Maternal and Child Health Services Title V Block Grant

State Narrative for Florida

Application for 2014
Annual Report for 2012

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and certifications are on file with the Department of Health's central office. The assurances and certifications can be made available by contacting:

Bob Peck
Florida Department of Health
Bin A-13 (HSFFM)
4052 Bald Cypress Way
Tallahassee, FL 32399-1723
Email: Bob_Peck@doh.state.fl.us

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

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

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

/2013/ Healthy Start Coalitions provide public input that assists in the determination of the services needed to identify priority target populations. Coalition board membership must include consumers of family planning, primary care, or prenatal care services, at least two of which are low-income or Medicaid eligible. Other members represent county and municipal governments, social service organizations, and local education. Along with the representation of county health departments, health advocacy interest groups, migrant and community health centers, hospitals,

local medical societies, and others, this helps to ensure widespread, inclusive input. In addition, in the course of developing their service delivery plans, coalitions use surveys to gain additional input from both providers and the general community, and share that information with the Department of Health. //2013//

/2013/ County Health Departments (CHD) are required, as recipients of Title X funding, to establish an advisory committee of five to nine members who are broadly representative of the community to review and approve all informational and educational materials prior to distribution to ensure the materials are suitable for the population and community for which they are intended. The advisory committees also discuss and advise the CHD staff on community concerns and needs as they relate to the reproductive age population. //2013//

/2014/ Children's Medical Services (CMS) enrollees receive medical and support services through 21 CMS area offices staffed by private physicians, in local private physician offices or other health care organizations, through regional programs, hospitals, referral centers and statewide specialty programs. CMS has a strong partnership with University Health Systems. Children's Medical Services Medical Services Regional Medical Directors work for the Florida Department of Health; many have private practices, or work with universities and hospitals. Each quarter the Medical Directors meet and discuss program direction, emerging issues facing children with special health care needs, and health delivery systems. This group serves as an advisory group to CMS State Leadership in influencing policy and program direction.//2014//

/2014/ Children's Medical Services contracts with the University of Florida Institute for Child Health Policy to produce the Family Satisfaction Report. This report presents the findings of a statewide satisfaction survey of parents and guardians whose children are enrolled in the network. The patient experience and outcomes of CSHCN, and the satisfaction of their parents are important indicators of the health of these children and the quality of the services they receive. The report presents key findings and recommendations based on the following modules: demographics, satisfaction, CMSN care coordinator feedback, transition, quality of life and functioning, and CAHPS. The survey is conducted by telephone. The information provided in this annual report is used for policy direction, policy revision, program planning, and quality improvement initiatives. //2014//

/2014/ The CMS Sexual Abuse Treatment, Child Protection Teams, Cardiac, Partners in Care: Together for Kids, Transition and Newborn Screen Programs work with statewide consultants, program steering committees, or advisory groups. These groups have representatives from health advocacy groups, community health centers, hospitals, local medical societies, physicians, and families, to ensure widespread, inclusive input in program evaluation, program direction, and quality improvement activities. //2014//.

II. Needs Assessment

In application year 2014, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

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

1. Prevent unintended and unwanted pregnancies.

2. Promote preconception health screening and education.

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

4. Prevent teen pregnancy.

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

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

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

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

Selection of priority needs for this assessment included the consideration of quantitative and qualitative data. There was substantial input from key stakeholders and providers. A needs assessment advisory group was formed that consisted of key partners in maternal and child health as well as consumer representation. This advisory group made initial recommendations using a nominal group process. There was consensus among the group especially around the issues pregnancy prevention, preconception health screening and education, and promoting safe infant sleep behaviors. Increasing access to primary care and medical homes for children, particularly children with special health care needs was also identified as a priority need, as well as increased early intervention services and health care transition.

/2013/ The Infant, Maternal, and Reproductive Health Section developed a priorities and performance measure worksheet to track progress on the issues identified in the five-year needs assessment. For each priority, a chart was developed to identify and track activities and strategies, persons responsible, deadlines, evaluation, and progress made in addressing priority issues. //2013//

/2013/ During 2012, staff from the Infant, Maternal, and Reproductive Health Section and the MCH Practice and Analysis Unit have met to develop health problem analyses (HPA) for each of the priorities related to infant and maternal health. They have identified major risk factors as well as both direct and indirect factors that contribute to the identified problems. Logic models have been developed that identify programs and funding that address the problem (inputs); activities and the persons or entities providing each activity (outputs); and the short, medium, and long-term impacts that identified activities have on the problem (outcomes). The HPA and the Logic Model is the basis for determining appropriate strategies to address each of the priorities. //2013//

/2014/ The department continues efforts to address priority needs identified in the 2010 five-year needs assessment. The department conducts a quarterly conference call with lead persons assigned to the Collaborative Innovation and Improvement Network (CoIIN) strategic priority areas, who facilitate activities needed to implement each strategy. The quarterly conference calls provide updates and solicit input on the activities and strategies identified. This helps document progress, revise strategies, and brainstorm new ideas. Priority needs currently being addressed utilizing the CoIIN initiative include preconception counseling, back sleeping, and bed sharing. //2014//

III. State Overview

A. Overview

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

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

/2013/ According to EDR estimates, there were 18,905,048 Florida residents as of April 1, 2011. //2013//

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

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

/2013/ According to Pew Hispanic Center estimates, Florida was among four states that show a significant decrease in the number of unauthorized immigrants over the past two years. Florida had the largest decrease, going from 1,050,000 unauthorized immigrants in Florida during 2008 to 850,000 in 2010. This decrease may be attributed to the weakened economy and the lack of jobs, as there have not been major changes to state laws or policies regarding this population. Estimates are based on data from the Current Population Survey conducted jointly by the U.S. Bureau of Labor Statistics and the Census Bureau. //2013//

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

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

public support and costs.

/2012/ There were 17,695 deliveries to undocumented immigrants paid by Medicaid in fiscal year 2009/2010, at a cost of $86.5 million. //2012//

/2013/ There were 17,080 deliveries to undocumented immigrants paid by Medicaid in fiscal year 2010/2011, at a cost of $89,131,153. While the total Medicaid deliveries have decreased by 17 percent over the past five years, the average cost per delivery has increased by 18 percent over that time period. //2013//

/2014/ There were 16,472 deliveries to undocumented immigrants paid by Medicaid in fiscal year 2011/2012, at a cost of $85,340,816. While the total Medicaid deliveries have decreased by 17 percent over the past five years, the average cost per delivery has increased by 18 percent over that time period. //2014//

The geography of Florida can also create challenges in both the delivery of services and the response to events or disasters. With a total area of 58,560 square miles, Florida ranks 22nd among states in total area, though 4,308 square miles are covered by water. Driving from Pensacola in the western panhandle to Key West at the southernmost point is nearly an 800 mile journey. The 1,197 miles of coastline become a target during hurricane season, and 2,276 miles of tidal shoreline are subject to concerns regarding water quality and fish and wildlife habitat degradation.

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

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

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

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

/2013/ In April 2012, Florida's unemployment rate fell to 9 percent. While this is still higher than the national rate of 8.2 percent, the gap between the state and national rate is closing. The state's unemployment rate is the lowest it has been since January 2009. While an estimated 836,000 in Florida remained unemployed, there were 7,328,700 jobs in Florida as of March 2012, up 89,800 from a year ago. //2013//

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

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

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

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

In an effort to address racial disparities in birth outcomes, the 2007 Florida Legislature passed a law creating a black infant health practice initiative. The purpose of the initiative was to review infant mortality in selected counties in order to identify factors in the health and social services systems contributing to higher mortality rates among black infants, and to produce recommendations on how to address the factors identified by the reviews. Broward, Dade, Duval, Gadsden, Hillsborough, Orange, Palm Beach, and Putnam counties were selected for the study. The quantitative analysis involved utilizing the Perinatal Periods of Risk process. This revealed that the highest rate of black feto-infant deaths occurred in the maternal health/prematurity period, which relates to a woman's health prior to pregnancy. As a result of the initiative, community action teams were formed in each county. The community action teams continue to address racial disparity issues within their communities. Recommendations from the study include: developing and implementing community education and outreach regarding racial disparity in infant mortality; focusing on strategies related to interconception care and education; focusing on infant safety including sleep position and safe sleep environment; working with providers on cultural sensitivity; reducing barriers to prenatal care; providing educational messages; reducing barriers to Medicaid; and improving father involvement during pregnancy and infancy.

Each year since 2002, the legislature has provided funding for Racial and Ethnic Disparity: Closing the Gap projects with a primary focus of addressing racial and ethnic disparity in the

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

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

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

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

/2014/ In honor of Black History Month, the Office of Minority Health sponsored a number of activities during February 2013. Activities included a Culture Day in the park with health exhibitions and health screenings. A statewide webinar entitled Sickle Cell Disease was held that included a presentation on sickle cell disease by Maria Amanza, M.D. and a personal testimony on living with sickle cell disease by Mrs. Linda Mason. Florida's Surgeon General, John Armstrong, hosted a symposium at Florida International University entitled "Health Equity In Florida: Beyond Diversity and Promotion of Healthy Lifestyles." The purpose of the symposium was to bring a panel together to begin a conversation on addressing health equity. //2014//

/2014/ In recognition of National Black HIV/AIDS Awareness Day on February 7, the HIV/AIDS program encouraged community-based organizations, faith-based organizations, and county health departments from across the state to conduct educational and outreach activities, HIV testing and many other special events that will empower and mobilize Black communities in the fight against HIV/AIDS. The program also conducts similar activities each October 15 in recognition of National Latino AIDS Awareness Day. Many additional Department of Health activities, conferences, and initiatives address the need to reduce racial and ethnic disparities in the incidence of HIV/AIDS. Examples include, but are not limited to: Man Up Community Mobilization Meetings; Sistas Organizing to Survive (SOS), a grassroots mobilization of Black women in the fight against HIV/AIDS; Florida's faith-based initiative; a statewide minority media campaign; collaboration with the NAACP to address HIV/AIDS disparities among Blacks; Building Organizational Proficiency Projects; and the Targeted Outreach for Pregnant Women Act (TOPWA), which identifies high-risk minority pregnant women through outreach and links them with prenatal care and other services. //2014//

/2014/ As part of a National Minority Health Month observance, the department sponsored a live webinar panel discussion entitled "Ethnic Diversity and Cultural Competency in Cancer Care." The purpose of the discussion was to share, and raise awareness of the

need for standards or guidelines for delivering culturally competent services to increasingly diverse patients and families. //2014//

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

The council voted to keep their focus on HIV education and cancer prevention at this time. The council is interested in addressing other needs as well, but there are trust and cultural tradition issues that must be addressed first. It is hoped that a Tribal Consultation to be held sometime in the summer of 2010 will allow the department to establish further trust and bonds, and gain a better understanding of the health needs of this vast and divergent population. The 2000 U.S. Census counted over 117,000 American Indians in Florida, although community leaders feel that estimate is much too low. With more than 581 different tribes, bands, and clans in the state, addressing the various cultural needs can be a challenge, but the effort is an important one, as the department works to help improve the lives of a population that is so important to the heritage of our state and nation.

/2014/ In honor of American Indian and Alaska Native Heritage Month, the Office of Minority Health and the American Indian Advisory Council presented several statewide webinar presentations during November 2012. Topics included diversity within the American Indian population in Florida and information on health disparities. //2014//

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

/2013/ The 2012 Legislature passed a bill calling for the reorganization of the Department of Health and a realignment of programs. One section of the bill ended the Healthy Communities, Healthy People program. //2013//

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

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

In an effort to address adolescent issues, the department created the Positive Youth Development Program in June 2009. The purpose of the program is to enhance the skills and

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

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

/2013/ A number of Florida's federal community health centers were recently granted a total of $21 million in funding through the Affordable Care Act. The money received this year is expected to help the centers serve 41,000 new patients in Florida. Federal community health centers provide a medical home for uninsured low-income clients. //2013//

/2013/ The 2012 Legislature passed a bill calling for the reorganization of the Department of Health. A section of the bill created a statute requiring that private providers offer information to women whose prenatal tests indicate a fetal diagnosis of Down syndrome or another developmental disability. As part of the bill, the department must develop a clearinghouse of information related to developmental disabilities, and make it available to providers for use in counseling pregnant women. An advisory council will be formed to assist in this task. The Infant, Maternal, and Reproductive Health Section will also coordinate with Children's Medical Services and the Agency for Persons with Disabilities to gather clearinghouse information. //2013//

/2014/ House Bill (HB) 1263 passed during the 2012 Florida Legislative Session requiring the Department of Children and Families (DCF) and Department of Health (DOH) to develop and implement a WIC electronic benefit transfer (EBT) system no later than July 2013. This also requires a parallel implementation of a web-based eligibility system necessary to assess participants and certify WIC EBT benefits. The implementation incorporates the first time introduction of EBT technology to 500,000 WIC Participants, 220 clinics and over 2,000 commercial grocery vendors in Florida. To meet the HB 1263 requirements, WIC EBT requirements were incorporated in the DCF acquisition for EBT processing services for SNAP and other cash benefits. The joint contracting process was highly successful and produced the very best cost per case month for WIC available in the nation today. Introduction of WIC EBT is extremely beneficial for the WIC participant, the authorized WIC grocer and the WIC Program. WIC EBT provides WIC participants with essential shopping flexibility to obtain the prescriptive foods throughout the month, thereby improving freshness of foods and enabling a more efficient pattern of consumption. WIC EBT eliminates extensive manual reviews and settlement procedures presently used under the paper check system garnering strong support from WIC grocers. One major vendor reported to the department's Surgeon General that WIC EBT implementation will reduce processing costs by 90 percent for that entire vendor chain. The WIC Program and taxpayer will realize significant benefits from EBT implementation. Vendor food products can be individually evaluated for price and availability continually. This provides the lowest possible food costs, allowing limited grant funding to extend benefits to the highest number of children up to the age of 5 years possible. In addition, the implementation of the new WIC data system along with EBT will streamline WIC operations creating efficiencies at the clinic and state level. //2014//

B. Agency Capacity

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

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

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

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

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

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

County health departments are responsible for ensuring students have access to quality health services that assess, protect and promote their health and ability to learn. Over 2,000 health staff personnel provide more than 18 million services to approximately 2.6 million K-12 students in

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

/2014/ As part of the reorganization of the Department of Health, the Division of Community Health Promotion was designated by the legislature in HB 1263 as the replacement for the Division of Family Health Services. This new name reflects a clearer focus on providing leadership and expertise to local communities, statewide partners and health professionals to support healthy lifestyles as well as better describes the scope of programs and services within the division. The majority of chronic diseases in later life are caused by habits developed earlier in life, such as poor nutrition, lack of physical activity, and tobacco use. The bureaus within the division now combine the agency's expertise in nutrition; infant, maternal and reproductive health; school and adolescent health; chronic disease prevention; and tobacco in one organizational unit. The current scope of programs reflects a life cycle approach, which takes into consideration the full spectrum of factors that impact an individual's health through all stages of life. This approach focuses on health and disease patterns across populations and over time, and improves service quality by eliminating barriers between programs, assuring consistent health messaging, leveraging the skills and talents of staff, and improving efficient allocation of resources. The MCH activities reside in the newly named Bureau of Family Health Services. //2014//

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

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

/2012/ Parents report high levels of provider and program satisfaction. More than 90 percent of

parents are satisfied with CMSN doctors. A total of 82 percent report care plans were developed, 77 percent reported the care coordinators coordinated care with doctors and specialists, and 41 percent said the care coordinators coordinated with the children's schools. //2012//

/2013/ Ninety-two percent of parents are satisfied with their child's primary care physician. Eighty-one percent reported a care plan was developed, 76 percent reported that the care coordinators coordinated care with doctors and specialists, and 33 percent said the care coordinator coordinated with their child's school. //2013//

/2014/ Ninety-four percent of parents are satisfied with their child's primary care physician. Seventy-four percent reported a care plan was developed, 82 percent reported that the care coordinators coordinated care with doctors and specialists, and 36 percent said the care coordinator coordinated with their child's school. //2014//

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

Goal #1: All children who are enrolled in CMS Programs and their families will partner in decision-making at all levels and will be satisfied with the services they receive.

Goal #2: All children who are enrolled in CMS Programs will receive coordinated, ongoing, comprehensive care within a medical home.

Goal #3: All children enrolled in CMS Programs and their families will have the resources to fund services within the guidelines of the CMS Program.

Goal #4: All children will be screened early and continuously assessed for emerging or changing special health care needs.

Goal #5: CMS Offices will identify culturally competent, comprehensive community-based service systems for all children enrolled in CMS Programs and their families.

Goal #6: Beginning at age 12, all teens and young adults with special health care needs who are enrolled in the CMS Network and their families will receive the services needed to make transitions to all aspects of adult life, including adult health care, work, and independence.

Each CMSN enrollee is eligible to receive care coordination. The care coordinator is a critical link in the development of a medical home for the child and family. Care coordination services are documented in the CMS Child Assessment and Plan (CAP). Staff utilizes CAP to record assessments, care plans, and notes. The integration of the six national goals into the CMS program goals, performance measures and CAP further enhances the care coordination activities by ensuring the provision of ongoing, coordinated and comprehensive care, within the context of a medical home.

/2012/ The CMSN served 95,668 children in 2009-10 and over 18,000 through the Early Steps (ES) Program. //2012//

/2013/ The CMSN served 107,861 children in 2010-11 and 26,021 with an active Individual Family Service Plan (IFSP) through the ES Program. //2013//

/2014/ The CMSN served 86,962 children in 2011-12 and 23,878 with an active IFSP through the ES Program. //2014//

/2012/ A Family Health Consultant (FHC) was hired in 2010 to collaborate and strengthen partnerships at the national, state, and local level. //2012//

/2013/ CMS employs and provides reimbursement to families to participate on state, federal, and local advisory boards, projects, and steering committees. //2013//

/2014/ The ES program employs a parent consultant and family resource specialist who ensure family input and involvement at the state level and local level. These parents are included in policy development and review, assist in quality assurance activities, training, participation in workgroups, and collaboration with other statewide family groups. The family resource specialist role includes providing information and support, training, dissemination of information, input into policy development, community resource development, service delivery evaluation, and family representation in local activities. //2014//

/2012/ Children who are "removed from home and placed in out of home care" become clinically eligible for CMS. Children in foster care will be served through CMSN, providing a medical home that is managed and coordinated with the primary health care provider. //2012//

/2013/ Children who are in the foster care program who are clinically eligible for the CMSN will be enrolled based on the local system of care agreements. //2013//

/2014/ CMS enrolls children in foster care who are clinically eligible. //2014//

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

/2012/ CMS Primary Care (PC) programs provide a medical home to CMS offering the full range of PC services as well as providing care coordination activities, parenting, safety and health education to enrolled families. The network supports the programs in the development of medical home practices. The PC Program is a collaborative effort between state government, local pediatric physician groups, and community providers. Number of clients served in 2009-10 was 40,532. //2012//

/2013/ CMS PC programs served 38,925 children in 2010-11. CMSN provides support by serving on the expert panel and learning collaborative planning team for the CHIPRA project. The project has held two learning collaboratives with the third planned in 2013. CMSN provides support to family members as a member of the core team for 20 practices participating in the project and collaborates in all categories of the project. //2013//

/2013/ CMS Primary Care programs served 39,463 in 20111-2012. CMSN continues to support the CHIPRA projects. /2013//

In 2008, Senate Bill 988 / House Bill 793 called for the creation of a time-limited task force to address the needs of young adults with disabilities moving into adult health care systems in Florida. CMS led the establishment of a statewide task force created though a legislative initiative. The task force included members of stakeholders and state agencies in order to assess the need for health care transition services, develop strategies to ensure successful transition from pediatric to adult health care systems, and identify existing and potential funding sources. Activities include working with local health planning councils to develop county-level data reports to provide information about youth and young adults, and secondary data sets for health condition, disability status, SSI enrollment, CMS enrollment, and other pertinent data.

/2012/ 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. FloridaHATS has organized a Medical Advisory Committee, comprised of pediatricians, pediatric and adult specialty physicians, a representative from the Florida Pediatric Society and the Florida Medical Association that meets to discuss how to achieve successful health care transition outcomes. Health care transition and insurance information is available at www.floridahats.org. //2012//

/2013/ FloridaHATS continues to collaborate with the three established health care transition coalitions in Pensacola, Jacksonville, and Tampa and initiating discussions with physicians and other interested potential stakeholders in Ft. Lauderdale and Miami to develop coalitions. //2013//

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

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

/2012/ There were 1,146 CMAT clients served during FY 2009-20010. //2012//

/2013/ There were 1,168 CMAT clients served during FY 2010-11. //2013//

/2014/ There were 1,230 CMAT clients served during FY 2011-12. //2014//

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

The Medical Foster Care (MFC) Program is a coordinated effort between the Florida Medicaid Program within the AHCA, CMS within the DOH, and the Child Welfare and Community Based Care (CBC) Program within the DCF. To be eligible for the MFC program, children must be under the age of 21, be identified as needing medically necessary services to meet their medical complex condition, be in the custody of the DCF, and be medically stable for care in the home setting. The MFC Program establishes and supervises the oversight and training of foster parents to provide MFC services for these children. Medical foster parents are Medicaid providers, child-specifically trained, and are responsible for performing most of the day to day functions necessary for the child's care. This program is a cost-effective alternative to hospitalization, long-term, in-home, private duty nursing, or skilled nursing facility placement. The program currently serves approximately 742 children per year.

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

/2013/ The MFC program served 711 children in 2010-11. //2013//

/2014/ The MFC program served 728 children in 2011-12. //2014//

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

/2012/ There were 44,860 enrollees in ES during calendar year 2010. //2012////

/2013/ There were 44,727 enrollees in ES during fiscal year 2010-11. //2013//

/2014/ There were 40,243 enrollees in ES during fiscal year 2011-12. //2014//

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

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

/2013/ Change in the goal referenced above, to ensure all newborns born in Florida are screened and testing is processed within one week of birth. Electronic birth registration and newborn screening information will be linked in 2012. Implementation of the SCID screening did not begin in 2011 as anticipated but is scheduled to begin in the 2012-13 state fiscal year. //2013//

/2014/ Electronic birth registration and NBS information will be linked in 2013 to ensure accurate data. In 2012, the Genetics and NBS Advisory Council recommended Critical Congenital Heart Disease (CCHD). SCID was added to Florida's panel of newborn screening disorders on October 1, 2012. //2014//

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

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

staff. The genetics telemedicine project enables a pediatrician and a University of Florida (UF) geneticist to communicate via two-way interactive video technology.

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

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

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

/2013/ The Pediatric HIV/AIDS Program provides services through a network of six Pediatric HIV Referral Centers and 11 CMS satellite clinics. Over 1,000 infants and children received services at a Pediatric HIV Referral Center or CMS HIV Satellite Clinic in FY 2010-11. //2013//

/2014/ The Pediatric HIV/AIDS Program provides services through a network of six Pediatric HIV Referral Centers and 11 CMS satellite clinics. Over 1,400 infants and children received services at a Pediatric HIV Referral Center or CMS HIV Satellite Clinic in FY 2011-12. //2014//

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

/2012/ During 2010-11, program sites expanded from seven to 14, providing services to over 1,100 children. //2012//

/2013/ 14 program sites serve approximately 500 children in 2011-12. //2013//

/2014/ During 2011-12, over 730 children were served in 14 program sites. //2014//

The DOH, CMS, Division of Prevention and Intervention, promotes the safety and well being of children in Florida by providing specialized services to children with special health care needs associated with child abuse and neglect. The division consists of three units: the Child Protection Unit, the Prevention Unit, and the Special Technologies Unit.

/2014/ The Division of Prevention and Intervention and the CMS Network Division were combined to form the Division of Children Medical Services Program. //2014//

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

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

/2013/ The CPTs handled 29,933 cases involving child victims and their families and provided 45,833 assessments. //2013//

/2014/ The CPTs handled 28,956 cases involving child victims and their families and provided 45,218 assessments. //2014//

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

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

/2013/ CPT Telehealth services are available at 14 sites and 437 children were provided medical or other assessments via telemedicine technology. Two sites that were funded by a grant were discontinued when the grant ended. //2013//

/2014/ CPT Telehealth services are available at nine sites and 667 children were provided medical or other assessments via telemedicine technology in 2011-2012. //2014//

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

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

/2013/ The SATP served 9,781 child victims plus 6,419 siblings and parents/caregivers in 2010-11. //2013//

/2014/ The SATP served 9,801 child victims plus 4,804 siblings and parents/caregivers in 2011-2012. //2014//

The CMSN works with the Special Technologies Unit to maintain the CMS contracted program with the UF pediatric endocrinology staff that provides telehealth services for CMS enrollees with diabetes and other endocrinology diagnoses served by the Daytona Beach CMS area office. The use of two-way interactive video technology has proven to be an effective way of ensuring the availability of expert medical services to outlying rural areas.Other initiatives include: a partnership with the Institute for Child Health Policy at the UF to refer CSHCN who are seen at three of the state's community health centers to a CMS office for enrollment; nutritional, neurological, and orthopedic consults for CMS enrollees in Ft. Pierce, West Palm Beach, and Ft. Lauderdale; craniofacial team meetings; various educational presentations between CMS area offices; and numerous administrative and consultative meetings with CMS staff. Some CMS offices are beginning to work with the UM to develop teledermatology clinics as well.

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

/2013/ CMS Area Offices continue to provide specialty services using telemedicine technology. Clinics include endocrinology, genetics, nutritional counseling, dermatology, and neurology. //2013//

CMS oversees the statewide Poison Information Center Network. Poison prevention and management information is provided 24 hours a day through a toll-free number. The centers provide access to poison information, triage of the potentially poisoned patient, collection of pertinent data, professional consultation for health care providers, and professional and consumer education. During fiscal year 2007-08, the network handled 191,494 calls, provided 6,395 consults, provided education services to 1,766 community programs, 372 professional events, and participated in 824 health fairs or other special events. Over 500,000 pieces of informational materials and 78 media/public relation activities were provided.

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

/2013/ During 2010-11, the network handled 186,153 calls provided by 8,947 consults. The network provided education services to 1,410 community programs, 308 professional events, and participated in 806 health fairs or other special events. Over 504,038 pieces of informational materials and 117 media public relations activities were provided. //2013//

/2014/ During 2011-12, a total of 176,073 calls were handled by 7,200 consults. Education services to 1229 community programs, and distributed 453,570 pieces of educational materials. //2014//

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

/2012/ In year 2009-10, over 380,000 copies of the Coping with Crying brochure were distributed.

Training was provided to parents of newborns in 23 facilities. //2012//

/2013/ In 2010-11, over 181,950 copies of the Coping with Crying brochure were distributed. Training was provided to parents of newborns in 143 facilities. //2013//

/2014/ In 2011-12, over 247,000 copies of the Coping with Crying brochure were distributed to 226 facilities. //2014//

The basic statutory authority for MCH is Section 383.011, Florida Statutes, Administration of Maternal and Child Health Programs. The statute authorizes the Department of Health to administer and provide MCH programs, including the WIC program and prenatal care programs. This statute also designates the Department of Health to be the agency that receives the federal MCH and Preventive Health Services Block Grant funds. Other statutes related to the MCH program:
Section 409.810, F.S., establishes Florida KidCare.
Section 154.01, F.S., authorizes the Department of Health to operate primary care programs through the county health department delivery system, establishing a system of comprehensive integrated care.
Section 91.297, F.S., provides the authority for the Department of Health to implement a comprehensive family planning program.
Section 381.0056, F.S., delineates the joint responsibilities and cooperative efforts the Department of Health and the Department of Education have in implementing the school health services program.
Section 381.0057, F.S., establishes comprehensive school health services to provide health services in the schools, to promote the health of students and to reduce teenage pregnancy.
Section 381.0052 (e), F.S., the Public Health Dental Program Act, makes available dental preventive and educational services to all citizens and treatment services to indigent persons.
Section 383.014, F.S., authorizes screening and identification of all pregnant women entering into prenatal care and all infants born in Florida, for conditions associated with poor pregnancy outcomes and increased risk of infant mortality and morbidity.
Section 383.216, F.S., establishes prenatal and infant coalitions for the purpose of establishing partnerships among the private sector, the public sector, state government, local government, community alliances, and MCH providers and advocates, for coordinated community-based prenatal and infant health care.

The basic statutory authority for CSHCN and their families is Chapter 391, Florida Statutes, known as the Children's Medical Services Act. Related statutes include statutory authority and mandates pertaining to: screening of infants for metabolic and other hereditary and congenital disorders; infant hearing impairment; perinatal and neonatal services; child protection; sexual abuse treatment; developmental evaluation and intervention; hematology; oncology; poison centers; and parent support and training programs. Other statutes related to the Children's Medical Services Program:
Section 383.144, F.S., Infant Hearing Impairment Program.
Section 383.15-.21, F.S., Regional Perinatal Intensive Care Centers Program.
Section 383.215, F.S., Developmental Intervention and Parent Support and Training.
Sections 415.5055, 415.5095, F.S., Child Protection Teams.
Section 402.24 F.S., Recovery of Third Party Payments for Medical Services.
Chapter 385, F.S., Chronic Disease, Hematology/Oncology Care Centers Program.
Section 395.038, F.S., Regional Poison Control Centers.
Chapter 187, F.S., State Comprehensive Plan.
Section 409.905, F.S., Early and Periodic Screening, Diagnosis and Treatment Services.
Chapter 411, F.S., Florida Prevention, Early Assistance and Early Childhood Act.
98.282, Florida Laws, Healthy Start Act.
Section 383.14, F.S., Screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.
Section 383.145. F.S., Newborn and infant hearing screening.

C. Organizational Structure

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

Chief of Staff: responsible for Communication and Marketing, and assists with policy direction.

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

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

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

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

/2014/ Under the department's reorganization in 2012, there were several changes in reporting structure and oversight responsibilities.

Chief of Staff: oversees initiatives of the Offices of Communications, Legislative Planning and Performance Improvement.

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

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

Deputy Secretary for Statewide Services: provides oversight and direction to the State's county health department directors and administrators who are responsible for the 67 county health departments and the Office of Public Health Statistics and Performance Improvement. //2014//

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

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

The Bureau of Family and Community Health is responsible for many of the Title V activities

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

/2013/ As part of the Department of Health reorganization bill passed by the 2012 Florida Legislature and signed into law by Governor Rick Scott, the Division of Family Health Services is now known as the Division of Community Health Promotion. The Bureau of Family and Community Health is now known as the Bureau of Family Health Services. //2013//

/2014/ The Maternal and Child Health (Title V) programs are located in the renamed Bureau of Family Health Services and the Division of Children's Medical Services. //2014//

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

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

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

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

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

/2013/ Dr. Farmer is no longer with the Department of Health. //2013//

/2013/ John H. Armstrong, MD, FACS, was appointed by Governor Scott as Florida State Surgeon General and Secretary of Health on April 27, 2012. Previously, he was Chief Medical Officer of the USF Health Center for Advanced Medical Learning and Simulation; Surgical Director of the USF Health American College of Surgeons Accredited Education Institute; and Associate Professor of Surgery, Department of Surgery, University of South Florida (USF) Morsani College of Medicine. He previously served as the Trauma Medical Director at Shands Hospital at the University of Florida Medical Center, and was a 2011 Exemplary Teacher at the University of Florida College of Medicine. //2013//

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

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

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

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

/2014/ Kim Barnhill, M.S., M.P.H, was named as Chief of Staff for the Florida Department of Health in July 2012. Her previous experience with the department includes overseeing dual county health departments, directing preventive dental programs for over three dozen counties, and serving as the Director of Statewide Services. In her duties as Chief of Staff, Ms. Barnhill also supervises the Offices of Legislative Planning, Communications, and Performance Improvement. //2014//

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

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

/2013/ Ms. Berfield is no longer with the Department of Health. //2013//

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

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

/2013/ Steven Harris, M.D. M.Sc., currently serves as the Deputy Secretary for Health and the Deputy State Health Officer for Children's Medical Services (CMS). Divisions under his leadership include the Division of Community Health Promotion and the Division of CMS Network, and he also oversees the CMS Clinics, giving him ultimate responsibility for Title V activities. Dr. Harris also oversees the Division of Emergency Preparedness and Community Support and the Division of Disease Control and Health Protection. //2013//

/2014/ Dr. Harris is no longer with the Department of Health. Celeste Philip, M.D, M.P.H., is presently serving as the Interim Deputy Secretary for Health and the Deputy State Health Officer for Children's Medical Services. In these roles, Dr. Philip provides leadership over the Division of Children's Medical Services and the 22 CMS Regional Offices; the divisions of Community Health Promotion, Disease Control and Health Protection, and Emergency Preparedness and Community Support; and the Office of Minority Health. //2014//

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

/2013/ Mr. Sentman has assumed a position with the Gadsden County Health Department.

//2013//

/2013/ Robert "Sterling" Whisenhunt has been named the Assistant Deputy Secretary for Health. He serves as the Statewide Services Director and is responsible for the oversight and provision of direction to the 60 County Health Department Directors and Administrators responsible for the 67 County Health Departments. //2013//

/2014/ C. Meade Grigg has been named as the Deputy Secretary for Statewide Services. He serves as the Statewide Services Director and is responsible for the oversight and provision of direction to the 60 County Health Department Directors and Administrators as well as the Division of Public Health Statistics and Performance Management. //2014//

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

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

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

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

/2013/ Ms. Phelps is no longer with the Department of Health. //2013//

/2013/ On April 30, 2012, Betsy Wood, B.S.N., M.P.H., was named Interim Director of the Division of Community Health Promotion, the division formerly known as Family Health Services. Ms. Wood has a vast array of experience within the department, including work within Children's Medical Services and as the unit director of the former Maternal and Child Health Office, now IMRH. She most recently served as Interim Director of the Division of Health Access and Tobacco and also serves as Chief of the Bureau of Chronic Disease Prevention and Health Promotion. //2013//

/2014/ Ms. Wood has been formally named as the Director of the Division of Community Health Promotion. //2014//

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

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

/2013/ Ms. Bradley is no longer with the Department of Health. //2013//

/2014/ Kris-Tena Albers, A.R.N.P., C.N.M., M.N., now serves as the Chief for the Bureau of Family Health Services. Ms. Albers formerly served as the Executive Community Health Nursing Director in the Infant, Maternal, and Reproductive Health Section. //2014//

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

/2013/ Dr. Sappenfield is no longer with the Department of Health. //2013//

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

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

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

/2014/ Margaret Rankin, R.N. B.S.N., was named as the Executive Community Health Nursing Director in the Infant, Maternal, and Reproductive Health Section in January 2013. Ms. Rankin oversees the statewide Healthy Start and Family Planning programs, as well as all maternal and child health initiatives. //2014//

Carol Scoggins, M.S., joined Infant, Maternal, and Reproductive Health in October 2009, serves as the Program Administrator for the Maternal and Child Health team, and has worked in Family Health Services since 2004.

/2013/ Christina Canty, M.P.A., C.P.M., joined Infant, Maternal, and Reproductive Health in June 2012 as a Program Administrator for the IMRH team responsible for budget, procurement, grants, and data analysis. //2013//

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

/2014/ Karen Coon is no longer with the Department of Health. Ms. Coon was replaced by Nita Harrelle who joined the Infant, Maternal, and Reproductive Health Section in December 2012 as the Program Administrator/Supervisor for the Healthy Start Contract Management Team. Her previous experience with the department includes working in the Bureau of Communicable Disease as the Perinatal HIV Prevention Coordinator, managing the Targeted Outreach for Pregnant Woman Act (TOPWA) program. //2014//

As of May 2011, there were 73 central office staff members in the Children's Medical Services Program. The CMS Network Division performs the duties for the Title V children with special health care needs component. There were 671 out-stationed staff members in the 21 CMS area offices located throughout the state. The senior level management employees include: Joseph Chiaro, M.D. Deputy, Secretary for CMS; Phyllis Sloyer, R.N., Ph.D., Division Director for CMS Network and Related Programs; Michael Haney, Ph.D., Division Director for CMS Prevention and Early Interventions Programs, Marybeth Vickers, R.N., MSN., Chief for CMS Network Operations Bureau, and Peggy Scheuermann, M.Ed., Deputy Division Director for CMS Prevention and Early Interventions Programs.

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

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

/2014/ During the 2012 legislative session, the Deputy Secretary position for CMS and the Division Director for CMS Prevention and Early Interventions Programs were eliminated. Due to this change, the Division of CMS Prevention and Early Intervention Program and the Division of Network and Related Programs were combined into the Division of Children's Medical Services Program, under the direction of one Division Director. Dr. Celeste Philip currently serves as Deputy State Health Officer for the CMS Program, as well as providing leadership for three other divisions and the Office of Minority Health. //2014//

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

/2013/ Phyllis Sloyer is no longer with the Department of Health. //2013//

Mary Beth Vickers, R.N., M.S.N., joined Children's Medical Services as Bureau Chief for CMS Network Operations in June 2010. She has been serving as Acting Division Director for CMS since November 2011. Previously, Ms. Vickers was the Executive Director of a home health agency, served as an instructor in nursing at Florida State University and Tallahassee Community College, and owned and operated a case management company. During her tenure with the Department of Health, she has worked as a nursing consultant with the Florida Board of Nursing and served in a variety of CMSN programs in the nursing consultant role, as well as the Director of the Qualify and Practice Management Unit.

/2014/ Ms. Vickers has been formerly named as the Division Director of Children's Medical

Services. //2014//

Peggy Scheuermann, M.Ed., C.P.M., the Bureau Chief for the CMS Bureau of Child Protection and Special Technology and has been with CMS since 1998. Prior to working for the Department of Health, Ms. Scheuermann worked for a variety of social services agencies in the areas of criminal justice, domestic violence, and child welfare. She currently serves on several statewide advisory councils on substance abuse prevention and child welfare.

Charlotte Curtis, R.N., B.S.N., C.P.M., has served as the Executive Community Health Nursing Director with the CMS Network since 2006, currently serving as the Director of Program Planning and Development. She has been serving as Acting Bureau Chief for CMS Network Operations since November 2011. Prior to joining CMS in January 2006, for the Partners in Care: Together for Kids Program/CHIPACC, she served as a Nursing Consultant for the Maternal and Child Health Unit and Executive Community Health Nursing Director for the Child and Adolescent Health Unit. She has been the Department of Health since 1998. Ms. Curtis has been instrumental in the development, implementation and expansion of the first publicly funded palliative care program in the nation, and provides technical assistance to other states who would like to replicate Florida's palliative care model.

/2014/ Ms. Curtis was appointed as Bureau Chief for CMS Network Operations and Title V CSHCN Director in November 2012. Ms. Curtis was also appointed to the Florida Developmental Disabilities Council in 2013. //2014//

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

/2014/ Ms. Redmon is no longer with Children's Medical Services. //2014//.

E. State Agency Coordination

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

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

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

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

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

The Department of Health works in partnership with the Department of Children and Families (DCF) and the Ounce of Prevention Fund of Florida on implementation of the Healthy Families Florida initiative. Healthy Families Florida provides a community-based approach that uses intensive home visiting and coordination with other support services to build an integrated, coordinated, and comprehensive system of support for the prevention of child abuse and neglect. The agencies work together to avoid duplication of services and to facilitate services needed by families served in either program.

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

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

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

Coordination with the Family Planning Program, which includes work on reducing teen

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

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

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

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

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

The Bureau of Chronic Disease Prevention and Health Promotion was established in 1998 to improve individual and community health by preventing and reducing the impact of chronic diseases and disabling conditions. The bureau administers the following programs: Heart

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

Projects that specifically relate to maternal and child health include:

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

/2013/ The 2012 Legislature passed a bill calling for the reorganization of the Department of Health and a realignment of programs. One section of the bill ended the Healthy Communities, Healthy People program. //2013//

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

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

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

diabetes due to previous or current history of GDM.

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

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

/2013/ The Bureau of Chronic Disease Prevention and the Infant, Maternal and Reproductive Health Section have entered into a collaborative project to focus on: 1) recognizing the rising prevalence of GDM; 2) screening more women identified with GDM postpartum for continued elevated blood glucose; and 3) the importance of treating those women identified with subsequent type 2 diabetes. Making systemic changes to the way we provide health care services to these women could substantially reduce these costly adverse health outcomes. //2013//

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

/2013/ The Florida Department of Health has been awarded continuing SSDI grant funds for a two-year grant cycle that runs from February 2012 through November 2014. For this grant cycle, the Florida Department of Health will develop analytic plans to measure, track, and assess Title V priority areas and the overarching Title V block grant themes. The Florida SSDI project will publish and/or disseminate data documents as determined by analytic plans. Two annual evaluations will be conducted to assess performance of grant activities and objectives; assess data products generated from SSDI grant efforts; measure the satisfaction of MCH stakeholders with SSDI output and products; and collect input on future MCH data needs and data processes. //2013//

In the fall of 2008, the Infant, Maternal, and Reproductive Health Section successfully applied for the HRSA First Time Motherhood/New Parents Initiative. Grant funding in the amount of $223,362 enabled us to partner with the Healthy Start Coalition of Pinellas, Inc. on a project

entitled Florida Right from the Start. The project will create a statewide social marketing campaign to promote positive birth outcomes by increasing awareness of preconception and interconception care, prenatal care, and parenting among first time parents. An evaluation team will gauge the effectiveness of the social marketing campaign based on increased awareness as measured by pre-intervention and post-intervention surveys. They will administer Web-based surveys to a convenience sample of first-time mothers and parents. They will also conduct Web-based post-implementation key informant surveys, and compile utilization statistics from the website and hotline to evaluate actual use. Funding for the second year is $230,064.

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

/2013/ In April 2011, the Department of Health and the Florida Association of Healthy Start Coalitions initiated a Healthy Start Redesign Process scheduled to conclude in March 2013. The goal of the redesign project is to increase delivery of effective, evidence-based services in order to better improve maternal and infant health outcomes for Florida residents. Major efforts during the two-year process include: review current literature and best practices nationwide that identify effective pregnancy, preconception, interconception, and infant support service practices; review and evaluate the Florida Healthy Start program components and services to assess which are research-informed and evidence-based; develop a comprehensive plan for implementing redesign elements to ensure program quality and fidelity; identify key effective program elements, processes, and quality indicators; develop a modular evaluation of the redesign that can be implemented in phases; and propose the elements, process, and options for a coalition allocation methodology that promotes quality, fidelity, and productivity. //2013//

/2013/ The Governor's Office of Adoption and Child Protection established a Child Abuse Prevention and Permanency Advisory Council to serve as its research arm and to guide the planning for the promotion of adoption, the support of adoptive families, and the prevention of abuse, abandonment and neglect. //2013//

/2013/ Florida is collaborating with other states in HRSA Region IV as part of March of Dimes, Every Woman Southeast Initiative. This multi-state partnership is designed to share and develop expertise on preconception and interconception health care, policies, research, programs, social marketing, and evaluation in order to improve the health of women and infants. Each of the states included in Region IV, Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee, have high rates of infant mortality and morbidity, chronic disease, sexually transmitted infections, obesity, unplanned pregnancy, and poverty. Minorities in these areas are affected at even greater rates. We hope this collaborative effort, with a focus on a woman's health before, during and after pregnancy, will have a positive impact on women's health, infant mortality and other pregnancy outcomes. //2013//

/2013/ The Department's Infant, Maternal, and Reproductive Health Section (IMRH) is contracting with the University of South Florida's Lawton & Rhea Chiles Center for Healthy Mothers and Babies to support the efforts of the Florida Perinatal Quality Collaborative (FPQC). The purpose of the FPQC is to improve maternal and infant health outcomes through the delivery of data-driven, value-added, and cost-effective MCH services. The FPQC engages perinatal health care stakeholders in the design, implementation, and evaluation of processes and quality improvement efforts. Their inaugural conference was held March 22-23, 2012 in Tampa. Physicians, nurses, nurse midwives, administrators, payers, health educators, community advocacy groups, and others interested in perinatal health were invited to attend. We expect that our partnership with the FPQC will lead to improved maternal and infant care, quality, and safety, and a decrease in non-medically indicated deliveries less than 39 weeks gestational age. The contract includes a Statement of Work that calls for the design and implementation of a plan for a quality

improvement project for women at risk for preterm delivery, and a quality improvement project for coordination and delivery of services to intra-partum and postpartum women at risk for adverse maternal and infant health outcomes. //2013//

/2014/ The Infant, Maternal, and Reproductive Health Section, Family Planning Program, collaborated with the Bureau of Communicable Disease, HIV/AIDS Program to provide educational materials in support of statewide efforts that focus on at-risk populations. Twenty-five (25) contraceptive kits were purchased and distributed to Targeted Outreach to Women with AIDS (TOPWA) program outreach workers. The kits contain samples and fact sheets for the most popular and effective contraceptive methods, and are used for educational and demonstrative purposes. Samples of safe sex materials and safe sex educational pamphlets were also included. The 25 kits were assembled into zippered three-ring binders with handles for ease of transport and accessibility in community settings. An additional 155 kits were purchased and distributed to county health department family planning programs for reproductive health counseling and education in clinic and community locations. Title V block grant funds were utilized to support these efforts. //2014//

/2014/ In May 2012, the Association of Maternal and Child Health Programs opened an opportunity for states to participate in a national project funded by the Kellogg Foundation called the Life Course Metrics Project. The project's goal is to develop standard life course indicators that will provide the means to improve monitoring and assessments of health for Florida's MCH population and the impacts of programs implemented. On behalf of the Department of Health, the Division of Community Health Promotion convened a state team and applied to participate. In June 2012, the department received notification of acceptance into the year-long project along with six other states. Shortly after award notification, Ghasi Phillips, CDC MCH Epidemiology assignee, assumed primary leadership and coordination role for the Florida team with Kris-Tena Albers, Florida's Title V Director, serving as co-lead. After a series of web/teleconferences for the state teams, in-state meetings, and two in-person meetings for the state leads, a list of measures were selected for consideration as life course indicators. Each participating state was assigned a set of measures to research and define by criteria that will assist assessments of each proposed indicator as a valid life course indicator. The Florida team was assigned 16 indicators to research and write-up as structured assessments. The research/assessments were written by volunteer public health and demography students, division staff, and two Healthy Start Coalition partners. The write-ups will be forwarded to the national project leads to assess with other states' submittals. The 16 measures researched by the Florida team included: adolescent depression, adolescent smoking, asthma, chlamydia, diabetes, gestational diabetes, HIV, hypertension, infant mortality, low birth weight, postpartum depression, pregnancy induced hypertension, pregnancy related death, preterm birth, repeat teen birth, and teen birth. //2014//

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	35.0	35.6	37.7	27.4	23.0
Numerator	3932	4046	4281	2904	1237
Denominator	1122596	1136803	1136370	1060331	537402

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
2012 hospital data includes only the first two quarters. Denominator was halved to get a more accurate representation of provisional indicator.

Notes - 2011
2011 includes only two quarters.

Narrative:
There were a number of efforts in FY2011 to reduce early childhood asthma. The Healthy Start program continued to assess the homes of and educate pregnant and parenting mothers for issues related to household indoor air quality, such as use of tobacco products, appropriate removal of dust and animal dander, and other allergens. Additionally, the Infant, Maternal, and Reproductive Health (IMRH) Section worked to reduce prenatal smoking rates through educating pregnant mothers on the relationship between secondhand smoke, SIDS, lung problems, ear infections, and more severe asthma and to refer mothers or their infants and children for medical specialty care if asthma is suspected.

To ensure safe early childhood educational environments, the department's Division of Environmental Health inspected daycare and pre-kindergarten facilities. The Asthma Prevention and Control Program, established in 2009 under a cooperative agreement with the Centers for Disease Control and Prevention, continued to coordinate statewide efforts to improve asthma outcomes and reduce disparities. The program goals are to increase the number of individuals with asthma who receive self-management education and to reduce the number of deaths, hospitalizations, emergency department visits, school or work days missed, and limitations on activity due to asthma. The program facilitates the Florida Asthma Coalition; conducts asthma surveillance and program evaluation; and works specifically to increase the number of childcare centers, schools, and hospitals that implement asthma management programs. Three separate peer networks were established to facilitate the sharing of strategies among childcare center managers, school administrators, and hospital staff. Evidence has shown that training combined with peer support is an effective way to engage new partners and establish sustainable systems. Additional information on the Asthma Prevention and Control Program is available at: www.doh.state.fl.us/Environment/medicine/Asthma/index.html

/2014/ The Bureau of Family Health Services maintains a number of asthma-related clinical guidelines and protocols for its county-level programs. For local department and school district registered school nurses, the bureau's Child and Adolescent Health Section has been updating it's Nursing Guidelines for the Delegation of Care for Students with Asthma in Florida schools serving Pre-Kindergarten (Pre-K) -- 12th grade students. Additionally, department school health liaisons monitor local school health programs for individualized health care planning for students with asthma. //2014//

/2014/ The Healthy Start Program and the IMRH Section continue to address childhood asthma through efforts to reduce tobacco use and educate pregnant and parenting mothers for issues related to household indoor air quality, such as use of tobacco products, and appropriate removal of dust, animal dander, and other allergens. //2014//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 02 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	100.0	100.0	76.4	77.7	
Numerator	140978	138961	108268	110663	
Denominator	140978	138961	141645	142389	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2012
Data for 2012 is not yet available.

Notes - 2010
Apparent drop in annual indicator is actually an error in data entry. Data for 2008 and 2009 had incorrect numerator data.

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

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 03 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	72.5	44.3	60.5	61.5	62.2
Numerator	1004	402	1097	1172	1198
Denominator	1384	907	1812	1905	1925
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
In Florida, infants up to age 1 year whose family income is at or below 200 percent of the Federal Poverty Level (FPL) are income eligible for Medicaid. For families with family income at or below 185 percent of FPL, the infant's coverage is financed by Title XIX of the Social Security Act. For families with incomes from 186 percent through 200 percent of the FPL, the infant's coverage is

financed by Title XXI of the Social Security Act (CHIP), but the child is enrolled in Medicaid. The Agency for Health Care Administration collects data on the number of CHIP enrollees who receive at least one initial or periodic screen and shares that with the Department of Health.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 04 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	69.7	71.2	71.3	72.0	71.2
Numerator	142059	138142	131093	137448	140197
Denominator	203696	193896	183900	190786	196957
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

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

/2014/ Currently, the department implements and monitors the MomCare program, as a part of the Healthy Start Program, in collaboration with Florida's Medicaid agency, the Agency for Health Care Administration (AHCA), and the Healthy Start Coalitions. As a result of action taken during Florida's 2011 legislative session, the implementation of the 1915b Waiver and SOBRA (MomCare) will be moved from the department to AHCA's purview beginning October 1, 2014. The department is working closely with AHCA and coalition staff in an effort to assure a seamless transition. //2014//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 07A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	76.9	71.4	70.5	73.7	
Numerator	1360513	1606835	1676229	1736576	
Denominator	1768710	2250889	2376663	2356719	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2012
Data for 2012 is not yet available.

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

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 07B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	32.4	29.7	29.4		
Numerator	116656	131003	145003		
Denominator	359656	441239	493660		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?					

Notes - 2011
Accurate report data are not yet available for 2011 from the Florida Medicaid Program. As soon as the corrected reports are available the data will be submitted.

Narrative:
Improving access to dental care for low-income persons below 200 percent of the federal poverty level is a priority of the department. Over the last several years, the department has funded initiatives to expand the infrastructure of county health department safety net dental programs. During 2011, three additional counties began to provide dental services, increasing the total number of Florida counties with dental programs to 53. A large majority of clients served through county programs are Medicaid-enrolled children, and during 2011 the number of Medicaid children receiving dental care through the CHDs grew from 112,848 in 2010 to 136,293, a 20.7

percent increase. A state oral health improvement plan for disadvantaged persons utilizes ongoing broad-based stakeholder input to facilitate the continued development of an integrated, coordinated oral health system between the public and private sectors. The state oral health coalition, Oral Health Florida, and numerous local coalitions work collaboratively to implement diverse strategies around prevention, education, and treatment.

/2014/ Improving access to dental care for low-income persons below 200 percent of the federal poverty level continues to be a priority of the department. The department continued to fund initiatives to expand the capabilities of local county health department safety net programs. Last year two additional counties were provided funds to establish dental programs. Florida continues to work with the Oral Health Florida coalition to facilitate coordination between the public and private sectors. Oral Health Florida utilizes ongoing broad-based stakeholder input to facilitate the continued development of an integrated, coordinated oral health system between the public and private sectors. Several local coalitions continue to educate their local communities on the diverse strategies which include preventive, educational and treatment measures. //2014//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 08 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	14.7	16.5	20.8	17.1	21.7
Numerator	12307	12506	16566	14447	23377
Denominator	83719	75723	79708	84352	107700
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

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

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

indicators for Medicaid, non-Medicaid, and all MCH populations in the State					
Percent of low birth weight (< 2,500 grams)	2011	matching data files	9.7	7.1	8.7

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

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2010	matching data files	7.5	4.6	6.3

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

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2011	matching data files	73.9	90.1	80.5

Notes - 2014
Percent of infants born to women who began care in the first trimester differs from the values provided on Form 11 NPM #18 because births with unknown linking information are excluded.

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

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2011	matching data files	59.6	72.2	64.6

Notes - 2014
Data for "all" column differ from numbers reported elsewhere in report, as this data comes from a different source. Source for this data looks at matched data files that exclude those without an SSN number. In the case of multiple births, multiple births are counted as one delivery, further skewing the results. Data for this indicator is more accurately reflected on Form 17.

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

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2012	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2012	200

Narrative:
Infants 0 to 1 whose family income is 185 percent of the Federal Poverty Level or below are income eligible for Title XIX-financed Medicaid. Infants 0 to 1 whose family income is between 186 percent and 200 percent of the Federal Poverty Level are income eligible for Title XXI-financed Medicaid.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**

Medicaid Children (Age range 1 to 6) (Age range 6 to 18) (Age range to)	2012	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 6) (Age range 6 to 18) (Age range to)	2012	 200 200

Narrative:
Children ages 1 to 6 whose family income is 133 percent of the Federal Poverty Level or below are income eligible for Title XIX-financed Medicaid. Children ages 1 to 6 whose family income is between 134 percent and 200 percent of the Federal Poverty Level are income eligible for Title XXI-financed Florida KidCare (CHIP). Children ages 6 to 19 whose family income is 100 percent of the Federal Poverty Level or below are income eligible for Title XIX-financed Medicaid. Children ages 6 to 19 whose family income is between 101 percent and 200 percent of the Federal Poverty Level are income eligible for Title XXI-financed Florida KidCare (CHIP).

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2012	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2012	

Notes - 2014
In Florida, pregnant women are not eligible for SCHIP coverage.

Narrative:
Pregnant women whose family income is 185 percent of the Federal Poverty Level or below are income eligible for Medicaid.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	3	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2014

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

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

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

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

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

Newborn Screening Files: When Newborn Screening data was linked to live birth certificates in 2004, the linkage showed that only a small percentage of live births are not receiving newborn screening. However, because screening of every newborn is important, plans are underway to integrate the data entry for live birth certificates and newborn screening at the delivery hospital to establish an ongoing process for identifying newborns that are not screened.

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

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

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	**Does your state participate in the YRBS survey? (Select 1 - 3)**	**Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)**
Youth Risk Behavior Survey (YRBS)	3	No
Florida Youth Tobacco Survey	3	No

Notes - 2014

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

IV. Priorities, Performance and Program Activities

A. Background and Overview

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

B. State Priorities

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

1. Prevent unintended and unwanted pregnancies.

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

2. Promote preconception health screening and education.

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

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

SPM# 4 The percentage of infants not bed sharing.
SPM# 5 The percentage of infants back sleeping.

4. Prevent teen pregnancy.

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

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

NPM#9 Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
SPM#7 The percentage of low-income children under age 21 who access dental care.

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

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

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

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

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

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

C. National Performance Measures

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	1362	1279	1294	1218	1142
Denominator	1362	1279	1294	1218	1142
Data Source	Florida Newborn Screening Program	Florida Newborn Screening Program	Florida Newborn Screening Program	Florida Newborn Screening Program	Florida Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

Florida statutes require that every newborn born in the state must be screened before one week of age. Although parents have the option to refuse the newborn screening test, it is estimated that most newborns participate in the screening process. This is a population-based service. All of the MCH population groups are served by this measure. Follow-up activities include contracts with genetic specialty centers for referral of patients with abnormal test results, and contracts with cystic fibrosis, endocrine, and hematology/oncology specialty centers. Specialty referral centers arrange for confirmatory testing and treatment for patients identified through the Florida Newborn Screening Program. Genetic counseling, follow-up, and nutritional counseling activities related to treatment and dietary management are also included. Educational materials are distributed to all birthing facilities regarding the 34 disorders that are tested in the newborn metabolic screening plus information about hearing screening.

In 2011, testing identified 1,218 babies with presumptive positive screening results. After confirmatory testing, 418 were found to have one of the 34 disorders. Of the 418 confirmed cases, all of them received timely follow-up and treatment. Final data for 2012 are not yet available.

Direct Health Care Service activities provided by the department include referral of patients with presumptive positive test results to genetic specialty centers, endocrine specialty centers, and

hematology/oncology specialty centers. Educational materials are distributed to all birthing facilities regarding the five disorders that are tested in the newborn metabolic screening. The previous two activities are population-based services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Florida contracts with three genetic specialty centers for referral of patients with abnormal PKU, Galactosemia, Biotinidase and other metabolic disorder test results.	X			
2. Florida contracts with three endocrine specialty centers for referral of patients with abnormal congenital hypothyroidism and congenital adrenal hyperplasia test results.	X			
3. Florida contracts with 10 hematology/oncology specialty centers for referral of patients with abnormal hemoglobinopathy test results.	X			
4. Florida contracts with 12 Cystic Fibrosis Centers for referral of patients with abnormal cystic fibrosis test results.	X			
5. Specialty referral centers arrange confirmatory testing and treatment to for patients identified through the screening program. Genetic counseling, follow-up and nutritional counseling activities (treatment and dietary management) are included.	X			
6. Educational materials are distributed to all birthing facilities regarding the 34 disorders that are tested in the newborn metabolic screening.			X	
7.				
8.				
9.				
10.				

b. Current Activities

As of October 1, 2012, when Severe Combined Immunodeficiency Disease was added to the screening panel, Florida Newborn Screening Program screens for 35 disorders, 36 including hearing. The Florida Newborn Screening Results (FNSR.Net) web-based program that was developed for physicians and hospitals to access newborn screening results served 2,956 registered users who accessed the site 92,400 times. This statewide outreach program is a population-based service. All newborns identified through the Newborn Screening Program with one of the disorders on the Recommended Uniform Screening Panel are medically eligible for the Children's Medical Services Network Program.

c. Plan for the Coming Year

Although delays prevented the linking of the electronic birth registration information with newborn screening, progress was made to upload the Vital Statistics electronic birth registry system (EBRS) data into the Newborn Screening data system for the purposes of linking. Linking algorithms are currently being explored to determine the best data fields on which to link the EBRS and Newborn Screening data. The linking procedure is expected to be completed by summer 2013. The Florida Newborn Screening just released a new system called "eReports" for hospitals and providers to access and enter hearing screening results. Training for this system will begin April 2013 and will continue for several months as users get acclimated to the new, more efficient, and more reliable method to enter results. Benefits of the eReports include efficiency, reliability, and accurate data for programmatic planning. A third data-related project

known as Electronic Laboratory Ordering/Electronic Laboratory Reporting (ELO/ELR) is in progress. This project will receive all of the data that is currently on the bloodspot specimen card via handwriting in a HL-7 formatted data packet from each of Florida's birthing facilities. As of March 2013, tests were being conducted between 12 hospitals selected as a part of a test group to send this information electronically. The benefits of the ELO/ELR project include a reduction in data entry at the Bureau of Laboratories, extremely reliable data, and increased turnaround time in reporting. Reporting will also be converted from a paper fax to a digital HL-7 file, which will allow hospitals to automatically upload their testing results into their respective Electronic Health Record (EHR) systems.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**213669**					
Reporting Year:	**2011**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	211532	99.0	22	12	12	100.0
Congenital Hypothyroidism (Classical)	211532	99.0	132	102	102	100.0
Galactosemia (Classical)	211532	99.0	83	3	3	100.0
Sickle Cell Disease	211532	99.0	259	214	214	100.0
Biotinidase Deficiency	211532	99.0	26	6	6	100.0
Congenital Adrenal Hyperplasia	211532	99.0	13	7	7	100.0
Cystic Fibrosis	211532	99.0	512	40	40	100.0
MS/MS disorders	211532	99.0	193	34	34	100.0

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance	52	54	53	55	69

Objective					
Annual Indicator	50.2	50.2	50.2	68.2	68.2
Numerator					
Denominator					
Data Source	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.	National Survey of Children with Special Health Ca	National Survey of Children with Special Health Ca	Florida State Profile data for CSHCN survey.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	70	71	72	73	74

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

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

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

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

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

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

In addition, CMS continues to collect data from each of the 21 area offices for its performance measures. The data is collected through the electronic records that are maintained for each CMS enrollee.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family-to-family support and contact will be facilitated throughout CMS.	X			
2. CMS staff will produce and market materials that explain the CMS Mission, Vision, Goals and Services via their website, printed materials, and other forms of media and advertising.			X	
3. Include CMS families in developing policy, training, and in-service education.		X		
4. A statistically significant number of Satisfaction Surveys will be obtained from children, teens, and young adults enrolled in CMS Programs or their families regarding the services received through CMS or a CMS contracted provider.				X
5. Data collection and analyses from each CMS area office for CMS Goals/Performance Measures on family partnering and satisfaction with services.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In 2012, CMS continues to partner with the American Academy of Pediatrics and the Florida Agency for Health Care Administration for the Pediatric Medical Home Demonstration Project. The CSHCN Director serves on the Expert Panel Group which guides the project. The project is a result of the Children's Health Insurance Program Reauthorization Act (CHIPRA) grant. A total of 16 pediatric primary care practices participate in the project. Core teams have been formed that participate in learning collaborations in 2011 and 2012. Parents serve as one of the four core team members. CMS sponsors the participation of the parents in the project.

CMS is conducting its annual family satisfaction surveys, as in the past, to continue describing and quantifying satisfaction and health-related quality of life for children enrolled in the CMSN.

c. Plan for the Coming Year

CMS will continue to participate with CHIPRA Pediatric Medical Home Demonstration Project as described above and support parent involvement. CMS will also continue to conduct satisfaction surveys with parents of CMS enrollees.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	45	47	44	46	38
Annual Indicator	41.9	41.9	41.9	36.2	36.2
Numerator					
Denominator					
Data Source	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.	Florida State Profile Data for CSHCN Survey	Florida State Profile data for CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	38	39	40	41	42

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

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

Notes - 2011

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

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

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
CMS continued to redefine the medical home concept to promote quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families that are family-centered, community-based, and culturally competent.

CMS participated in a CHIPRA Quality Improvement Project in partnership with Illinois. The Florida CHIPRA Quality Improvement Project will: 1. Test the collection of new CMS core measures and other selected supplemental measures of high priority; 2. Collaborate with ongoing statewide Health Information Exchange (HIE) and Health Information Technology (HIT) development efforts to ensure that child health quality objectives are integrated, and child health performance measurement and quality improvement are fully supported; 3. Support implementation of enhanced medical homes, through training and technical assistance for practice redesign addressing core medical home measures and creating strong referral and coordination networks, as well as through the integration of HIT; 4. Evaluate the impact of the changes on the quality, coordination and efficiency of children's health care and in particular, children with special health care needs; and 5. Build on measure development and HIT to support collaborative quality improvement projects to improve client outcomes. CMS is represented on the advisory committee for the CHIPRA project, facilitated parent partner participation in the project, and supported the practices with care coordination staff for the Florida Pediatric Medical Home Demonstration Project.

CMS continued to expand the Medical Home Implementation Project and worked towards providing comprehensive medical home initiatives for all CMS enrolled clients. Physicians continued to partner with CMS in the medical home project and incorporated medical home care coordination, care management, and quality improvement teams in their practices. Medical home practices were offered the opportunity to participate in webinars and receive technical assistance through CMS contracted providers. Technical assistance included practice improvement techniques, ongoing quality improvement initiative (working toward NCQA Medical Home Recognition), medical home care coordination, and ongoing program evaluation. The CMS contracted providers recruited area physicians to become CMS credentialed providers and encouraged participation in the medical home project and conducted assessments of medical home readiness.

CMS continued research and development of a medical home strategic plan to provide direction for implementing medical home statewide throughout the CMS regions and contracted providers. CMS continued outreach, education, and recruitment of CMS pediatricians to participate in the statewide medical home plan.

CMS began phased rollout and implementation of an electronic administrative claiming process and comprehensive system of payment accuracy, and entered the design phase of the electronic care coordination documentation system. CMS began development of a comprehensive electronic health record for clients utilizing specialty clinics through the area offices. CMS focused on improving clinical services through the development of clinic standards, the development of medical homes throughout the state, newborn screening expansion, and enhancement of the Early Steps Program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Demonstrate the importance of medical home to the health and well being of children with special health care needs through statewide data collection, satisfaction surveys, and performance measures.				X
2. Medical home interagency leadership and collaboration through workgroups and participation in the Florida Pediatric Medical Home Demonstration Project.				X
3. National health care transition expertise, model of care, services, resources, training and technical assistance.				X
4. Support initiatives in Telehealth, and other innovative delivery systems, that are built on the CMS medical home.				X
5. Educate physicians and families on the benefits and use of Telehealth.		X		
6. Identify and recruit potential or approved providers to serve CMS children with special health care needs and their families with a focus on recruiting specialists, dental providers, and adult providers.		X		
7. Development and design of third party administrator system. Development and design of electronic documentation care coordination module for statewide implementation in 2014.				X
8. Collaborate with other state agencies and community partners to provide services to children with special healthcare needs, foster children, and Medicaid beneficiaries in a medical home.				X
9. Medical home community outreach opportunities to educate the public in general about medical home at CMS.		X		
10.				

b. Current Activities

CMS medical home projects focused on recruitment of physicians, specialists, and adult providers to provide services for CMS enrolled clients. Performance improvement reviews of the provider credentialing processes were conducted to improve efficiency and focus on expanding the CMS provider network.

CMS participated in the second phase of a CHIPRA Quality Improvement Project in partnership with Illinois. The Florida Pediatric Medical Home Demonstration Project focused on Core Quality Measures to improve the quality of care, quality of care coordination, implement more comprehensive models of service delivery, and demonstrate the impact of a model electronic health record. CMS is represented on the advisory committee for the CHIPRA project and supported the practices with care coordination staff.

CMS continued to implement the phased rollout of an electronic administrative claiming process

and comprehensive system of payment accuracy; entered the design phase of the statewide, web-based platform, care coordination documentation system and electronic health record; and conducted an assessment of processes, performance measures, and outcomes. Addressing recommendations from the Transition Taskforce Report (2009), CMS conducted an assessment of the existing health care transition process to increase access to medical homes for YSHCN with the goal of supporting seamless systems of health care transition for clients transitioning to adult health care services and providers.

c. Plan for the Coming Year

CMS will continue to redefine and improve the medical home concept to promote quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families that are family-centered, community-based, and culturally competent.

CMS will conduct an assessment of care coordination guidelines and policies in preparation for the phased rollout of the statewide, web-based platform, care coordination documentation system, and electronic health record. The care coordination process is performed by care coordinators located in the medical home practice or in the local office. CMS care coordination core elements encompass: assessment, plan of care created with the client and caregiver, home visits, family advocacy, linkage to specialists and community-based resources, coordination of health financing resources, coordination with school-based services, chronic disease management, preventative education, and health care transition planning. CMS is assessing national care coordination certification to improve client outcomes.

CMS will develop a transition medical home pilot in collaboration with transition contractors and expand health care transition service delivery for YSHCN. The Transition Taskforce Report, CMS health care transition algorithm, and existing strategic plans provide the framework for the development of a transition medical home process that will be implemented in 2014. CMS is collaborating with contracted providers to ensure that YSHCN, between the ages of 12-21, are linked to the appropriate health care transition planning, services, and resources to increase access to medical homes.

CMS will continue to recruit medical home physicians for the medical home implementation project. Medical home activities will include development of a medical home strategic plan to provide direction for implementing medical home statewide throughout the CMS regions and contracted providers. CMS will continue performance improvement reviews of the provider credentialing processes and evaluate recruitment of physicians, specialists, and adult providers, in order to provide services for CMS enrolled clients, improve efficiency, and focus on expanding the CMS provider network. CMS will continue outreach, education, and recruitment of CMS pediatricians to participate in the statewide medical home plan.

CMS will reach out to stakeholders in the state and in the Florida Pediatric Medical Home Demonstration Project to assess opportunities to develop and host medical home training opportunities in collaboration with the American Academy of Pediatrics and national and local partners to link them with experts.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2008	2009	2010	2011	2012

Performance Data					
Annual Performance Objective	62	64	60	62	60
Annual Indicator	58	58	58	56.5	64.3
Numerator					435089
Denominator					676655
Data Source	Florida State Profile data for CSHCN survey	Florida State Profile data for CSHCN survey	Florida State Profile data for CSHCN survey	Florida State Profile data for CSHCN survey	CSHCN survey and American Community Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	67	68	69	70	71

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

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

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

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
The U.S. Department of Health and Human Services Health Resources and Services Administration estimates that 14 to 19 percent of children in the United States have a special health care need (2010 HRSA National Survey of Children with Special Health Care Needs -- 2007 Chartbook).

In state fiscal year 2011-12 (July 1, 2011- June 30, 2012), the Children's Medical Service (CMS) Network for children with special health care needs provided health benefits coverage to 69,174 Title XIX-funded and 34,543 Title XXI-funded unduplicated children. In addition, 10,144 unduplicated children qualified for "Safety Net" services, state-funded limited services for children ineligible for Title XIX or Title XXI coverage, or whose private health insurance coverage was insufficient to meet the child's needs.

The Florida KidCare (FKC) Coordinating Council, created by section 409.818(2)(b), Florida Statutes, includes a diverse membership that makes recommendations to improve the implementation and operation of the Florida KidCare program. Some of the council recommendations from the January 2013 report address fully funding the FKC program, including annualization needs, projected growth, outreach, and increased medical and dental costs; implementing a medical income disregard for children with catastrophic illness who would otherwise qualify for Title XXI subsidies; implementing the state option Family Opportunity Act; implementing presumptive eligibility for FKC applicants, and taking advantage of federal funding to cover otherwise eligible legal immigrant children and pregnant women.

Florida KidCare provides families with a variety of written and electronic reminders about premium payments and renewal requirements. In addition to these activities, member services staff in the Children's Medical Services (CMS) Network communicate with enrollees' families to remind them about premium payments to reduce cancellations for nonpayment. The CMS Network Central Office periodically sends notices to families whose children who have been canceled from Title XXI-funded CMS Network coverage for nonpayment of premium or noncompliance with review to advise that they may contact Florida KidCare to find out how to reactivate coverage if their children are uninsured.

DOH maintains the FKC website. Staff provides FKC information to families through CMS, county public health departments, school health, and Healthy Start programs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate and coordinate with Medicaid and KidCare offices to strengthen outreach and enrollment strategies.		X		
2. Identify children at risk for and with special health care needs.		X		
3. Utilize quality of care measures for children enrolled in CMS Programs.			X	
4. Track health expenditures and costs of services.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Florida Healthy Kids Corporation supports community outreach campaigns targeting organizations whose memberships and clientele focus on families potentially eligible for FKC. As part of the CHIP reauthorization law, the U.S. Department of Health and Human Services awarded almost $1 million to the USF Covering Kids and Families (CKF) Project to help find and enroll eligible children in FKC, and to promote retention, with special emphasis on racial and ethnic minority groups. The Department of Children and Families provides materials and information to their community partners to contact families who do not qualify for Medicaid to

encourage them to apply for FKC for their children.

In 2011, the CKF project received a CHIPRA Round II award to expand its outreach efforts. The Agency for Health Care Administration (AHCA) works with the CKF project to build partnerships and create community-based coalitions to promote and sustain FKC.
During the 2012 session, the Florida legislature enacted language that allows income eligible children of state employees to enroll in Title XXI-funded FKC.

In collaboration with other FKC partners, the DOH continued to reach out to families with potentially eligible children and encourage them to apply for coverage or help eligible children retain their health care coverage.

c. Plan for the Coming Year

During the 2013 session, the state legislature made changes to the CMS "Safety Net" program, which provides limited services to children with serious special health care needs who do not qualify for Medicaid or CHIP funding. Children with serious special health care needs who are unable to access, due to lack of providers or lack of financial resources, may receive specialized services or essential family support services based on a sliding fee scale.

In early 2013, the Covering Kids and Families project applied for a Connecting Kids to Coverage Cycle III grant from the federal government to increase the number of application assistance center networks throughout the state where families may apply and receive assistance. Partnerships will be in geographic areas of the state with diverse populations and high rates of uninsured children who may qualify for Florida KidCare. The expansion of one-on-one application/renewal assistance best practices established under the project's Cycle I and Cycle II grants will ensure that families will have help from trusted sources within their own communities, increasing their confidence as well as the expectation that they will apply for coverage successfully.

The Florida KidCare program partners continue to conduct outreach for new enrollment, but also are focused on retention to ensure continuity of care. The Florida KidCare Evaluation Work Group directed the University of Florida's Institute for Child Health Policy to conduct focus groups with families of children whose Florida KidCare coverage was canceled for nonpayment of premium or noncompliance with renewal requirements to identify possible strategies to improve retention efforts. Families of children with special health care needs will be included in the research to determine if they face additional challenges that may require different strategies.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	87	88	89	90	65
Annual Indicator	85.9	85.9	85.9	63.2	63.2
Numerator					
Denominator					
Data Source	Florida State	Florida State	Florida State	Florida State	Florida State Profile data

	Profile data for CSHCN survey.	Profile data for CSHCN survey.	Profile data for CSHCN survey.	Profile data for CSHCN survey.	for CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	67	69	71	73	75

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

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

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

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

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
CMS area offices in various areas continued to provide specialty services through telemedicine. The clinics included neurology, genetics, nutrition, and dermatology in the southeast Florida area.

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

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

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

CMS continues to partner and collaborate with other agencies and organizations to help families navigate the system of care more easily. One example is the partnership with the Department of Children and Families where outreach has been provided to families who participate in the Medical Foster Care Program so they are successful in caring for medically complex children.

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

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

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Establish and maintain CMS Programs that support all caregivers and partners.				X
2. Support children, teens, and young adults, and family leadership programs that identify families as leaders and potential leaders.			X	
3. Promote use of telemedicine.		X		
4. Support family organizations/initiatives as they engage families of children at risk for and with special health care needs in effective partnerships.			X	
5. Evaluate the potential benefit of telehealth and telemedicine services for CMS enrollees and their families.	X			
6. Data collection and analyses from each CMS area office for CMS Goals/Performance Measures on community-based service systems.				X
7. Provision of a Pharmacy Benefits Program to CMS enrollees.	X			
8.				
9.				
10.				

b. Current Activities

The Institute for Child Health Policy (ICHP), University of Florida, continues to conduct annual satisfaction surveys from randomly selected parents of CMS enrollees. Results indicated that 89 percent of the respondents had one person they thought of as their child's personal doctor or nurse. In 2012, 95 percent of parents reported the "CMSN is the right program for my child." Additionally, 94 percent are satisfied with their Primary Care Providers, and 91 percent with the CMSN benefits they receive.

In 2012, Department of Health, CMS Program served on the Multisystem Subcommittee of the Governor's Children's Cabinet. This subcommittee works to coordinate services for children who are served by one or more agency. An Interagency Agreement has been implemented to collaborate with the Department of Children and Families, the Agency for Persons with Disabilities, the Department of Education, the Agency for Health Care Administration, the Department of Juvenile Justice, and the Guardian ad Litem Program, to look at ways to ensure well organized and easy to access to community-based service systems for children and youth including those with special health care needs and their families.

In 2012, CMS Program supported and participated in the Family Café Annual Conference. This conference brings together state agencies and families for the goal of a one stop shop for families to learn about resources and to receive information in a three day conference.

c. Plan for the Coming Year

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

CMS will continue to provide telemedicine specialty clinics through two-way interactive video teleconferencing. The telehealth program benefits CMS children and families by reducing travel time, costs, and inconvenience. Access to specialty care is improved by reducing wait times. CMS will continue to evaluate ways in which to expand telemedicine services.

CMS will continue to use the web-based provider application process to increase CMS Network provider participation, and enhancements will be made to the system in 2013-2014. The Department of Health, CMS Program will continue to serve on the Multisystem Subcommittee of the Governor's Children's Cabinet.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	34	36	34	36	38
Annual Indicator	33.8	33.8	33.8	37	37
Numerator					
Denominator					
Data Source	Florida State Profile data	Florida State Profile data	Florida State Profile data	Florida State Profile data	Florida State Profile data for CSHCN

	for CSHCN survey.	for CSHCN survey.	for CSHCN survey.	for CSHCN survey.	survey.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	40	42	44	46	48

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

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

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

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

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the

sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
CMS enrollees from 12 to 21 years of age continued to receive information and resources related to transition from their care coordinator. This activity was documented in the child's CMS electronic records. Each CMS area office or region has a transition liaison that serves as a point of contact for CMS and participates in quarterly transition conference calls to link CMS care coordinators with transition experts.

CMS continued to contract for transition related activities with the University of Florida Institute for Child Health Policy (ICHP), the Jacksonville Health and Transition Services program (JaxHATS), and the Florida Health and Transition Services program (FloridaHATS). ICHP, in collaboration with CMS, developed transition materials for CMS enrollees; provided transition technical assistance to CMS nurse care coordinators and social workers; and maintained online educational courses for CMS staff on transition topics. The JaxHATS program provided clinical services for 199 patients, age 16-26 in state fiscal year 2011-2012. In addition to health-related services, JaxHATS provided or promoted skill-building strategies to help patients achieve greater independence and decision-making skills; collaborated with schools, agencies, and community resources on transition related activities; and referred patients to specialty physicians and adult providers.

The FloridaHATS program provided leadership for three community-based healthcare transition coalitions and others that have been building such relationships, promoted their ability for providers to offer health services for adolescents and young adults; developed a directory of available primary care and specialty physicians around Florida for individuals who are transitioning from pediatric to adult providers; and developed informational brochures on health insurance.

CMS worked with FloridaHATS and the Florida Department of Juvenile Justice (DJJ) to update the DJJ online information for parents that explains how the juvenile justice system works and what to expect when a child or adolescent comes under their authority. The information included a section about how the DJJ screens for health history and their provision of health care services. The intent is to prevent delays or interruptions in health care needs and regimens. The statewide CMS Area Offices work with local DJJ staff to facilitate up-to-date medical records while following HIPAA and family consent documentation.

The CMS health care transition website maintains pdf files for health care transition-related brochures as well as links to health care transition websites, including FloridaHATS, JaxHATS, the University of South Florida's Project 10, and the national center for health care transition, "Got Transition?". The website serves as a state and national health care transition resource with new and updated resources added.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Plan for the eventual transition of all teens and young adults with special health care needs to adult services.		X		
2. CMS Network Care Coordinators will coordinate and facilitate transition activities with each teen beginning at age 12, to meet their needs.		X		
3. Create and maintain a Transition Guide on the CMS Internet.				X
4. Participate in a collaborative partnership with community organizations and state agencies to support the New Freedom			X	

Initiative and the Healthy and Ready to Work Transition services and systems.				
5. Create and maintain a CMS Youth Advisory Board staffed by CMS enrollees who are between 12 to 21 years of age.				X
6. Data collection and analysis from each CMS area office for CMS Goals/Performance Measures on youth transition.				X
7. CMS Transition Liaisons facilitate communication and link CMS care coordinators to transition experts to improve the transition service delivery system.			X	
8. Health care transition services provided to Youth and Adolescents with Special Health Care Needs by the Health and Transition Services providers.	X			
9.				
10.				

b. Current Activities
The JaxHATS and FloridaHATS contracts remain active. These contracts provide CMS enrollees, families, and staff with a variety of health care services and resources related to all aspects of transition.

Each CMS Area Office has an assigned care coordinator or supervisor acting as the Transition Liaison for their office. Transition-related information is sent by the CMS Central Office to the Area Office Transition Liaisons for distribution to the other CMS staff. This is an effective way of sharing important transition information statewide within CMS.

CMS transition collaborative partners continue to include the Department of Education, the Division of Vocational Rehabilitation, the Agency for Persons with Disabilities, the Department of Children and Families, the Department of Juvenile Justice, and the Agency for Health Care Administration. CMS participates in the State Secondary Transition Interagency Committee (SSTIC) with those partners. Projects underway that are developed by the SSTIC include trainings and webinars to help teachers become more familiar with the healthcare aspects of transition and to help students, and their parents, prepare for their transition into adult life.

CMS entered into a Memorandum of Agreement with the Florida Association of Community Health Centers (FACHC) to ensure a smooth transition when CMS enrollees age out of CMS if they receive primary care services from a local Federally Qualified Health Center (FQHC).

c. Plan for the Coming Year
CMS will continue to work with the JaxHATS and FloridaHATS programs to develop a health care transition delivery system. FloridaHATS will continue to conduct meetings of the Medical Advisory Committee to discuss health care transition issues with health care providers and promote community-based transition collaboratives around the state. FloridaHATS and CMS will continue to work with the FACHC and the FQHCs toward developing more options for health care transition for adolescents and young adults with special health care needs.

CMS is collaborating with transition partners to review and update transition training modules, resources, and tools for CMS clients, caregivers, and other transition stakeholders throughout the next fiscal year. CMS will host meetings with transition partners to discuss opportunities for health care transition delivery system development. CMS is reviewing opportunities to utilize the new electronic documentation system and care coordination guidelines to focus on medical home and transition. CMS will continue to expand its role as a national health care transition resource and best practice by providing leadership and technical assistance to local, state, and national partners and organizations.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	90	90	90	90	90
Annual Indicator	84.4	81.9	81.1	86.1	83.0
Numerator	200168	195839	187679	190618	177944
Denominator	237166	239120	231417	221391	214519
Data Source	DOH Survey of Immunization Two-Year-Old Children	DOH Survey of Immunization Two-Year-Old Children	DOH Survey of Immunization Two-Year-Old Children	DOH Survey of Immunization in 2-Year-Old Children	DOH Survey of Immunization in 2-Year-Old Children
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	90	90	90	90	90

a. Last Year's Accomplishments

The following initiatives were designed to improve immunization coverage levels in 2-year-old children: the department's missed immunization opportunities policy; outreach clinics; linkages with WIC and CMS; community partnerships and immunization coalitions; coordination with

Healthy Start and managed care organizations; promotion of the Standards for Pediatric Immunization Practices in the private sector; measurement of immunization coverage levels in public and private site reviews; outreach and increased enrollment in Medicaid and SCHIP; and continued implementation of the Vaccines for Children Program. Activities performed that impact this measure generally fall within the category of population-based services, offering disease prevention interventions to the entire population. Changes in immunization rates of 2-year-old children can be attributed to the following: immunization registry implementation reaching more private health care providers and ongoing partnerships with WIC in all county health departments.

During CY 2012, provisional data indicate that 83 percent of 2-year-olds received four diphtheria, tetanus, pertussis; three polio; one measles, mumps, rubella; three Haemophilus Influenza B; three hepatitis B; and one varicella immunizations (4-3-1-3-3-1 series). The Immunization Section shipped 4.6 million doses of vaccine to over 1,800 public and private healthcare providers. Florida SHOTS (statewide immunization registry) is functional in all 67 county health departments, for over 6,500 healthcare providers and includes over 700 partners who have uploaded 41 million records in 2012. Florida SHOTS is available for enrollment to private healthcare providers, schools, and licensed childcare centers. The registry includes approximately 15 million patient records. Additionally, the majority of school districts in Florida have schools that participate in the program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Recommend all health care providers implement the Standards for Pediatric Immunization Practices.				X
2. Continue implementation of the registry (Florida Shots) in the private sector.				X
3. Implement/Continue missed opportunities policy for public and private health care providers.			X	
4. Continue WIC/Immunization linkage.		X		
5. Statewide initiative to improve collaboration with public and private stakeholders/partners in order to increase immunization coverage levels in this target population.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In CY 2013, we continue activities to meet and surpass the state and national goal of 90 percent of all 2-year-old children who are appropriately immunized with the complete 4-3-1-3-3-1 series statewide. Specific activities include parent education; involvement of Healthy Start, immunization coalitions, and community partnerships; linkage with WIC, CMS and managed care organizations; identification of pockets of need for under-immunization; tracking immunizations in the health department; implementation of recall systems; public and private provider site reviews to assess coverage levels and promote the Standards of Pediatric Immunization Practices; increased enrollment of the registry in the private sector; continued implementation of the Vaccines for Children Program; and a statewide initiative to improve collaboration with stakeholders/partners to increase coverage levels in the target population. County health departments work with WIC, local medical societies, CMS, and others to develop/implement their immunization plans.

c. Plan for the Coming Year
Our objective for CY 2014 is that 90 percent of 2-year-olds receive age-appropriate immunizations. Outreach, promotion, and surveillance of rates will be utilized to support efforts in the private sector. The department will continue to coordinate with Healthy Start and Immunization coalitions to increase parent education about the importance of childhood immunizations and encourage local community partnerships. We will continue to recommend that all healthcare providers implement the Standards for Pediatric Immunization Practices, and continue expansion of the registry (Florida Shots) in the private sector (infrastructure-building activities). The department will continue an active partnership with coalitions and service agencies. We will continue to implement the missed opportunities policy for public and private health care providers (population-based) and continue the WIC and CMS/Immunization linkage (enabling). We will continue to implement the statewide initiative to improve collaboration with stakeholders/partners in order to increase coverage levels in this target population.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	20.5	20	17.5	15	13.4
Annual Indicator	20.4	17.6	15.3	13.4	12.2
Numerator	7286	6261	5398	4723	4193
Denominator	357335	355066	352069	353110	344403
Data Source	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	12.1	12	11.9	11.8	11.7

a. Last Year's Accomplishments
Provisional data for 2012 indicate a birth rate of 12.2 per 1,000 for teens 15 to 17, which is below the annual performance objective of 13.4 per 1,000. Family planning, positive youth development education and comprehensive school health service projects share the responsibility of providing reproductive health care services to teens throughout the state. Family planning provided an array of services to teenagers beginning with preconception risk assessment, counseling, dispensing contraceptive methods when requested, screening for sexually transmitted disease, and pregnancy testing.

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

The Adolescent Health Program is designed to enhance skills and improve the health status of adolescents and young adults through opportunities and programs developed in collaboration with families, communities, schools and other public and private organizations. The program provides a network of community-based support to help adolescents succeed as they move into adulthood by focusing on the assets of individual youth and their families. Sponsored programs will reinforce positive attitudes, healthy behaviors, and activities, as well as reduce risk-taking behaviors such as sexual activity, substance abuse, suicide, and behaviors that increase risk of unintentional injury and chronic disease.

During the FY2012 school year, 46 of the 67 county health departments provided Comprehensive School Health Services Programs in 520 schools, serving 391,744 students in high-risk communities with high teen birth rates. Comprehensive school health programs are designed to provide services that improve student health, reduce high-risk behaviors, and reduce teen pregnancy. The birth rate for comprehensive school health 6th -- 12th grade females was 7.15 per 1,000. This is accomplished through maintenance of high levels of school nursing services, including nursing assessments, referral and case management, health education classes, and prevention interventions. These projects provided 532 pregnancy prevention interventions to 2,768 students and 2,138 pregnancy prevention classes to 46,590 students. A total of 427 referrals were made for aftercare and support services coordinated through Healthy Start and school district Teenage Parent Programs. These services enabled 78 percent of parenting teens to return to school after giving birth. Both Healthy Start and Teenage Parent Programs provide these parenting teens with counseling to prevent repeat births.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Teen pregnancy prevention classes, and case management and aftercare for students in Comprehensive School Health Services Projects who give birth.		X		
2. Conducting abstinence-only education classes.		X		
3. Conducting statewide abstinence media campaign.			X	
4. Developing community and Department of Health program collaboration.				X
5. Promoting consumer involvement.		X		
6. Provision of confidential family planning counseling and education.	X			
7. Provision of confidential family planning comprehensive contraceptive services.	X			
8.				
9.				
10.				

b. Current Activities

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

The Adolescent Health Program also receives a Title V Abstinence Education Grant in the amount of $2,878,201 per year for five years. The grant funds community-based organizations, faith-based organizations, and county health departments to conduct abstinence education activities in their communities. The funded providers are using evidence-based models, and are evaluated to ensure curriculum fidelity.

c. Plan for the Coming Year

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

The Adolescent Health Program will continue to manage grants for locally funded projects that deliver positive youth development education.

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

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	34	39	40	14	14.1
Annual Indicator	37.1	13.9	13.8		
Numerator	27758	11801	12515		
Denominator	74906	84651	90882		
Data Source	DOH Public Health	DOH Public Health	DOH Public Health		

	Dental Program	Dental Program	Dental Program		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?					
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	14.2	14.3	14.4	14.5	

Notes - 2011
Accurate report data are not yet available for 2011 from the Florida Medicaid Program. As soon as the corrected reports are available the data will be submitted.

Notes - 2010
The Department of Health does not have data on the number of third grade children in Florida who receive sealants on permanent molars. In the absence of data, a proxy measure is provided for 2009 and after.

a. Last Year's Accomplishments
The Department of Health does not have data on the number of third grade children in Florida who receive sealants on permanent molars. In the absence of data, a proxy measure is provided for 2009 and after. For the numerator, it uses the total number of third graders (8-year-olds) who receive a sealant from a county health department plus the number of 8-year-olds who receive a sealant from a dentist in private practice paid by Medicaid. The denominator is the number of Medicaid-enrolled 8-year-olds during the year. Based on the reporting lag of Medicaid claims, data for 2011 is not available.

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

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote the development of school-based sealant programs.				X
2. Promote increased sealant utilization in county health department safety net programs.	X			
3. Develop and maintain sealant promotional material on Internet site.			X	
4. Promote the development of a surveillance system to capture sealant utilization data on permanent molars of third and ninth graders.				X
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
The Public Health Dental Program continues to promote the development of school-based sealant programs and the early placement of sealants on permanent first and second molars in county health department programs. The department provides links on its internet website where sealant promotional material is available. The department continues to support the strategy contained in the State Oral Health Improvement Plan which relates to increasing the number of school-based dental sealant programs. A HRSA Grant to States to Support Oral Health Workforce Activities was awarded in 2009 through which an education and prevention specialist position was established. A HRSA Grant to States to Support Oral Health Workforce Activities awarded in 2010 supports the funding of additional dental sealants provided to children through the expansion of school-based sealant programs in local county health departments. The department provided funding this fiscal year to eleven county health departments to expand access to dental sealant programs. This initiative should contribute to increased access to dental sealants for low-income and minority populations.

c. Plan for the Coming Year
The Public Health Dental Program will continue to promote and financially support the development and expansion of school-based sealant programs through federal and state funding. The department will improve its quality improvement process, and the coordination with local school systems to increase the number of dental sealants placed on children. The program will use its funding to continue the process of implementing the State Oral Health Improvement Plan and forging partnerships with the members of the coalition in order to meet the recommendations and objectives of the plan. The HRSA funding is ending this year, however, the program is seeking additional funds to continue to augment the infrastructure of the program. Through the department's reducing oral health disparities initiative to support county health department infrastructure expansion, incremental progress will continue to expand access to low-income and minority populations. The Florida Department of Health Public Health Dental Program continues to support the maintenance of a web automated interactive educational program which is available at www.mouthwiseflorida.com. This site allows the viewer to receive information about oral health for all stages of life: youth, teens, parents (caretakers) and dental professionals. The program is in English and Spanish. Resource links are included for further information. This messaging includes the promotion of dental sealants.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	3	2.9	1.7	1.6	2
Annual Indicator	1.9	2.1	2.0	2.1	1.6
Numerator	66	72	64	69	53
Denominator	3449949	3422460	3261716	3274059	3314695
Data Source	DOH Office of Vital Statistics.	DOH Office of Vital Statistics.	DOH Office of Vital Statistics.	DOH Office of Vital Statistics.	DOH Office of Vital Statistics.
Check this box if you cannot report the numerator because 1.There are fewer than 5					

events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	1.5	1.5	1.4	1.4	1.4

Notes - 2012
Data is incomplete for 2012. It is expected that once the number of deaths is calculated for the entire year, the indicator will be significantly higher. Thus, the annual objectives for this measure are higher than the indicator for 2012.

a. Last Year's Accomplishments
The Department of Health (DOH) Injury Prevention Program is the lead agency for Safe Kids Florida, part of the Safe Kids Worldwide Campaign, a global effort to prevent injuries to children 14 and under. Over 81 percent of children 14 and younger in Florida live in a county where Safe Kids 11 local coalitions and six state chapters are operating. Florida's Safe Kids chapters and coalitions were active in child passenger safety by distributing child safety seats, training Child Passenger Safety Technicians, and launching public awareness campaigns. In 2011, the childhood unintentional injury fatality rate in Safe Kids counties was 28 percent lower than the rate in non-Safe Kids counties, which corresponds to 110 fewer deaths than expected had the fatality rates been the same.

The Bicycle Helmet Program was administered through a grant from the Florida Department of Transportation from 2000--2001 and from 2004--2011. The program utilized community partners to fit and distribute thousands of helmets to children in low income households throughout Florida. Prior to distributing helmets, the community partners received bicycle safety education and training on the correct fit and proper positioning of helmets.

Since the program's inception at the Department of Health, over 159,100 helmets have been distributed statewide through the Bicycle Helmet Promotion Program, representing a total benefit to society of over $92,300,600 (based on a Children's Safety Network Report). At the end of 2011, the Florida Bicycle Helmet Promotion Program was moved to the University of Florida Pedestrian and Bicycling Safety Resource Center and is no longer administered by the Injury Prevention Program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Through the local Safe Kids coalitions and chapters, conducted numerous car seat check-up events on an ongoing basis and during National Child Passenger Safety Week, National Safe KidsWeek, and Buckle Up America Week.		X		
2. Through the local Safe Kids coalitions and chapters, implement the Battle of the Belts program, developed in an effort to increase safety belt use amongst teenagers.		X		

3. Through the local Safe Kids coalitions and chapters, implement International Walk to School month to promote health and safety for kids walking to school.		X		
4. Through the local Safe Kids coalitions and chapters, implement the federal Safe Routes to School (SRTS) program, including Walking School Buses and Bike Rodeos..		X		
5. Through the local Safe Kids coalitions and chapters, implement the Click-it or Ticket campaign designed to increase awareness of traffic safety.		X		
6. Through the local Safe Kids coalitions and chapters, implement the 2012 Never Leave Your Child Alone in a Car Campaign.		X		
7. Through the local Safe Kids coalitions and chapters, train Child Passenger Safety Technicians to conduct car seat check-up events.		X		
8.				
9.				
10.				

b. Current Activities

Through the 11 local Safe Kids Coalitions and seven chapters, numerous car seat check-up events are conducted on an ongoing basis and during National Child Passenger Safety Week, National Safe Kids Week, and Buckle Up America Week. In 2012, the Florida Distracted Driving Policy Subcommittee supported the Florida Booster Seat Coalition by hosting numerous booster seat give away events.

The DOH Injury Prevention Program has a representative on numerous committees and coalitions dedicated to reducing injury and death from motor vehicle crashes. These include the Florida Teen Safe Driving Coalition, the Florida Highway Safety Strategic Planning Committee, the Florida Traffic Records Coordinating Committee, the Florida Safe Mobility for Life Coalition, the Florida Bicycle/Pedestrian Safety Committee, and the Florida Impaired Driver Coalition.

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

c. Plan for the Coming Year

The Injury Prevention Program is closing out the 2009-2013 Florida Injury Prevention Strategic Plan and creating the 2014-2018 plan. Safe Kids Worldwide has increased their focus group area to include 19 years and under. Therefore, an added goal for the next plan cycle is distracted driving to protect our teenage population. In 2011, the National Highway Traffic and Safety Administration reported that our youngest and most inexperienced drivers are most at risk, with 16 percent of all distracted driving crashes involving drivers under 20, and 11 percent of all drivers under the age of 20 involved in fatal crashes were reported as distracted at the time of the crash. This age group has the largest proportion of drivers who were distracted. Florida has amended their Uniform Crash Report in 2011 to be able to capture state specific distracted driving crash data in the future.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	38	38.5	39	39.5	40
Annual Indicator					46.2
Numerator					
Denominator					
Data Source	CDC National Immunizatin Survey	CDC National Immunizatin Survey	CDC National Immunization Survey	CDC National Immunization Survey	CDC National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	46.5	46.7	46.9	47.1	47.3

Notes - 2012
The Department uses data provided by the CDC based on the National Immunization Survey.

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

Notes - 2010
Florida uses data provided by the CDC based on the National Immunization Survey. The last data currently available on the CDC website is for 2007. Data for this year is not yet available.

a. Last Year's Accomplishments

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

The Department of Health does not track breastfeeding data in the non-WIC population. Provisional data from the CDC National Immunization Survey, which tracks data by birth year, indicates that provisional data shows 46.2 percent of all infants in Florida were being breastfed at six months of age in 2009. Our WIC program tracks breastfeeding rates monthly and this data helps us assess our progress in improving breastfeeding rates during the year.

WIC continued participation in the U.S. Department of Agriculture breastfeeding peer counseling program. The Florida WIC Program is in its eighth year of receiving a USDA grant for the program. This special grant allowed expanded breastfeeding promotion and support in all counties above and beyond what could be accomplished with the regular WIC grant. From September 2011 to September 2012, the percentage of WIC infants who were fully breastfed at six (6) months increased from 13.8 percent to 14.5 percent. Services have been established or expanded to all 43 local WIC agencies to provide breastfeeding promotion and support above and beyond what the regular WIC grant could accomplish. According to data in the WIC Data System, there were 191 individuals that were paid by the breastfeeding peer counseling grant. This number fluctuates since it is an ongoing challenge to retain experienced peer counselors. From October 2011 to September 2012, peer counselors provided 208,987 individual services and 35,156 individuals attended classes. The program continues to meet the Loving Support(c) Through Peer Counseling requirements and targets prenatal and postpartum women. Funding from the USDA decreased again from the previous grant year in the spring of 2012.

In late spring 2012, the state WIC office sponsored three webinairs of three hours each for local WIC agencies on the new WIC Breastfeeding Peer Counseling Program Loving Support(c) Through Peer Counseling -- A Journey Together developed by USDA. Local WIC agency breastfeeding coordinators and peer counselor coordinators attended. Each local agency was sent two Loving Support(c) Through Peer Counseling: A Journey Together training notebooks, a WIC Managers notebook, and a Training WIC Peer Counselors notebook. The notebooks include facilitator prompts, speaker notes, and handouts.

In the summer of 2012, the state WIC breastfeeding coordinator worked with two separate FAMU public health interns on breastfeeding projects such as a Breastfeeding and Fathers flyer and a bibliography resource.

The Florida WIC program continued to sponsor the Florida breastfeeding coalition monthly conference calls. The state WIC program purchased and distributed World Breastfeeding Week kits to the local WIC agencies for use in promoting World Breastfeeding Week 2012.

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

The Department of Health requires that each county health department establish and adopt a written policy that protects, promotes, and supports breastfeeding as the preferred, normal method of infant feeding. Breastfeeding education and support is one of the services offered through the Healthy Start program.

The Florida Department of Health previously received funding from the American Recovery and Reinvestment Act for the Communities Putting Prevention to Work (CPPW) Program. As of March 2012, 52 percent of school districts (35 school districts) have adopted breastfeeding support policies. This funding source expired in May 2012.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Tracked Infants Ever Breastfed rates and Infants Currently Breastfed rates and the Percentage of WIC Breastfeeding Women/Total Infants for WIC.				X
2. Sponsored monthly telephone conference calls for statewide Florida Breastfeeding Coalition group to support coalition activities.				X
3. Sponsored monthly telephone conference calls for statewide WIC breastfeeding coordinators to share breastfeeding promotion and support activities and ideas.				X
4. Breastfeeding education and support offered through Healthy Start.	X			
5. Breastfeeding peer counselor programs now active in 43 WIC local agencies.		X		
6. Sponsored monthly telephone conference calls for peer counseling program administrators to share information and support.				X
7. Sponsored monthly telephone conference calls for peer counseling program administrators to share information and support.			X	
8. Purchased and distributed World Breastfeeding Kits to local WIC agencies to assist in celebrating WBW in August 2012.		X		
9.				
10.				

b. Current Activities

Healthy Start, county health department, WIC, and breastfeeding peer counseling staff continue to promote breastfeeding and assist mothers to successfully breastfeed. WIC continues to provide breast pumps and breast pump kits when funding is available, so more women have the equipment they need to breastfeed successfully.

WIC will continue to monitor breastfeeding rates and the percentage of women in WIC who breastfeed. Efforts to improve data collection and evaluation are ongoing.

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

c. Plan for the Coming Year

For FY2013, WIC will focus on emphasizing strategies and activities that help WIC mothers to continue breastfeeding, a population with traditionally lower breastfeeding rates.

WIC will distribute breastfeeding equipment and information, as funding is available. WIC will

continue the monthly conference calls with breastfeeding staff in the coming year, as well as our efforts to collect, link, and validate breastfeeding data and statistics, monitor breastfeeding rates, and evaluate breastfeeding outcomes. WIC will post the peer counseling evaluation study in 2013.

The WIC program will continue to monitor the new national food packages and policies in support of exclusive breastfeeding. Breastfeeding peer counseling programs will be ongoing as long as funding is continued from the USDA Loving Support grant. The new WIC Florida WISE computer system will be launched and local WIC agency staff will learn how to use and navigate the breastfeeding counseling/documentation screens.

WIC and Healthy Start will continue to coordinate their efforts so more women and families receive the education and support they need. The Department of Health will continue to promote and support breastfeeding through both county health department policies and guidelines and through the WIC and Healthy Start programs. The Department of Health will continue working with the Florida Breastfeeding Coalition on statewide breastfeeding activities.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	99	99	99	99	99
Annual Indicator	95.5	95.5	95.9	95.8	95.1
Numerator	220970	211357	205749	204721	202966
Denominator	231417	221391	214519	213722	213406
Data Source	CMS Newborn Screening Data Base	CMS Newborn Screening Data Base	CMS Newborn Screening Data Base	CMS Newborn Screening Data Base	CMS Newborn Screening Data Base
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	99	99	99	99	99

a. Last Year's Accomplishments

Section 383.145, Florida Statutes, mandates that all babies born in Florida have their hearing screened prior to hospital discharge or within the first 30 days of life. The program collects hearing results on all babies born in Florida through the metabolic specimen card and paper forms submitted to the State Laboratory and the Newborn Screening Program. Sometimes information for the same patient does not "link" resulting in two records for one patient. Efforts to decrease unlinked patients have been very aggressive for 2011 births and even more so for 2012 births, giving the appearance of fewer patients screened resulting in a decreased percentage of patients screened for these years. However, data is now more accurate.

A number of accomplishments occurred during the previous year. The percentage of babies screened by one month of age increased. The percentage of babies diagnosed with a hearing loss by three months of age also increased. The percentage of babies lost to follow-up/lost to documentation decreased. We doubled the amount of onsite training/technical assistance visits with hospitals and audiologists from 50 to 100. We recognized 35 different hospitals for excellent hearing screening data performance primarily in the areas of low not reported and low not screened. Annual winners were also rewarded for their continued efforts throughout the year. Eight outpatient audiology providers were recognized for excellent hearing evaluation data performance in the area of submitting diagnostic data timely. Four Local Early Steps offices were recognized for excellent early intervention hearing services data performance in the area starting services timely.

CMS held four statewide conference calls on various topics related to newborn hearing screening, including Early Intervention Services for Children Who Are Deaf or Hard of Hearing, Healthy Start In Florida, Ensuring Appropriate Hearing Screening Follow-Up, and Documenting & Reporting Hearing Screenings and Evaluations. There was an average of 50 participants for each call and positive feedback has been received on all of them. The division maintained a registry of 83 audiologists skilled in providing pediatric services to infants. Initial testing on web-based data reporting system called eReports™ was completed. This will allow facilities to enter hearing screening results onsite, cutting down on data entry and allowing the results to reach Florida Newborn Screening Program accurately and more quickly.

A designated pediatric champion was utilized to educate physicians on appropriate hearing screening follow-up protocol. CMS purchased a customized video on the importance of retesting after not passing the newborn hearing screening prior to discharge. A link and over 5,000 DVDs were distributed to multiple audiences, including birthing facilities, midwives, obstetricians, audiologists, Healthy Start coalition offices, county health departments, WIC offices, the Department of Health YouTube channel, and Lamaze instructors. Along with the help of our focus group that included parent input, CMS created and sent out over 4,000 copies of a referral folder to birthing facilities to distribute to parents of children who referred on their initial screening prior to discharge who need further follow-up.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Distribution of educational materials to obstetricians, pediatricians, family practitioners, midwives, parents, hospitals and early intervention providers regarding universal newborn hearing.				
2. Providing technical assistance to all Florida birth facilities hearing screening personnel regarding newborn hearing screening.				
3. Reporting of hearing screen results on metabolic specimen cards submitted to the state laboratory.				
4. Running data system reports to provide statistical information				

regarding births and the number of babies that refer on the hearing screen.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CMS continues rewarding three hospitals and one outpatient audiology provider a month and two Local Early Steps offices a quarter for excellent data. CMS will continue distribution of educational materials for parents, and continue to provide onsite training and technical assistance. The division continues to use a designated pediatric champion to educate physicians on appropriate hearing screening follow-up protocol. Additional data system enhancements have been implemented to improve reporting capabilities. CMS is conducting additional statewide conference calls on the various topics related to newborn hearing screening.

c. Plan for the Coming Year
CMS plans to complete beta testing of eReports™ and to train all birth hospitals on how to use eReports™. The division also plans to refine linking capabilities with Vital Statistics, and to accomplish successful HL7-based electronic transfer of hearing screening results with birth hospitals.

Goals for the coming year included further increases in the percentage of babies screened by one month of age, the percentage of babies diagnosed with a hearing loss by three months of age, the percentage of babies enrolled in early intervention services by six months of age. CMS plans to further decrease the percentage of babies lost to follow-up/lost to documentation. Additional plans include the use GIS and computer training to analyze statewide data, collaboration with Florida's Agency for Healthcare Administration regarding the sharing of discharge date, and filling any gaps in audiology follow-up services in the state.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	13.2	18.8	16.5	16.3	14
Annual Indicator	19.2	16.7	17.8	14.3	12.7
Numerator	785000	676000	756700	576000	532302
Denominator	4084000	4046000	4242600	4042000	4187900
Data Source	US Census 2007 Estimates	US Census 2009 Estimates	US Census 2009 Estimates	US Census	US Census
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years					

is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	12.5	12.5	12.5	12.5	12.5

a. Last Year's Accomplishments

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

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

Administrative program enhancements to improve retention were a major focus again in 2011. The Florida KidCare partner agencies worked to identify activities that could be accomplished without legislative action. For example, families with cell phone numbers are able to sign up for text reminders about premium payments and make the payments electronically. Simplified administrative renewals also were introduced that created pre-populated forms from data matches for families to review and sign.

In 2011, the Covering Kids and Families project received a CHIPRA Round II award to expand its outreach efforts. Continuing its partnership with AHCA and Healthy Kids, Covering Kids projects held press conferences and participated in back-to-school events; added 47 new business partners to its existing 35 business partners; oversaw 18 "Boots-on-the-Ground" projects, and recruited and trained new partners. As part of its "CHIPRA II" grant focusing on school outreach, 19 district-wide school projects will establish sustainable enrollment and retention approaches. The English Language Learners component will focus on children enrolled in public school English as a second language program and their parents and children participating in Refugee Youth programs.

The 2012 Florida legislative session ended in early March 2012. The bill that extends Florida KidCare subsidized coverage to income eligible dependents of state employees was signed into law by the Governor. The Florida KidCare program partners also continue to work on ways to improve administrative simplification that do not require legislative action.

Florida's percentage of uninsured children has declined. Like other states, much of the success is due to the Children's Health Insurance Program and children's Medicaid. Nevertheless, the American Community Survey showed that 11.8 percent of Florida children are uninsured, compared to the national child uninsurance rate of 7.5 percent. The Florida KidCare program partners--the Department of Health, Children's Medical Services; the Agency for Health Care Administration; the Department of Children and Families, and the non-profit Florida Healthy Kids Corporation--continue to work collaboratively and with other partners to reduce child uninsurance in the state.

With the adoption of Title XXI-funded coverage for state employees' dependents, from July 2012 through December 2012, approximately 1,000 children of state employees became enrolled in subsidized Florida KidCare.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ensure families are informed that they can apply for Medicaid using the KidCare application year-round.		X		
2. Policy development and evaluation of effects of Florida KidCare program changes on Florida KidCare enrollment and child uninsurance.				X
3. Provide care coordination and other services to uninsured and underinsured families of children with special health care needs.	X			
4. Statewide notification of KidCare open enrollment.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Department of Health, Agency for Health Care Administration, Department of Children and Families, and the Florida Healthy Kids Corporation collaborate with the University of South Florida's Covering Kids and Families project and other entities to reach out to families whose children could qualify for Florida KidCare. As part of the federal CHIP reauthorization law, the U.S. Department of Health and Human Services awarded almost $1 million to the University of South Florida Covering Kids and Families (CKF) Project to help find and enroll eligible children in Florida KidCare, and to promote retention, with special emphasis on racial and ethnic minority groups whose children are more likely to be uninsured.

Florida Healthy Kids staffs subcommittees, which include Florida KidCare partner agency participation, provides advice on additional ways to improve overall program enrollment, retention, satisfaction and quality. Florida KidCare launched a smart phone application to allow a user to learn about Florida KidCare. It also sends a message to the nearest application assister to contact the family to provide additional information and assistance. AHCA started the "CHIP In" initiative, which allows organizations to provide short-term assistance with Florida KidCare premium payments for families experiencing financial difficulties.

c. Plan for the Coming Year

In early 2013, the Covering Kids and Families project applied for a Connecting Kids to Coverage Cycle III grant from the federal government to increase the number of application assistance center networks throughout the state where families may apply and receive assistance. Partnerships will be in geographic areas of the state with diverse populations and high rates of uninsured children who may qualify for Florida KidCare. The expansion of one-on-one application/renewal assistance best practices established under the project's Cycle I and Cycle II grants will ensure that families will have help from trusted sources within their own communities, increasing their confidence as well as the expectation that they will apply for coverage successfully.

The Florida KidCare program partners will continue to conduct outreach for new enrollment, but also are focused on retention to ensure continuity of care. The Florida KidCare Evaluation Work Group directed the University of Florida's Institute for Child Health Policy to conduct focus groups with families of children whose Florida KidCare coverage was canceled for nonpayment of premium or noncompliance with renewal requirements to identify possible strategies to improve retention efforts.

In the fall of 2013, a new third party administrator (TPA) for Florida KidCare will assume eligibility and enrollment functions from the current TPA. The new TPA will provide additional ways for families to update accounts online, as well as continue the administrative simplification of the renewal process.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	30.3	30	29.4	28.7	28.5
Annual Indicator	30.9	29.6	28.9	28.8	28.3
Numerator	49822	53043	51176	51346	49118
Denominator	161088	178926	176988	178223	173603
Data Source	Office of WIC and Nutrition Services	Office of WIC and Nutrition Services	Office of WIC and Nutrition Services	Office of WIC and Nutrition Services	Office of WIC and Nutrition Services
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	28.2	28.1	27.9	27.7	27.5

a. Last Year's Accomplishments

Data from FFY2012 indicate 28.3 percent of children ages 2-5 who receive WIC services had a BMI at or above the 85th percentile. This was slightly below the objective of 28.5 and below last year's indicator of 28.6 percent.

The Florida Department of Health Bureau of WIC Program Services conducted a number of activities during FFY2012 to continue to help reduce the number of children deemed overweight based on body mass index.

Nutrition kits continued to be developed to promote healthy lifestyles. This fiscal year's topics included limiting soda and other sweetened beverages, awareness of portion sizes, and using the fruit and vegetable vouchers. Included as part of these kits were lesson plans, English, Spanish, and Haitian/Creole flyers and training flipcharts, coloring sheets for children, posters, and bulletin board ideas.

The Florida WIC Program requires local WIC agencies to develop a biennial nutrition program plan and to choose an objective in each of the following areas: nutrition education, breastfeeding, and program administration. In the nutrition program plan for federal fiscal years 2012-2013, a total of 21 local WIC agencies, which includes 35 counties, selected a nutrition education objective addressing obesity interventions for children 24 months and older.

Web-based trainings were provided on the new World Health Organization's (WHO) growth charts for children less than 24 months and client-centered counseling skills.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to encourage local WIC agencies to use prevention of overweight as a major nutrition education focus in their nutrition education and breastfeeding promotion efforts.	X			
2. Continue to provide tools on healthy eating and physical activity for WIC families such as nutrition education materials, and nutrition education kits focusing on healthy nutrition.	X			
3. Continue to translate all campaign materials and nutrition education materials into Spanish and Haitian/Creole. The Hispanic population has the highest percentage of overweight children on WIC.		X		
4. Provide data to local WIC agencies each quarter which tracks the percentage of 2-5 year old WIC children who are > 85th percentile in each county.				X
5. Post all nutrition education kit information on the Intranet for other DOH staff in the state to use.			X	
6. Post nutrition campaign materials and nutrition education materials on the Internet for Floridians to use as well as other state agencies to adopt and use – www.FloridaWIC.org			X	
7.				
8.				
9.				
10.				

b. Current Activities
WIC staff is actively involved in the implementation of the WIC data system modifications to allow electronic benefits transfer (EBT) cards to replace WIC food checks. The new electronic system automates the delivery, redemption, and reconciliation of WIC benefits. EBT supports the redemption of the client's assigned food prescription stipulated by the nutrition professional. The food prescription is based on USDA requirements and the client's nutritional risk.

In July 2013, EBT will be implemented as a pilot in Miami-Dade County. Implementation will proceed through the rest of the state by spring 2014. New EBT and data system training modules and training manuals are being developed for Florida WIC staff. The competency-based trainings will need to be completed by local agency staff prior to implementation of the new data system and EBT.

The nutrition education kits for FY2013 are on the following topics: increasing whole grain consumption, physical activity for families, encouraging low fat milk, and eating healthy when dining out.

The Florida WIC Program is working with other bureaus within the Department of Health, as well as the Department of Agriculture and Consumer Services, Department of Children and Families, and Department of Education to coordinate nutrition materials that would promote a Living Healthy Florida message.

c. Plan for the Coming Year
The Bureau of WIC Program Services will finalize the statewide implementation of electronic benefits transfer cards. WIC will continue to develop and distribute nutrition education kits that encourage healthy lifestyles and overweight prevention.

Living Healthy Florida materials will be produced and utilized with WIC clients as a joint project with the Department of Health, Department of Children and Families, Department of Education, and Department of Agriculture and Consumer Services.

Local WIC agencies will be given the option to choose objectives, which could include a decrease obesity/overweight in children objective, for federal fiscal years 2014-2015.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	8	7.9	7.8	8.5	9.2
Annual Indicator	8.6	9.6	8.1	8.1	8.1
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PrAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	7.9	7.8	7.7	7.6	7.5

Notes - 2012
Since Florida’s birth certificate does not ask about smoking during the third trimester, PRAMS data is used to determine performance on this indicator. Data come from the 2010 PRAMS, the last year available. For the PRAMS data, the numerator and the denominator are weighted to be representative of the state.

Notes - 2011
Since Florida’s birth certificate does not ask about smoking during the third trimester, PRAMS data is used to determine performance on this indicator. Data come from the 2010 PRAMS, the last year available. For the PRAMS data, the numerator and the denominator are weighted to be representative of the state.

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

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

Since 2007, when Florida's Comprehensive Statewide Tobacco Education and Use Prevention Program was established, Florida has 500,000 less adult tobacco users. As part of Tobacco Free Florida, Florida provides "3 Free Ways To Quit -- call, click, or come in." The Florida Quitline is available 24 hours a day, 7 days a week. Telephone counseling is available in English, Spanish, and a variety of other languages through a translation service. Pregnant tobacco users who are ready to quit receive expanded services including 10 counseling sessions and with a medical release, may receive a two-week starter kit of nicotine replacement therapy (NRT). Self-help materials are also provided by mail. The Florida Quitline is one of the nation's busiest serving over 81,000 users in Fiscal Year 2011-2012 and nearly 48,000 tobacco users accessed counseling services over the telephone.

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 NRT through this free online service. Both the telephone and online services provide another feature to help tobacco users in their quit attempts. Text2Quit is a new digital service that texts positive messages to tobacco users before, during, and after they quit. WebCoach is in its second year of operation and during fiscal year 2011-2012, a total of 18,890 users were served.

If callers prefer an in-person option for tobacco cessation they are referred to the Area Health Education Centers (AHEC), which provide free smoking cessation services in a group environment. In fiscal year 2011-2012, the AHECs provided over 10,000 tobacco users with smoking cessation through two different courses, Quit Smoking Now and the Tools To Quit course. The Quit Smoking Now is normally taught in six one-hour sessions over a six-week period and the Tools to Quit is a two-hour course.

In addition, the AHECs provide training for health care professionals and students based on the Clinical Practice Guidelines for Treating Tobacco Use and Dependence. The AHECs trained health care practitioners and students to identify tobacco users and refer them for treatment each time they are seen in a clinical setting. The AHECs are working with health care delivery systems on systems change implementation.

The Tobacco Free Florida campaign continued its efforts to educate Florida residents on the negative health effects of tobacco through a media campaign utilizing proven messages to encourage tobacco cessation. The campaign's $21 million budget is used mainly to place media because Tobacco Free Florida is using media housed in the Centers for Disease Control and Prevention's resource center. The Tobacco Free Florida brand has over 90 percent brand recognition.

The department met quarterly with the Tobacco Education and Use Prevention Advisory Council to discuss program activities and receive advice on the overall program operation. Council members represent Florida's recognized experts in tobacco control and the department is grateful for the passionate commitment to the effort. The Bureau of Tobacco Free Florida continued to work to prevent Florida's youth and young adults from initiating tobacco use, promote cessation of tobacco use among Florida's youth and adults, and to eliminate Floridians' exposure to

secondhand smoke.

County health departments, Healthy Start coalitions, and Department of Health staff monitored prenatal smoking indicators and compliance with guidelines on counseling all pregnant women and women of childbearing age on the dangers of tobacco use and second-hand smoke. In 2012, a total of 13,949 pregnant women received 29,200 healthy Start smoking cessation services during the prenatal period. In addition, 6,745 mothers, family members, or caregivers received 16,745 Healthy Start smoking cessation services in 2012 postpartum.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provision of guidelines directing health care providers to counsel women of childbearing age and all pregnant women on the dangers of tobacco use.				X
2. Monitoring of prenatal smoking indicators by county health department and state health office staff.				X
3. Training and technical assistance on the Make Yours a Fresh Start Family program and ACOG's Smoking Cessation During Pregnancy: A Clinician's Guide to helping Pregnant Women Quit Smoking.				X
4. Forwarding information on tobacco cessation and secondhand smoke through conference calls, site visits, meetings, and email communications.			X	
5. Monitoring of compliance with Healthy Start Standards and Guidelines standards for tobacco cessation.				X
6. Promoting partnerships with public and private sector prenatal care providers to increase access to smoking cessation services and implement programs and policies supportive of prenatal smoking cessation and reduction of second hand smoke.				X
7. Educating the public about dangers of smoking during pregnancy and about the QuitLine using mass media.			X	
8. Enhancing preconception identification of smokers and enhanced interventions.				X
9.				
10.				

b. Current Activities

Tobacco Free Florida continues its cessation services as described in detail under Section A. Last Year's Accomplishments. During this fiscal year, the WebCoach will be upgraded to include a Spanish Language feature. Other improvements and enhancements to cessation services will be researched and considered for implementation. Tobacco Free Florida's website, TobaccoFreeFlorida.com, will add smoking cessation resources on its provider page for health care practitioners whose patients include pregnant women. In addition, the AHEC contracts will encourage systems change activities in large obstetric practices. These activities advocate for systems change including identification and referral for tobacco users during each visit, practitioner and staff training, and information regarding free and available cessation services for their patients.

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

smoke, and also connect women to additional resources.

Current research on smoking cessation is shared during statewide conference calls with county health departments, Healthy Start coalitions, and Department of Health staff.

c. Plan for the Coming Year

In April 2011, at the conclusion of a competitive procurement process, the department awarded a contract to facilitate the Florida Healthy Start program redesign. The goal of the redesign is to increase the delivery of effective, evidence-based services in order to improve maternal and infant health outcomes including reducing infant and maternal morbidity and mortality. One of the core components of the redesign is smoking cessation. The redesign approved the implementation of Florida's 3 Free Ways to Quit and the Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) program. SCRIPT is an evidence-based program shown to be effective in helping thousands of pregnant women quit smoking. It is designed to be a component of a patient education program for prenatal care providers, and is cited by the Agency for Healthcare Research & Quality's Smoking Cessation Clinical Practice Guidelines. Healthy Start coalitions will begin training staff on the SCRIPT program beginning July 1, 2013 and will formally implement July 1, 2014.

Family planning providers across the state screen their clients for the extent of tobacco use, and provide information on the Florida's 3 Free Ways To Quit.

We will continue to encourage all health care providers to counsel women of childbearing age and all pregnant women on the dangers of tobacco use as well as the dangers of secondhand smoke. We will also continue to monitor compliance with the Healthy Start Standards and Guidelines for tobacco cessation.

Tobacco Free Florida will go through a competitive selection process during the Fiscal Years 2014-2015 Florida Quitline vendor. The plan is to use the Invitation to Negotiate purchasing process and contract for a three-year period with one renewal period. Cessation Services are evolving and Tobacco Free Florida will research new opportunities as they come available and if appropriate, may make additions to the current services provided.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	5.6	5.5	6	5.8	6
Annual Indicator	5.8	6.8	4.5	6.9	7.8
Numerator	71	82	54	83	94
Denominator	1219853	1203143	1193291	1207467	1207071
Data Source	DOH Vital Statistics	DOH Vital Statistics	DOH Vital Statistics	DOH Vital Statistics	DOH Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of					

events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	7.4	7	6.6	6.4	6.2

a. Last Year's Accomplishments
Final data for 2012 indicated an increase in the teen suicide rate from the previous year, going to 7.79 per 100,000 in 2011 from 6.87 per 100,000 in 2011. There were 94 teen suicides among age 15 through 19 year-olds, compared to 83 the previous year.

During FY2012, registered school nurses and social workers provided school health services and health education to 520 schools and 391,744 youth in the comprehensive school health services programs, and continued to refer students for community-based mental health services. These registered nurses and social workers also provided prevention interventions and classes in mental health, suicide prevention, violence prevention, conflict resolution, alcohol prevention, and drug prevention.

The state legislated and funded Statewide Office of Suicide Prevention and the Suicide Prevention Coordinating Council continued to provide a centralized structure that integrate and coordinate the statewide suicide prevention effort and provide unified direction and strategies that can be implemented at the state and local levels. This includes a website that provide links to resources for the layperson and professionals that work with children and adolescents to prevent suicide. The website can be found at http://www.helppromotehope.com/

Success in youth suicide prevention depends heavily on provision of suicide prevention strategies and resources for both the adults and peers that interact daily with teens. To this end, the legislature amended section 1006.07, Florida Statutes, adding provisions that all instructional and administrative personnel have access to suicide prevention resources that have been approved by the Statewide Office for Suicide Prevention, and that personnel who choose to participate in suicide prevention training shall receive in-service credit hours as determined by each district school board.

Additionally, Florida's 2012 Annual Prevention Conference provided a presentation on Florida's suicide prevention plan and three Gate Keeper Training Workshops utilizing the question, persuade, refer (QPR) technique.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Suicide prevention and small group prevention-interventions and health education classes in Comprehensive School Health Services Programs.		X		
2. Youth suicide prevention train-the-trainer workshops for gatekeepers.			X	
3. Coalition building by the Florida Suicide Prevention Coordinating Council.				X
4. Utilization of proven mental health screening programs.			X	
5. Implementation of research-based suicide prevention pilot				X

projects.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
During FY2013, registered school nurses and social workers from comprehensive school health services programs will work with school staff and refer students for community-based mental health services. Staff will provide prevention interventions and classes in mental health, suicide prevention, violence prevention, conflict resolution, alcohol prevention, and drug prevention.

c. Plan for the Coming Year
During FY2013, registered school nurses and social workers from the comprehensive school health services programs will continue to coordinate with school staff and refer students for community-based mental health services. They will also continue to provide prevention interventions and classes in mental health, suicide prevention, violence prevention, conflict resolution, alcohol prevention, and drug prevention.

The Florida Suicide Prevention Coordinating Council will continue to meet four times per year while planning and designing strategies to implement the Florida Suicide Prevention Strategy.

It is expected that during FY2013, health, mental health, education, and law enforcement professionals will work together on strategies to identify youth at risk for suicide so they can receive appropriate prevention and intervention services.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	90	90	90	90	90
Annual Indicator	86.9	88.3	91.5	88.8	91.3
Numerator	3365	3279	3157	3099	3121
Denominator	3874	3715	3452	3488	3417
Data Source	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	91.6	91.8	92	92.2	92.4

a. Last Year's Accomplishments

Perinatal specialists including physicians, nurses, and ancillary staff at the 11 designated Regional Perinatal Intensive Care Centers provide comprehensive high-risk obstetrical outpatient clinics to enhance care for high-risk patients. Two of the Regional Perinatal Intensive Care Centers continue to provide obstetrical satellite clinics in five rural locations. The provision of these services increases the probability that very low birth weight infants will be born at hospitals with level III neonatal intensive care units.

Children's Medical Services registered nurse consultants and physician consultants review and monitor the Regional Perinatal Intensive Care Center Programs annually to monitor quality of care for high-risk obstetrical patients and appropriate placement for neonates in neonatal intensive care units.

Other activities include the provision of yearly educational programs to the community health providers by Regional Perinatal Intensive Care Center staff. Many Regional Perinatal Intensive Care Centers also participate in the Florida Perinatal Quality Collaborative, whose first initiative is to promote no elective deliveries before 39 weeks. The populations served are high-risk pregnant women and low birth weight/sick infants.

During 2012, a total of 91 percent of very low birth weight infants were born at high-risk facilities, an increase from the 88 percent in 2011. Florida continues to strive towards meeting the goal of 90 percent annually.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Regional Perinatal Intensive Care Centers (RPICC) staff from two of the RPICCs provides five high-risk obstetrical satellite clinics.	X			
2. RPICC staff at the 11 designated facilities provides a comprehensive high-risk obstetrical outpatient clinic.	X			
3. RPICC staff provides yearly educational programs to the community health providers.			X	
4. RPICCs are monitored annually by physicians and Children's Medical Services Central Office consultants to ensure the quality of care for high risk obstetrical patients and appropriate placement of neonates in the Level III NICU.				X
5. Identify hospitals that are inappropriately delivering low birth weight infants, to provide education and linkage to an appropriate facility for high risk mothers and infants.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CMS goal is to ensure that high-risk obstetrical patients and very low birth weight newborns receive care at appropriate level hospitals. The Regional Perinatal Intensive Care Centers continue to provide direct health care services including inpatient services, outpatient services, and satellite clinics in rural areas.

Regional Perinatal Intensive Care Centers provide educational programs to community health providers and serve as a referral source for underserved areas.

c. Plan for the Coming Year

The goal for the coming year is to support services to increase the percentage of very low birth weight infants who deliver and receive care at hospitals with level III neonatal intensive care units. Plans include continuation of high-risk obstetrical satellite clinics. Regional Perinatal Intensive Care Center staff will continue to provide services at their established outpatient clinics and satellite clinics to enhance access to high-risk obstetrical maternal care and education.

Children's Medical Services will continue to monitor the Regional Perinatal Intensive Care Center programs to ensure appropriate placement of neonates in the Level III NICUs. The CMS RPICC consultants will identify delivering facilities that inappropriately deliver very low birth weight neonates, and encourage the establishment of linkages necessary to transfer high-risk obstetrical women to appropriate delivering facilities.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	79.5	80	80.5	81	81.5
Annual Indicator	76.9	78.3	79.3	80.3	80.1
Numerator	159426	154752	147843	154294	159018
Denominator	207324	197693	186373	192194	198518
Data Source	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	82	82.5	83	83.5	84

a. Last Year's Accomplishments
Provisional data for 2012 indicate 80.1 percent of pregnant women received prenatal care in the first trimester. This rate is slightly lower than the 80.3 percent reported in 2011, and lower than the 2012 performance objective of 81.5 percent. The department continued to experience an increase in the number of uninsured pregnant women and a decrease in providers of prenatal care across the state.

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

The department worked with Healthy Start coalitions statewide to ensure an adequate infrastructure for the provision of first trimester prenatal care and continuous care for all pregnant women. Work continued with the coalitions to promote awareness among providers that Medicaid pays additional reimbursement to providers who screen clients for Healthy Start in the first trimester. Policies were developed that promote wellness among women of childbearing age, and helped educate women on the importance of first trimester entry.

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

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

In April 2011, at the conclusion of a competitive procurement process, the department awarded a contract to facilitate the Florida Healthy Start program redesign. The goal of the redesign is to increase the delivery of effective, evidence-based services in order to improve maternal and infant health outcomes including reducing infant and maternal morbidity and mortality. One of the core components of the redesign is prenatal care.

In an effort to reduce travel cost, improve efficiency, and avoid duplication, the department conducted an analysis of the MCH and Family Planning performance improvement activities. The analysis resulted in FP staff expanding their performance improvement activities to include MCH program monitoring. This transition takes into consideration the similarities of the Title X and Title V programs and the overlap of performance measures evaluated, ensures women are receiving services on a continuum throughout the lifespan, and increases focus on preconception and interconception care. The Infant, Maternal and Reproductive Health leadership team was awarded a Certificate of Commendation Davis Productivity Award. This recognition is geared to Florida's state government employees whose work significantly and measurably increases

productivity, promotes innovation, and improves the delivery of state services and/or saves money for Florida taxpayers and businesses.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Continue work through Healthy Start coalitions to encourage providers to see patients during the first trimester of their pregnancies			X	
2. Continue focusing special technical assistance for counties with first trimester entry levels below the state average, and develop and implement strategies to improve access to early prenatal care.				X
3. Continue to promote the use of preconception health guidelines in the county health departments.				X
4. Continue the MomCare program.		X		
5. Continue Presumptive Eligibility and Simplified Eligibility Medicaid application processes to expedite entry into prenatal care.		X		
6. Continue working through the Healthy Start coalitions to implement strategies to remove barriers and improve access to care as well as develop solutions for increasing the first trimester entry rate.				X
7.				
8.				
9.				
10.				

b. Current Activities

In March 2013, the department completed the Healthy Start Redesign process and is currently in the implementation phase. The Colorado Department of Public Health's Prenatal Plus Program model was the model selected to address prenatal women in Florida. In Colorado, the Prenatal Plus Program has been effective in increasing the number of women who stop smoking, gain an adequate amount of weight, and resolve psychosocial problems, and has decreased the number of infants who are born at low birth weight.

In January of 2013, the department determined that 31 out of the 67 county health departments in the state do not offer prenatal services. Some Florida counties do not have obstetrical providers or hospitals that offer delivery services. The department's link with Florida's Healthy Start program is imperative in connecting women with prenatal care providers.

Currently, the department implements and monitors the MomCare program, as a part of the Healthy Start Program, in collaboration with Florida's Medicaid agency, the Agency for Health Care Administration (AHCA), and the Healthy Start Coalitions, who are an administrative agency by statute. During Florida's 2011 legislative session, the implementation of the 1915b Waiver and SOBRA (MomCare) will be moved from the department to AHCA's purview beginning October 1, 2014. The department is working closely with AHCA and coalition staff in an effort to assure a seamless transition.

c. Plan for the Coming Year

The department will continue to work with the Department of Children and Families (DCF) and the ACCESS community network to educate providers on the Medicaid application process. Through MomCare, the department will continue to help pregnant women in obtaining prenatal appointments and following up on their medical care. It will also continue to encourage CHDs to provide presumptive eligibility for pregnant women, allowing immediate access to Medicaid services and will continue to encourage providers outside of the CHD to use the Simplified Eligibility Medicaid application. This streamlined process requires no face-to-face contact, reducing some of the stigma barriers in accessing Medicaid insurance.

The department will continue to work with the Healthy Start coalitions to encourage providers to see patients during the first trimester, and to partner with the coalitions to implement strategies to remove barriers and improve access to care. Florida's new Prenatal Plus Program model will be instrumental in this endeavor. Staff will provide special technical assistance to counties with first trimester entry levels below the state average, and develop and implement strategies to improve access to early prenatal care. This will be accomplished through continued quality improvement visits to counties, as well as through working in collaboration with Healthy Start coalitions statewide.

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

The department continues to work closely with the Healthy Start coalitions and DCF in addressing issues for women accessing Medicaid coverage for pregnancy, or accessing provider services once Medicaid has been approved.

From 1995--2009, Florida had a reportedly five-fold increase in hospital inpatient discharges of newborns diagnosed with Neonatal Abstinence Syndrome (NAS), increasing from 0.4 to 4.4 discharges per 1000 live births. To address this problem, Florida's Attorney General established the Prescription Drug Abuse and Newborn Task Force to determine the full extent of NAS in Florida and provide lawmakers with recommendations on how to address the problem. A key finding from the task force is women avoiding prenatal care fearing the involvement of child welfare agencies. Another objective is to assess evidence-based methods for caring for a newborn withdrawing from prescription drugs and how nurses can assist the mother in caring for their child. The department has requested technical assistance from the CDC in the form of an EPI-Aid to address this issue.

D. State Performance Measures

State Performance Measure 1: *The percentage of Part C eligible children receiving service*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	98	98	98	98	98
Annual Indicator	93.1	93.8	92.9	94.3	97.6
Numerator	30976	33471	35223	35079	34637

Denominator	33276	35685	37907	37189	35490
Data Source	Early Steps Data System Annual Report.	Early Steps Data System Annual Report.	Early Steps Data System Annual Report.	Early Steps Data System Annual Report.	Early Steps Data System Annual Report.
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	98	98	98	98	98

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

Preventing the incidence of disabilities for infants and children is a state priority. It addresses the continuing need to provide adequate screening, assessment, and services to ensure infants and children receive the services they need to help them lead more healthy lives.

In accordance with the 2004 reauthorization of the IDEA, Early Steps publicly reported on statewide and local Early Steps performance. A determination of each local Early Steps was made in accordance with the provisions of IDEA and to identify local Early Steps that meet requirements and those in need of some level of assistance or intervention to meet the requirements of IDEA. Florida's Early Steps program was determined to meet the requirements of IDEA by the U. S. Department of Education Office of Special Education Programs in June 2012.

The Florida Developmental Disabilities Council commissioned and financed an intricate study of the Early Steps system to identify opportunities to promote the sustainability of the service system and a Strategic Plan was developed. Various workgroups have been working on the 40 recommendations contained in the plan and many of the recommendations have been implemented.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Evaluate current service delivery system to improve services for infants and toddlers with disabilities and their families.				X
2. Provide ongoing outreach, public awareness and education.		X		
3. Identify, evaluate and provide services to eligible infants and toddlers through contracts with 15 regional programs.	X			
4. Maintain reduced service coordination caseload size at 1/65.				
5. Develop and implement state policy and standards for providing services in natural environments, and implement a centralized system for provider enrollment.				X
6. A Continuous Improvement system that includes Quality Assurance monitoring, identification of noncompliance, technical assistance to help local programs achieve and maintain compliance, and implementation of sanctions for systemic noncompliance.				X
7. Provide for an Early Steps Data System to maintain an electronic record of all children served and services provided.		X		
8. Provide advocacy, training and support services for families.				X
9. Coordinate with Medicaid, Insurance, Department of Education and other agencies to access funding and support for service delivery system.				X
10. Implement a child and family outcomes measurement system to determine the extent to which child and family outcomes are positively impacted by receipt of services through Early Steps.				X

b. Current Activities

Monitoring and technical assistance is provided to local Early Steps (ES) to promote performance, improve child and family outcomes, and ensure services are provided in accordance with federal regulations and state policy. Local ES with identified noncompliance are required to develop a Continuous Improvement Plan to ensure compliance within one year

In accordance with federal requirements, an annual performance report was submitted on February 15, 2013, which includes actual target data for July 1, 2011 through June 30, 2012.

Florida's Early Steps system was awarded a CDC Learn the Signs Act Early implementation grant for the purpose of educating health and early care and education providers and parents about developmental monitoring and referral for early intervention services. Grant activities were implemented between June 2012 and March 2013. Impact of the grant includes increased referrals from early care and education providers across the state.

c. Plan for the Coming Year

Early Steps will continue to implement the infrastructure and improvement activities described in the Florida Part C State Performance Plan. Emphasis will be placed on performance which improves results for infants, toddlers and their families in accordance with OSEP's Results Driven Accountability. Recruitment and retention of a highly qualified work force to meet the service needs of eligible children will be a focus, with special emphasis on the Team-Based Primary Service Provider model of intervention and evidence-based intervention for Early Steps children and their families. Remaining action steps in the Strategic Plan for Sustainability will be addressed.

State Performance Measure 2: *The percentage of births with inter pregnancy interval less than 18 months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				36.6	35.2
Annual Indicator	38.8	38.2	36.9	35.7	35.3
Numerator	49241	46307	42308	41496	42782
Denominator	127031	121282	114682	116089	121159
Data Source	Florida CHARTS	Florida CHARTS	Florida CHARTS	Florida CHARTS	Florida CHARTS
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	34.9	34.6	34.3	34	33.7

a. Last Year's Accomplishments
Florida's CHARTS data for 2011 indicate that 35.7 percent of all births had an interpregnancy interval less than 18 months, with a provisional rate of 35.3 percent for 2012. The Family Planning Program, Healthy Start, MomCare, and community agencies provided an array of services to ensure new mothers have a method of contraception selected prior to the birth of the baby.

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

The Infant, Maternal, Reproductive Health (IMRH) Section continues to work with Healthy Start Coalitions statewide to ensure an adequate infrastructure for the provision of first trimester prenatal care and continuous care for all pregnant women. The IMRH Section developed policies that promoted wellness among women of childbearing age and helped educate women on the importance of spacing pregnancies to have an interval between pregnancies of 18 months or longer.

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

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide preconception and interconception care education and counseling to all clients seen in the family planning clinics.	X			
2. Provide education for family planning providers on the benefits and implementation of clients having reproductive life plans, as well as counseling techniques to encourage clients in developing individual reproductive life plan.		X		
3. Encourage county health departments to utilize the limited examination guidelines to initiate a contraceptive method without			X	

having to wait for a physical examination appointment.				
4. Provide emergency contraception at the county health departments.	X			
5. Encourage prenatal providers to discuss the contraceptive method that will be used following delivery by the eighth month of pregnancy.		X		
6. Ensure CHD clients (females and males) have access to and are informed about sterilization services.				X
7. Market the availability of family planning services in isolated communities.			X	
8.				
9.				
10.				

b. Current Activities
The IMRH Section implemented preconception health guidelines for the county health department clinics, Healthy Start coalitions, and with county health department family planning clinical staff.

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

In April 2011, a Family Planning Advisory Committee was created to assist the Department of Health in identifying the Family Planning Title X health priorities for the 2012-13 and 2013-2014 grant cycles. The advisory committee members were asked to identify potential family planning priority topic areas for the state to address. The primary priority topic areas identified were: unintended pregnancy and contraceptive use; access to family planning services; and the Medicaid Family Planning Waiver.

The IMRH Section is working with county health departments to expand access to a broad range of acceptable and effective family planning methods and related preventive health services to include long acting reversible contraceptives.

c. Plan for the Coming Year
The IMRH Section will continue to focus efforts toward counties with a percentage of births with interpregnancy intervals less than 18 months that is higher than the overall state percentage. The counties will be provided technical assistance to develop and implement strategies in reducing the percentage of births with interpregnancy intervals less than 18 months. The IMRH Section will accomplish this through continued performance improvement visits to counties and quarterly conference calls, focusing on preconception and interconception care; and collaborating with the with Healthy Start Coalitions, MomCare, and other community agencies that work with mothers and babies, to ensure women are receiving services on a continuum throughout the lifespan.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2008	2009	2010	2011	2012

Performance Data					
Annual Performance Objective				21	22
Annual Indicator		19.8	19.4	19.4	19.4
Numerator					
Denominator					
Data Source		PRAMS 2009	PRAMS 2010	PRAMS 2010	PRAMS 2010
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	23	24	25	26	27

Notes - 2012
Data Source: PRAMS 2010 19.4 percent of all women received at least five preconception health topics before they got pregnant.

Notes - 2011
Data Source: PRAMS 2010 19.4 percent of all women received at least five preconception health topics before they got pregnant.

Notes - 2010
Data Source: PRAMS 2010 19.4 percent of all women received at least five preconception health topics before they got pregnant.

a. Last Year's Accomplishments
The department continued to participate in the AMCHP initiative aimed at strengthening preconception health through collaborative efforts with Title V and Florida's Medicaid agency. Activities centered on increasing the rate of postpartum visits as well as improving the quality and content of the visit to promote interconception health, particularly for women with a history of adverse birth outcomes. Staff continued to incorporate and monitor the provision of preconception health education and counseling services to family planning clients during county health department clinic visits. Staff also made available an online training on preconception health issues for Family Planning Waiver eligibility staff.

The department has completed the process of redesigning the Healthy Start program to improve consistency of services throughout the state and ensure the use of evidence-based interventions. Preconception and interconception health were two main components included as core services to be implemented.

Through the process of data collection, analysis, and interpretation, the department's Pregnancy-Associated Mortality (PAMR) team aims to identify factors or determinants associated with pregnancy-related deaths and propose recommendations in order to reduce morbidity and prevent mortality. Obesity has been found to be a major risk factor in pregnancy. The Florida PAMR team findings show the percentage of pregnancy-related deaths were higher among women with pre-existing chronic disease and who were also overweight or obese than for those with pre-existing conditions who were of normal weight. In an effort to move recommendations to practice, members of the Florida team presented these findings through an annual report posted on the department's website and presented poster findings at professional meetings such as the National Perinatal Association, the Florida Perinatal Quality Collaborative, and Maternal Child Health Epidemiology Conferences.

The department was one of 10 sites chosen to form a collaborative project to foster integration of maternal and child health and chronic disease programs in the development of a diabetes prevention initiative. The initiative was supported by the Association of Maternal and Child Health Programs (AMCHP), the Centers for Disease Control and Prevention (CDC) and the

National Association of Chronic Disease Directors (NACDD) to address the impact that gestational diabetes mellitus (GDM) has on the life of the mother and infant, during pregnancy and in the future.

The department formed the Florida GDM Collaborative Team to identify goals and strategies to lower the prevalence of GDM and subsequent type 2 diabetes in women with a history of GDM. The initiative was the first step to assess the prevalence of GDM in the state and identify populations most at risk. With this knowledge, education campaigns about GDM can be better directed toward women and providers to improve the quality of care during pregnancy, but more importantly postpartum.

To move the GDM project in to practice the department incorporated GDM information into existing outreach materials aimed to educate women and providers about interconception care and preventing chronic disease. The department also explored avenues for creating checklists for healthcare providers that include information about postpartum screening for blood glucose for women diagnosed with GDM. Additionally, the department determined that improving data collection and reporting at multiple points in the health care system would ensure that efforts made to improve postpartum screening for elevated blood glucose would be properly documented for enhanced administrative research and reporting.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote and encourage the integration of comprehensive preconception health services for women into all health care settings.				X
2. Encourage health care providers and staff to integrate preconception education into their professional practices.			X	
3. Promote the use of preconception health guidelines in the county health departments statewide.		X		
4. Work with Healthy Start Coalitions on the provision of preconception and interconception education and counseling services throughout the state.			X	
5. Integrate preconception and interconception education and counseling into the redesign of the Healthy Start program.				X
6. Provide ongoing preconception health outreach and education through the local Healthy Start coalitions and other partners.			X	
7. Monitor the provision of preconception health education and counseling services during clinic visits to all family planning clients.		X		
8.				
9.				
10.				

b. Current Activities

The department is enhancing the relationship with the Agency for Health Care Administration to explore ways preconception and interconception care might be incorporated into future Medicaid managed care plans. Although this has been a slow process, gains have been made and relationships built.

The department conducts a quarterly conference call with lead persons assigned to the Collaborative Innovation and Improvement Network (CoIIN) strategic priority areas, who facilitate activities needed to implement each strategy. Engaging lead persons is critical to accomplish the

work that needs to be done. The quarterly conference calls provide updates and solicit input on the activities and strategies identified. This helps document progress, revise strategies, and brainstorm new ideas.

The department promotes reproductive life planning for all women of childbearing age as a component of primary care and promotes access to reproductive health services as needed through the Family Planning Program.

The department is an active participant in the Life Course Metrics Project designed to identify and promote a set of indicators that can be used to measure progress using the life course approach to improve maternal and child health.

The department supported the preconception health social marketing campaign Baby Steps to a Healthy Pregnancy. The campaign includes web banners, print ads, radio and TV PSAs. The department also supported the Show Your Love preconception health campaign.

c. Plan for the Coming Year

After conducting a health problem analysis of contributing factors to preconception health, a logic model at the state level will continue to be defined to address these risk factors with outcome measures to assess strategy effectiveness.

Preconception and interconception education and support are core interventions that will be included in the Healthy Start program redesign. Models selected for implementation will have components of preconception and interconception care with training beginning July 1, 2013 to all Healthy Start program staff.

The department will continue to work with the CoIIN to promote collaborative efforts between Title V and Medicaid and improve preconception and interconception health care services for all women covered by Medicaid.

The department will also continue to incorporate and monitor the provision of preconception health education and counseling services during county health department family planning clinic visits.

State Performance Measure 4: *The percentage of infants not bed sharing.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				78	79
Annual Indicator	73.7	76.9	79.3	79.3	79.3
Numerator					
Denominator					
Data Source	PRAMS	PRAMS 2009	PRAMS 2010	PRAMS 2010	PRAMS 2010
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	80	81	82	83	84

Notes - 2012
PRAMS data for 2010, which indicated that 79.3 percent of infants were not sharing a bed.

Notes - 2011
PRAMS data for 2010, which indicated that 79.3 percent of infants were not sharing a bed.

Notes - 2010
PRAMS data for 2010, which indicated that 79.3 percent of infants were not sharing a bed.

a. Last Year's Accomplishments
After conducting a health problem analysis of contributing factors to SUID, a logic model at the state level was developed to address these risk factors with outcome measures to assess strategy effectiveness. These two documents have been instrumental in aligning and focusing the MCHBG activities with other initiatives such as the State Health Improvement Plan (SHIP), Infant Mortality Summit-Blue Print for Change and the Collaborative Improvement and Innovation Network (CoIIN).

The SHIP is a plan for the entire public health system--all stakeholders including state and local governments, health care providers, employers, community groups, universities and schools, environmental groups, and many more. The SHIP enables loosely-networked system partners to coordinate for more efficient, targeted, and integrated health improvement efforts; to identify priorities specific to Florida's statewide needs; raise awareness of public health issues and stimulate increased involvement of stakeholders; provide a common agenda for health; link statewide efforts to national initiatives; increase accountability; and build collaborations that produce results.

The SHIP plan incorporates and builds on the many activities the department has participated in this past year including but not limited to the Collaborative Improvement and Innovation Network (CoIIN); AMCHP Initiative: Optimizing Health Reform to Strengthen Preconception Health and Improve Birth Outcomes; Maternal Mortality Initiative Child Abuse Prevention and Permanency Plan (CAPP); and the Life Course Metrics Project.

One of the strategies of the SHIP plan was to partner with Florida's Department of Children and Families (DCF) to initiate an educational health care provider and consumer campaign on safe sleep. The department also partnered with the Ounce of Prevention Fund of Florida to accomplish this task. Two public service announcements (PSAs) were developed on safe sleep and were aired on radio and TV statewide in English and Spanish. To increase the amount of exposure, the department required a three to one match when purchasing airtime. The department was very pleased that one of the PSAs was shown during the 2012 SuperBowl. The PSAs can be viewed at: http://www.ounce.org/safe_sleep_videos.html and click on the Safety link and Twins link.

In June 2010, Florida's Office of Adoption and Child Protection launched and completed the five-year CAPP plan. In accordance with State law (section 39.001, Florida Statutes), this five-year prevention and permanency plan provides for the prevention of child abuse, abandonment and neglect; promotion of adoption; and for the support of adoptive families. The plan incorporated the work of over 600 people statewide including many department staff. One strategy of the CAPP is that by June 30, 2015, Florida will have implemented selected prevention efforts based upon the findings of an All Child Death Review process that provides for the review of the deaths of all children from birth until the age of 18 who have died in Florida.

Currently, the department provides administrative oversight for Florida's Child Abuse Death Review Committee (CADR) and provides technical assistance and funding to the Fetal Infant Mortality Review (FIMR) teams. In an effort to increase collaboration between the CADR and FIMR teams, a Memorandum of Agreement (MOA) was developed by the department for the

unfunded FIMR teams in order to establish uniformity between the funded and unfunded FIMR projects. Additionally, the department facilitates a quarterly FIMR conference call to provide technical assistance and provide a forum for FIMR teams to share best practices. Also, department staff participates in the quarterly CADR meetings.

The department provided a statewide Florida-focused informational webinar on SUIDs to MCH professionals and partners that gave an overview of sudden unexpected death definition; prevalence of risk and protective safe sleep behaviors; the results of an active surveillance study on sleep-related deaths; and federal/state initiatives to reduce sleep-related infant deaths. Dr. William Sappenfield (University of South Florida) served as the webinar moderator and guided an interactive discussion between the audience and a panel of subject matter experts. Over 300 log-ins participated.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide training on safe sleep recommendations and reasons why parents may not be following them.				X
2. Technical assistance and training on how to talk with parents and caregivers about safe sleep issues.				X
3. Provide information on safe sleep through conference calls, site visits, and meetings.			X	
4. Provide information about available written materials and DVDs on safe sleep.			X	
5. Provide training on screening and treatment for depression since depressed women are more likely to bed share.			X	
6. Provide training to law enforcement on death scene investigation.				X
7.				
8.				
9.				
10.				

b. Current Activities

In April 2011, at the conclusion of a competitive procurement process, the Florida Department of Health awarded a contract to facilitate the Florida Healthy Start program redesign process. In March 2013 the department completed the process and is currently beginning the implementation phase. The goal of the redesign was to increase the delivery of effective, evidence-based services in order to improve maternal and infant health outcomes including reducing infant and maternal morbidity and mortality. One of the core components is safe sleep practices and environment.

The department continues to engage a multidisciplinary state team to work on the reduction of safe sleep practices and environment. With technical assistance from the multi-state team leads and HRSA's Abt consultants on the CollN Safe Sleep team, the department is working to translate project concepts and measures into a Plan Do Study Act (PDSA) quality improvement framework.

Information on the latest research findings and technical assistance is shared throughout the year through statewide conference calls to Healthy Start and county health department staff.

The department is currently developing a second informational webinar for healthcare professionals and paraprofessionals on effective community interventions to improve the

competency of healthcare staff to deliver safe sleep education.

c. Plan for the Coming Year
Florida PRAMS data (2011) has been recently received and descriptive and inferential analyses are being conducted to update prevalence and risk/protective factors of safe sleep behaviors. Analyses of WIC administrative data are also being conducted to identify maternal factors associated with breastfeeding behaviors, as well as an evaluation of a statewide breastfeeding peer counseling initiative.

In partnership with DCF and the Ounce of Prevention Fund of Florida, the department will repeat the safe sleep PSAs and will add a social media marketing campaign on SUID prevention and infant safe sleep environments. Additionally and as part of the SUID prevention campaign, the department will incorporate breastfeeding outreach messages to pregnant and breastfeeding women.

The department plans to develop and implement a questionnaire to Florida hospitals regarding their safe sleep policies, and of pediatricians and family practice physicians to assess their safe sleep education to parents.

Another strategy includes the development of training for WIC staff to encourage discussion of safe sleep practices with their clients and continued training for Healthy Start and county health department staff on how to deliver SUID risk reduction education at the local level.

Department staff will continue to participate at the CADR meetings and to host and provide technical assistance and funding to the FIMR teams.

The implementation phase of the Healthy Start Redesign will continue with training beginning July 1, 2013 on the Prenatal Plus model with the prenatal component of Partners for a Healthy Baby incorporated into the model.

Specific strategies will be implemented and their outcomes evaluated throughout the remainder of the grant cycle and will coincide with CoIIN safe sleep activities.

State Performance Measure 5: *The percentage of infants back sleeping.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				65	66
Annual Indicator	64.4	61.3	65.1	65.1	65.1
Numerator					
Denominator					
Data Source	PRAMS	PRAMS 2009	PRAMS 2010	PRAMS 2010	PRAMS 2010
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	67	68	69	70	72

Notes - 2012
2010 PRAMS report.

Notes - 2011
2010 PRAMS report.

Notes - 2010
Data for 2010 were available thru Florida PRAMS. The difference between 2009 (61.3; CI: 58.1-64.4) and 2010 (65.1; CI: 62.0- 68.1) is not statistically significant. 2011 is not available yet. We used the same information for 2011 and 2012 that we found in 2010. For the PRAMS data, the numerator and the denominator are weighted to be representative of the state.

a. Last Year's Accomplishments
After conducting a health problem analysis of contributing factors to SUID, a logic model at the state level was developed to address these risk factors with outcome measures to assess strategy effectiveness. These two documents have been instrumental in aligning and focusing the MCHBG activities with other initiatives such as the State Health Improvement Plan (SHIP), Infant Mortality Summit-Blue Print for Change and the Collaborative Improvement and Innovation Network (CoIIN).

The SHIP is a plan for the entire public health system--all stakeholders including state and local governments, health care providers, employers, community groups, universities and schools, environmental groups, and many more. The SHIP enables loosely-networked system partners to coordinate for more efficient, targeted, and integrated health improvement efforts; to identify priorities specific to Florida's statewide needs; raise awareness of public health issues and stimulate increased involvement of stakeholders; provide a common agenda for health; link statewide efforts to national initiatives; increase accountability; and build collaborations that produce results.

The SHIP plan incorporates and builds on the many activities the department has participated in this past year including but not limited to the Collaborative Improvement and Innovation Network (CoIIN); AMCHP Initiative: Optimizing Health Reform to Strengthen Preconception Health and Improve Birth Outcomes; Maternal Mortality Initiative Child Abuse Prevention and Permanency Plan (CAPP); and the Life Course Metrics Project.

One of the strategies of the SHIP plan was to partner with Florida's Department of Children and Families (DCF) to initiate an educational health care provider and consumer campaign on safe sleep. The department also partnered with the Ounce of Prevention Fund of Florida to accomplish this task. Two public service announcements (PSAs) were developed on safe sleep and were aired on radio and TV statewide in English and Spanish. To increase the amount of exposure, the department required a three to one match when purchasing airtime. The department was very pleased that one of the PSAs was shown during the 2012 Super Bowl. The PSAs can be viewed at: http://www.ounce.org/safe_sleep_videos.html and click on the Safety link and Twins link.

In June 2010, Florida's Office of Adoption and Child Protection launched and completed the five-year CAPP plan. In accordance with state law (section 39.001, Florida Statutes), this five-year prevention and permanency plan provides for the prevention of child abuse, abandonment and neglect; promotion of adoption; and for the support of adoptive families. The plan incorporated the work of over 600 people statewide including many department staff. One strategy of the CAPP is that by June 30, 2015, Florida will have implemented selected prevention efforts based upon the findings of an All Child Death Review process that provides for the review of the deaths of all children from birth until the age of 18 who have died in Florida.

Currently, the department provides administrative oversight for Florida's Child Abuse Death Review Committee (CADR) and provides technical assistance and funding to the Fetal Infant

Mortality Review (FIMR) teams. In an effort to increase collaboration between the CADR and FIMR teams, a Memorandum of Agreement (MOA) was developed by the department for the unfunded FIMR teams in order to establish uniformity between the funded and unfunded FIMR projects. Additionally, the department facilitates a quarterly FIMR conference call to provide technical assistance and provide a forum for FIMR teams to share best practices. Also, department staff participates in the quarterly CADR meetings.

The department provided a statewide Florida-focused informational webinar on SUIDs to MCH professionals and partners that gave an overview of sudden unexpected death definition; prevalence of risk and protective safe sleep behaviors; the results of an active surveillance study on sleep-related deaths; and federal/state initiatives to reduce sleep-related infant deaths. Dr. William Sappenfield (University of South Florida) served as the webinar moderator and guided an interactive discussion between the audience and a panel of subject matter experts. Over 300 log-ins participated.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide training on safe sleep recommendations and the reasons why parents choose not to follow them.			X	
2. Technical assistance and training on how to talk with parents and caregivers about safe sleep issues.	X			
3. Provide information on safe sleep through conference calls, site visits, and meetings.	X			
4. Provide information about available written materials and DVDs for parents and caregivers on safe sleep.		X		
5. Monitor compliance with guidelines for prenatal education regarding risk reduction for sudden unexpected infant death.	X			
6. Share best practices.		X		
7. Train law enforcement on death scene investigation.				X
8.				
9.				
10.				

b. Current Activities

In April 2011, at the conclusion of a competitive procurement process, the Florida Department of Health awarded a contract to facilitate the Florida Healthy Start program redesign process. In March 2013 the department completed the process and is currently beginning the implementation phase. The goal of the redesign was to increase the delivery of effective, evidence-based services in order to improve maternal and infant health outcomes including reducing infant and maternal morbidity and mortality. One of the core components is safe sleep practices and environment.

The department continues to engage a multidisciplinary state team to work on the reduction of safe sleep practices and environment. With technical assistance from the multi-state team leads and HRSA's Abt consultants on the CollN Safe Sleep team, the department is working to translate project concepts and measures into a Plan Do Study Act (PDSA) quality improvement framework.

Information on the latest research findings and technical assistance is shared throughout the year through statewide conference calls to Healthy Start and county health department staff.

The department is currently developing a second informational webinar for healthcare

professionals and paraprofessionals on effective community interventions to improve the competency of healthcare staff to deliver safe sleep education.

c. Plan for the Coming Year

Florida PRAMS data (2011) has been recently received and descriptive and inferential analyses are being conducted to update prevalence and risk/protective factors of safe sleep behaviors. Analyses of WIC administrative data are also being conducted to identify maternal factors associated with breastfeeding behaviors, as well as an evaluation of a statewide breastfeeding peer counseling initiative.

In partnership with DCF and the Ounce of Prevention Fund of Florida, the department will repeat the safe sleep PSAs and will add a social media marketing campaign on SUID prevention and infant safe sleep environments. Additionally and as part of the SUID prevention campaign, the department will incorporate breastfeeding outreach messages to pregnant and breastfeeding women.

The department plans to develop and implement a questionnaire to Florida hospitals regarding their safe sleep policies, and of pediatricians and family practice physicians to assess their safe sleep education to parents.

Another strategy includes the development of training for WIC staff to encourage discussion of safe sleep practices with their clients and continued training for Healthy Start and county health department staff on how to deliver SUID risk reduction education at the local level.

Department staff will continue to participate at the CADR meetings and to host and provide technical assistance and funding to the FIMR teams.

The implementation phase of the Healthy Start Redesign will continue with training beginning July 1, 2013 on the Prenatal Plus model with the prenatal component of Partners for a Healthy Baby incorporated into the model.

Specific strategies will be implemented and their outcomes evaluated throughout the remainder of the grant cycle and will coincide with CoIIN safe sleep activities.

State Performance Measure 6: *The percentage of teen births, ages 15-17, that are subsequent (repeat) births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				8.8	8.1
Annual Indicator	9.8	9.5	9.0	8.3	7.4
Numerator	713	602	486	391	309
Denominator	7286	6308	5398	4723	4193
Data Source	Florida CHARTS	Florida CHARTS	Florida CHARTS	Florida CHARTS	Florida CHARTS
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance	7.3	7.2	7.1	7	6.9

Objective					

a. Last Year's Accomplishments

The family planning program provided services to 14,135 teens age 15-17 during 2012, with 30,267 visits and 84,536 services for this age group. The program provided a total of 197,431 services to 34,485 teens. Provisional statistics indicate a decrease in repeat teen pregnancies, as the rate decreased from 8.3 percent to 7.4 percent from calendar year 2011 to calendar year 2012, and the number of repeat teen pregnancies dropped from 391 to a provisional number of 309 in 2012.

A sexually transmitted infection Family Planning Program grant stressing preconception health, which included gonorrhea and chlamydia testing for women under the age of 26, continued in eight county health departments during FY2011-12. The eight county health departments participating had high rates of gonorrhea and chlamydia. Clients under the age of 26 received preconception health counseling, gonorrhea and chlamydia testing, pregnancy testing, and emergency contraception. A total of 4,966 family planning clients received preconception health services through the sexually transmitted infection project during 2012. Decreased rates of chlamydia in the participating county health departments for the ages of 15-19 and for women under the age of 26 were significantly significant for both groups for 2012.

Teen pregnancy prevention materials were ordered and distributed to county health department staff. The teen and young adult focused Choices magazine published by Bridging the Gap Communications, Incorporated, was ordered and mailed to county health department staff for client educational materials. A total of 23,250 magazines were provided to the county health departments. In addition, Contraceptive Education Kits were purchased and shipped to each clinical family planning site. The Family Planning Program collaborated with the Bureau of Communicable Diseases, HIV Program to provide contraceptive education kits to 25 Targeted Outreach to Pregnant Women with AIDS (TOPWA) outreach workers for HIV prevention education in six counties with high HIV/AIDS prevalence.

The Healthy Start population of pregnant women and mothers of infants up to age 3 were counseled about the availability of family planning services, to inform clients of where to obtain family planning services in order to delay repeat births. Healthy Start also offered interconception counseling as a Healthy Start service to encourage women to allow 18 months between delivery of a baby and a subsequent pregnancy.

The Adolescent Health Program implemented two initiatives during 2012, the Teenage Pregnancy Prevention Project and the Abstinence Education Program. The Teenage Pregnancy Prevention Project utilized evidence-based curriculum in 24 non-metropolitan counties with notably high rates of teen pregnancy, school drop-out, and course failure. The facilitators within the 24 counties are trained in the Teen Outreach Program, an evidence-based curriculum. Approximately 8,500 students participated in the Teen Outreach Program in 2012. The Abstinence Education Program funded 13 providers during 2012. This includes county health departments and community based organizations utilizing evidence-based curricula with youth ages 12-19. These curricula included Project AIM, Making A Difference and Promoting Health Among Teens. Programming was provided in schools, youth centers, and community organizations. Approximately 700 students were provided services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide confidential family planning counseling, education and comprehensive contraceptive services.	X			
2. Increase access to contraceptive services for teen mothers		X		

ages 15-17.				
3. Increase the number of sexually active teens who receive reproductive health services at family planning clinics.			X	
4. Reduce the proportion of pregnancies that were conceived within 18 months of a previous birth by providing preconception health counseling.			X	
5. Provide individual and small group pregnancy prevention interventions with Adolescent Health Services, Teen Pregnancy Prevention Grants and Healthy Start Programs.	X			
6. Provide School Health case management and care coordination in Comprehensive School Health Projects to enable parenting students to remain in school and graduate.		X		
7. Collaboration of Department of Health programs striving to reduce subsequent teen pregnancy.			X	
8.				
9.				
10.				

b. Current Activities
Reproductive health education, method counseling, and family planning services are provided to all teens that request family planning services.

The Sexually Transmitted Infection Project continues for the third and last funding year in eight counties.

County health departments and Healthy Start coalitions continue to provide Healthy Start services, including interconception care to reduce subsequent births in teens.

The Family Planning Program plans to purchase and distribute teen pregnancy prevention educational materials. The purchasing process will begin after the start of fiscal year 2013-2014 to ensure availability of Title X family planning funds.

Full implementation and evaluation for the Teen Outreach Program will continue during the 2013-2014 school year. An increase in participants is expected during the current grant year. Approximately 10,000 students are expected to receive services through the Making a Difference and Promoting Health Among Teens curricula, during the 2013-2014 grant year.

c. Plan for the Coming Year
The plan to reduce subsequent births to teens age 15-17 includes the provision of family planning services in all 67 county health departments, including: pregnancy prevention counseling; contraception method counseling, including abstinence education; contraceptive services; comprehensive reproductive health education; Healthy Start services; and school health services. A special emphasis is planned for providing teens with highly effective methods of contraception, including long-acting reversible contraceptives.

The Family Planning Program requested funds in the 2013-2014 Title X non-competitive grant to extend gonorrhea and chlamydia testing statewide for women requesting pregnancy testing or emergency contraception.

Educational brochures written for teens and young adults will be purchased and provided for the staff in all 67 county health departments to distribute to teens in their area. Program office staff will continue to encourage county health department staff to utilize FMMIS to identify teens that have lost Medicaid to refer for the Medicaid Family Planning Waiver. School health nurses will

address with teens their eligibility for Medicaid Family Planning Waiver services. County health departments, Healthy Start coalitions, and agencies and programs involved in welfare reform will continue to educate and collaborate with other community agencies in reducing subsequent teen births.

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

The Adolescent Health Program's two initiatives, the Teenage Pregnancy Prevention Project and the Abstinence Education Program, continue and will be in the fourth year of five funding years.

State Performance Measure 7: *The percentage of low-income children who access dental care*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	23.8	26.7	26.9	30.3	38.4
Annual Indicator	29.5	30.1	38.0		
Numerator	617240	625191	777423		
Denominator	2092022	2077021	2045849		
Data Source	DOH Public Health Dental Program	DOH Public Health Dental Program	DOH Public Health Dental Program		
Is the Data Provisional or Final?					
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	38.6	38.8	39	39.2	

Notes - 2011
Data for 2011 are not yet available. Most of the data comes from Medicaid paid claims and CHC but will not be available until late summer/early fall 2011.

a. Last Year's Accomplishments
The percentage of low-income children under 21 who access dental care had remained virtually constant 2006 through 2009. Apparent small annual increases may reflect measurement error rather than actual change. However certain facets of oral health care improved with the increase in 2010. The number of children treated by county health department dental programs grew by nearly 12 percent in 2010 over the previous year reaching over 167,840 children and another 15 percent in 2011 reaching 193,766 children. This increase resulted from growth in the number of county dental programs and in the productivity of county health department dentists.

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

Preliminary estimates for 2011 show that 77.3 percent of Florida's population obtains water from community systems that provide the benefits of fluoridation. Long-term benefits will reduce treatment needs and improve access to existing providers.

County health department program guidelines and monthly conference calls for dental directors provided by the central office can improving quality improvement activities and provide resources for newly hired dental directors as a foundation for technical assistance inquiries.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Facilitate the continued development of an integrated coordinated oral health system between the public and private sectors.				X
2. Conduct community-based dental projects.	X			
3. Promote increased access through county health department safety net programs.	X			
4. Promote the integration of oral health education in WIC Child Nutrition and other county health department programs as appropriate.				X
5. Promote the start of oral health practices in infancy and appropriate use of fluoride products throughout early childhood in conjunction with the CDC's Brush Up on Healthy Teeth campaign.			X	
6. Promote the development of community and school-based preventive and educational programs.			X	
7. Update Internet site to facilitate information exchange.				X
8.				
9.				
10.				

b. Current Activities

The program will continue activities outlined in the state oral health improvement plan. Through a HRSA Grant to States to Support Oral Health Workforce Activities a pool of funds was established to help county health departments establish or expand dental facilities and services to implement or expand school-based sealant initiatives. Other initiatives include working with the Florida Dental Association to utilize oral health educational materials in practice FCAT testing among third graders, funding water fluoridation initiatives in local communities and supporting oral health coalitions throughout the state.

The program developed an interactive social media website with targeted oral health messaging in English and Spanish for children teens parents and providers. The program will continue to emphasize the integration of oral health into all appropriate DOH programs through the development of protocols and implementation activities at the county level.

Preliminary estimates for 2012 show that 76.6 percent of Florida's population obtains water from community systems that provide the benefits of fluoridation. Long-term benefits will reduce treatment needs and improve access to existing providers.

c. Plan for the Coming Year

The program will continue to promote the increased access to fluoridation. Through the department's Reducing Oral Health Disparities initiative the program will continue to promote increased access to care by facilitating increased capacity through county health department programs. These funds will help make incremental progress which will continue to expand access to low-income and minority populations.

The program is planning more specific quality improvement activities. The program will continue to provide technical assistance as needed. The program will pursue the planning and establishment of a surveillance system to initiate an ongoing collection of data to show the prevalence of oral disease in the state. The department plans to establish the surveillance of third graders. The department is also planning the development of a comprehensive oral health plan. The program is also working to revise and improve the data collection methods established. These program initiatives will lead to a more efficient way to plan around the needs of the state.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	8.8	8.7	8.7	8.7	8.6
Numerator	20369	19297	18719	18558	18180
Denominator	231417	221391	214463	213237	212238
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
Factors that may contribute to the risk of low birth weight and very low birth weight include mother's race, age, multiple birth, education, socioeconomic status, and substance use during pregnancy. Black infants are twice as likely as white infants to be born at a low birth weight.

/2014/ Black mothers accounted for 22.9 percent of resident live births in Florida in 2011. In 2011, 16 percent of all mothers had less than a high school education. A total of 14,232 mothers (6.7 percent) reported smoking during pregnancy. There were 7,183 multiple births in 2011 (3.4 percent of total births). //2014//

The department continues to promote prenatal smoking cessation through public awareness and the provision of classes, counseling and cessation methods as one of many strategies to address both low and very low birth weight. The WIC prenatal caseload has been expanded, the percentage of pregnant women whose delivery is paid for by Medicaid has been increased, and the department started new preconception health initiatives and looked at more effective ways of providing prenatal care. Family planning efforts were also strengthened, including the Medicaid family planning waiver.

Low birth weight deliveries raise the risk of infant mortality, morbidity, and developmental

disability, and also cause greater health care costs. The percentage of twins and multigestation pregnancies is no longer increasing in Florida and does not contribute to these recent trends. The department has recently studied the increase in preterm and late preterm births, a major determinant of low birth weight. Approximately one-third of the increase in preterm births is related to Cesarean delivery.

/2014/ In 2011, babies weighing less than 2,500 grams accounted for 8.7 percent of all live births, with a provisional rate of 8.6 for 2012. //2014//

/2014/ In July 2012, the department contracted with the Florida Perinatal Quality Collaborative (FPQC) to promote perinatal care quality improvement efforts. One issue of focus is to decrease non-medically indicated deliveries less than 39 weeks gestational age in at least an additional seven Florida hospitals with maternity services. The FPQC has been very effective using the March of Dimes (MOD) toolkit and process and currently are working with the MOD and the Florida Hospital Association to recruit other hospitals to participate. //2014//

/2014/ The department participated with the Association of State and Territorial Health Officials (ASTHO) and the MOD challenge to reduce premature births by 8 percent by 2014. The department supported a preconception health public awareness campaign with a specific focus on healthy weight maintenance, caring for chronic conditions, pregnancy planning and the reduction of risk factors such as tobacco, drug, and alcohol use. All of these efforts should increase the likelihood that every infant may be born as healthy as possible. //2014//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	7.0	7.0	7.0	6.9	6.9
Numerator	15754	14990	14639	14215	14161
Denominator	223888	214201	207682	206097	205399
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
Same as HSI #01A above, except for the following data interpretation.

In Florida, singleton birth babies weighing less than 2,500 grams accounted 7.0 percent of all live singleton births in 2010, with a provisional rate of 6.9 in 2011. The difference between all births with low birth weight (8.7 percent) and singleton births with low birth weight (7.0 percent) in 2010 is attributable to multiple births. Studies have shown that more than half of twins and other multiples are born low birth weight. Previous increases in multiple births have been associated with older age at childbearing and an increase in fertility therapies.

/2014/ Singleton birth babies weighing less than 2,500 grams accounted 6.9 percent of all

live singleton births in 2011, with a provisional rate of 6.9 in 2012. //2014//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	1.7	1.6	1.6	1.6	1.6
Numerator	3851	3544	3522	3433	3404
Denominator	231417	221391	214463	212237	212238
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
Same as HSI #01A above, except for the following data interpretation.

The percentage of infants born very low birth weight in Florida has remained consistently at or near 1.6 percent since 2006. The risk of death in the first year of life for infants born with very low birth weight is more that 90 times greater than infants born at more than 2,500 grams.

/2014/ The percentage of infants born with very low birth weight remains at 1.6 percent. //2014//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	1.3	1.3	1.3	1.3	1.3
Numerator	2919	2708	2674	2626	2654
Denominator	223888	214201	207735	206097	205399
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
Same as HSI #01A above, except for the following data interpretation.

In Florida the percentage of singleton infants born very low birth weight in Florida has remained at 1.3 percent from 2003 to 2010, and the provisional rate for 2011 is also 1.3 percent. The difference between all births with very low birth weight (1.6 percent) and singleton births with very

low birth weight (1.3 percent) is attributable to multiple births.

/2014/ The percentage of singleton infants born with very low birth weight remains at 1.3 percent. //2014//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 03A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	9.0	9.5	8.9	9.0	6.2
Numerator	311	325	290	295	206
Denominator	3449949	3422460	3261716	3274059	3314695
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
The death rates from unintentional injuries and motor vehicle crashes among children ages 14 years and younger are influenced by Florida's ability to maintain a strong Safe Kids Coalition and Chapter network. The Injury Prevention Program is the lead agency for Safe Kids Florida, the statewide organization. Florida has a Safe Kids presence in 36 of the 67 counties and covers 81 percent of the children ages 19 and under. Safe Kids conducts community activities that provide education on prevention of children's unintentional injuries. Child passenger safety education and child safety seat check ups events are a regular Safe Kids activity. In 2009, the childhood unintentional injury fatality rate in Safe Kids counties was 30 percent lower than the rate in non-Safe Kids counties which corresponds to 116 fewer deaths than expected had the fatality rates been the same.

/2013/ In 2010, the childhood unintentional injury fatality rate in Safe Kids counties was 30 percent lower than the rate in non-Safe Kids counties which corresponds to 104 fewer deaths than expected had the fatality rates been the same. //2013//

/2014/ In 2011, the childhood unintentional injury fatality rate in Safe Kids counties was 28 percent lower than the rate in non-Safe Kids counties which corresponds to 110 fewer deaths than expected, had the fatality rates been the same. //2014//

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

/2014/ The counties Safe Kids currently covers are Baker, Broward, Clay, Collier, Dade, Duval, Flagler, Hillsborough, Lee, Manatee, Nassau, Orange, Palm Beach, Pasco, Pinellas, Polk, Putnam, St. Johns, Sarasota, Volusia, Bay, Lake, Sumter, Leon, Marion, Okaloosa and Santa Rosa. //2014//

The death rate per 100,000 due to unintentional injuries among children aged 14 years and

younger remained relatively stable year to year from 2005 to 2007. In 2008, the death rate decreased 20 percent from the previous year, but increased slightly in 2009. Overall, the death rate decreased 16 percent from 2005 to 2009. This decrease is due in part to a decrease in motor vehicle deaths.

/2014/ Data for 2011 shows a death rate due to unintentional injuries among children aged 14 years and younger of 9.01 per 100,000. This rate is consistent with the rates in the previous few years of 8.9 in 2010, 9.5 in 2009, and 9.0 in 2008. //2014//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 03B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	1.9	2.1	2.0	2.1	1.6
Numerator	66	72	64	69	53
Denominator	3449949	3422460	3261716	3274059	3314695
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
The rates of all non-fatal injuries and motor vehicle crashes among children ages 14 years and younger are influenced by Florida's ability to maintain a strong Safe Kids Coalition and Chapter network. The Injury Prevention Program is the lead agency for Safe Kids Florida, the statewide organization. Florida has a Safe Kids presence in 36 of the 67 counties and covers 81 percent of the children ages 19 and under. Safe Kids conducts community activities that provide education on prevention of children's unintentional injuries. Child passenger safety education and child safety seat check ups events are a regular Safe Kids' activity. In 2009, the childhood unintentional injury fatality rate in Safe Kids counties was 30 percent lower than the rate in non-Safe Kids counties which corresponds to 116 fewer deaths than expected had the fatality rates been the same.

/2013/ In 2010, the childhood unintentional injury fatality rate in Safe Kids counties was 30 percent lower than the rate in non-Safe Kids counties, which corresponds to 104 fewer deaths than expected had the fatality rates been the same. //2013//

/2014/ In 2011, the childhood unintentional injury fatality rate in Safe Kids counties was 28 percent lower than the rate in non-Safe Kids counties which corresponds to 110 fewer deaths than expected, had the fatality rates been the same. //2014//

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

/2014/ Data for 2011 show the death rate per 100,000 for unintentional injuries among

children aged 14 years and younger due to motor vehicle crashes was 2.1 in 2011. This rate is consistent with the rates in the previous few years of 2.0 in 2010, 2.1 in 2009, and 1.9 in 2008. //2014//

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

Health Status Indicators Forms for HSI 03C - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	26.6	20.9	18.1	16.9	16.6
Numerator	643	505	441	413	411
Denominator	2421365	2413540	2437270	2442802	2471366
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

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

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

/2014/ The death rate per 100,000 for unintentional injuries among children aged 15 through 24 years has continued to decrease every year. The rate was 16.9 in 2011, a 7 percent decrease from the 2010 rate of 18.1, which is a 13 percent decrease from the 2009 rate of 20.9. //2014//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	178.4	183.3	187.8	181.5	92.4
Numerator	6154	6274	6127	5944	3064
Denominator	3449949	3422460	3261716	3274059	3314695
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Numerator is just first six months of data for 2012.

Narrative:
The rates of all non-fatal injuries and non-fatal injuries from motor vehicle crashes among children ages 14 years and younger are influenced by Florida's ability to maintain a strong Safe Kids Coalition and Chapter network. The Injury Prevention Program is the lead agency for Safe Kids Florida, the statewide organization. Florida has a Safe Kids presence in 36 of the 67 counties and covers 81 percent of the children ages 19 and under. In 2008, the childhood unintentional injury fatality rate in Safe Kids counties was 31 percent lower than the rate in non-Safe Kids counties which corresponds to 106 fewer deaths than expected had the fatality rate been the same as non-Safe Kids counties. Safe Kids conducts community activities that provide education on prevention of children's unintentional injuries. Child passenger safety education and child safety seat check ups events are a regular Safe Kids' activity.

/2013/ In 2010, the childhood unintentional injury fatality rate in Safe Kids counties was 30 percent lower than the rate in non-Safe Kids counties which corresponds to 104 fewer deaths than expected had the fatality rate been the same as non-Safe Kids counties. //2013//

/2014/ In 2011, the childhood unintentional injury fatality rate in Safe Kids counties was 28 percent lower than the rate in non-Safe Kids counties which corresponds to 110 fewer deaths than expected had the fatality rates been the same. //2014//

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

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

/2014/ The hospitalization rate per 100,000 of all non-fatal injuries among children aged 14 years and younger was 181.6 per 100,000 in 2011, a 3.4 percent decrease from the 2010 rate of 187.9 per 100,000. //2014//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	23.1	22.7	21.3	19.8	9.4
Numerator	797	777	695	649	312
Denominator	3449949	3422460	3261716	3274059	3314695

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Numerator is just first six months of data for 2012.

Narrative:
The rates of all non-fatal injuries and non-fatal injuries from motor vehicle crashes among children ages 19 years and younger are influenced by Florida's ability to maintain a strong Safe Kids Coalition and Chapter network. The Injury Prevention Program is the lead agency for Safe Kids Florida, the statewide organization. In 2008, the childhood unintentional injury fatality rate in Safe Kids counties was 31 percent lower than the rate in non-Safe Kids counties which corresponds to 106 fewer deaths than expected had the fatality rate been the same as non-Safe Kids counties. Safe Kids conducts community activities that provide education on prevention of children's unintentional injuries. Child passenger safety education and child safety seat check ups events are a regular Safe Kids' activity.

/2013/ In 2010, the childhood unintentional injury fatality rate in Safe Kids counties was 30 percent lower than the rate in non-Safe Kids counties which corresponds to 104 fewer deaths than expected had the fatality rate been the same as non-Safe Kids counties. //2013//

/2014/ In 2011, the childhood unintentional injury fatality rate in Safe Kids counties was 28 percent lower than the rate in non-Safe Kids counties which corresponds to 110 fewer deaths than expected had the fatality rates been the same. //2014//

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

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

/2014/ The hospitalization rate per 100,000 of non-fatal-injuries due to motor vehicle crashes among children aged 14 years and younger decreased every year from 2008 to 2011, from 23.1 in 2008 to 19.8 in 2011, a decrease of 14.3 percent. //2014//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 04C - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	140.9	128.0	115.9	112.6	60.9
Numerator	3412	3090	2825	2751	1504

Denominator	2421365	2413540	2437270	2442802	2471366
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Numerator is just first six months of data for 2012.

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

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

/2014/ Data for 2011 show a rate of 112.6 per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years. This represents a decrease of 3 percent from the rate of 115.9 per 100,000 in 2010 and a 12 percent decrease from the rate of 128 per 100,000 in 2009. //2014//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	28.3	33.8	33.5	32.3	30.9
Numerator	16737	19858	19554	18970	18160
Denominator	592198	588376	583708	588009	586777
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
Close examination of the disease distribution reveals that 80 percent of all reported cases of chlamydia are reported in populations 26 and under. Chlamydia trachomatis is the most prevalent sexually transmitted bacterial infection reported among persons age 15 to 24. The

highest rate among females was in the 20 to 24 age group (34.3 per 1,000); the rate for females in the 15 to 19 age group was slightly lower at 33.3 per 1,000 population. The high rates of chlamydia seen in females may be due to existing policy which places stronger emphasis on screening and treatment of chlamydia in women than in men.

/2014/ Provisional data for 2012 indicate a rate of 30.9 per 1,000 women aged 15 through 19 years with a reported case of chlamydia. The highest rate among females was in the 20 to 24 age group, with provisional data for 2012 indicating a rate of 36.6 per 1,000 with a reported case of chlamydia, which is greater than the rate of 34.9 per 1,000 in that age group for 2001. //2014//

Chlamydia trends and rates continue to rise in persons age 15 to19 in the state. Some of this rise may be explained by the increase in testing, improved access to care afforded to clients in clinics and county health departments, increase in electronic lab reporting, and shifting of testing technology to an more sensitive and specific test in the past two years. Additionally, increased disease awareness, HEDIS performance measures, and Healthy People 2020 benchmarks have prompted communities to increase screening in a population of sexually active females that has been previously underserved as well as uninsured.

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

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	9.0	10.9	11.3	11.5	12.2
Numerator	26631	31650	32588	34080	36360
Denominator	2951483	2916948	2888081	2956586	2974662
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

Reported chlamydia infections increase each year. Approximately 76,191 chlamydia cases were reported in 2011. Reported cases among female cases aged 20 through 44 years of age accounted for 45 percent (34,006) of all reported chlamydia cases in Florida. The number of cases in this cohort increased 4.4 percent from 2010 to 2011.

/2014/ A total of 77,854 chlamydia cases were reported in 2012. Reported cases among female cases aged 20 through 44 years of age accounted for 47 percent (36,360) of all reported chlamydia cases in Florida. The number of cases in this cohort increased 6.6 percent from 2011 to 2012. //2014//

National trends indicate chlamydia infections are most prevalent in women under the age of 25. When compared by quintiles the case rate of 34.9 per 1,000 among 20-24 year olds females is higher than any other age specific rate. The rate for females in the 15-19 age-groups was slightly lower at 32.3 per 1,000. Historically, chlamydia morbidity is low in females over the age of 30. Rates of infection in females under 30 were more than five times the rates of older women. The vast differences in the distribution of chlamydia infections by age are caused by higher biological susceptibility to STD infections, risky sexual behaviors, and a combination of other factors that leave adolescents and young adults disproportionately affected with chlamydia compared to older populations.

/2014/ Provisional data for 2012 indicate a case rate of 39.6 per 1,000 for women 20-24, which remains higher than any other age specific rate. The rate for females in the 15-19 age groups was lower, at 30.9 per 1,000. //2014//

The Bureau of STD supports the national screening criteria recommended by the Centers for Disease Control and Prevention. The bureau also aligns with revised Healthy People 2020 STD Objectives for chlamydia screening. The highest rates of chlamydia seen in females 20-24 in recent years may be due to existing policy, which places stronger emphasis on screening and treatment of chlamydia in women than in men.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	214962	136573	47291	1844	8811	307	20136	0
Children 1 through 4	859842	546292	189162	7376	35246	1216	80550	0
Children 5 through 9	1102167	714578	239074	8349	53999	1470	84697	0
Children 10 through 14	1137725	751148	244151	5601	47074	1403	88348	0
Children 15 through 19	1207071	804515	261710	10388	52540	1464	76454	0
Children 20 through 24	1264295	855590	261393	10888	68857	1433	66134	0
Children 0 through 24	5786062	3808696	1242781	44446	266527	7293	416319	0

Notes - 2014

Narrative:
Population estimates for 2011 show there were 5,798,317 children younger than 24. Of that number, 4,298,316 (74.1 percent) are white and 1,274,976,154 (22 percent) are black. Florida only gathers race data categorized as race white, black, or other. Estimates for other racial groups are based on proportion of 2010 deliveries in that racial group. Of all children up through age 24, there were an estimated 13,670 American Indians or Native Alaskans (0.24 percent), 81,875 Asians (1.4 percent), and 2,235 Native Hawaiians or other Pacific Islanders (0.04 percent). A total of 127,245 (2.2 percent) reported more than one race. There were no significant changes in the percentages for each race when broken down by the specific age groups listed on Form 21.

/2014/ Population estimates for 2012 show there were 5,786,061 children younger than 24. Of that number, 3,808,696 (65.8 percent) are white and 1,242,781 (21.5 percent) are black. Florida only gathers race data categorized as white, black, or other. Estimates for other racial groups are based on the proportion of 2011 deliveries in that racial group. Of all children through age 24, there were an estimated 44,445 American Indians or Native Alaskans (0.77 percent), 266,528 Asians (4.8 percent), and 7,293 Native Hawaiians or other Pacific Islanders (0.13 percent). A total of 416,319 (7.2 percent) reported more than one race. There were no significant changes in the percentages for each race when broken down by the specific age groups listed on Form 21. While the population of Florida continues to grow more diverse, the significant changes from the previous year's estimates is probably due to more accurate reporting and more people describing themselves as more than one race. //2014//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	152019	57016	0
Children 1 through 4	604805	264090	0
Children 5 through 9	777340	317695	0
Children 10 through 14	813639	317355	0
Children 15 through 19	870271	331410	0
Children 20 through 24	917861	1627291	0
Children 0 through 24	4135935	2914857	0

Notes - 2014

Narrative:
Florida does not gather data on the number of Hispanics. In order to complete HSI #06B the Florida Department of Health, Office of Planning, Evaluation, and Data Analysis provided projections for the 2011 population of 0-24 year olds by race-ethnicity. According to those projections, of the 5,798,317 children 24 or younger, 1,544,437 (26.6 percent) are identified as Hispanic or Latino.

/2014/ According to 2012 population projections, of the 5,786,061 children 24 or younger,

1,627,291 (28 percent) are identified as Hispanic or Latino. //2014//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	186	91	91	0	1	0	2	1
Women 15 through 17	4193	2520	1500	9	12	1	113	38
Women 18 through 19	11651	7300	3885	23	48	6	280	109
Women 20 through 34	163616	116343	37483	225	4660	205	2358	2342
Women 35 or older	32734	24173	5923	45	1546	33	397	617
Women of all ages	212380	150427	48882	302	6267	245	3150	3107

Notes - 2014

Narrative:
When compared to whites, black women account for a disproportionate number of births at younger ages. While provisional data for 2011 indicate that 65.8 percent of the total births were white and 21.5 percent were black, births to women less than 15 were 52.1 percent white and 42.1 percent black. Births to women 15 through 17 were 57.6 percent white and 38.4 percent white. Births to women 18 through 19 were 62.5 percent white and 34.3 percent black. White and black women 20 through 34 were broken down by race at percentages similar to the total births, with white women accounting for 71.7 percent of the births and black women 22.7 percent of the births in that age category. White women account for a slightly disproportionate number of births to women 35 or older, where 74.5 percent of the births were white and 17.5 percent were black.

/2014/ Provisional data for 2012 indicate there were 212,380 total live births in Florida. Of the 2012 provisional total, 150,427 were white (70.8 percent), 48,882 were black (23 percent), 302 were American Indian or Native Alaskan (0.14 percent), 6,267 were American Indian or Native Alaskan (3 percent), and 245 were Native Hawaiian or Other Pacific Islander (0.12 percent). More than one race was reported for 3,150 births (1.5 percent) and 3,107 births were other or unknown (1.5 percent).

Of the total births, women younger than 15 had 186 babies (0.09 percent of the total), women 15 through 17 had 4,193 babies (2 percent), women 18 through 19 had 11,651 babies (5.5 percent), women 20 through 34 had 163,616 babies (77 percent), and women 35 or older had 32,734 babies (15.4 percent).

When compared to whites, black women account for a disproportionate number of births at younger ages. While 70.8 percent of the total births were white and 23 percent were black, births to women less than 15 were 49 percent white and 49 percent black. Births to women 15 through 17 were 60.1 percent white and 35.8 percent white. Births to women 18 through 19 were 62.7

percent white and 33.4 percent black. White and black women 20 through 34 were broken down by race at percentages similar to the total births, with white women accounting for 71.1 percent of the births and black women 22.9 percent of the births in that age category. White women account for a slightly disproportionate number of births to women 35 or older, where 73.8 percent of the births were white and 18 percent were black. //2014

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	130	55	1
Women 15 through 17	2877	1296	20
Women 18 through 19	8537	3057	57
Women 20 through 34	118865	43582	1169
Women 35 or older	22689	9761	284
Women of all ages	153098	57751	1531

Notes - 2014

Narrative:
Of the 212,699 births in 2011 (provisional), 152,945 (71.9 percent) were not Hispanic or Latino, 58,584 (27.5 percent) were Hispanic or Latino, and 1,170 (0.6 percent) were ethnicity not reported.

/2014/ Of the 212,380 births in 2012 (provisional), 153,098 (72 percent) were not Hispanic or Latino, 57,751 (27.2 percent) were Hispanic or Latino, and 1,531 (0.7 percent) were ethnicity not reported. //2014//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	1280	686	518	1	9	1	43	22
Children 1 through 4	240	153	70	2	3	0	8	4
Children 5 through 9	131	85	39	0	1	0	5	1
Children 10 through 14	147	98	42	1	1	0	4	1
Children 15 through 19	584	396	170	0	3	0	8	7

Children 20 through 24	1077	720	314	3	12	0	16	12
Children 0 through 24	3459	2138	1153	7	29	1	84	47

Notes - 2014

Narrative:
Of the 3,577 in 2011 total deaths to children 24 and younger, 2,138 (59.8 percent) were white, 1,241 (34.7 percent) were black, 5 were American Indian or Native Alaskan (0.14 percent), 41 were Asian (1.1 percent), 101 were more than one race reported (2.8 percent), and 51 (1.4 percent) were other or unknown. There were 1,344 deaths from birth to age 1, white infants accounted for 681 deaths (50.7 percent) and black infants accounted for 573 deaths (42.6 percent) in that age category, yet black infants account for just 22.9 percent of infants 0-1. Black children account for 22 percent of the population in all other ages groups on this form, yet they account for 31.6 percent of the deaths in children 1 through 4; 33.3 percent of the deaths in children 5 through 9; 28.2 percent of the deaths in children 10 through 14: 26.5 percent of the deaths in children 15 through 19: and 31.2 percent of the deaths in children 20 through 24. Overall, in children from birth through 24, black children account for 22 percent of the population, and 34.7 percent of the deaths. In contrast, white children account for 74 percent of the population from birth through 24, but only 59.8 percent of the deaths.

/2014/ Of the 3,459 in 2012 total deaths to children 24 and younger, 2,138 (61.9 percent) were white, 1,153 (33.3 percent) were black, 7 were American Indian or Native Alaskan (0.2 percent), 29 were Asian (0.8 percent), 1 was Native Hawaiian or other Pacific Islander (0.03 percent), 84 were more than one race reported (2.4 percent), and 47 (1.4 percent) were other or unknown. There were 1,280 deaths from birth to age 1, white infants accounted for 686 deaths (53.6 percent) and black infants accounted for 518 deaths (40.5 percent) in that age category, yet black infants account for just 23 percent of infants 0-1. Black children account for 21.5 percent of the population in all other ages groups on this form, yet they account for 29.2 percent of the deaths in children 1 through 4; 29.8 percent of the deaths in children 5 through 9; 28.6 percent of the deaths in children 10 through 14: 29.1 percent of the deaths in children 15 through 19: and 29.2 percent of the deaths in children 20 through 24. Overall, in children from birth through 24, black children account for 21 percent of the population and 34.7 percent of the deaths. In contrast, white children account for 65.8 percent of the population from birth through 24, and 61.8 percent of the deaths. //2014//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	966	292	22
Children 1 through 4	182	56	2
Children 5 through 9	95	35	1
Children 10 through 14	103	43	1
Children 15 through 19	458	126	0
Children 20 through	873	203	1

24			
Children 0 through 24	2677	755	27

Notes - 2014

Narrative:
Of the 3,637 total deaths to children 24 and younger, 2,877 (79 percent) were not Hispanic or Latino. Of the total deaths, 754 (20.8 percent) were Hispanic or Latino, even though children of those ethnicities account for 26.3 percent of the children 0 through 24. Hispanic or Latino infants account for 28.9 percent of infants from birth to 1, but only 22.9 percent of the infant deaths.

/2014/ Of the 3,459 total deaths to children 24 and younger, 2,677 (77.4 percent) were not Hispanic or Latino. Of the total deaths, 755 (21.8 percent) were Hispanic or Latino, even though children of those ethnicities account for 28.1 percent of the children 0 through 24. Hispanic or Latino infants account for 26.5 percent of infants from birth to 1, but only 22.8 percent of the infant deaths. //2014//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	4521766	2953106	981388	33557	197670	5860	350185	0	2012
Percent in household headed by single parent	16.2	15.8	24.3	8.9	5.3	0.6	3.8	0.0	2012
Percent in TANF (Grant) families	1.2	0.6	2.4	0.4	0.0	2.9	0.2	0.2	2012
Number enrolled in Medicaid	2267721	659224	656117	4831	24832	0	42	922675	2012
Number enrolled in SCHIP	359239	119347	40059	138	5249	866	8769	184811	2012
Number living in foster home care	16052	10056	4908	36	18	9	922	103	2012
Number enrolled in food stamp program	1794960	797268	585384	3473	8183	5192	23511	371949	2012
Number enrolled in WIC	410936	109101	118263	665	3286	286	12508	166827	2012
Rate (per 100,000) of juvenile crime arrests	2134.5	2134.5	4624.2	232.4	164.4	1962.4	2134.5	2134.5	2012

Percentage of high school drop-outs (grade 9 through 12)	1.9	1.4	3.1	2.4	0.6	2.2	1.3	1.3	2012

Notes - 2014

Narrative:
/2014/ Of children 19 and younger in Florida, 16.2 percent live in a household headed by a single parent and among these 15.8 percent are white and 24.3 percent are black. About 1.2 percent of all children in Florida live in families that receive Temporary Assistance for Needy Families (TANF) grants and of these children 0.6 percent are white and 2.4 percent are black. There are 2,267,721 children 19 and younger on Medicaid, of which 659,224 are white and 656,117 are black. A total of 359,239 children are enrolled in SCHIP of which 119,347 are white and 40,059 are black. Of the 16,052 children 19 and younger in foster care, 10,056 are white and 4,908 are black. A total of 1,794,960 children are enrolled in the food stamp program. Of these, 797,268 are white and 585,384 are black. The rate for juvenile crime arrest in Florida is 2,134 per 100,000, with a rate of 1,712 per 100,000 for whites and 4,624 per 100,000 for blacks. In Florida, 1.9 percent of all children are high school dropouts with 1.4 percent being white and 3.1 percent being black. Numbers or estimates for other races can be found on Form 21, #09A. //2014//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	3218074	1287566	0	2012
Percent in household headed by single parent	8.7	15.1	0.0	2012
Percent in TANF (Grant) families	1.4	0.7	0.0	2012
Number enrolled in Medicaid	1634035	682174	144432	2012
Number enrolled in SCHIP	359239	116296	242943	2012
Number living in foster home care	10796	2356	57	2012
Number enrolled in food stamp program	1183013	611947	0	2012
Number enrolled in WIC	244109	166827	0	2012
Rate (per 100,000) of juvenile crime arrests	2563.0	1090.1	0.0	2012
Percentage of high school drop-outs (grade 9 through 12)	1.9	1.9	1.9	2012

Notes - 2014

Narrative:
/2014/ Of children 19 and younger identified as Hispanic or Latino, 15.1 percent live in a household headed by a single parent. About 0.7 percent of Hispanic or Latino children live in TANF families, compared to 1.4 percent of children who are not Hispanic or Latino. Of the 2,267,721 children 19 and younger on Medicaid, 682,174 are Hispanic or Latino. Of the 359,239 children enrolled in SCHIP, 116,296 are identified as Hispanic or Latino. Of the

16,052 children 19 and younger in foster care, 2,356 are Hispanic or Latino. Hispanic or Latino children account for 611,947 of the 1,794,960 children in the food stamp program. Of the 410,936 children in WIC, Hispanic or Latino children account for 166,827 of the total. The rate for juvenile crime arrest for Hispanic or Latino children is 1,090 per 100,000. About 1.9 percent of Hispanic or Latino children are high school dropouts. //2014//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	0
Living in urban areas	4194708
Living in rural areas	286818
Living in frontier areas	0
Total - all children 0 through 19	4481526

Notes - 2014

Narrative:
/2012/ In Florida, 4,324,937 children 19 and younger live in urban areas, and 300,665 live in rural areas. //2012//

/2014/ In Florida, 4,194,708 children 19 and younger live in urban areas, and 286,818 live in rural areas. //2014//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	18934175
Percent Below: 50% of poverty	7.4
100% of poverty	21.9
200% of poverty	37.6

Notes - 2014

Narrative:
/2012/ Of the 18,819,000 people living in Florida, we estimate that 5.7 percent live below 50 percent of the federal poverty level. Approximately 15.6 percent live below 100 percent of the federal poverty level, and 35.3 percent live below 200 percent of the federal poverty level. //2012//

/2014/ Of the 18,934,175 people living in Florida, an estimated 7.4 percent live below 50 percent of the federal poverty level. Approximately 21.9 percent live below 100 percent of the federal poverty level, and 37.6 percent live below 200 percent of the federal poverty level. //2014//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	4481526
Percent Below: 50% of poverty	10.1
100% of poverty	26.9
200% of poverty	45.4

Notes - 2014

Narrative:
/2012/ Of the 4,625,602 children 19 and younger living in Florida, the department estimates that 7.9 percent live below 50 percent of the federal poverty level. Approximately 19.6 percent live below 100 percent of the federal poverty level and 43.1 percent live below 200 percent of the federal poverty level. /2012/

/2014/ Of the 4,481,526 children 19 and younger living in Florida, the department estimates that 10.1 percent live below 50 percent of the federal poverty level. Approximately 26.9 percent live below 100 percent of the federal poverty level, and 45.4 percent live below 200 percent of the federal poverty level. //2014//

F. Other Program Activities

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

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

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

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

Fetal and Infant Mortality Review: An information-gathering process designed to identify

deficiencies in the maternal and infant health care system. Through individual case review, local FIMR projects attempt to identify factors that may contribute to fetal and infant death.

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

Pregnancy Associated Mortality Review: A population-based surveillance and selective case review process aimed at reducing maternal mortality in Florida. The PAMR project monitors trends in pregnancy-associated deaths, and identifies gaps in care, service delivery problems, and areas in which communities can facilitate improvements in the service delivery system for women.

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

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

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

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

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

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

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

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

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

G. Technical Assistance

State performance measure issue #5, the percentage of infants back sleeping. The department requests assistance with developing survey questions for birthing hospitals to assess hospital staff knowledge, beliefs, and practices regarding safe sleep behaviors and survey questions for physicians to assess their safe sleep education to parents. Assistance is needed to increase the state's ability to meet its objectives, and decrease the number of sleep-related infant deaths.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2012		FY 2013		FY 2014	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	18672124	18672124	18904025		18920363	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	169216415	169216415	169390341		169402594	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	187888539	187888539	188294366		188322957	
8. Other Federal Funds *(Line10, Form 2)*	468939035	291513375	362324908		415342314	
9. Total *(Line11, Form 2)*	656827574	479401914	550619274		603665271	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2012		FY 2013		FY 2014	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	35454567	35454567	35775930		35781362	
b. Infants < 1 year old	4922680	4922680	5648831		5649689	

c. Children 1 to 22 years old	66193132	66193132	65938028		65913035	
d. Children with Special Healthcare Needs	62529306	62529306	62137141		62146575	
e. Others	0	0	0		0	
f. Administration	18788854	18788854	18794436		18832296	
g. SUBTOTAL	187888539	187888539	188294366		188322957	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		65357		66392	
c. CISS	0		0		0	
d. Abstinence Education	0		2787643		2829101	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	332767932		199194063		235279327	
h. AIDS	0		0		0	
i. CDC	13508355		15113250		14244365	
j. Education	0		0		0	
k. Home Visiting	0		0		0	
k. Other						
Other Funds					53893782	
USDA CACFP Grant					109029347	
others (see notes)	42141303		50072987			
USDA CACFP grant	80426801		95091608			

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2012		FY 2013		FY 2014	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	34195714	35698823	33892986		35781362	
II. Enabling Services	79101075	78913186	79083634		79095642	
III. Population-Based Services	25740730	24425510	26361211		24481984	
IV. Infrastructure Building Services	48851020	48851020	48956535		48963969	
V. Federal-State Title V Block Grant	187888539	187888539	188294366		188322957	

Partnership Total						

A. Expenditures

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

B. Budget

Federal funding through the Title V MCH Block Grant provides needed support to our statewide efforts. Of the $18,920,363 budgeted as the expected federal allotment for FY2014, $5,881,183 is budgeted for preventive and primary care for children (31.1 percent), $8,539,800 for children with special health care needs (45.1 percent) which meets the 30 percent requirements. In addition, $1,741,377 (9.2 percent) is budgeted towards Title V administrative costs. Total state match for FY2014 is $169,402,594, which exceeds the state's FY 1989 maintenance of effort amount of $155,212,322. Sources of other federal funds include the SSDI grant, Abstinence Education, WIC, CDC grant awards, the USDA CACFP grant, Florida's Medipass Waiver, Family Planning, TANF, School Health, and Preventive Health Services Block Grant. A complete list of other federal funds with funding amounts is included on Form 2 and the notes for Form 2. Budget numbers for Florida are included on forms 2, 3, 4, and 5.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.