received an assessment from a lactation consultant within 24 hours of the NICU admission. FPQC received feedback from hospitals wanting to extend the initiative to improve their outcome measures. In July 2018, with support from the Department, FPQC started a sustainability phase of the MOM Initiative to allow hospitals to continue their efforts of providing the mother's own milk to VLBW infants. Thirteen of the original 25 hospitals participated in MOM sustainability. In addition to providing regular educational opportunities through webinars for the hospitals participating in MOM sustainability, FPQC provided technical assistance to hospitals when requested. MOM sustainability completed with participating NICUs on average sustaining their breastfeeding measure by initiative end, with 71 percent of infants having more than half of their feeding volume comprising of MOM by day 14 of life.

The Baby Steps to Baby Friendly (BSBF) Project, a past component of Florida's Healthy Babies Initiative, has motivated and incentivized hospitals in Florida to improve maternity care breastfeeding practices and policies and achieve recognition. Currently, there are 26 hospitals with the Baby Friendly designation in Florida.

Florida's Enhanced Breastfeeding Project is addressing health inequities to mitigate breastfeeding disparities among vulnerable populations including rural, minority, and low socioeconomic communities. There are several county health departments implementing two to three evidenced-based strategies within their local communities as part of the project. Qualitative review of hospital success stories and anecdotal evidence have shown that the BSBF project has also served as a catalyst for community engagement. New breastfeeding support groups in rural areas and local breastfeeding coalitions have been established as a result of the project.

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

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

Data from the 2015 Florida Pregnancy Risk Assessment Monitoring System (PRAMS) show that the percent of Florida women who initiate breastfeeding is higher, at 88.7 percent, than the Healthy People 2020 goal of 81.9 percent. However, duration drops quickly to 78.1 percent at 4+ weeks and to 58.0 percent at 12+ weeks. This survey is a valuable tool for recognizing trends and identifying a focus for breastfeeding promotion efforts. Survey data can be found at: http://www.floridahealth.gov/statistics-and-data/survey-data/pregnancy-risk-assessment-monitoring-system/

Perinatal/Infant Health - Application Year

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

The Department will continue efforts to target the most vulnerable infants in our state by aiming to increase the number of VLBW infants who receive breast milk. Title V funds will continue to support the FPQCs sustainability phase of the hospital-based quality improvement project, the Mother's Own Milk (MOM) Initiative, by promoting-evidence-based interventions to increase the use of breast milk for VLBW infants in Florida's NICUs. Thirteen of the original 25 hospitals signed up to participate in the sustainability phase of the project. FPQC has developed a technical assistance plan, that includes phone conferences, webinars, and site visits, for participating hospitals. The sustainability phase will allow the FPQC, with support from the Department, to continue providing encouragement and guidance so that hospitals can increase their level of preparedness to support and promote the use of breastmilk for infants in the NICU.

To enhance our reach to the African-American community, we are designing a safe infant sleep and breastfeeding education toolkit for African-American Greek Organizations (sororities and fraternities) to share during their outreach community activities. The toolkit includes the official AAP recommendations, data-related content on safe sleep and breastfeeding, developing partnerships with other organizations, event ideas, and tips on evaluating the effectiveness of their community event.

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

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

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

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

The Department will research implementing the breastfeeding support program Pacify. Pacify's telelactation services empower women to connect with International Board-Certified Lactation Consultants (IBCLCs) through two-way video on personal devices such as smartphones and tablets. Live video support from IBCLCs is available 24/7, in English and Spanish, through the Pacify mobile application. Increasing access to IBCLCs is an evidence-based strategy for increasing

rates of breastfeeding, and the provision of telelactation services have effectively improved outcomes in several public health programs

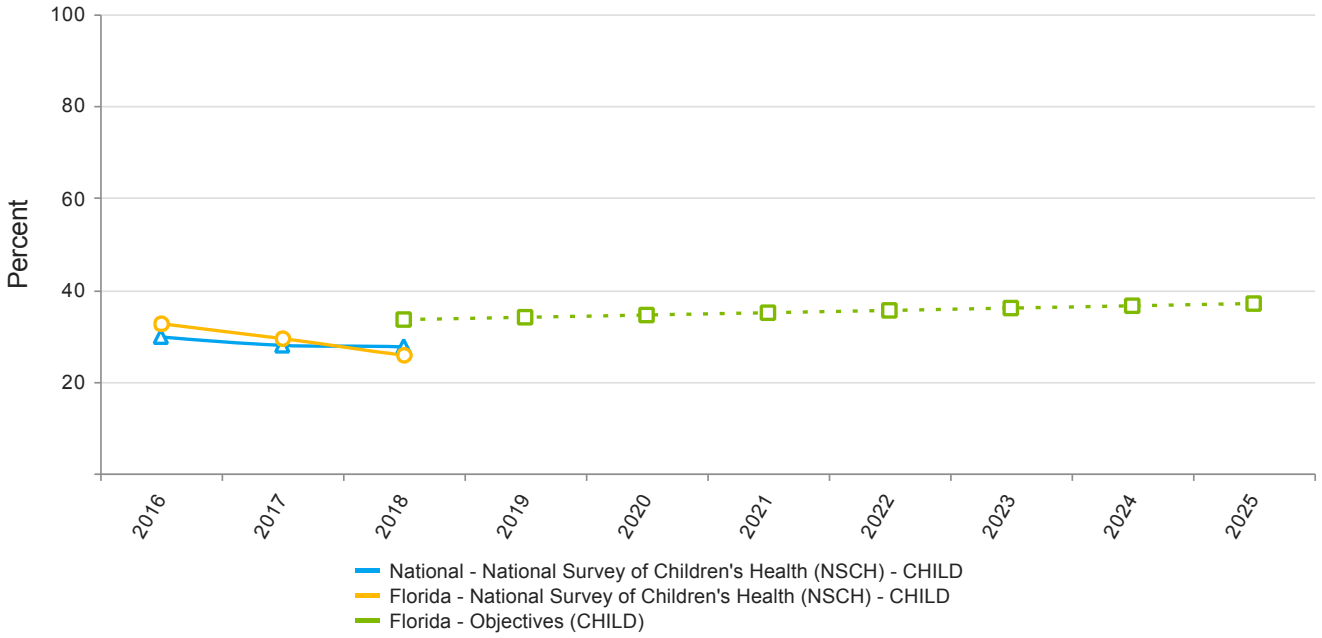
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	90.8 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2017_2018	17.8 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2016	12.7 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2017	10.9 %	NPM 8.1

National Performance Measures

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



Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CHILD				
	2016	**2017**	**2018**	**2019**
Annual Objective			33.5	34
Annual Indicator		32.5	29.4	25.8
Numerator		428,914	394,477	364,148
Denominator		1,321,058	1,341,890	1,409,470
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018

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

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	34.5	35.0	35.5	36.0	36.5	37.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			54
Annual Indicator			49
Numerator			
Denominator			
Data Source			Safe and Healthy Schools Florida
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	55.0	56.0	57.0	58.0	59.0	60.0

State Performance Measures

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

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		37.4	38.9	40.4
Annual Indicator	35.9	37.4	38.5	48.7
Numerator	986,425	1,037,798	1,045,121	755,818
Denominator	2,745,598	2,774,485	2,716,229	1,551,734
Data Source	Florida Agency for Health Care Administration	Florida Agency for Health Care Administration	Florida Agency for Health Care Administration	Florida Agency for Health Care Administration
Data Source Year	2016	2017	2018	2017/2018
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	41.9	43.4	44.9	46.4	47.9	49.4

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

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		45.1	34.7	35.2
Annual Indicator	42.6	34.2	32.9	32.1
Numerator	545,146	435,455	396,388	384,878
Denominator	1,279,782	1,273,260	1,204,876	1,198,761
Data Source	2011-12 National Survey of Children's Health	2016 National Survey of Child Health	2016 National Survey of Child Health	2017-18 National Survey of Child Health
Data Source Year	2011-2012	2016	2016-2017	2017-2018
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	35.7	36.2	36.7	37.2	37.7	38.2

State Action Plan Table

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

Priority Need

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

NPM

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

Objectives

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

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

3. By June 30, 2020, increase the number of Florida counties where registered school nurses are implementing Healthy Lifestyle Interventions based on the 5210 programs from eight counties to four. The 5210 program is based on five servings of fruits and vegetables, less than two hours of recreational screen time, one hour or more of physical activity and zero sweetened drinks per day.

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

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

Strategies

1. Promote/educate county school health programs about the use of the Healthy Lifestyle Intervention Individualized Healthcare Plan and coding this service data in the Department's Health Management System. Promote the Intervention on at least one School Health Services Program statewide conference call and during county School Health Program on-site monitoring meetings conducted by school health liaisons during the 2020–21 school year.

2. Promote/educate county school health programs on the requirements, application process, and benefits of becoming a Florida Healthy District on at least one School Health Services Program statewide conference call and during county school program onsite monitoring meetings conducted by school health liaisons during the 2020–21 school year.

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

4. Promote the Center for Disease Control and Prevention's Whole School, Whole Community, Whole Child approach by educating county school health programs on strategies to expand school health advisory committee representation, including student/parent involvement, on at least one School Health Services Program statewide conference call and during county school health program on-site monitoring meetings conducted by school health liaisons during the 2020–21 school year.

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

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

NOMs

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

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

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

Priority Need

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

SPM

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

Objectives

1. By June 30, 2021 increase the number of low-income children under age 21 receiving a preventive dental service from a school-based sealant program from 146,535 children (SFY 2018-2019) to 153,862 children, an increase of 5 percent.

2. By September 30, 2021, increase the number of school-based sealant programs (internal or external) completing annual reports in FLOSS from 48 programs (SFY 2018-2019) to 54 programs.

3. By June 30, 2021, increase the number of schools reached by school-based sealant programs (internal or external) from 943 schools (SFY 2018-2019) to 990 schools, an increase of 5 percent.

Strategies

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

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

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

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

Priority Need

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

SPM

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

Objectives

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

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

Strategies

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

Child Health - Annual Report

In 2018-19, Florida's pre-kindergarten through 12th grade student population numbered over 2.8 million students, residing in 67 counties that are geographically, socioeconomically and culturally diverse. Among this student population, there were 747,535 reported student health conditions, which included life-threatening allergies (32,465), asthma (143,983), cardiac conditions (10,998), diabetes (9,444), mental health conditions (27,648) and seizure disorders (18,740). Body mass index (BMI) screening results indicated that 366,996 (60.78 percent) of students were at a healthy weight, whereas 211,743 (35.07 percent) had results at or above the 85th percentile (overweight and obese categories).

The Department's School Health Program continued its statewide leadership to ensure the provision of health services and health education to children in all of Florida's public and participating non-public schools. The program provided oversight and technical assistance to all 67 county School Health Programs, including county health departments, local education agencies, and their community partners, pursuant to Florida Statutes and Administrative Code.

Local county health departments, in collaboration with local education agencies and community partners, worked to ensure Florida's pre-kindergarten through 12th grade students had access to health services that assess, protect, and promote their health and ability to achieve their individual potential. During 2018-2019, the School Health Program performed 37 on-site programmatic monitoring visits, two vision service provider contract monitoring visits, and conducted four statewide programmatic conference calls.

The Department and the Florida Department of Education (DOE) partnered and promoted implementation of the Coordinated School Health approach in Florida public schools. The Bureau of Chronic Disease Prevention worked with DOE's Office of Healthy Schools to support the Florida Partnership for Healthy Schools Healthy School District self-assessment and recognition program. As part of this collaboration, the School Health Program reviewed and scored the health services section of each county's application. The Department and DOE's Bureau of Exceptional Education and Student Services collaborated on school entry immunization compliance activities and began planning for the development of an online training portal for registered school nurse trainings with continuing education that launched in 2019.

In addition, the School Health Program continued to develop partnerships with the Florida School Health Association and the Florida Association of School Nurses and presented programmatic updates at their 2018 annual conferences. Also, the program continued its commitment to support the National Association of School Nurses (NASN) initiative, Every Student Counts, by preparing 2018-2019 state-level data for a national standardized minimum dataset of key school health indicators.

Each year, the State Office's School Health Services Program participates in monthly Walking School Bus events. During Walking School Bus events, adult volunteers ensure the safety of Florida students (kindergarten-12th grade) by walking them to school. This activity helps promote physical activity and wellness for students and Department staff alike.

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

Dental caries (tooth decay) remain the most common preventable chronic infectious disease among young children and adolescents in the United States. Dental caries are five times more common than asthma. Nationally in 2016-2017, approximately 45.8 percent of youth ages 2-19 had dental caries (untreated and treated decay) in their primary or permanent teeth. Among children ages 6-11, approximately 50.5 percent had dental caries and 15.3 percent had untreated decay, with rates for black and Hispanic children being higher than for white and Asian children. If dental decay is left untreated, it can

cause pain and infection leading to problems with chewing, swallowing, speaking, and learning. These problems jeopardize children's physical growth, self-esteem, and capacity to socialize.

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

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

Oral health data is needed for ongoing surveillance, establishing the burden of oral health disease, and informing statewide programmatic planning efforts. To address the need for state level oral health surveillance data, the Department's Public Health Dental Program (PHDP) has established a surveillance system for monitoring oral health status, risk factors, and access to dental services among various populations. The PHDP has completed surveillance projects on third grade children (2013-2014 and 2016-2017), Early Head Start and Head Start children (2014-2015 and 2017-2018), and older adults in congregate meal sites (2015-2016). In addition, PHDP worked with the Florida Dental Hygienists' Association to evaluate previous surveillance projects among children using Title V to enhance the upcoming 2021-2022 Third Grade Project.

Title V supported the continued development and enhancement of the Public Health Dental Program's Florida's Linked Oral Status System (FLOSS) Database. The two newest modules include the School-Based Sealant Program Module and the Oral Health Surveillance Module. The School-Based Sealant Program Module is used by all agencies and programs providing services at schools in Florida to enter aggregate data and information regarding their local School-Based Sealant Programs on a yearly basis. The PHDP has collected data on the number of children served, schools visited, services provided, and other programmatic information during the 2016-2017, 2017-2018, and 2018-2019 school years. The system is accessible by both the Department internal and non-Department external partners and serves as the true statewide data warehouse for important public health dental measures for children. The Oral Health Surveillance Module is used to collect and validate data using the Basic Screening Survey Methodology developed by the Association of State and Territorial Dental Directors, for populations such as preschool and school age children. The 2017-2018 Head Start Oral Health Screening Project used this new module for the first time to collect oral health indicators and consent form questions entered by dental hygienist screeners in the field and then validated against paper records by PHDP staff. The PHDP will use the Oral Health Surveillance Module for the upcoming third grade and adolescent screening projects. Using the FLOSS database for this data collection and validation has reduced data entry errors and improved overall data quality. During SFY 2019-2020, Title V funding has continued to support the development of the FLOSS database to improve functionality, enhance data quality and accuracy, and meet the dynamic business needs of the PHDP and FLOSS users.

The Department's Public Health Dental Program has analyzed the 2017-2018 Head Start surveillance data and a report with the full results will be disseminated to our partners and the public.

Preliminary Key Findings:

- Nearly one in four Head Start children aged 3-6 years (24.0%) had untreated decay
    - Non-Hispanic Black children (28.3%) had the highest prevalence of untreated decay.
- Approximately one third of Head Start children (34.3%) had dental caries (treated or untreated decay).
    - Children aged 5 years had the highest rate of dental caries experience (41.9%).
- One in five of Head Start children (20.8%) had an early dental treatment need.
- Approximately 3.1% of Head Start children had an urgent dental treatment need.

Florida's overall Head Start population estimates are above the Healthy People 2020 goals related to the prevalence of untreated decay and dental caries among children ages 3-5 years. (Table 1). The oral health screenings did not capture dental sealants among Florida's Head Start children because they do not have molars to be sealed.

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

Oral Health Indicator	Florida's Status 2017-2018	National Target for Children Age 3-5 Based on Healthy People 2020 Goals
Dental Caries Experience	34.3%	30.0%
Untreated Dental Decay	24.0%	21.4%
Dental Sealants	---	1.5%

The Department works to make continued progress to improve access to preventive dental care for children in Florida. Title V funding has been provided to county health departments through Schedule C to initiate and expand the provision of preventive services for children in Early Head Start, Head Start, Women Infant and Children (WIC), Early Learning Centers, and schools throughout Florida. Continued collaborative partnerships with School-Based Sealant programs to share information on evidence-based prevention and early intervention practices facilitates the promotion of oral disease prevention efforts starting in young children.

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

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

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

Child Health - Application Year

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

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

The School Health Services program was awarded a one-million-dollar grant for the 2020-2021 school year under the Substance Abuse and Mental Health Services Administration to implement evidence trauma based mental health training in schools affected by Hurricane Michael including the counties: Jackson, Calhoun, Liberty, Bay, Gulf and Gadsden. The School Health Services Program will work with the National Center for School Mental Health at the College of Medicine of the University of Maryland to implement the evidence-based curriculum. The effectiveness of the training will be evaluated by the SHAPE system, a program developed by the National Center for School Mental Health to determine the effectiveness of mental health services in schools.

The Department's School Health Services Program will continue to develop collaborative partnerships with the Florida Department of Education (DOE) Office of Healthy Schools, DOE Office of Safe Schools, Bureau of Exceptional Education and Student Services (BEESS), Florida Partnership for Healthy Schools. These partnerships promote implementation of the CDC's Whole School, Whole Community, Whole Child (WSCC) model in Florida's school districts and provide professional development for registered school nurses. The WSCC model is an evidence-based approach to advance the development of state, district, and school infrastructures which promote and maintain health and wellness for students, families, communities and school staff, and support student academic achievement. The School Health Advisory Committee (SHAC), a statutory requirement for each county School Health Program, is an important vehicle for counties to develop their WSCC models. However, gaining and maintaining SHAC representation from all 10 components of the WSCC model is an ongoing challenge for most county School Health Programs. The School Health Program will continue to address this need offering SHAC related updates and SHAC development content during its 2019-20 monthly conference calls. Also, SHAC development will continue to be a primary focus of school health liaisons during on-site program monitoring meetings with county School Health Program staff.

The School Health Services Program will work with DOE to advance the Partnership's Florida Healthy School District self-assessment and recognition program. In addition, the School Health Program will educate county school health programs on the requirements, application process and benefits of becoming a Florida Healthy District on at least one programmatic statewide conference call and during county School Health Services Program on-site program monitoring meetings during the 2019–20 school year. These activities will support Objective 3 to increase the number of Florida school districts that apply for recognition as a Florida Healthy District for the 2019-2021 application period.

The Florida Healthy School District Self-Assessment Tool was developed by experts from state agencies, school districts and community partners to assist school districts achieve the highest standards related to the CDC's Coordinated School Health and WSCC models, based on district infrastructure, policy, programs, and practices identified from national and

state guidelines, best practices and Florida Statutes. This planning tool helps school districts assess and determine current status and what they could do to remove health-related barriers to learning as they work towards recognition as a Florida Healthy District. Districts are encouraged to include school superintendents, school boards, school administrators, school nurses, component area experts, parents, and the SHAC in the assessment process.

The School Health Services Program will promote school nurses' use of the Healthy Lifestyle Intervention by educating county School Health Programs about the Healthy Lifestyle Individualized Healthcare Plan and coding this service in the Department's data system. This training will be provided on at least one programmatic statewide conference call and will be a focus of liaisons' on-site program monitoring meetings with county School Health Program staff during the 2019–20 school year. These activities will support Objectives 1 and 2.

Challenges:

- Florida's registered school nurse to student ratio is 1 to 2,449 (2018-2019); whereas the National Association of School Nurses (NASN), American Academy of Pediatrics and American Academy of Nursing recommend one professional registered school nurse for every school, all day, every day. Inadequate registered nursing staff limits the ability to organize and conduct health education classes, wellness promotion activities and additional registered nursing services such as Healthy Lifestyle Interventions.
- Over a ten-year period (2008-2018) reported chronic and complex conditions among pre-kindergarten through 12th grade students increased 38.11 percent (from 552,878 to 763,588).
- There are an estimated 282,464 children or 6.6 percent of Florida's children under the age of 19 uninsured according to the United States Census Bureau Small Area Health Insurance Estimates (2016). For many students, the registered school nurse is the only licensed healthcare professional to which they have access, including for clinical guidance and support to practice a healthy lifestyle.
- The shift in community primary care services from county health departments to other healthcare providers, such as federally qualified health centers, presents challenges to ensuring students in need of follow-up care receive necessary services.
- School district prioritization of academic and standardized testing schedules presents ongoing challenges to including student health promotion activities during the school day, such as health education and additional initiatives to increase student physical activity.

Title V funding has been consistently used to establish new School-Based Sealant Programs (S-BSPs) in Florida. These evidence-based programs increase access and reduce barriers to preventive dental care for low-income children in Title I schools, Early Head Start (EHS), Head Start (HS), Early Learning Coalition (ELC) centers, and Women Infant and Child (WIC) sites. For the first time during SFY 2018-2019, in addition to initiating programs the Department used Title V funding to expand existing sustainable S-BSPs. This resulted in providing funding for the expansion of S-BSPs in ten counties with high unmet needs due to a lack of dental providers, transportation barriers, low social economic factors influencing access to care and one new program. These expansion counties were Citrus, DeSoto, Flagler, Jackson, Martin, Okeechobee, Pasco, St. Lucie, Volusia, and Walton while the new program was established in Lake county. These S-BSPs provided preventive services to children in EHS, HS, WIC and ELC children. Final data reveal the eleven counties funded by Title V provided services to 28,287 children including 32,269 screenings/assessments, 55,346 dental sealants, 26,960 fluoride varnish applications, and 33,855 oral health instructions during SFY 2018-2019. For SFY 2019-2020, Title V funded twelve counties to expand their programs to reach additional schools and children. These counties were Bay, Calhoun/Liberty, Charlotte, Clay, Hendry/Glades, Highlands, Jackson, Nassau, Orange, Polk, Wakulla and Walton. Title V funding will continue to fund the expansion of existing programs for SFY 2020-2021. It is anticipated that eight existing programs will receive funding during SFY 2020-2021.

To promote S-BSPs to children and increase positive consent rates from parents, the PHDP produced and disseminated a postcard explaining dental sealants and their effectiveness in preventing tooth decay to each of the new programs, utilizing Title V funding. The postcards incorporate best practices for health literacy and implementation of healthy oral health

behaviors in second and third grade children, the target population of the S-BSPs. The postcard encourages discussion of improved oral hygiene, specifically the benefits of dental sealants, between teachers, children and their parents or guardians. Along with the postcard, the PHDP purchased educational workbooks which align with statewide tests. These workbooks provide education on maintaining good oral health and encourage the discussion with parents on promoting oral hygiene in the home. The PHDP will continue to provide Florida S-BSPs with quality improvement and assurance guidance, technical assistance and training to ensure local program efficiencies and increased capacity of children served through these programs.

The PHDP will continue to partner with other state agencies and not-for-profit organizations, such as Oral Health Florida, to plan and implement programs to benefit the oral health needs of children and families. The PHDP actively participates on various Oral Health Florida action teams (committees) and the leadership council, to support initiatives to increase oral health services for children and families in Florida. In 2018 the PHDP received the Centers for Disease Control and Prevention's State Actions to Improve Oral Health Outcomes 5-year grant in support of oral health promotion and disease control. As part of the grant, the PHDP has partnered with Oral Health Florida's School Health Action Team to establish a Sealant Work Group for improving the sustainability of S-BSPs. The Sealant Work Group will address the quality of S-BSP services by facilitating meetings and conducting regional trainings to assist S-BSPs with improving their sustainability and increasing the number of children served and preventive services provided. Working with county health department dental programs, federally qualified health centers, and local oral health coalitions across the state, preventive services will continue to be provided to low income children in Title I Schools, EHS, HS, ELC, and WIC sites. Providing services to children in school settings eliminates many barriers that impact access to dental care. S-BSPs are supported and enhanced by Title V funding and make it possible to reach high-risk children in need of dental services and improve dental outcomes for children in the state.

During the coming year, the PHDP will continue to increase statewide data capacity and serve as the state's S-BSP data warehouse across all agencies through the FLOSS Database. Participation in the FLOSS database, especially for outside entities, will be encouraged through the Sealant Work Group of Oral Health Florida's School Health Action Team. In addition, the PHDP is in the planning phase of the 2021-2022 Third Grade Oral Screening Project, which will collect data using FLOSS.

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

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

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

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

the economy.

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

Nationally there is growing interest to address the sources of family adversity, which have the potential to promote long-term positive outcomes by producing positive changes in family income, environment, stress, and relationships. Research cites “cliff effects” as a particularly problematic disincentive associated with many work support policies. Cliff effects penalize households financially for progressing beyond income thresholds of work support eligibility.
There are systemic barriers that hinder a family’s ability to become economically self-sufficient and by strategically aligning systems of care, there is the opportunity to ensure that all children live in stable and nurturing environments.

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

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

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

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

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

Research is clear that poverty is the single greatest threat to children’s development and overall well-being. In 2017, 52 percent of children in Florida resided in low-income households with a parent employed full-time compared to 53 percent in the nation. Poverty greatly impedes children’s ability to learn and contributes to social, emotional, and behavioral problems. Poverty also can contribute to poor physical and mental health.

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

As part of the solution to address this issue, the Department is participating in AMCHP’s Infant Mortality CoIIN SDOH project.

Increasing Health Equity capacity in the public health workforce and integrating health equity principles and frameworks into policies and programs is a priority of the Department. Key maternal and child health outcomes and risk factors are heavily influenced by health inequities and the social determinants of health, which requires public health efforts to go beyond traditional services and interventions to impact change in populations affected by disparate health outcomes. To effectively address existing health inequities in Florida, public health agencies and organizations will need to first deliver learning opportunities to the public health workforce to increase individual professional competencies and increase organizational capacity to advance health equity. To then integrate health equity into the public health system and communities requires incorporating elements of health equity into policies and programs that impact maternal and child health populations. Our participation will help the Department establish a process for formally assessing MCH policies and programs from a healthy equity perspective by December 31, 2020.

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

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

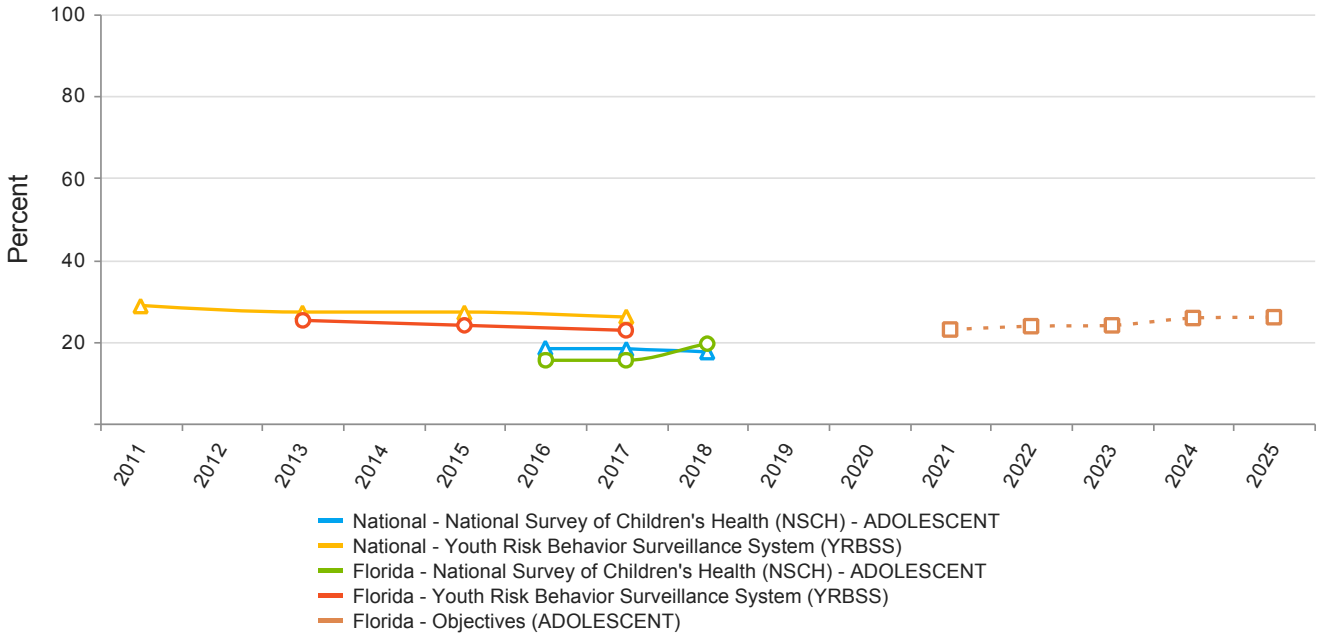
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2018	30.7	NPM 9
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2016_2018	9.0	NPM 9
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	90.8 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2017_2018	17.8 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2016	12.7 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2017	10.9 %	NPM 8.2

National Performance Measures

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2019
Annual Objective	
Annual Indicator	22.8
Numerator	181,534
Denominator	796,158
Data Source	YRBSS-ADOLESCENT
Data Source Year	2017

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT	
	2019
Annual Objective	
Annual Indicator	19.5
Numerator	290,239
Denominator	1,491,681
Data Source	NSCH-ADOLESCENT
Data Source Year	2017_2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	23.0	23.8	24.0	25.8	26.0

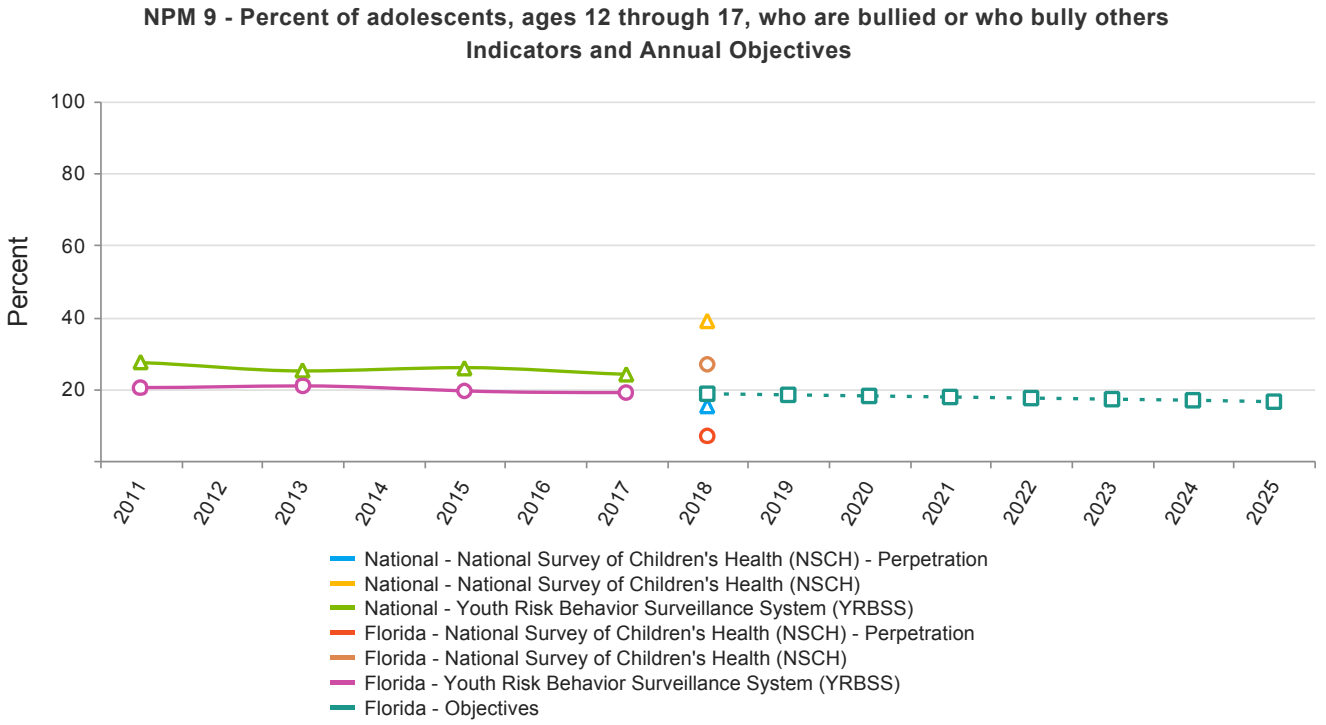
Evidence-Based or –Informed Strategy Measures

ESM 8.2.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	49
Numerator	
Denominator	
Data Source	Safe and Healthy Schools Florida
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	56.0	57.0	58.0	59.0	60.0



Federally Available Data				
Data Source: Youth Risk Behavior Surveillance System (YRBSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	20.2	19	18.7	18.4
Annual Indicator	19.5	19.5	18.9	18.9
Numerator	150,914	150,914	156,700	156,700
Denominator	772,407	772,407	827,044	827,044
Data Source	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2015	2015	2017	2017

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - Perpetration			
	2017	**2018**	**2019**
Annual Objective			18.4
Annual Indicator			6.9
Numerator			98,203
Denominator			1,426,809
Data Source			NSCHP
Data Source Year			2018

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2017	**2018**	**2019**
Annual Objective			18.4
Annual Indicator			26.8
Numerator			383,474
Denominator			1,429,420
Data Source			NSCHV
Data Source Year			2018

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	18.1	17.8	17.5	17.2	16.9	16.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			13,100
Annual Indicator			12,625
Numerator			
Denominator			
Data Source			FDOH - Adolescent Health Program
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	13,500.0	13,900.0	14,300.0	14,700.0	15,100.0	15,500.0

State Action Plan Table

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

Priority Need

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

NPM

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

Objectives

1. By September 30, 2021, decrease the number of Florida high school students who experienced bullying on school property from 14.3 percent (2017) to 13 percent (2021).

2. By September 30, 2021, decrease the number of Florida high school students who experienced electronic bullying in the past 12 months from 11.5 percent (2017) to 10 percent (2021).

3. By September 30, 2021, increase the number of youth participating in positive youth development programs from 12,300 (2017) to 13,000 (2021).

Strategies

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

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

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

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

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

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

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

NOMs

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

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

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

Priority Need

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

NPM

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Objectives

1. By June 30, 2020, increase the percentage of successful referrals for growth and development screening with body mass index (BMI) results at or above the 95th percentile resulting in students receiving services from a health care provider from 32.25 percent (2017-18 baseline) to 36.37 percent. This measure is the sum of completed referrals to healthcare providers and completed Healthy Lifestyle interventions by registered school nurses.

Strategies

1. Promote/educate county school health programs about the use of the Healthy Lifestyle Intervention Individualized Healthcare Plan and coding this service data in the Department's Health Management System. Promote the Intervention on at least one School Health Services Program statewide conference call and during county School Health Program on-site monitoring meetings conducted by school health liaisons during the 2020–21 school year.

2. Promote/educate county school health programs on the requirements, application process, and benefits of becoming a Florida Healthy District on at least one School Health Services Program statewide conference call and during county school program onsite monitoring meetings conducted by school health liaisons during the 2020–21 school year.

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

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

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

ESMs	Status
ESM 8.2.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.	Active

NOMs
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Adolescent Health - Annual Report

The Adolescent Health Program (AHP) empowers and educates youth to make healthy choices and improves the health of adolescents and young adults by decreasing the percentage of youth engaging in risky behaviors that lead to teen pregnancy, sexually transmitted infections, substance abuse, and violence. The AHP continues to implement the Sexual Risk Avoidance Education (SRAE)Program, which began in 2010.

The SRAE Program funded 12 providers, 7 local health departments, and five community or faith-based providers in middle school, high school, and community settings. In the 2018-2019 grant year, the Sexual Risk Avoidance Program was successfully delivered to 12,625 youth and to 2,725 parents and guardians.

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

While there were no major changes to the state plan, the impact of Hurricane Michael in the fall of 2018 delayed implementation in panhandle areas. This also required agency staff from other parts of the state to work emergency response. Maintaining community partnerships and meeting numbers after a natural disaster presented a major challenge for AHP staff.

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

Bullying is a serious detriment to a child’s health, sense of well-being, safety, education, and emotional development, and greatly increases the risk of self-injury and suicide. According to the 2019 CDC Youth Risk Behavioral Survey, 14.9 percent of Florida high school students were bullied on school property and 11.3 percent were bullied electronically. Bullying is defined as an attack or intimidation with the intention to cause fear, distress, or harm that is either physical (hitting, punching), verbal (name calling, teasing), or psychological/relational (rumors, social exclusion); a real or perceived imbalance of power between the bully and the victim; and repeated attacks or intimidation between the same children over time. Data from the 2019 YRBS indicate that a significantly higher number of students experiencing bullying described their grades as Ds and Fs in school during the past 12 months. The number of ninth and 10th grade students reporting being bullied is significantly higher than for students in 11th and 12th grade. Female students are significantly more likely than males to have experienced some form of bullying, name calling, or teasing in the past year.

Adolescent Health - Application Year

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

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

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

The AHP also continues to implement the Sexual Risk Avoidance Grant from the Administration of Children and Families that began in 2010. This program provides $3,800,000 per year to fund county health departments and community-based organizations. The funded providers use evidence-based, proven-effective sexual risk avoidance education curricula including *Choosing the Best*, *Making A Difference*, and *Real Essentials* to deliver the program. All classes are delivered in school or community-based settings. Providers are monitored regularly to ensure fidelity to the curricula and adherence to grant guidelines. The monitoring, conducted by program contract managers, includes observation of the educator conducting classes with youth and or parents/significant adults.

The AHP is currently funding 12 providers through September 2020. These providers include seven local health departments and five community-based providers in middle school, high school, and community settings.

Students who are perceived as different by other students are more likely to be bullied. These more vulnerable students include LGBT youth; students with physical, learning, or mental health disabilities; and students who are targeted for differences in race, ethnicity, or religion. Both students who bully and students who are bullied can suffer lasting psychological effects, including post-traumatic stress disorder (PTSD).

The best deterrent to bullying and cyberbullying is to create a culture of acceptance and communication. Such a culture empowers students to find positive ways to resolve conflicts and includes administration, teachers, and other staff who can support students in making constructive decisions and respond proactively when aggression of any kind exists on the school campus.

The Department's Violence and Injury Prevention Section (VIP) addresses statewide injury (both intentional and unintentional) prevention through technical assistance, information, and resources to community partners. One such program intended to address bullying is the evidence-based *Green Dot* strategy. *Green Dot* is implemented in north Florida high schools and is a comprehensive approach to violence prevention. Capitalizing on the power of peer and cultural influence across all levels of the socioecological model, *Green Dot* emphasizes that individual choices to take personal responsibility for a safe community leads to cultural norms shifts of nonviolence. VIP currently supports three providers implementing this strategy on nine High School Campuses and two providers implementing in the communities of Palm Beach and Punta Gorda.

Green Dot supports the theory that a cultural shift is necessary to measurably reduce the perpetration of power-based personal violence. To create that shift, a critical mass of peer influencers must engage in a new behavior to make violence less sustainable within any given community. The new behavior includes identification of personal connection to violence, barriers to intervention, workaround solutions for barriers, and opportunities to identify risk factors for power-based personal violence before it occurs. Prevention in the form of behavior modeling through social media and peer to peer conversations is also a component of *Green Dot*. The intervention focuses on teen dating violence, bullying, sexual harassment, stalking, and sexual assault.

It is also important to look at the effects of trauma on children and young adults as it is far more pervasive than adults imagine. The National Survey of Children's Exposure to Violence found that over 60 percent of children surveyed experienced some form of trauma, crime, or abuse in the prior year, with some experiencing multiple traumas. Often, children and adolescents do not have the necessary coping skills to manage the impact of stressful or traumatic events. As such, as many as one in three students who experience a traumatic event might exhibit symptoms of PTSD. Following a child's exposure to a traumatic event, parents and teachers are likely to observe the following symptoms:

- Reexperiencing — constantly thinking about the event, replaying it over in their minds, nightmares.
- Avoidance — consciously trying to avoid engagement, trying not to think about the event.
- Negative Cognitions and Mood — blaming others or self, diminished interest in pleasurable activities, inability to remember key aspects of the event.
- Arousal — being on edge, being on the lookout, constantly being worried.

Symptoms resulting from trauma can directly impact a student’s ability to learn. Students might be distracted by intrusive thoughts about the event that prevents them from paying attention in class, studying, or doing well on a test. Exposure to violence can lead to decreased IQ and reading ability. Some students might avoid going to school altogether.

Exposure to violence and other traumatic events can disrupt a youths’ ability to relate to others and to successfully manage emotions. In the classroom setting, this can lead to poor behavior, which can result in reduced instructional time, suspensions, and expulsions. Long-term results of exposure to violence include lower grade point averages and reduced graduation rates, along with increased incidences of teen pregnancy, joblessness, and poverty.

The root causes of and complex factors contributing to violence are found at the individual, family, community, and societal levels. All systems and disciplines can and must play a valuable role in preventing violence, reducing harm, and mitigating the lifelong effects of violence and trauma.

In 2019, VIP partners and providers began focusing on three important strategies for addressing violence on the community level: supporting economic opportunities for women, leadership skills for young girls, and building protective environments. These strategies are in developmental stages and range from safe zones in school libraries to online programming for young women.

Research and action in preventing violence in schools and communities includes improving the environments in which young people live and learn; implementing policies and programs that establish new norms for nonviolent behaviors; equipping young people with competencies for positive development; and providing opportunities for employment, mentoring, substance abuse treatment, and access to health and mental health services, including trauma-informed care.

The Department applies a public health approach to violence prevention, concentrating primarily on preventing youth violence, sexual violence, intimate partner violence, and exposure to trauma. This approach involves research, evaluation, and training and technical assistance across many of society’s systems, such as schools, law enforcement and the courts, mental health, child welfare, and juvenile justice agencies. The Department’s priority to address the social determinants of health is embedded throughout this application and the commitment of leadership as evidenced by the State Health Improvement Plan and Agency Strategic Plan to impact Florida’s long-term health outcomes.

Children with Special Health Care Needs

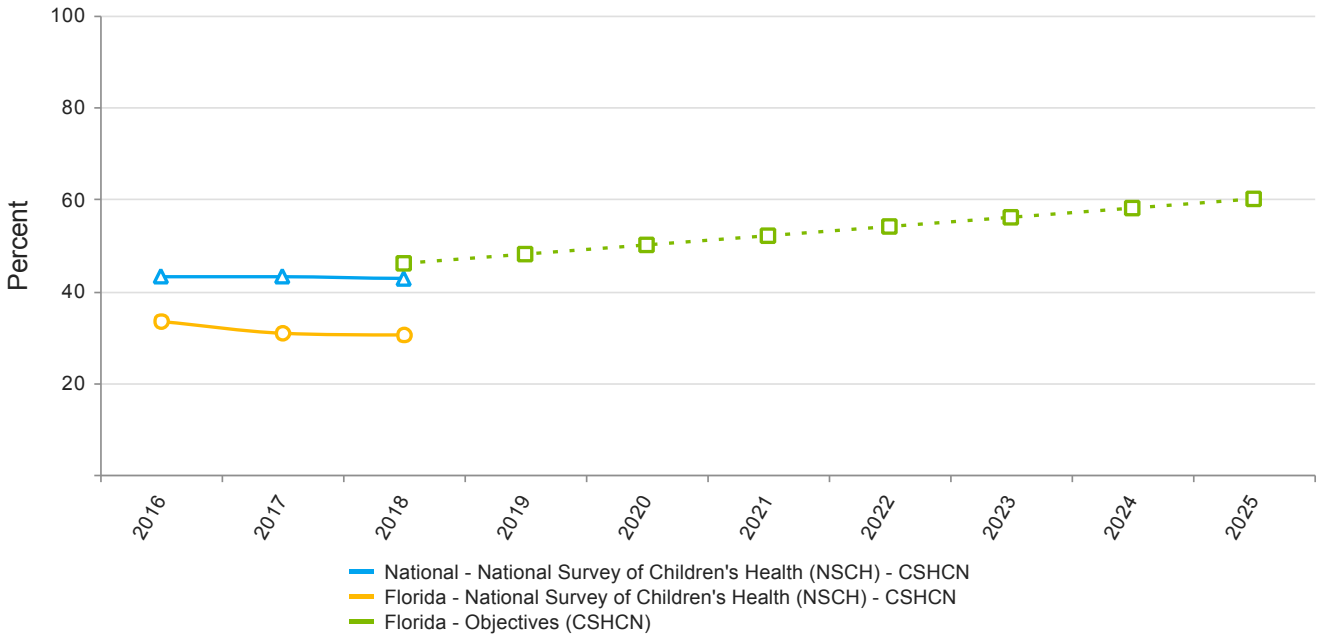
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2017_2018	7.5 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	48.2 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	90.8 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2017_2018	3.9 %	NPM 11

National Performance Measures

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

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			46	48
Annual Indicator		33.5	30.8	30.3
Numerator		298,857	264,895	238,785
Denominator		891,111	860,723	787,817
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	50.0	52.0	54.0	56.0	58.0	60.0

Evidence-Based or –Informed Strategy Measures

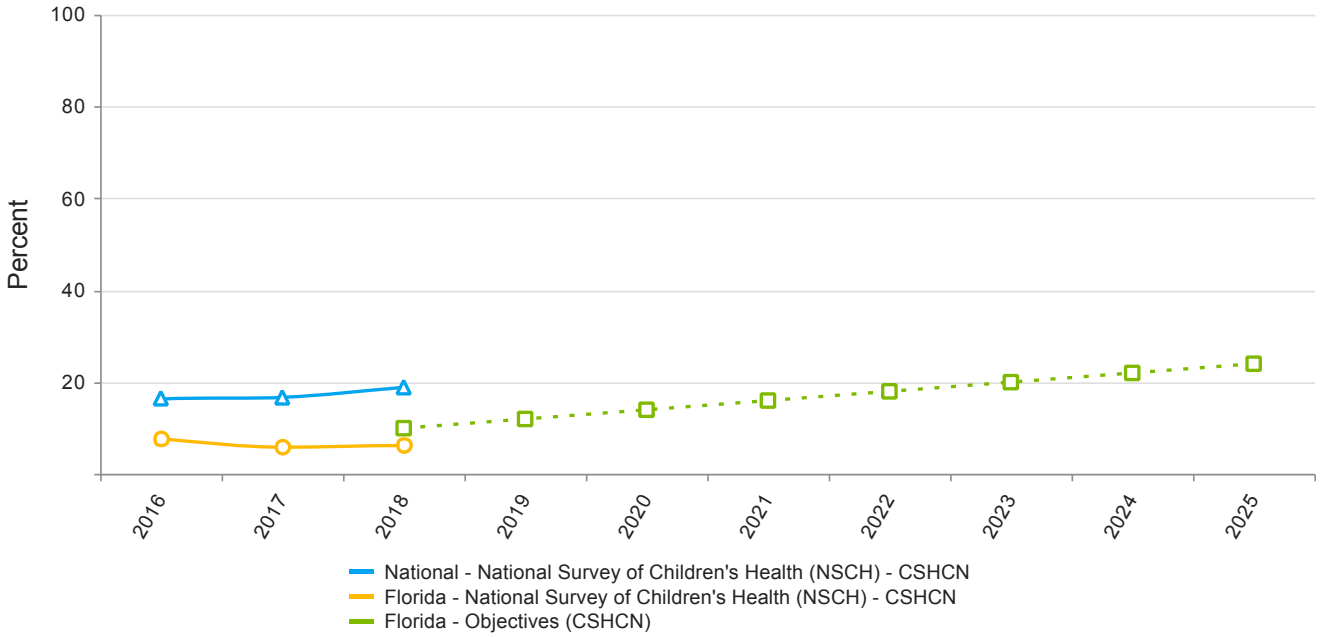
ESM 11.1 - Percent of satisfaction of access to care for families of children with special health care needs who received care in a patient centered medical home or by a primary care provider.

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			50
Annual Indicator			80.6
Numerator			25
Denominator			31
Data Source			CMS Internal Survey
Data Source Year			2020
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	80.0	80.5	81.0	81.5	82.0	82.5

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



NPM 12 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			10	12
Annual Indicator		7.5	5.9	6.4
Numerator		27,551	25,281	24,937
Denominator		368,685	426,713	387,391
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	14.0	16.0	18.0	20.0	22.0	24.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of satisfaction of access for youth with special health care needs who report having access to community-based resources necessary to make transition to adult health care.

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			50
Annual Indicator			4.5
Numerator			2
Denominator			44
Data Source			CSHCN
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	55.0	60.0	65.0	70.0	75.0	80.0

State Performance Measures

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

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		58	50	51
Annual Indicator	57.7	49.1	46.5	48.2
Numerator				99,630
Denominator				206,702
Data Source	National Survey of Children's Health	National Survey of Children's Health	National Survey of Children's Health	National Survey of Children's Health
Data Source Year	2011-2012	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	52.0	53.0	54.0	55.0	56.0	57.0

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

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			75
Annual Indicator			89.3
Numerator			25
Denominator			28
Data Source			CMS Internal Survey
Data Source Year			2020
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	89.0	89.5	90.0	90.5	91.0	91.5

State Action Plan Table

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

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

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

Objectives
1. By September 30, 2021, increase the number of pediatric providers in Florida identified as having a certified, recognized and/or accredited patient-centered medical home model by 5 percent.
2. By September 30, 2021, document the baseline of family satisfaction with access to care in a patient-centered medical home and primary care setting as evidenced by survey results.
3. By September 30, 2021, 100 percent of CMS Title V staff receive patient-centered medical home education and training annually as evidenced by electronic reporting systems.

Strategies
1a. Assess number and type of current patient-centered medical homes.
1b. Provide education, resources, and technical assistance to primary care providers for practice transformation towards patient-centered medical homeness.
2a. Assess family satisfaction with access to PCMH. Provide feedback, education, and technical assistance to practice for quality improvement initiatives.
2b. Create online repository for recognized PCMHs for families to be able to access.
3. CMS Title V staff will receive patient-centered medical home training during orientation and annually with completion documented through an electronic reporting system.

ESMs	Status
ESM 11.1 - Percent of satisfaction of access to care for families of children with special health care needs who received care in a patient centered medical home or by a primary care provider.	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

Priority Need

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

NPM

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

Objectives

1. By September 30, 2021, 100 percent of CMS Title V staff will receive transition-specific education and training annually as evidenced by electronic reporting systems.

2. By September 30, 2021, increase by 10 percent the number of providers who receive transition-specific education, training, and resources as evidenced by verbal, written, and/or electronic reporting.

3. By September 30, 2021, document the baseline number of educators who receive transition- education, training, and resources as evidenced by electronic reporting systems for baseline assessment.

4. By September 30, 2021, document percentage of children and families who accessed Department sponsored transition-education websites as evidenced by electronic reporting systems.

5. By September 30, 2021, 75 percent youth and families with special health care needs will report having access to community-based resources necessary to facilitate and achieve successful health care transition when surveyed.

6. By September 30, 2021, increase youth with special health care needs voice in transition program activities as evidenced by a 5 percent increase in the type and number of youth-led health and education transition-specific activities.

Strategies

1. CMS Title V staff will receive transition education during orientation and annually with completion documented through an electronic reporting system.

2. Providers are provided with transition education, training, and resources. Promote the six core elements of health care transition per national guidelines.

3. Educators are provided with transition education, training, and resources.

4. Assess, develop, monitor, improve quality, and promote public access to transition-specific, age-appropriate education materials to support the aspects of health, work/school, self-determination, and self-management for children with special health care needs.

5. Assess, develop, monitor, improve quality, and promote community-based resources and other supports necessary to facilitate and achieve successful health care transition for patients and families with special health care needs.

6. Promote growth in the youth voice and program involvement at the community, state, and national level for health and education transition-specific activities.

ESMs	Status
ESM 12.1 - Percent of satisfaction of access for youth with special health care needs who report having access to community-based resources necessary to make transition to adult health care.	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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

Priority Need

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

SPM

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

Objectives

1. By September 30, 2019, 100 percent of CMS Title V staff receive education and training on issues related to pediatric behavioral health annually as evidenced by electronic reporting systems.

2. By September 30, 2019, increase by 5 percent the number of primary care and specialty care providers who receive pediatric behavioral health education and training as evidenced by manual and electronic reporting systems.

3. By September 30, 2019, increase by 5 percent the number of providers who were provided or accessed electronically behavioral health resources as evidenced by manual and electronic reporting systems.

4. By September 30, 2019, determine the percentage of children and families who were provided or accessed electronically behavioral health education materials or resources as evidenced by manual and electronic reporting systems.

5. By September 30, 2019, determine collaboration efforts with primary care and behavioral health partners at local, state and national level as evidenced by meeting attendance, type of activities, memorandum of agreements/understandings and contracts and the Wilder Collaboration Factors Inventory.

Strategies

1. CMS Title V staff will receive behavioral health education during orientation and annually with completion documented through an electronic reporting system.

2. Providers will be offered opportunities for education/training for pediatric behavioral health care diagnosis including infant mental health, autism spectrum disorder and other emerging topics identified

3. Providers are equipped with resources to help improve access to behavioral health care.

4. Provide children and families with educational and other resources (i.e. parent based screening tools, resources, websites, directories) to promote access to behavioral health services.

5. Build system of care capacity for behavioral health services statewide with stakeholders at the local, state, and national level. Promote evidenced based strategies such as integrated care. Pilot behavioral health implementation projects. Evaluate Results. Build Sustainability. Replicate efforts that show promising practices.

State Action Plan Table (Florida) - Children with Special Health Care Needs - Entry 4

Priority Need

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

SPM

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

Objectives

1. By September 30, 2021, 100 percent of CMS Title V staff receive education and training on issues related to pediatric behavioral health annually as evidenced by electronic reporting systems.

2. By September 30, 2021, increase by 5 percent the number of primary care and specialty care providers who receive pediatric behavioral health education and training as evidenced by manual and electronic reporting systems.

3. By September 30, 2021, increase by 5 percent the number of providers who were provided or accessed electronically behavioral health resources as evidenced by manual and electronic reporting systems.

4. By September 30, 2021, determine the percentage of children and families who were provided or accessed electronically behavioral health education materials or resources as evidenced by manual and electronic reporting systems.

5. By September 30, 2021, determine collaboration efforts with primary care and behavioral health partners at local, state and national level as evidenced by meeting attendance, type of activities, memorandum of agreements/understandings and contracts and the Wilder Collaboration Factors Inventory.

Strategies

1. CMS Title V staff will receive behavioral health education during orientation and annually with completion documented through an electronic reporting system.

2. Providers will be offered opportunities for education/training for pediatric behavioral health care diagnosis including infant mental health, autism spectrum disorder and other emerging topics identified

3. Providers are equipped with resources to help improve access to behavioral health care.

4. Provide children and families with educational and other resources (i.e. parent based screening tools, resources, websites, directories) to promote access to behavioral health services.

5. Build system of care capacity for behavioral health services statewide with stakeholders at the local, state, and national level. Promote evidenced based strategies such as integrated care. Pilot behavioral health implementation projects. Evaluate Results. Build Sustainability. Replicate efforts that show promising practices.

State Action Plan Table (Florida) - Children with Special Health Care Needs - Entry 5

Priority Need

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

SPM

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

Objectives

1. By September 30, 2021, 100 percent of CMS Title V staff will receive workforce development training as evidenced by electronic and manual reporting systems.

2. By September 30, 2021, 85 percent of CMS Title V staff will report having an increase in public health knowledge and skill set as a result of participating in workforce development trainings as evidenced by electronic and manual self-reporting surveys.

Strategies

1a. CMS Central Office will convene a statewide workgroup to strategically plan the development of the workforce training.

1b. CMS Title V staff will complete needs assessment surveying what type of training they feel they need to transition from direct care services to public health services.

1c. CMS will partner with the National Maternal Child Health Workforce Development Center or other national stakeholder for assistance in the planning, development, and implementation of the workforce training.

1d. CMS will implement workforce development utilizing various adult learning methods in a variety of venues including: face-to-face, webinars, coaching calls, etc.

2a. CMS leadership will develop specific skill building modules in change management/adaptive leadership, systems integration and evidenced-based decision making,

2b. CMS leadership will evaluate staff perception of increased public health knowledge and skill set after each training session.

2c. CMS leadership will analyze the results of each training session and utilizing the continuous quality improvement planning cycle for future training needs.

2d. CMS leadership will develop additional trainings as workforce needs are identified.

CMS is strengthening its public health services and systems for all CYSHCN with the goal that every child with medically complex conditions receive high quality, evidence-based, family-centered care, regardless of health insurance. This plan started with existing CMS condition-specific specialty contracts (regardless of their funding source). Contracts were re-aligned to include tasks associated with: 1) Identified Title V CYSHCN priorities 2) The *Standards for Systems of Care for Children and Youth with Special Health Care Needs, version 2.0* 3) Implementation of a Quality of Life measurement tool 4) Completion of the CYSHCN single organization assessment tool.

A framework of change management and adaptive leadership was instrumental in this realignment and in launching a Learning Action Network (LAN) and Quality Improvement initiative, done in partnership with the National Institute for Children's Health Quality (NICHQ). Seven condition-specific programs (Behavioral Health, Craniofacial, Endocrine, Chronic Kidney, Hematology-Oncology, HIV/AIDS and Pulmonary), representing 24 tertiary care/university teams across the state have joined in this endeavor. This foundation transformed these historical specialty contracts, focused on direct care services, into the emergence of Statewide Networks for Access and Quality (SNAQs). A series of virtual meetings and in-person meetings and an online platform (for data and resource sharing amongst teams) supported the training, coaching and peer-to-peer learning in quality improvement methods. These teams were guided in the development and testing of small cycles of change using the Plan Do Study Act (PDSA) cycle and sequence of improvement within their individual institutions. At the time of this writing, over 40 PDSA cycles have been completed for approximately 20 active quality improvement projects in these organizations across the state.

Community systems approaches include the evidence-informed strategy of public health detailing. This initial pilot program was expanded with the use of 17 regional CMS staff (which includes five family leaders) that were experts in direct services for CYSHCN. Extensive training in the core functions of public health and Title V CYSHCN priorities was provided. This public health detailing workforce provides outreach, education, training and linkage of resources to community partners including providers that serve CYSHCN. CMS hopes to expand the next phase of this pilot initiative with 10 additional staff.

Additional informed strategies for community systems approaches includes the integration of multisector service systems that work together on community needs, addressing social determinates of health. CMS developed a framework for its regional network for access and quality (RNAQ) model. The aim is to work with existing community partnerships with the goal to improve access and quality for children in their community. Tenets of this model follow the core functions of public health and includes the *Standards for Systems of Care for Children and Youth with Special Health Care Needs, version 2.0.* CMS developed a request for application for community partners to apply for this funding and successfully awarded funding for two community programs to pilot this model. Implementation has begun with one of the programs and the second is imminent. Results from these programs will inform future decision making.

For NPM 11, CMS partnered with the University of Central Florida's Health Advancing Resources to Change Health Care (UCF HealthARCH), Florida's only designated National Committee for Quality Assurance (NCQA) partner in quality. UCF provided 1:1 technical assistance support to 24 pediatric practices regarding Patient Centered Medical Home (PCMH) practice transformation, it is anticipated that 80-90 percent will complete transformation and becoming PCMH recognized by June 30, 2020. In order increase the impact and build capacity with this resource, a population health approach is being implemented for 2020.

Public health detailing efforts for the first six months of operations showed that 360 community providers were given education, technical assistance and resources on the need and value of becoming a PCMH. Of those 39 percent (N=140) indicated they would like to have additional knowledge on how to become a PCMH as a barrier and 48 percent (N=174) expressed interest in receiving further technical assistance in becoming a PCMH. To meet this identified need, in collaboration with UCF, a PCMH readiness assessment tool was developed and training was provided for the public health detailing specialist to implement. These readiness assessments will be used to stage readiness for the next PCMH cohort (which will be increased to accommodate 36 practice sites) or the option to participate in a LAN to assist them in moving

further along in readiness for consideration of the next cohort. This LAN will consist of eight virtual meetings with a two- day in-person meeting to introduce and review the six core components needed to become a PCMH. Open offices hours will be offered to provide additional technical assistances as providers work towards PCMH transformation. The public health detailing specialist will participate in the LAN activities for skill building capacity to further support and sustain this model. Geo-mapping of Florida's current designated PCMH practices is occurring, to help identify unmet needs in underserved areas for intentional outreach and engagement in these activities.

For NPM 12, continued collaboration is ongoing with FloridaHATS (our state transition partner) and Got Transition (our national transition partner). Public health detailing efforts, in the first six-months of operations, included promoting the Six Core Elements of Healthcare Transition with 453 community providers. CMS is working with all of Florida's MCHB partners and other transition experts to collaboratively update and create a uniform Transition education module, which will be an additional resource for health care providers. CMS is currently researching evidenced-based or informed approaches as well as exploring other state's CYSHCN transition programs activities to assist in the development of a request for proposal for a statewide youth led transition council. This helps ensure youth voice is incorporated into future transition program planning, policy development and initiatives and may provide an opportunity to tap into existing resources without duplication of efforts. The Jacksonville Health and Transition Services program (JaxHATS) continues to provide clinic services and skill-building strategies to transitioning youths.

In conjunction with Got Transition, CMS Title V and the CMS Managed Care Plan operated by WellCare, are in the beginning stages of an 18-month project related to exploring, developing and implementing a small pilot focused on value-based payments to increase the percentage of 18 to 21-year-old members who transition from a pediatric provider to an adult care provider. Elements of this may include coordinated exchange of current medical information, plan of care, communication between pediatric and adult providers, and facilitated integration into adult care consistent with Got Transition's Six Core Elements of Health Care Transition.

In addressing our SPM specific to access to mental (behavioral) health treatment, CMS is expanding the evidenced-based practice of Behavioral Health Integration (BHI) by increasing the reach from two to five contracted university partners, also known as academic hubs. This includes the University of South Florida, Florida State University, University of Florida, University of Miami and Florida International University. National guidelines and frameworks (such as the Center of Excellence for Integrated Health Solutions) steered the development of tasks and deliverables in the BHI contracts which include ongoing quality improvement activities. The academic hubs partner with pediatric primary care practices and behavioral health organizations. The aim is to improve identification and treatment of children with behavioral health care needs by increasing the confidence, knowledge, and skill sets of pediatric primary care providers through skill building, technical assistance, and the availability of expert mental health clinicians to support management of behavior health conditions in primary care settings. This includes the use of telehealth.

Current academic hubs represent five out seven regions in Florida and along with our external stakeholders, form a statewide network that collaborates on monthly statewide calls to ensure quality improvement, addressing challenges and barriers for future sustainability. External stakeholders include other state agencies such as Florida's Department of Children and Families: Substance Abuse and Mental Health agency; Agency for Health Care Administration; family representatives from the National Alliance on Mental Illness, etc. Future efforts include identifying partners in the two remaining regions. A university partner will serve as the external evaluator to inform future decision making for sustainability and further replication of this model.

In the wake of our nation's pandemic, COVID-19, key issues for all children will include their emotional wellbeing and mental health. CMS will continue to survey needs and anticipates furthering its initial investment in behavioral health treatment, especially telehealth. As part of these activities CMS's Title V CYSHCN director is participating in the HRSA MCHB funded grant with the American Academy of Pediatrics, to improve care of children with ECHO's model of education; Florida teams who care for children with medical complexity will be eligible to participate.

Florida's Pediatric Psychiatry Hotline, funded by the Agency for Health Care Administration (AHCA), provides timely telephonic psychiatric consultation to primary care clinicians. CMS partnered with this existing resource to add care coordination services. This will help build capacity for additional referrals and include linkage to community resources for psychosocial supports and social determinates of health.

Public health detailing specialists provided education on the need for integrated behavioral health services to 462 community providers. Resources linkage was comprised of community specific resources, including those for social determinates of health, developed pediatric behavioral health guidelines by CMS, Florida's Best Practice Psychotropic Medication Guidelines (sponsored by AHCA), AAP Behavioral Health Took Kits and informational flyers about Florida's Pediatric Psychiatry Hotline. Practices that are interested in integrating behavioral health services and demonstrate readiness will be staged for engagement with their regional academic hubs.

Children with Special Health Care Needs - Application Year

This coming year, the CYSHCN team will be implementing new activities and sustaining existing activities outlined in the updated action plan based on the recently conducted needs assessment. Florida will continue with the priority areas related to medical home and behavioral health. While not a specifically called out priority area, transitioning from pediatric to adult systems of care will continue to be an important component and has been incorporated into the medical home and behavioral health priority areas moving forward.

New Performance Objectives (PO), Evidence-Based Strategy Measures (ESM) and State Outcome Measures (SOM) have been identified to better assist us in improving our program's performance through results-based accountability and are in the action plan table. Each PO now has an affiliated ESM and SOMs were developed to capture satisfaction with access to care in each of the priority needs.

CYSHCN staff plan to initiate or continue the following activities, organized by aligned strategy and priority need:

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

Strategy 11.1: Identify, evaluate, and enhance education and technical assistance provided to DOH team members, providers (pediatric, family medicine, and adult), families, family partners, and other partners serving children and youth with special health care needs (CYSHCN) regarding the patient-centered medical home model and related topics that impact the health and wellness of CYSHCN

11.1.a.i: Identify training needs/gaps in knowledge for DOH team members, providers, families, and other partners serving CYSHCN.

11.1.a.ii: Identify or develop additional educational materials and trainings to meet the needs/gaps in knowledge identified for each audience listed in activity 11.1.a.i, incorporating evidence-based strategies and interventions as available.

11.1.a.iii: Define measurements of success/outcomes for educational materials provided and trainings and set benchmarks for each.

11.1.a.iv: Integrate Public Health Core Competencies, Public Health Core Functions, and the Maternal and Child Health pyramid in trainings for audiences as needed.

11.1.a.vi: Continue to engage various condition specific provider groups serving CYSHCN, through a learning collaborative approach to share best practices, focus activities on strengthening the system of care for CYSHCN and their families utilizing the Standards for Systems of Care for Children and Youth with Special Health Care Needs, version 2.0, and work together on quality improvement projects to improve the health and wellness of CYSHCN and their families.

11.1.a.xi: Continue to encourage the utilization of quality of life tools and measures and track partners that have incorporated such tools and measures into practices.

11.1.b.i: Research evidence-based strategies to inform education and outreach activities to assist practices in identifying and addressing social determinants of health as well as strategies for health promotion (including behavior change) in CYSHCN utilizing the life course framework for cross cutting impact across Maternal and Child Health populations.

11.1.b.ii: Generate an underserved report that includes CYSHCN as well as populations known to the Medical Foster Care and the Children's Multidisciplinary Assessment Team Programs.

11.1.b.iii: Identify communities for targeted education and outreach based on the underserved.

Strategy 11.2.1 Create a cohort of caregivers of CYSHCN that are educated and equipped to be a partner in their child's care

11.2.1.a.i: Title V Family Leaders and other family partners will convene a workgroup of caregivers of CYSHCN to learn about needs related to the provider/patient partnership.

11.2.1.a.ii: Research current outreach documents for caregivers on the topic of enhancing patient/provider partnerships in a medical home or integrated behavioral health home.

11.2.1.a.iii: Use current available resources or develop a one-page tip sheet and other resources identified through the workgroup in 11.2.1.a.i. in understandable terms for caregivers to enhance the provider/patient partnership in a medical home or integrated behavioral health home.

Strategy 11.2.2: Leverage work with existing and potential partners to increase opportunities for families of CYSHCN to become family partners at the individual, community, and systems level

11.2.2.a.i: Continue to support Family Organizations in Florida in their efforts of educating and supporting families with CYSHCN.

11.2.2.a.ii: Identify other organizations that support families, family partnerships, and the utilization of the PCMH model to determine collaboration opportunities.

Strategy 11.3.1: Create a pipeline of providers that are engaged in enhancing their practice sites based on the foundational principles of patient-centered medical homes

11.3.1.a.i: Geomap current PCMH's serving pediatrics, CYSHCN, including Children with Medical Complexity to identify underserved communities and populations.

11.3.1.a.ii: Monitor and evaluate the numbers and geographic locations of PCMH sites annually.

11.3.1.b.i: Continue to identify providers/practices interested in becoming PCMH certified. (including providers that may fill gaps identified from activity 11.3.1.a.i).

11.3.1.b.ii: Title V Specialists will conduct assessments and share data with UCF HealthArch to identify practice sites ready for transformation and for other practice sites that are not ready for transformation.

11.3.1.b.iii: Increase outreach efforts in order to identify 36 pediatric /Family providers/practices annually that are interested in becoming PCMH Certified and have been assessed for readiness.
11.3.1.b.iv: Implement a Learning Action Network for pediatric/adult providers/practice sites that are not yet ready for PCMH transformation, but that would like to learn best-practices for creating a PCMH-like practice.

Partnerships: Strategy 11.3.1 will be accomplished, in part, through a partnership with the University of Central Florida's (UCF) Health ARCH (Advancing Resources to Change Healthcare).

Strategy 11.3.2: Leverage work with existing and potential partners to increase the spread of patient-centered medical homes

11.3.2.a.i: Support the Agency for Health Care Administration in their efforts of increasing PCMH utilization.

11.3.2.a.ii: Identify other organizations that support the utilization of the PCMH model to determine collaboration opportunities.

11.3.2.a.iii: Continue to explore partnerships with organizations that will increase the capacities of PCMHs to be a part of Patient Centered Medical Neighborhoods.

Strategy 11.4: Work with other Title V CYSHCN Programs and internal Department of Health colleagues to identify and implement activities that will increase the numbers of family practice and adult providers that serve young adults with special health care needs

11.4.a.i: Collaborate with the "Big five" most populous states which includes Florida to identify evidence-based or evidence-informed strategies to identify and increase the numbers of adult providers and practices that have the knowledge and capacity to care for young adults with special health care needs

Priority Need: Increase access to behavioral health services

Strategy 1.1.1: Identify, evaluate, and enhance education and technical assistance provided to DOH team members, providers (pediatric, family medicine, and adult), families, family partners, and community service providers regarding accessing or providing access to behavioral health services and related topics that impact behavioral health and wellness

1.1.1.a.i: Identify or create online Parent Training Webinars on "How To Navigate" the mental health system of care.

1.1.1.a.ii: Train PCP's, DOH team members, and MFC parent providers on Trauma Informed Care and effective behavioral health management strategies and other identified behavioral health related topics.

1.1.1.a.iii: Disseminate developmentally appropriate information to providers, communities and families to increase awareness of behavioral health resources across the lifespan.

1.1.1.a.iv: Educate providers and families on GOT transition's 6 core elements to support behavioral health transitions.

1.1.1.a.v: Train providers in cultural competency and family engagement strategies.
1.1.1.a.vi: Track the number of providers that move to integrating behavioral health activities as a result of interaction with an educational opportunity or training.

Strategy 1.1.2. Collaborate with organizations on existing or developing Public Awareness Campaigns to increase awareness of mental health and reduce stigma

1.1.2.a.iii: Organize community events and provide behavioral health education to reduce stigma, increase behavioral health awareness, importance of early identification and improve access to treatment.

Strategy 1.1.3 Leverage work with existing and potential partners to increase awareness, prevention identification, treatment activities, and treatment resources

1.1.3.a.i: Collaborate with State and community partners to educate on behavioral health early screening and anti-stigma activities.

1.1.3.a.ii: Collaborate with State and system stakeholders such as DCF, AHCA, FL AACAP, FL AAP & Children's hospitals to support behavioral health Initiatives.

1.1.3.a.vii. Collaborate with partners to increase the availability and capacity of medical-therapeutic homes (foster care).

Strategy 1.2.1: Identify, develop, and disseminate resources for change management for traditional and non-traditional providers to begin behavioral health integration

1.2.1a.ii: Utilize System Mapping to discover behavioral health resources for providers, communities and families, as well as to identify gaps and needs.

1.2.1a.iii: Continue to partner with University, State and community stakeholders to expand capacity for behavioral health services in identified rural and underserved communities.

Strategy 1.2.2: Leverage work with existing and potential partners to increase the accessibility and utilization of needed behavioral health services

1.2.2a.i: Improve communication between providers and the mental health community through partnership development.

1.2.2.a.iv: Continue to partner with University, State and community stakeholders to implement evidence-based models of behavioral health integration in primary care or other identified care settings.

1.2.2.a.v: Continue to leverage established behavioral health hubs to partner with practices and to facilitate increasing access to care.

Strategy 1.2.3: Create a pipeline of providers that are engaged in enhancing their practice sites by improving behavioral health awareness, prevention, identification and treatment

1.2.3.a.i: Identify practice sites to participate in practice site improvement.

1.2.3.a.ii: Survey identified practice sites regarding integrated behavioral health (IBH) needs and knowledge deficits.

1.2.3.a.iii: Create a learning collaborative based on survey results from 1.2.3.a.ii.

1.2.3.a.v: Create a workgroup that will research, conduct focus groups, and listening sessions to identify key components needed by Florida providers for steps to integrate behavioral health into primary care settings.

Strategy 1.3.1: Identify, develop, and disseminate resources for traditional and non-traditional providers, as well as community partners, on available activities and resources that enhance mental health protective factors and build resilience in the families they are serving

1.3.1a.i: Utilize System Mapping to discover available resources, as well as to identify gaps and needs.

Strategy 1.3.2: Leverage work with existing and potential partners to increase activities for families that enhance mental health protective factors and build resilience

1.3.2.a.i: Improve communication between families, providers and the mental health community through partnership development.

1.3.2.a.ii: Support organizations in Florida in their efforts to provide activities and supports for families, such as parenting classes and support for financial activities including tax preparation assistance.

1.3.2.a.iii: Identify other organizations that support healthy families and health neighborhoods.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Builiding - Annual Report

The health of families is one of Florida's most important priorities. The foundation of a family begins with the health of the parents. The Florida Department of Health (Department) recognizes that mental health is a key component to overall health. To address the immense need for behavioral and mental health services in Florida, MCH applied for and was awarded a grant from the Health Resources and Services Administration (HRSA): *The Development of a Sustainable Screening and Treatment Model to Improve Maternal Mental Health Outcomes in Florida*.

The specific focus of this grant is new for the Department, but builds on existing infrastructure and capacities from numerous statewide agencies, partners and other stakeholders. In the 2017-1018 Florida Legislative Session, a new law was enacted that directed the Department to initiate a statewide perinatal mental health education and referral service through a telephone help line. A total of $104,320 was appropriated in recurring and $21,600 in non-recurring funds. In addition, the Department administers the Florida Healthy Start Program, which has been doing routine perinatal depression and related risk screening since 2016. The Department is also partnered with the Florida State University (FSU) Center for Behavioral Health Integration (CBHI), which includes faculty, staff and community partners who have been working on perinatal mental health integration in obstetrics practices since 2000. One statewide and two regional maternal mental health coalitions have established vital infrastructure and relationships with clinical and community partners for several years. Based on the existing infrastructure, capacity and existing partnerships Florida is posed to be successful with this proposed project focus.

This grant from HRSA, known as BH IMPACT: Improving Maternal and Pediatric Access to Care and Treatment for Behavioral Health, in Florida, is to increase routine screening and referral by prenatal care providers, the project team will develop and implement a perinatal screening and treatment model to directly train health care providers in prenatal health care practices and birthing hospitals. Community mental health providers will be trained in evidence-based management of perinatal mental health disorders and have access to a professional perinatal psychiatrist for consultation to increase the use of evidence-based therapeutic interventions for perinatal depression. Mental health and substance abuse referral networks will also grow through provider outreach, development of community resource guides, and expansion of the Moving Beyond Depression and Mothers & Babies programs in statewide home visiting programs. Title V funding will be used to hire a psychiatrist to be available for inquiries related to care for pregnant women with perinatal depression.

Additionally, Florida was one of five states to be selected by the CDC and Association of State and Territorial Health Officers (ASTHO) for a site placement of a Maternal & Neonatal Opioid Prevention Coordinator to support the Opioid, Maternal Health, and Neonatal Abstinence Syndrome Initiative (OMNI) The coordinator’s role was specifically designed to support the MORE project by identifying and drawing together stakeholders in communities with high rates of NAS to help connect resources, identify system barriers, and share insights, gaps, and lessons learned with the broader Florida Neonatal Abstinence Syndrome (NAS) stakeholder group.

In the first five months of the project, our coordinator met with state teams and visited or conducted virtual meetings with 18 counties to meet with local leaders and learn about their biggest challenges in addressing OUD among pregnant women. Most of these counties have hospitals in the MORE initiative, the others either requested a meeting or were otherwise a high-need county. Meetings were structured around a framework designed to identify current needs, system barriers, relationship strengths, and areas that communities self-identified as areas where they needed help to improve.

Several issues rose to the top in most communities, including challenges with implementing SBIRT, identifying sufficient MAT providers (especially for buprenorphine), getting women to accept treatment once the need had been identified, and not knowing where to refer pregnant or postpartum patients for care.

In response to these issues we worked in partnership with the Florida Hospital Association, FPQC, and AHCA to launch a statewide webinar series addressing Narcan, Stigma, Plans of Safe Care, SBIRT, and Communication & Referral that was

attended by an average of 100 participants for each session, with most hospitals participating in more than one session. We also developed a video series that includes four brief videos addressing the same topics, including one that is designed to encourage women to enter treatment.

We have brought together these partners as well as Healthy Start in a coordinated effort to address many of the challenges faced in each community, taking care to highlight best practices in collaboration at the community and hospital level.

The Department's Violence and Injury Prevention (VIP) Section plays a key role in the development of the state's suicide prevention plan; the Governor's Challenge action plan to address suicide among services members, veterans, and their families; the Governor's Youth & Children Cabinet Information Technology Workgroup, and the State Health Improvement Plan's Behavioral Health Priority Area Workgroup goals and objectives.

VIP works closely with the Department of Children and Families (DCF), home to the Statewide Office of Suicide Prevention (SOSP) and the state's lead designated agency for Substance Abuse Mental Health Services Administration (SAMHSA) funding. DCF works with the Florida Association of Managing Entities (FAME), a system-wide behavioral health network. Managing Entities (MEs) contract regionally with providers on behalf of DCF. The MEs do not provide direct services; rather, MEs contract with local, direct service providers, tailoring to the specific behavioral health needs in communities. DCF and FAME coordinate efforts with Florida Suicide Prevention Coalition, the nonprofit organization representing local suicide prevention coalitions throughout the state. The Florida Suicide Prevention Coalition is responsible for the annual statewide suicide prevention conference, held in the Spring. The Department has presented at the conference two of the last three years.

Cross-Cutting/Systems Building - Application Year

The School Health Services Program was awarded a one-million-dollar grant for the 2020-2021 school year under the Substance Abuse and Mental Health Services Administration to implement evidence based trauma mental health training in schools affected by Hurricane Michael including the counties: Jackson, Calhoun, Liberty, Bay, Gulf and Gadsden. The School Health Services Program will work with the National Center for School Mental Health at the College of Medicine of the University of Maryland to implement the evidence-based curriculum. The effectiveness of the training will be evaluated by the SHAPE system, a program developed by the National Center for School Mental Health to determine the effectiveness of mental health services in schools.

As many as one-third of women with Opioid Use Disorder have a comorbid mental health condition such as depression, anxiety, or other diagnoses, making treatment more complex as both the substance use and concurrent mental health issues must be treated at the same time. Florida has a shortage of obstetricians and other primary care providers for pregnant/postpartum women who are trained to screen, diagnose, and treat and refer women with mental health and substance use disorders during pregnancy and in the post-partum period. Families often find it difficult to find and access services, and many women are unwilling to admit to substance use for fear that their prenatal care physician will no longer provide care. It is not uncommon to have pregnant women with OUD who must travel to neighboring counties, or even further, to find a provider who can treat them. We are working on strategies to make perinatal psychiatric support services more accessible to physicians so that they can continue to treat women in their own communities, rather than sending them an hour or more away for care. Telehealth programs are a promising approach, and a pilot model in Florida is already providing these services to physicians in specific counties. We hope to expand this model statewide.

The Department anticipates hiring an Opioid Coordinator who will continue the work of the ASTHO/OMNI grant mentioned above and collaborate with the BH IMPACT project as well to help meet the substance use and mental health needs of pregnant and post-partum women.

The Department will continue their efforts related to the perinatal mental health grant from HRSA, BH IMPACT. The purpose of the project is to develop a sustainable screening and treatment model to improve maternal mental health outcomes in Florida. Over the five-year grant period the team members will work to achieve the following overarching goals:

- Build capacity in Florida to fully and competently deliver all aspects of screening, referral, engagement, and mental health consultation trainings to all major obstetrics practices and birth hospitals in the targeted region.
- Build and implement a screening and treatment model for maternal mental health in all major prenatal health care practices in the targeted region.
- Develop and implement training program for obstetrics providers on tool use, follow up, and the Massachusetts Child Psychiatry Access Program (MCPAP) model; develop and refine the psychiatric consultation model.
- Initiate and maintain provider participation and engagement in the program.
- Expand mental health and substance abuse referral networks in the regions.
- Increase statewide maternal mental health resources and capacity.
- Increase access to screening, referral, and treatment for women in rural and non-rural areas through telehealth resources.
- Train community mental health providers in evidence-based psychotherapy and management of perinatal mental health disorders.
- Develop and implement a State Data Dashboard System.

The VIP Section will continue their suicide prevention efforts. The Department of Children and Families (DCF) also facilitates the Suicide Prevention Coordinating Council (SPCC). Established by Florida statute, the SPCC meets quarterly and advises the Office of Suicide Prevention and provides annual recommendations to the legislature of top priorities for preventing suicide. The State Surgeon General is a Council member. Meetings are also attended by the Bureau Chief of Family Health Services, who serves as the Surgeon General's alternate, and the Administrator of the VIP Section, also in the

Bureau of Family Health Services, who has been recognized by the Committee as a permanent guest. The SPIAC is a workgroup under the Council. Once the new state suicide prevention plan is implemented in the Fall of 2020, SPIAC will transition into the Strategic Plan and Evaluation Workgroup, tasked with tracking and measuring success of the state action plan goals, objectives and activities. The Council nominated the Department's VIP Section Administrator to continue in role as Chair.

The Strategic Plan and Evaluation Group meets monthly. The VIP Section Administrator was also nominated to serve as Co-Chair of the Data Analysis Workgroup, which also meets monthly. The Data Analysis Workgroup identifies and links relevant data sources for suicide surveillance. The Department's Injury Epidemiologist is a member of this workgroup. The VIP Section Administrator also serves as a Department representative of the Veterans' workgroup. This SPCC workgroup is comprised of participating members of the Governor's Challenge to Prevent Suicide Against Veterans, Service Members, and their Families. The final workgroup under the SPCC is Communications. The Department will request membership on this workgroup to align messaging.

Additional DOH VIP partners include the Florida Department of Veteran's Affairs, the Department of Education, the Department of Elder Affairs, the Agency for Persons with Disabilities, the Florida Department of Law Enforcement, the Florida Council Against Sexual Violence and the Florida State University College of Medicine. University partners include the University of Central Florida, the contracted provider of Garrett Lee Smith Youth Early Intervention and Suicide Prevention grant, and includes, among their faculty, recognized experts in the Zero Suicide project. The UCF Center for Behavioral Health Research & Training is recognized by the SAMHSA Suicide Prevention Branch as an expert resource for the adapted version of the Zero Suicide strategy for public health departments. UCF is also a partner in the FL Implementation of the National Strategy for Suicide Prevention (FINS) Project, with the DCF State Office of Suicide Prevention, USF), and Florida Hospital. Using a mentorship model, FINS integrates the National Strategy for Suicide Prevention to ensure that health and behavioral health settings and adult-serving systems are prepared to engage and treat at-risk adults with culturally competent evidence-based/best-practice (EB/BP) suicide prevention, treatment, safety planning, and care coordination services. The goals of the project include: transform health and behavioral health systems infrastructure through the development of Zero Suicide advisory committees, suicide prevention policies and procedures, and the integration of EB/BP measures and mechanisms to monitor suicide care; enhance the collaboration of local and state-level partnerships to promote Zero Suicide and National Suicide Prevention Lifeline utilization; develop workforce training capacity to utilize EB/BP suicide prevention strategies; enhance care coordination strategies to increase the number of recovery and support linkages for at-risk adults to be sustained in treatment; improve the sharing, and tracking of suicide-related indicators (suicide ideation, attempts, deaths, and service utilization) via regional and state-level data surveillance systems.

Finally, the Violence and Injury Prevention Section is currently recruiting two new team members, a Suicide Prevention Coordinator, and a Mental Health liaison. There two positions will work closely together to continue agency-wide capacity building efforts as well as solidifying relationships with other state agencies to ensure a comprehensive approach and system of care for addressing, intervening and preventing suicide and mental health stigma.

III.F. Public Input

The framework used for the CYSHCN Needs Assessment was to first engage families and stakeholders for input to assess needs, then to examine strengths and capacity, and finally selecting priorities and setting performance objectives as outlined in the state action plan. Families and Youth completed paper and electronic surveys developed in English, Spanish and Creole. This was done by Title V attendance and face-to-face engagement at forums such as the annual Family Café (an event that brings together thousands of individuals with disabilities) and the annual Florida Youth Council. Further electronic surveys were disseminated by family organization groups through social media and posted on our website. Additionally, six family focus groups were conducted (including a mixed method of in person and virtual) to better understand system strengths and needs from the family perspective. As providers are also essential to the system of care for CYSHCN, focus groups for their input were also completed.

The CYSHCN Needs Assessment utilized an advisory group to steer the direction of the needs assessment process. This core group provided the CMS Needs Assessment Team with valuable feedback related to the needs assessment activities and included representation from families and various family organization including our newest engaged partner the Florida Military Family Special Needs Network. As priorities were determined additional workgroups were formed with families and stakeholders participating in the development of action plans.

CMS has a long-standing relationship with private physicians, university health systems, hospitals, and regional and local programs that support CYSHCN. CMS has ongoing communication with these groups to ensure feedback loops for ongoing quality improvement and continued understanding of the needs of CYSCHN and our system of care partners.

To measure satisfaction with access to care in a patient-centered medical home (PCMH) or primary care setting and transition for young adults, two separate surveys were created and made available electronically in English, Spanish, and Creole. Open ended responses allowed respondents the opportunity to provide recommendations for improvement and information on successfulness of accessing services. Surveys were disseminated through family organizations who utilized social media platforms to engage families. It is important to note that both survey responses this year were dramatically decreased, as compared to the previous year using the same method, which may have been a result of the national COVID pandemic that was ongoing at the time of dissemination.

According to survey results, approximately 80% of families of CSHCNs were satisfied with access to care received in a patient-centered medical home or by a primary care provider. Specifically, 25 out of 31 respondents were satisfied (11) and very satisfied (14) with their ability to access care from their child's primary care physician or patient-centered medical home. The remainder of the respondents (20%) reported being neutral with access. Themes for family satisfaction included availability of services, caring relationship with physicians, responsive staff, extended office hours and available appointments. Recommendations for improvement included consideration of incentives for increased access to quality doctors; increasing office hours (weekends/afterhours); telehealth opportunities; online appointment booking; increased coordination care/communication for children with special needs; closer relationships between patient/family/pediatrician; more access to specialists and increasing adult providers and hospitals competency in transition issues; alleviating burden of cost for insured families.

CMS also conducted a transition satisfaction survey for young adults. This survey, specifically for young adults ages 18 to 25, was used to determine satisfaction related to their ability to access health care and related services in their community. According to survey results received, approximately 22% (2) of young adults reported satisfaction with access to community-based resources necessary to make transition to adult health care and approximately 44% (4) maintain neutrality by neither agreeing nor disagreeing with satisfaction to access. Neutral and dissatisfaction themes included access to community-based supports for young adult respondents, confusion with Medicaid eligibility, lack of adult providers qualified and receptive to caring for medically complex clients such as severely autistic clients. One respondent stated, *"Finding a practitioner that understands your feeding tube, muscle tone and seizure disorders is impossible".* –White Male,

age 22-24, Leon County. Recommendations for improvement included enhanced information for your adults to better understand the Medicaid eligibility process; increased coordination in training with families and schools professional to better understand daily challenges that youth face; increasing access to psychiatrists in underserved areas; incentivizing professionals willing to work with the special needs and medically complex adult population. CMS is using this information in collaboration with stakeholders at the state and community level to explore models for enhancing services available to youths and young adults during and after transitioning to the adult system of care.

The Maternal and Child Health Block Grant and needs assessment documents are available over the Internet on the Department's website. In addition, the Department created an MCH Block Grant inbox dedicated to comments and suggestions regarding the block grant application. The block grant documents and the link to the inbox can be found at: http://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/mch-block-grant.html.

III.G. Technical Assistance

There are no current technical assistance needs identified.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - AA348_DOH and Medicaid DUA.pdf

V. Supporting Documents

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

Supporting Document #01 - Title V Process and Results Description.pdf

Supporting Document #02 - OMNI Partnership Attachment.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - DOH_ORG_CHART.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Florida

	FY 21 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 20,703,392	
A. Preventive and Primary Care for Children	$ 6,230,706	(30%)
B. Children with Special Health Care Needs	$ 8,991,764	(43.4%)
C. Title V Administrative Costs	$ 1,447,565	(7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 16,670,035	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 15,527,544	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 139,684,778	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 155,212,322	
A. Your State's FY 1989 Maintenance of Effort Amount $ 155,212,322		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 175,915,714	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 29,183,143	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 205,098,857	

OTHER FEDERAL FUNDS	FY 21 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 1,872,466
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 11,200,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Safeguarding Two Lives: Expanding Early Identification & Access to Perinatal Mental Health	$ 650,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 3,834,831
US Department of Education > Other > School Health	$ 11,625,846

	FY 19 Annual Report Budgeted		FY 19 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 20,922,688		$ 19,444,613	
A. Preventive and Primary Care for Children	$ 6,747,011	(32.2%)	$ 6,288,156	(32.3%)
B. Children with Special Health Care Needs	$ 8,585,354	(41%)	$ 7,464,576	(38.3%)
C. Title V Administrative Costs	$ 1,844,123	(8.8%)	$ 1,415,638	(7.3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 17,176,488		$ 15,168,370	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 155,212,322		$ 155,212,322	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 155,212,322		$ 155,212,322	
A. Your State's FY 1989 Maintenance of Effort Amount $ 155,212,322				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 176,135,010		$ 174,656,935	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 16,568,999		$ 16,085,512	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 192,704,009		$ 190,742,447	

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 4,435,757	$ 3,834,831
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 1,602,442	$ 1,374,265
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 10,530,800	$ 10,575,755
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Division of Healthy Start and Perinatal Services		$ 300,661

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: This is the amount of the actual grant award for FY 2019	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Based on feedback received from the 2020 grant application review, we reexamined how we were counting clients. We previously were dividing expenditures based on Healthy Start service numbers. This year we used total number of women screened for Healthy Start, total number of infants screened for Healthy Start, total number of adolescents served by the Sexual Risk Avoidance grant, and the total number of children served by Public Health Dental as well as children served by Healthy Start.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Budgeted is what we had on FY19 application, however our actual budget after realigning $1,200,000 to MCH for Healthy Babies was $7,464,576. Also, please note program projected expenditures due COVID19 is $9,192,539.	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: We had several staff vacancies in the Maternal and Child Health Unit during this grant period. We experienced turn over in leadership which effected being able to fill other vacant positions. Leadership is actively working on filling the vacancies.	

Data Alerts: None

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

State: Florida

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 1,487,079	$ 1,628,595
2. Infants < 1 year	$ 2,543,606	$ 2,644,467
3. Children 1 through 21 Years	$ 6,230,706	$ 6,288,156
4. CSHCN	$ 8,991,764	$ 5,959,367
5. All Others	$ 2,672	$ 1,508,390
Federal Total of Individuals Served	$ 19,255,827	$ 18,028,975

IB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 28,325,617	$ 28,325,617
2. Infants < 1 year	$ 13,632,142	$ 13,632,142
3. Children 1 through 21 Years	$ 107,195,695	$ 107,195,695
4. CSHCN	$ 6,447,721	$ 6,447,721
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 155,601,175	$ 155,601,175
Federal State MCH Block Grant Partnership Total	$ 174,857,002	$ 173,630,150

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**

Field Note:
Total amount projected to be spent due to COVID is $9,182,539. The total reported FY19 expended is $7,464,576. CYSHCN was $5,959,367 ($36%). $1,505,209 went to the All Others category for Florida's Public Health emergencies.

Data Alerts:

- CSHCN, Annual Report Expended does not equal Form 2, Line 1B, Children with Special Health Care Needs, Annual Report Expended. A field-level note indicating the reason for the discrepancy was provided.

Form 3b
Budget and Expenditure Details by Types of Services

State: Florida

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 2,440,775	$ 2,471,835
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 821,548	$ 880,100
B. Preventive and Primary Care Services for Children	$ 1,619,109	$ 1,591,617
C. Services for CSHCN	$ 118	$ 118
2. Enabling Services	$ 14,615,964	$ 13,715,757
3. Public Health Services and Systems	$ 3,646,653	$ 3,257,021
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 118
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 739,722
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Well Woman Care and Dental to Adults at CHDs		$ 880,100
Direct Care to Children by CHDs		$ 851,895
Direct Services Line 4 Expended Total		$ 2,471,835
Federal Total	$ 20,703,392	$ 19,444,613

IIB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 155,212,322	$ 155,212,322
3. Public Health Services and Systems	$ 0	$ 0
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 155,212,322	$ 155,212,322

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Florida

Total Births by Occurrence: 221,508 **Data Source Year: 2018**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	221,042 (99.8%)	1,515	490	490 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Holocarboxylase Synthase Deficiency	Homocystinuria	Isovaleric Acidemia
Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)
Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)
Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency
X-Linked Adrenoleukodystrophy				

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Hearing*	211,696 (95.6%)	8,536	259	257 (99.2%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

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

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Hearing* - Referred For Treatment**
	Fiscal Year:	**2019**
	Column Name:	**Other Newborn**

Field Note:
Two babies diagnosed in Florida, and were in the process of moving to another state and therefore were not referred to Early Steps.

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Florida

Annual Report Year 2019

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	131,453	93.4	1.9	4.7	0.0	0.0
2. Infants < 1 Year of Age	64,661	97.2	0.8	2.0	0.0	0.0
3. Children 1 through 21 Years of Age	293,829	96.5	0.7	2.8	0.0	0.0
3a. Children with Special Health Care Needs	58,766	77.1	20.9	2.0	0.0	0.0
4. Others	0					
Total	489,943					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	221,542	Yes	221,542	77	170,587	131,453
2. Infants < 1 Year of Age	221,772	Yes	221,772	95	210,683	64,661
3. Children 1 through 21 Years of Age	4,980,897	Yes	4,980,897	64	3,187,774	293,829
3a. Children with Special Health Care Needs	959,321	Yes	959,321	9	86,339	58,766
4. Others	16,096,388	Yes	16,096,388	0	0	0

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2019**
	Field Note: The pregnant women count is the count of women served in program components 25, 26, and 27 (Improved Pregnancy Outcome, Healthy Start Prenatal non-CHD, Healthy Start Prenatal CHD).	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2019**
	Field Note: The infant count is the count of infants (age=0) served in program components 29, 30, and 31 (Child Health, Healthy Start Child - non-County Health Department, and Healthy Start Child - CHD).	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2019**
	Field Note: The children age 1 to 22 is the count of children age 1 to 22 served in program component 29, 30, and 31 (Child Health, Healthy Start Child - non-CHD, and Healthy Start Child - CHD) during calendar year 2017. The total CSHCN is included in this rule based on how the TVIS calculates the total, with the row for CSHCN not calculated in the total. Actual total for Row 3 Children 1-22 years of age was 214,469 (not including CSHCN).	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2019**
	Field Note: The CSHCN count is the unduplicated count of clients served under Title V during the reporting period. Even if a client has moved between CMS T19 and T21 programs during the reporting period, we still count him/her once.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**
	Field Note: Florida does not collected data on others. There are no fiscal categories for others to generate a total to include on form 5- line 4, so we cannot establish a number for others. Those services are included in categories above.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2019**
	Field Note: Pregnant women percentage calculated on the number of pregnant women screened for Healthy Start.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2019**
	Field Note: Infant percentage calculated on the number of infants who received newborn screening.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2019**
	Field Note: Children 1-22 percentage calculated on the number of children in public schools plus number served in 5a.	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2019**
	Field Note: CSHCN percentage calculated on the total count of clients in CMS T19 and T21 programs during the reporting period, not unduplicated if a client moved between the two programs.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**
	Field Note: Florida does not collect data on others. There are no fiscal categories for others to generate a total to include on form 5b-line 3a, so we cannot establish a number for others. Those services are included in categories above.	

Data Alerts: None

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

State: Florida

Annual Report Year 2019

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	219,488	90,630	46,230	67,637	223	6,871	150	3,651	4,096
Title V Served	131,453	54,279	27,687	40,508	133	4,115	90	2,187	2,454
Eligible for Title XIX	122,764	50,691	25,857	37,831	125	3,843	84	2,042	2,291
2. Total Infants in State	221,508	92,831	46,818	66,129	254	6,584	159	3,330	5,403
Title V Served	64,661	27,098	13,667	19,304	74	1,922	47	972	1,577
Eligible for Title XIX	62,889	26,356	13,292	18,775	72	1,869	46	945	1,534

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

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

State: Florida

A. State MCH Toll-Free Telephone Lines	2021 Application Year	2019 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 451-2229	(800) 451-2229
2. State MCH Toll-Free "Hotline" Name	Family Health Line	Family Health Line
3. Name of Contact Person for State MCH "Hotline"	Julie Beaman	Liz Gonzalez
4. Contact Person's Telephone Number	(850) 245-4425	(850) 558-9592
5. Number of Calls Received on the State MCH "Hotline"		8,884

B. Other Appropriate Methods	2021 Application Year	2019 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Florida

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

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Jeffrey Brosco, MD, PhD
Title	Title V CSHCN Director
Address 1	4052 Bald Cypress Way, Bin A-13
Address 2	
City/State/Zip	Tallahassee / FL / 32399
Telephone	(850) 901-6303
Extension	
Email	Jeffrey.Brosco@flhealth.gov

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

Form Notes for Form 8:

None

Form 9
State Priorities – Needs Assessment Year

State: Florida

Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Promote safe and healthy infant sleep behaviors and environments including improving support systems, and daily living conditions that make safe sleep practices challenging.	Continued
2.	Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of- school activities in a safe and healthy environment.	Continued
3.	Promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children.	Continued
4.	Promote breastfeeding to ensure better health for infants and children and reduce low food security.	Continued
5.	Improve access to health care for women, specifically women who face significant barriers to better health, to improve preconception health.	Continued
6.	Increase access to medical homes and primary care for children with special health care needs.	Continued
7.	Improve health care transition for adolescents and young adults with special health care needs to all aspects of adult life.	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 5

Field Note:
Increase the percent of higher risk mothers and very low birth weight newborns that deliver at hospitals with a Level III+ Neonatal Intensive Care Unit (NICU).

Form 10
National Outcome Measures (NOMs)

State: Florida

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

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	72.8 %	0.1 %	152,604	209,564
2017	73.7 %	0.1 %	154,802	210,027
2016	74.9 %	0.1 %	158,547	211,662
2015	75.7 %	0.1 %	161,407	213,229
2014	75.6 %	0.1 %	159,417	210,735
2013	73.2 %	0.1 %	152,189	207,988
2012	73.1 %	0.1 %	150,595	205,947
2011	73.8 %	0.1 %	150,478	203,797
2010	72.7 %	0.1 %	144,841	199,326
2009	71.7 %	0.1 %	149,827	209,106

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	70.5	1.8	1,505	213,623
2016	69.7	1.8	1,499	215,216
2015	77.5	2.2	1,227	158,276
2014	71.9	1.9	1,500	208,654
2013	70.2	1.9	1,440	205,062
2012	67.5	1.8	1,373	203,326
2011	68.0	1.8	1,387	203,908
2010	69.5	1.9	1,426	205,038
2009	68.2	1.8	1,433	210,025
2008	65.2	1.7	1,438	220,446

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2018	16.7	1.2	186	1,114,454

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	8.7 %	0.1 %	19,217	221,471
2017	8.8 %	0.1 %	19,653	223,561
2016	8.7 %	0.1 %	19,589	224,935
2015	8.6 %	0.1 %	19,306	224,193
2014	8.7 %	0.1 %	19,065	219,927
2013	8.5 %	0.1 %	18,346	215,338
2012	8.6 %	0.1 %	18,260	213,076
2011	8.7 %	0.1 %	18,527	213,363
2010	8.7 %	0.1 %	18,681	214,525
2009	8.7 %	0.1 %	19,247	221,319

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	10.3 %	0.1 %	22,701	221,437
2017	10.2 %	0.1 %	22,851	223,511
2016	10.1 %	0.1 %	22,822	224,921
2015	10.0 %	0.1 %	22,407	224,173
2014	9.9 %	0.1 %	21,846	219,909
2013	10.0 %	0.1 %	21,594	215,168
2012	10.2 %	0.1 %	21,810	212,925
2011	10.3 %	0.1 %	22,018	213,054
2010	10.5 %	0.1 %	22,436	214,301
2009	10.6 %	0.1 %	23,344	221,161

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	27.5 %	0.1 %	60,947	221,437
2017	27.0 %	0.1 %	60,295	223,511
2016	26.3 %	0.1 %	59,240	224,921
2015	25.7 %	0.1 %	57,676	224,173
2014	25.7 %	0.1 %	56,543	219,909
2013	26.4 %	0.1 %	56,704	215,168
2012	27.1 %	0.1 %	57,640	212,925
2011	27.8 %	0.1 %	59,291	213,054
2010	30.2 %	0.1 %	64,627	214,301
2009	32.1 %	0.1 %	70,945	221,161

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

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

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	4.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	6.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	6.5	0.2	1,453	224,372
2016	6.5	0.2	1,475	225,728
2015	6.6	0.2	1,486	224,944
2014	6.5	0.2	1,425	220,685
2013	6.6	0.2	1,417	216,119
2012	6.6	0.2	1,419	213,877
2011	6.9	0.2	1,473	214,141
2010	6.8	0.2	1,459	215,306
2009	6.8	0.2	1,520	222,137

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	6.1	0.2	1,364	223,630
2016	6.1	0.2	1,382	225,022
2015	6.2	0.2	1,399	224,269
2014	6.1	0.2	1,344	219,991
2013	6.1	0.2	1,322	215,407
2012	6.1	0.2	1,306	213,148
2011	6.5	0.2	1,379	213,414
2010	6.5	0.2	1,397	214,590
2009	6.9	0.2	1,527	221,394

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	4.1	0.1	907	223,630
2016	4.2	0.1	936	225,022
2015	4.4	0.1	986	224,269
2014	4.2	0.1	913	219,991
2013	4.0	0.1	868	215,407
2012	4.0	0.1	847	213,148
2011	4.3	0.1	920	213,414
2010	4.4	0.1	937	214,590
2009	4.5	0.1	994	221,394

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	2.0	0.1	457	223,630
2016	2.0	0.1	446	225,022
2015	1.8	0.1	413	224,269
2014	2.0	0.1	431	219,991
2013	2.1	0.1	454	215,407
2012	2.2	0.1	459	213,148
2011	2.2	0.1	459	213,414
2010	2.1	0.1	460	214,590
2009	2.4	0.1	533	221,394

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	211.5	9.7	473	223,630
2016	225.8	10.0	508	225,022
2015	243.0	10.4	545	224,269
2014	234.6	10.3	516	219,991
2013	227.5	10.3	490	215,407
2012	229.9	10.4	490	213,148
2011	245.5	10.7	524	213,414
2010	251.2	10.8	539	214,590
2009	257.9	10.8	571	221,394

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	101.5	6.7	227	223,630
2016	85.3	6.2	192	225,022
2015	81.2	6.0	182	224,269
2014	87.7	6.3	193	219,991
2013	93.8	6.6	202	215,407
2012	83.0	6.2	177	213,148
2011	82.0	6.2	175	213,414
2010	85.3	6.3	183	214,590
2009	86.3	6.3	191	221,394

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.5 - Notes:

None

Data Alerts: None

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

Federally available Data (FAD) for this measure is not available/reportable.

NOM 10 - Notes:

Florida does not collect this data.

Data Alerts:

1.	Data has not been entered for NOM 10. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	7.2	0.2	1,558	215,435
2016	7.3	0.2	1,592	217,561
2015	7.2	0.2	1,156	160,465
2014	6.8	0.2	1,433	210,719
2013	6.4	0.2	1,319	207,144
2012	6.0	0.2	1,240	205,662
2011	6.0	0.2	1,229	206,301
2010	4.9	0.2	1,024	208,052
2009	3.5	0.1	740	213,310
2008	2.3	0.1	518	223,776

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	12.5 %	1.6 %	487,771	3,895,296
2016_2017	11.8 %	1.5 %	451,376	3,817,682
2016	13.5 %	1.8 %	516,250	3,829,255

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	18.9	1.0	393	2,078,730
2017	20.2	1.0	416	2,063,833
2016	19.7	1.0	402	2,044,233
2015	20.3	1.0	410	2,015,646
2014	20.1	1.0	401	1,995,207
2013	19.5	1.0	385	1,975,876
2012	19.2	1.0	375	1,954,997
2011	20.7	1.0	402	1,941,084
2010	20.9	1.0	407	1,945,037
2009	21.3	1.1	412	1,936,378

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 15 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	30.7	1.1	741	2,412,669
2017	34.8	1.2	831	2,385,070
2016	35.6	1.2	834	2,343,610
2015	32.4	1.2	755	2,330,369
2014	31.6	1.2	730	2,309,604
2013	29.3	1.1	676	2,303,428
2012	31.8	1.2	734	2,309,847
2011	33.0	1.2	768	2,327,390
2010	32.2	1.2	759	2,359,229
2009	35.5	1.2	841	2,365,899

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2018	15.3	0.7	549	3,599,580
2015_2017	15.4	0.7	551	3,576,111
2014_2016	14.7	0.6	522	3,543,901
2013_2015	13.2	0.6	465	3,525,120
2012_2014	12.6	0.6	445	3,518,703
2011_2013	13.0	0.6	459	3,542,990
2010_2012	14.1	0.6	509	3,600,735
2009_2011	14.7	0.6	539	3,661,955
2008_2010	16.8	0.7	624	3,707,519
2007_2009	20.1	0.7	748	3,712,629

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2018	9.0	0.5	323	3,599,580
2015_2017	8.4	0.5	301	3,576,111
2014_2016	7.9	0.5	280	3,543,901
2013_2015	7.4	0.5	262	3,525,120
2012_2014	7.6	0.5	269	3,518,703
2011_2013	7.5	0.5	264	3,542,990
2010_2012	6.7	0.4	242	3,600,735
2009_2011	6.0	0.4	221	3,661,955
2008_2010	5.6	0.4	209	3,707,519
2007_2009	6.0	0.4	224	3,712,629

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	18.9 %	1.7 %	787,817	4,164,368
2016_2017	20.9 %	1.7 %	860,723	4,111,292
2016	21.8 %	1.8 %	891,111	4,087,976

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	7.5 %	2.0 %	58,905	787,817
2016_2017	8.9 %	1.9 %	76,934	860,723
2016	10.0 %	2.2 %	89,423	891,111

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	1.2 %	0.4 %	42,945	3,506,346
2016_2017	2.9 %	0.6 %	98,023	3,402,055
2016	4.5 %	1.1 %	152,296	3,378,120

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	9.8 %	1.4 %	341,961	3,472,387
2016_2017	9.5 %	1.4 %	320,691	3,378,156
2016	8.2 %	1.2 %	275,127	3,347,819

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	48.2 %	6.5 %	206,702	428,700
2016_2017	46.5 %	6.0 %	213,092	458,660
2016	49.1 %	6.7 %	215,430	439,176

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	90.8 %	1.4 %	3,762,232	4,143,910
2016_2017	87.8 %	1.5 %	3,597,248	4,098,477
2016	86.7 %	1.7 %	3,541,192	4,082,443

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

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

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	12.7 %	0.1 %	24,635	193,749
2014	12.7 %	0.1 %	23,253	182,567
2012	13.7 %	0.1 %	23,575	171,832
2010	14.6 %	0.1 %	28,384	194,924
2008	15.0 %	0.1 %	22,538	150,046

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	10.9 %	0.7 %	71,768	655,860
2015	12.2 %	0.6 %	83,663	686,671
2013	11.7 %	0.6 %	84,417	724,463
2011	11.6 %	0.6 %	78,253	676,673
2009	10.3 %	0.5 %	67,562	655,412
2007	11.2 %	0.7 %	76,092	679,809
2005	10.9 %	0.5 %	75,662	693,406

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	17.8 %	2.6 %	318,848	1,786,940
2016_2017	16.9 %	2.5 %	299,302	1,775,792
2016	17.9 %	2.7 %	302,065	1,690,458

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	7.4 %	0.2 %	311,663	4,224,475
2017	6.9 %	0.2 %	291,327	4,198,690
2016	6.2 %	0.2 %	258,020	4,142,576
2015	6.9 %	0.2 %	281,867	4,102,077
2014	9.2 %	0.3 %	372,586	4,052,007
2013	11.0 %	0.3 %	443,880	4,025,110
2012	10.8 %	0.3 %	431,221	3,997,922
2011	11.9 %	0.3 %	474,740	3,992,737
2010	12.8 %	0.3 %	513,357	3,999,244
2009	14.8 %	0.3 %	600,227	4,056,356

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	70.1 %	3.8 %	237,515	338,704
2017	76.2 %	3.4 %	254,411	333,967
2016	67.1 %	4.3 %	217,900	324,777
2015	66.7 %	3.7 %	209,945	315,014
2014	72.7 %	4.4 %	227,360	312,870
2013	70.0 %	4.4 %	217,207	310,138
2012	68.6 %	3.8 %	213,601	311,516
2011	66.7 %	3.5 %	214,657	321,764
2010	68.2 %	3.5 %	231,322	339,366
2009	49.0 %	3.4 %	174,338	355,765

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	54.6 %	1.8 %	2,155,885	3,952,127
2017_2018	46.1 %	1.7 %	1,766,170	3,833,617
2016_2017	56.7 %	1.8 %	2,148,061	3,787,799
2015_2016	47.9 %	1.8 %	1,777,685	3,712,793
2014_2015	48.0 %	1.9 %	1,780,234	3,712,688
2013_2014	50.3 %	1.9 %	1,867,932	3,714,239
2012_2013	46.9 %	2.6 %	1,722,142	3,672,407
2011_2012	43.9 %	3.3 %	1,632,951	3,716,498
2010_2011	38.9 %	1.9 %	1,442,929	3,709,328
2009_2010	37.9 %	2.4 %	1,366,413	3,605,312

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

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

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	64.1 %	3.4 %	766,311	1,194,804
2017	59.8 %	3.3 %	705,301	1,180,162
2016	55.9 %	3.4 %	661,631	1,182,903
2015	53.7 %	3.6 %	630,533	1,173,544

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	90.1 %	2.0 %	1,076,282	1,194,804
2017	91.1 %	1.8 %	1,075,554	1,180,162
2016	89.7 %	2.2 %	1,061,480	1,182,903
2015	87.3 %	2.5 %	1,024,631	1,173,544
2014	90.7 %	2.1 %	1,061,277	1,169,950
2013	84.8 %	2.8 %	990,810	1,168,561
2012	86.8 %	2.6 %	1,006,684	1,160,414
2011	77.5 %	2.7 %	899,634	1,160,986
2010	61.9 %	3.3 %	688,244	1,111,347
2009	47.2 %	3.1 %	536,871	1,137,222

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	76.3 %	3.0 %	911,070	1,194,804
2017	80.2 %	2.7 %	946,112	1,180,162
2016	76.3 %	2.9 %	902,900	1,182,903
2015	70.4 %	3.3 %	825,716	1,173,544
2014	72.2 %	3.4 %	844,322	1,169,950
2013	72.3 %	3.3 %	844,690	1,168,561
2012	68.6 %	3.5 %	796,377	1,160,414
2011	61.2 %	3.1 %	710,999	1,160,986
2010	55.1 %	3.4 %	612,809	1,111,347
2009	52.7 %	3.1 %	599,159	1,137,222

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	16.7	0.2	9,829	588,946
2017	18.2	0.2	10,708	587,833
2016	19.3	0.2	11,195	579,919
2015	20.8	0.2	11,957	574,463
2014	22.5	0.2	12,816	568,741
2013	24.6	0.2	13,962	568,335
2012	28.1	0.2	15,952	568,628
2011	29.6	0.2	17,125	578,320
2010	32.3	0.2	19,127	593,034
2009	36.6	0.3	22,021	601,533

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 23 - Notes:

None

Data Alerts: None

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

Federally available Data (FAD) for this measure is not available/reportable.

NOM 24 - Notes:

The most recent PRAMS data we have available is 2015. This data may be available by January 2021.

Data Alerts:

1.	Data has not been entered for NOM 24. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	3.9 %	1.0 %	160,483	4,132,738
2016_2017	4.8 %	1.1 %	197,693	4,077,844
2016	5.0 %	1.2 %	201,082	4,062,104

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Florida

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

Federally Available Data				
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	68	69	70	71
Annual Indicator	68.8	69.6	69.0	76.4
Numerator	2,287,771	2,337,875	2,350,898	2,630,508
Denominator	3,324,933	3,359,251	3,405,087	3,443,178
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	72.0	73.0	74.0	75.0	76.0	77.0

Field Level Notes for Form 10 NPMs:

None

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2019
Annual Objective	
Annual Indicator	78.9
Numerator	2,737
Denominator	3,469
Data Source	Florida CHARTS
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	79.4	80.0	80.5	81.0	81.6

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	81.3	82.3	83.2	84
Annual Indicator	81.1	76.1	82.6	79.2
Numerator	171,099	155,283	190,605	168,560
Denominator	210,888	203,992	230,680	212,751
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	84.7	85.3	85.8	86.2	87.1	87.8

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	27.7	29.4	31.1	32.8
Annual Indicator	18.4	24.3	21.3	23.4
Numerator	37,940	49,156	47,798	48,426
Denominator	206,047	201,974	224,023	206,578
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	34.5	36.2	36.9	37.5	39.6	41.3

Field Level Notes for Form 10 NPMs:

None

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data				
	2016	2017	2018	2019
Annual Objective	78.3	73.3	74.5	75.4
Annual Indicator	69.5	74	74	74
Numerator				
Denominator				
Data Source	FL PRAMS Data	FL PRAMS Data	FL PRAMS	FL PRAMS
Data Source Year	2014	2015	2015	2015
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	76.3	77.1	77.9	78.9	79.8	80.9

Field Level Notes for Form 10 NPMs:

None

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data			
	2017	2018	2019
Annual Objective			82
Annual Indicator	78	78	78
Numerator			
Denominator			
Data Source	FL PRAMS Data	FL PRAMS Data	FL PRAMS
Data Source Year	2015	2015	2015
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	83.0	84.0	85.0	86.0	87.0	88.0

Field Level Notes for Form 10 NPMs:

None

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data			
	2017	2018	2019
Annual Objective			62
Annual Indicator	60	60	60
Numerator			
Denominator			
Data Source	FL PRAMS Data	FL PRAMS	FL PRAMS
Data Source Year	2015	2015	2015
Provisional or Final ?	Provisional	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	63.0	64.0	65.0	66.0	67.0	68.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: FL PRAMS data for this measure will be available late in 2018 or early 2019. Data provided is an estimate based on CDC data from 2014 that 55 percent of babies nationwide were sleeping with soft objects or loose bedding. Indicator and objectives will be updated when FL PRAMS data becomes available.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: FL PRAMS data for this measure will be available late in 2018 or early 2019. Data provided is an estimate based on CDC data from 2014 that 55 percent of babies nationwide were sleeping with soft objects or loose bedding. Indicator and objectives will be updated when FL PRAMS data becomes available.	

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

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CHILD				
	2016	**2017**	**2018**	**2019**
Annual Objective			33.5	34
Annual Indicator		32.5	29.4	25.8
Numerator		428,914	394,477	364,148
Denominator		1,321,058	1,341,890	1,409,470
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018

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

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	34.5	35.0	35.5	36.0	36.5	37.0

Field Level Notes for Form 10 NPMs:

None

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2019
Annual Objective	
Annual Indicator	22.8
Numerator	181,534
Denominator	796,158
Data Source	YRBSS-ADOLESCENT
Data Source Year	2017

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT	
	2019
Annual Objective	
Annual Indicator	19.5
Numerator	290,239
Denominator	1,491,681
Data Source	NSCH-ADOLESCENT
Data Source Year	2017_2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	23.0	23.8	24.0	25.8	26.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data				
Data Source: Youth Risk Behavior Surveillance System (YRBSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	20.2	19	18.7	18.4
Annual Indicator	19.5	19.5	18.9	18.9
Numerator	150,914	150,914	156,700	156,700
Denominator	772,407	772,407	827,044	827,044
Data Source	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2015	2015	2017	2017

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - Perpetration			
	2017	**2018**	**2019**
Annual Objective			18.4
Annual Indicator			6.9
Numerator			98,203
Denominator			1,426,809
Data Source			NSCHP
Data Source Year			2018

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2017	**2018**	**2019**
Annual Objective			18.4
Annual Indicator			26.8
Numerator			383,474
Denominator			1,429,420
Data Source			NSCHV
Data Source Year			2018

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	18.1	17.8	17.5	17.2	16.9	16.5

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			46	48
Annual Indicator		33.5	30.8	30.3
Numerator		298,857	264,895	238,785
Denominator		891,111	860,723	787,817
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	50.0	52.0	54.0	56.0	58.0	60.0

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			10	12
Annual Indicator		7.5	5.9	6.4
Numerator		27,551	25,281	24,937
Denominator		368,685	426,713	387,391
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	14.0	16.0	18.0	20.0	22.0	24.0

Field Level Notes for Form 10 NPMs:

None

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data				
Data Source: National Vital Statistics System (NVSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	6.5	6.4	6.3	6.2
Annual Indicator	5.8	5.1	4.8	4.5
Numerator	12,970	11,454	10,639	9,836
Denominator	223,231	224,109	221,925	220,538
Data Source	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	6.1	6.0	5.9	5.8	5.7	5.6

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Florida

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

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		58	50	51
Annual Indicator	57.7	49.1	46.5	48.2
Numerator				99,630
Denominator				206,702
Data Source	National Survey of Children's Health	National Survey of Children's Health	National Survey of Children's Health	National Survey of Children's Health
Data Source Year	2011-2012	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	52.0	53.0	54.0	55.0	56.0	57.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The survey methods changed from the 2011/12 survey when the 2016 indicator was determined and the 2016 survey when the 2017 indicator was determined. The apparent drop in percentage is due to the change in methodology rather than less children being served. Objectives were adjusted to reflect new data.

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

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		37.4	38.9	40.4
Annual Indicator	35.9	37.4	38.5	48.7
Numerator	986,425	1,037,798	1,045,121	755,818
Denominator	2,745,598	2,774,485	2,716,229	1,551,734
Data Source	Florida Agency for Health Care Administration	Florida Agency for Health Care Administration	Florida Agency for Health Care Administration	Florida Agency for Health Care Administration
Data Source Year	2016	2017	2018	2017/2018
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	41.9	43.4	44.9	46.4	47.9	49.4

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		45.1	34.7	35.2
Annual Indicator	42.6	34.2	32.9	32.1
Numerator	545,146	435,455	396,388	384,878
Denominator	1,279,782	1,273,260	1,204,876	1,198,761
Data Source	2011-12 National Survey of Children's Health	2016 National Survey of Child Health	2016 National Survey of Child Health	2017-18 National Survey of Child Health
Data Source Year	2011-2012	2016	2016-2017	2017-2018
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	35.7	36.2	36.7	37.2	37.7	38.2

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The survey methods changed from the 2011/12 survey when the 2016 indicator was determined and the 2016 survey when the 2017 indicator was determined. The apparent drop in percentage is due to the change in methodology rather than less children being read to. Objectives were adjusted to reflect new data.

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

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			75
Annual Indicator			89.3
Numerator			25
Denominator			28
Data Source			CMS Internal Survey
Data Source Year			2020
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	89.0	89.5	90.0	90.5	91.0	91.5

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Numerator was 25.5, unable to enter decimal. Actual percentage was 91%.

Form 10
Evidence-Based or –Informed Strategy Measure (ESM)

State: Florida

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

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		27,000	44,000	44,500
Annual Indicator	25,558	43,507	26,508	54,553
Numerator				
Denominator				
Data Source	Well Family System	Well Family System	Well Family System	Well Family System
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	45,000.0	45,500.0	46,000.0	46,500.0	47,000.0	47,500.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
In 2017, Healthy Start Coalitions began reporting numbers in the new Well Family System. This caused the significant change in the indicator data, and required us to update the objectives.

ESM 3.1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	78.9
Numerator	2,737
Denominator	3,469
Data Source	Florida CHARTS
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	79.4	80.0	80.5	81.0	81.6

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			19
Annual Indicator			26
Numerator			
Denominator			
Data Source			Baby-Friendly USA
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	20.0	21.0	22.0	23.0	24.0	30.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.1 - The number of birthing hospitals that are Safe Sleep Certified

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			17
Annual Indicator			10
Numerator			
Denominator			
Data Source			Cribs for Kids
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	19.0	21.0	23.0	25.0	27.0	28.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data not available.	

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

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			54
Annual Indicator			49
Numerator			
Denominator			
Data Source			Safe and Healthy Schools Florida
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	55.0	56.0	57.0	58.0	59.0	60.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.2.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	49
Numerator	
Denominator	
Data Source	Safe and Healthy Schools Florida
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	56.0	57.0	58.0	59.0	60.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			13,100
Annual Indicator			12,625
Numerator			
Denominator			
Data Source			FDOH - Adolescent Health Program
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	13,500.0	13,900.0	14,300.0	14,700.0	15,100.0	15,500.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Percent of satisfaction of access to care for families of children with special health care needs who received care in a patient centered medical home or by a primary care provider.

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			50
Annual Indicator			80.6
Numerator			25
Denominator			31
Data Source			CMS Internal Survey
Data Source Year			2020
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	80.0	80.5	81.0	81.5	82.0	82.5

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
2019 was a documented baseline. Due to COVID-19, the 2020 survey had a low yield (N=31) but captured satisfaction at 80%, updated annual objectives.

ESM 12.1 - Percent of satisfaction of access for youth with special health care needs who report having access to community-based resources necessary to make transition to adult health care.

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			50
Annual Indicator			4.5
Numerator			2
Denominator			44
Data Source			CSHCN
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	55.0	60.0	65.0	70.0	75.0	80.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Due to COVID there was a low response rate (N=2), with 44% (N=4) neither agreeing or disagreeing.

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

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			7,000
Annual Indicator			9,736
Numerator			
Denominator			
Data Source			Well Family System
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	7,250.0	7,500.0	7,750.0	8,000.0	8,250.0	9,800.0

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: Florida

SPM 1 - The percentage of children that need mental health services that actually receive mental health services.
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase the percentage of children with a mental/behavioral condition who receive treatment.
Definition:	**Numerator:** Number of children that needed mental health services that actually received mental health services. **Denominator:** Number of children that needed mental health services. **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MHMD-5: Increase the proportion of children with mental health problems who receive treatment.
Data Sources and Data Issues:	National Survey of Children's Health
Significance:	Linking children who have mental health and behavioral health conditions to timely and appropriate treatment will improve health outcomes and improve the child's ability to function optimally at home, at school, and in society

SPM 2 - The percentage of low-income children under age 21 who access dental care.
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To increase the number of eligible low-income children who receive dental care.
Definition:	**Numerator:** Number of Medicaid eligible children (unduplicated) age 0-20 receiving any dental or oral health service. **Denominator:** Total number of Medicaid eligible children age 0-20. **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	OH-8: Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year.
Data Sources and Data Issues:	Agency for Health Care Administration (Medicaid DSS)
Significance:	Oral health is vitally important to overall health and well-being. Oral health is much more than just healthy teeth. Oral health is a state of being free from chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects, periodontal disease, tooth decay and tooth loss, and other disease and disorders that affect the oral cavity. Good oral health also includes the ability to carry on basic human functions such as chewing, swallowing, speaking, smiling, and singing. These functions are critical in our communication with others and interaction with the world. Oral health is also firmly linked with overall health. Research has shown a link to diabetes, heart and lung disease, stroke, respiratory illnesses, and conditions of pregnant women including the delivery of pre-term and low birth weight infants. Changes in the mouth often are the first signs of problems elsewhere in the body, such as infectious diseases, immune disorders, nutritional deficiencies, and cancer. Maintaining good oral and physical health requires a multi-faceted approach including a healthy diet, proper exercise, access to health care professionals, and public health initiatives such as fluoridated community water and preventive dental services including dental sealants. Dental disease is largely preventable through effective health promotion and dental disease prevention programs. Collaborative partnerships among individuals, communities, health care providers and governing bodies are necessary to achieve optimal oral health in Florida.

SPM 3 - The percentage of parents who read to their young child age 0-5 years
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To increase the number of parents who read to their child age 0-5.
Definition:	**Numerator:** Number of children aged 0 to 5 years whose parents report that someone in their family read to the child every day in the past week. **Denominator:** Number of children aged 0 to 5 years. **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	EMC-2.3 Increase the proportion of parents who read to their young child.
Data Sources and Data Issues:	National Survey of Children's Health
Significance:	Encouraging parents to read to their child has a positive impact on children, including but not limited to, increased positive parenting, improvement in the parent-child bond, and improved language development in children.

SPM 4 - The percentage of individuals who received workforce development that reported improved public health competency and capacity.
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Establish a sustainable public health workforce, improving competency and capacity of the public health system serving Children and Youth with Special Health Care Needs.
Definition:	**Numerator:** Number of Title V staff, families and partners participating in a sponsored workforce development event reporting improved public heath competency and capacity. **Denominator:** Number of Title V staff, families and partners that participated in a sponsored workforce development event. **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	PHI-2 Increase the proportion of Tribal, State, and local public health personnel who receive continuing education consistent with the Core Competencies for Public Health Professionals
Data Sources and Data Issues:	Office of Children's Medical Services Managed Care Plan and Specialty Programs Data
Significance:	The development and implementation of a learning culture, with training and support activities, will improve competency and capacity of the public health agency's workforce. Necessary strategic skills development positions the Title V workforce to meet the evolving needs of the public. This includes improved access to care, quality improvement tools to drive transformation, and the promotion of integration within public health and across organizational boundaries including primary care, the community based service delivery systems and other key partnerships.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Florida

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Florida

ESM 1.1 - The number of interconception services provided to Healthy Start clients
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase the number of interconception care services provided to clients in the Healthy Start Program
Definition:	**Numerator:** Number of interconception services provided to Healthy Start clients **Denominator:** N/A **Unit Type:** Count **Unit Number:** 80,000
Data Sources and Data Issues:	Department of Health, Health Management System
Significance:	Interconception care helps providers identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management. The goal to improve the woman's health and help reduce health risks to her future baby, resulting in improved outcomes for newborns and mothers.

ESM 3.1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	Increase the availability of Level III beds in NICUs.
Definition:	**Numerator:** Number of very low birthweight infants **Denominator:** Number of Level III NICU beds **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Florida CHARTS
Significance:	To ensure that the state has the capacity for all very low birthweight infants to be born in a Level III NICU.

ESM 4.1 - The number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation. NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation.
Definition:	**Numerator:** The number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Baby Steps to Baby Friendly USA multi-year tracker
Significance:	Baby Friendly birthing hospitals offer an optimal level of care for infant feeding and mother/baby bonding. They provide mothers with the information, confidence, and skills necessary to successfully initiate and continue breastfeeding their babies or feed formula safely. Breastfeeding provides the most complete nutrition possible, the optimal mix of nutrients and antibodies necessary for each baby to thrive. Studies have shown that breastfed children have far fewer and less serious illnesses than those who never receive breast milk, including a reduced risk of SIDS, childhood cancers, and diabetes. Recent studies show that women who breastfeed enjoy decreased risks of breast and ovarian cancer, anemia, and osteoporosis. Both mother and baby enjoy the emotional benefits of the very special and close relationship formed through breastfeeding.

ESM 5.1 - The number of birthing hospitals that are Safe Sleep Certified
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To increase the number of Florida birthing hospitals that are Safe Sleep Certified.
Definition:	**Numerator:** Number of Florida birthing hospitals in Florida that are Safe Sleep Certified **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Cribs for Kids in Florida
Significance:	Safe sleep guidelines are endorsed by the American Academy of Pediatrics, the National Institute of Health, the CDC and by other nationally recognized programs. A hospital safe sleep certification process would ensure that participating hospitals develop a policy to support safe sleep efforts and that trusted hospital professionals provide consistent safe sleep messaging to parents.

ESM 8.1.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of students who attend schools in Florida Healthy School Districts.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>The number of school districts that apply for the evidence-based Florida Healthy School District recognition.</td></tr>
<tr><td>Denominator:</td><td>N/A</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Florida Partnership for Healthy Schools</td></tr>
<tr><td>Significance:</td><td>The Florida Healthy School District Self-Assessment Tool was developed by experts from state agencies, school districts, and community partners to assist districts in achieving the highest standards in infrastructure and the eight component areas of the Centers for Disease Control and Prevention’s (CDC) Coordinated School Health (CSH) model. It was piloted, field tested and fully vetted prior to its release in 2009.

Districts that earn recognition as a Florida Healthy School District have made a high level commitment to meeting the health needs of students and staff by removing barriers to learning and maximizing district resources through the implementation of the CSH/Whole School, Whole Community, Whole Child (WSCC) approach including physical education and physical activity.</td></tr>
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ESM 8.2.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.
NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
ESM Subgroup(s):	Adolescents 12 through 17
Goal:	Increase the number of students who attend schools in Florida Healthy School Districts.
Definition:	**Numerator:** The number of school districts that apply for the evidence-based Florida Healthy School District recognition. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Florida Partnership for Healthy Schools
Significance:	The Florida Healthy School District Self-Assessment Tool was developed by experts from state agencies, school districts, and community partners to assist districts in achieving the highest standards in infrastructure and the eight component areas of the Centers for Disease Control and Prevention's (CDC) Coordinated School Health (CSH) model. It was piloted, field tested and fully vetted prior to its release in 2009. Districts that earn recognition as a Florida Healthy School District have made a high level commitment to meeting the health needs of students and staff by removing barriers to learning and maximizing district resources through the implementation of the CSH/Whole School, Whole Community, Whole Child (WSCC) approach including physical education and physical activity.

ESM 9.1 - The number of students who participate in an evidence-based program that promotes positive youth development and non-violence intervention skills
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To increase the number of students who participate in an evidence based program that promotes positive youth development and non-violence intervention skills.
Definition:	**Numerator:** The number of students completing Positive Youth Development programs and the number of students participating in the Green Dot high School strategy overview and bystander training.. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 50,000
Data Sources and Data Issues:	Programmatic sign in sheets/class rosters and the Florida Department of Health Sexual Violence Data Registry
Significance:	Positive Youth Development is an evidence-based strategy that focuses on asset-building and goal-setting as a means of risk reduction. PYD programs have been proven to positively impact teen birth, healthy relationships, college and career preparation, and overall self-esteem. The PYD approach supports the physical, emotional, social and mental health of adolescents. Research shows risk factors such as poor social competence, low academic achievement, impulsiveness, truancy, and poverty increase an individual's risk of violence. Developing youth life skills, improving their participation and performance in school, and increasing their prospects for employment can help protect them from violence, both in childhood and later in life. Developing life skills for intervention and self-empowerment can help young people avoid violence, by improving their social and emotional competencies and teaching them how to deal effectively and non-violently with conflict.

ESM 11.1 - Percent of satisfaction of access to care for families of children with special health care needs who received care in a patient centered medical home or by a primary care provider.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To increase the percentage of family satisfaction with access to care received in a patient-centered medical home and/or primary care for children that have special health care needs.
Definition:	**Numerator:** Percent of families reporting at least an 80% satisfaction rate **Denominator:** All families surveyed **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Survey: University Florida Institute for Child Health Policy
Significance:	Patient experience is main component of achieving high-quality care. Systematic review of studies demonstrates positive association between patient experience and clinical effectiveness and patient safety, decreasing health care costs. The identified priority need included primary care, and not just patient-centered medical home, which necessitated the inclusion of this in the measure. The results of this measure will help drive quality improvement activities, driven by family input, to improve access.

ESM 12.1 - Percent of satisfaction of access for youth with special health care needs who report having access to community-based resources necessary to make transition to adult health care.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	To increase the percent of youth satisfaction with access to community based resources necessary to make transition to adult health care.
Definition:	**Numerator:** Number of youth you have access to community-based resources to make transition to adult health care. **Denominator:** All youth surveyed **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Survey: University of Florida Institute for Child Health Policy
Significance:	The successful transition of youth and young adults with special health care needs, is essential to individual self-determination and self-management. Youth perception of satisfaction with access to community based resources needed to make a transition to adult health care will help drive quality measures to ensure their transition needs are met from their perspective. This will help drive program development and quality improvement activities to support the achievement of successful outcomes.

ESM 14.1.1 - The number of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to Healthy Start clients
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	To increase the number of pregnant women who receive Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services.
Definition:	**Numerator:** Number of SCRIPT services provided to Healthy Start clients. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 50,000
Data Sources and Data Issues:	Well Family System
Significance:	Smoking during pregnancy creates risks for adverse outcomes.

Form 11
Other State Data

State: Florida

The Form 11 data are available for review via the link below.

Form 11 Data